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 26th January 2021

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, 26th JANUARY 2021, 2.00 – 3.45pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	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 24th November 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.05pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.10pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.25pm	3
2.4	Quality Dashboard (Q3)	Medical and Quality Director	2.35pm	4
3. Items for decision / approval				
3.1	GIDS - CQC report	Chief Executive/Medical and Quality Director and Divisional Director for Gender	2.45pm	5
4. Items for noting				
4.1	Guardian of Safer Working (Q3) Report	Medical and Quality Director	3.15pm	6
4.2	Serious Incidents Report (Q3)	Medical and Quality Director	3.25pm	7
5 Board Committee Reports				
5.1	Education and Training Committee	Committee Chair	3.35pm	8
5.2	Audit Committee	Committee Chair	3.40pm	9
6. Any other matters				
6.1	Any other business	All	3.45pm	
7. Date of Next Meeting				
	30th March 2021, 2.00pm – 4.00pm – Online / The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			

AGENDA Part 1

Board of Directors Meeting Minutes (Part 1)
24th November 2020, 1.30pm-4.10pm, via Zoom

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

AP	Item	Action to be taken	Resp	By
1.	1.3.1	Amendments to the minutes of the previous meeting	FF	Immed

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.

2. Operational items

2.1 Chair and non-executives' reports

2.1.1 Prof Burstow noted that he had emailededhe chair of the Integrated Care System Chair (ICS), Mike Cooke, regarding relocation.

2.1.2 The board of directors noted the report.

2.2 Chief executive's report

2.2.1 Mr Jenkins presented the report and highlighted:

Covid

- The Trust continues to proactively respond to the continuing rise in Covid indicators.
- In preparation of the next phase, divisional level planning had been completed as well as further assessments that included individual risk, team level risk, Infection, Prevention and Control (IPC) and estates planning.
- The decision was taken to stop all face-to-face teaching/training events and continue to limit the numbers of any clinical groups.
- Emergency Preparedness, Resilience and Response (EPRR) Gold command meets on a weekly basis to take stock of the changing situation and ensuring that any relevant information is shared as appropriate.
- Gloucester House had gone back to remote learning due to two members of staff and a pupil having tested positive.

2.2.2 Regarding Covid, Dr Sinha noted that work was in line with most other Trusts and that the challenges were around testing. The Trust would be receiving the lateral flow testing kits where staff will be expected to do the testing twice a week.

2.2.3 Responding to Mr Holt, Mr Jenkins noted that overall remote working has been effective and matches the needs of the organisation, however there is a concern about the impact on staff wellbeing as a result of a sustained lack of face to face contact with their colleagues. Longer term we will be looking at blended working arrangements.

2.2.4 Responding to Ms Sequeira, Dr Sinha noted that the Trust needs to ensure that it is giving staff clear messaging about what we know and do not know about the vaccination. There are different messages out there from local to national which may cause a degree of chaos.

2.2.5 Responding to Prof Bhugra, Mr Jenkins noted that Dr Caldwell is leading on the Covid vaccination in the North Central London (NCL) and the Trust would be able to easily get intelligence of when it was likely to be rolled out.

2.2.6 Dr Sinha noted that we would need to manage the Covid vaccination programme very carefully especially as there has to be a time lag between the flu vaccination which is still ongoing and the Covid vaccine

2.2.7 The board of directors noted the report.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- The Trust had made a forecast for H2/full year to NCL ICS of a net deficit of £2.3m, and the key assumptions underpinning this are set out in the report.
- If top-up payments and Covid19 income and costs were ignored, the Trust will forecast and underlying deficit of £5.3m.
- The Trust had lower levels of income and higher levels of non-staff costs. The lower income reflects in the shortfalls in short course and deferment of research projects.
- Non-staff costs are higher mainly in IT and relocation (some of which had had to be counted as revenue).
- The forecast assumes £450k of efficiencies which have yet to be identified. There are a number of material uncertainties within the forecast, namely the accrual for annual leave and the provision for legal costs.

2.3.2 Responding to Mr Levenson, Mr Noys noted that £2.8m of the additional income was the top-up and £600k was Covid income.

2.3.3 Responding to questions from Ms Farrow, Mr Noys noted that the legal costs were mostly for the Judicial Review and that there were no new legal costs, and that the annual leave accrual would be a significant amount that would need to be calculated.

2.3.4 Dr Hodges noted that usually staff are allowed to carry 5 days over, however when we signed up with NCL there was an agreement that if staff were forced to work during Covid, they could carry an additional 5 days.

2.3.5 Mr Holt noted that the Trust has to be careful that it is not seen as allowing staff to carry forward large quantities of leave as this could be deemed as not being considerate towards their health and wellbeing.

2.3.6 Mr Noys noted that as there was no system to see what leave staff have accrued, there would need to be an exercise to get this information.

2.3.7 Mr Kent noted that each service had a record of what leave staff have and that would be available.

2.3.8 The board of directors noted the report.

2.4 Quality Dashboard (Q2)

2.4.1 Dr Sinha presented the report and highlighted:

- There were positives from remote working as the DNA figures lowered although it was 10% higher than the last quarter.

- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthy.

- There was an improvement in data streams.

- There was a sharp increase in referrals between quarters one and two of 721.

- There were no notifiable incidents in this quarter relating to patient safety, and there were a healthy number of safeguarding alerts.

- Compliance with targets for first appointment and treatment appointment were mixed and, compliance with referral to treatment appointments increased across Camden CAMHS and other CAMHS but decreased in Adolescent services in particular those under 18 years of age.

- Complaints were paused in quarter one, and in quarter two 40 were received. There are challenges in catching up with the responses.

- Among the outcome measures Time 1 and Time 2 Goal Based Measure (GBM) completion rates have continued to decrease and both remain under target. Work is being done to improve GBM, Carenotes reminders and data completion.

- Workforce data – sickness absence rate is down; mandatory training was on hold for quarter one but has begun to increase in quarter two. Staff appraisal were also on hold in quarter one and are to be completed by the end of November 2020.

2.4.2 Responding to Dr Colson, Mr Kent noted that in they were looking into the wait times closely and were revising the contact/frequency of letters to patients from six weekly to three monthly, and were reviewing the clinical sessions by zoom/face-to-face. It is about trying to find the right balance.

2.4.3 Responding to Ms Farrow, Dr James noted that the figures in the report on complaints was higher and to her knowledge there was only one outstanding.

2.4.4 Dr Sinha noted that we need to think about how we look at the data and have dialogues with services/patients. The numbers are quite small and may have an impact on the overall percentage of the Trust. The challenge is waiting lists as well.

2.4.5 Prof Burstow suggested that a deep dive needed to be undertaken by Integrated Governance Committee (IGC) into the collection of data within the Trust and brought back to the board.

2.4.6 Responding to Dr Colson, Dr Sinha noted that DET have something more dynamic on what is topical and opportune. The long/short courses applications/completions/response times has a good impact. It was also very impressive on the equality work that was happening in DET.

2.4.7 Mr Rock noted that there are good outcomes for student enrolments and this surpassed achievement compared to last year. With the two big programmes the recruitment was slightly lower and will be working on the next recruitment cycle to get more students. International activity reduced due to the pandemic and the outturn this financial year it was on track on the forecast of income due to digital delivery.

2.4.8 The board of directors noted the report.

3. Items for discussion

3.1 Quality Account 2019/20

3.1.1 Ms Shipman was in attendance for this report and presented the report and highlighted:

- This year due to the pandemic the timescales were amended with NHS England/NHSI recommending publication to NHS Choices by 15th December 2020.

- The report was reviews by Integrated Governance Committee in September and by the Audit Committee in October who requested confirmation about the 'dropout rate' in the waiting times quality priority, and some further explanation for the reduction in patient improvement for the Goal Based Measure (GBM) outcome measure to 22% compared with 57% in 2018/19.

- Analysis and narrative is provided within the report in respect to Key Performance Indicators and CQUINS.

- The report presents the Trust Quality Priorities to be measured in the year 2020/2021.

- No External Auditor statement is required this year as a result of the pandemic, and positive statements have been received and included in the report from our Commissioners, Camden Local Authority, Healthwatch and Trust Governors.

3.1.2 Mr Jenkins noted that the Quality Accounts are part of the Trust's public accounting.

3.1.3 Ms Shipman informed the board that the naming of the Operations Board on the Flows of Assurance map was to be amended.

3.1.4 Mr Jenkins thanked Ms Shipman and her team for their work into pulling this altogether.

3.1.5 The board of directors noted the report, and approved the Quality Accounts for submission.

4. Items for decision

4.1 Freedom to Speak Up Report (FTSUG)

4.1.1 Mr Sumpton was in attendance for this and, presented the report and highlighted:

- He was appointed into the role in January 2020 replacing Ms Rusbridger.
- Since being in post the themes of concern have been around patient care/safety, bullying/harassment/behaviour and staff safety/care or a combination.
- Overall, there had been one formal whistleblowing complaint that had been raised through the FTSUG for which there is a current investigation in progress.
- The Trust scored as one of the highest ranked in the FTSUG index report for 2019 which is based on four questions in the NHS Annual Staff Survey (2018).
- The 2020 results showed a decline which was a source of concern. Behind this there appeared to be issues around communication and a lack of trust/confidence by some staff to raise concerns.
- Mr Sumpton attended the Race Equality Network (formerly the BAME Network). There had been particular concerns expressed that some staff from BAME backgrounds in the Trust do not believe that they will be listened or that the information they provide would be acted upon. This was a very important issue for the Trust to address.
- It would be helpful for the board, senior leadership team and FTSUG to consider a plan for how to keep 'speaking up' at the forefront of the Trust's agenda and to promote the important Trust values of valuing staff wellbeing and embracing diversity.

4.1.2 Responding to Prof Bhugra, Mr Sumpton noted that due to the pandemic he was unable to see staff in the physical way as he had taken up post just prior to the pandemic. Service leadership have invested in this role, however working three and three quarter hours a week was not enough. Having more time will allow the new FTSUG to get out more messages.

4.1.3 Responding to Dr Colson, Mr Sumpton noted that the Trust would need to adopt early intervention model to address issues with staff to give them the confidence to raise concerns.

4.1.4 Responding to Ms Farrow, Mr Sumpton noted that the Trust was taking the right approach however it will take time to make progress. Constant communications should be key to giving staff messages that it is safe to talk or raise concerns.

4.1.5 Mr Kent thanked Mr Sumpton for all the work with TAP in his FTSUG role and that managers embodied a way of speaking in a direct way.

4.1.6 Dr Sinha and Dr Hodges both thanked Mr Sumpton for the work done and the energy he brought to the role and being accessible.

4.1.7 Dr Sinha added that listening to what Mr Sumpton had said, it would be beneficial in empowering middle management to become the agents of change. Dr Hodges noted that there is an opportunity with the Strategic Review to do this.

4.1.8 Responding to Mr Levenson, Mr Sumpton noted that he recommended mandatory training about speaking up as it is important. He added that 'everything is a FTSUG issue and then it is decided which door it needs to go through'. The 40 cases in the report, this is based on the London Ambulance Service and compared to this the Trust is doing pretty well. A lot of work has been done on the process and procedures and now it is about how staff relate to this.

4.1.9 Mr Jenkins thanked Mr Sumpton for all his hard work and appreciated his directness. The role of middle management in dealing with this will be crucial.

4.1.10 Prof Burstow noted that there are a number of issues that as a Trust need to address and how we achieve this. The Strategic Review is to add capacity for middle management to help address the perception in para 3.9 that there are 'untouchables' within the organisation. That the board should lead by example an do the mandatory training. In relation to para 4.1, the Trust would also need to look at a way in which to reward and recognise this role in the future and consider the recommendation made by Mr Sumpton.

4.1.11 Prof Burstow thanked Mr Sumpton for his work and a well led discussion today.

4.1.12 The board noted its thanks to Mr Sumpton.

4.1.13 The board of directors noted the report.

5. Items for discussion

5.1 Education and Training Annual Complaints Report

5.1.1 Ms Bratt was in attendance for this.

5.1.2 Ms Bratt presented the report and noted that there was one correction. Point 2.2, should be nine formal and 3 informal that went to Mr Jenkins and one to Internal Audit.

5.1.3 Responding to Dr Colson, Ms Bratt noted that in relating to GDPR there was more than one complaint around confidentiality and how we were processing the data on CPD courses. The data is reported to Health Education England (HEE) and on the equalities data, a lot of students ticked 'prefer not to say'. We have made changes to the data collection.

5.1.4 The board of directors noted the report.

5.2 Board Assurance Framework (BAF)

5.2.1 Mr Jenkins presented the report and highlighted:

- Risk 10b – the 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.

5.2.2 Mr Holt suggested that this item should be brought back to the board for a fuller debate after the Strategic Review in March/April 2021 with the Risk Appetite.

5.2.3 Prof Burstow noted that this could be done at the Board Seminar and that we could look at what other Trusts are doing.

5.2.4 The board noted the report.

5.3 Operational Risk Register (Q2)

5.3.1 Ms Shipman was in attendance for this item and presented the report.

5.3.2 The board noted the report.

5.4 Guardian of Safer Working Report (Q2)

5.4.1 Dr Sinha presented the report.

5.4.2 The board noted the report.

5.5 Serious Incidents Report (Q2)

5.5.1 Dr Sinha presented the report and noted that it was a reasonable period in quarter two.

5.5.2 Dr Sinha noted that he had a call with the CQC inspectors later in the week on the incident.

5.5.3 The Board noted the report.

5.6 NHS People Plan Report

The item was not discussed and will be taken forward to another Board meeting as the Director of HR and Corporate Governance was seconded to NHS England and NHS Improvement to the Covid vaccination programme.

5.7 Race Equality Strategy

5.7.1 Mr Jenkins noted that work is being done on developing a Story Board as a refresh of this and will be seeking views/consultations across the Trust.

5.7.2 A RES Steering Group is being started to have oversight of the work to steer this refresh and the first meeting will be taking place on 25th November. After this meeting we aim to get a document out for sign off at the extra-ordinary board meeting on 15th December 2020.

5.7.3 We have focused on this agenda since 2017 and we have not yet made sufficient progress.

5.7.4 A draft document will be shared together with a long hand strategy and the story board.

5.7.5 The board noted the report.

5.8 EU Exit

5.8.1 Mr Noys presented the report and highlighted:

- The Trust is not aware of any significant or critical EU Exit related issues.

5.8.2 Responding to Mr Holt, Dr Sinha noted that the cost impact of treatment does not impact on community settings.

5.8.3 The board noted the report.

6. Board Committee Reports

6.1 Education and Training Committee

6.1.1 The board of directors noted the report.

6.2 Equality, Diversity and Inclusion Committee

6.2.1 The board of directors noted the report.

6.3 Integrated Governance Committee

6.3.1 Dr Sinha noted that the RAG rating of risks will be standardised across all the committees of the Trust.

6.3.2 Prof Burstow noted that the meeting had changed in terms of how business is conducted and that there is now a better balance between historic assurance and the prospective identification of issues. He thanked Dr Sinha and Dr Colson.

6.3.3 The board noted the report.

6.4 Audit Committee

6.4.1 Mr Holt noted that there was a full agenda at the last meeting. There was an in-depth look into the Finchley Road overspend and recommendations were made. There was constructive discussions around this.

6.4.2 Mr Jenkins noted the Mr Noys had taken action to strengthen the resource in estates.

6.4.3 The board noted the report.

7. Any other matters

7.1 Any other business

7.1.1 Prof Burstow informed the Non-Executive Directors that there would be a meeting of EARC after the board meeting.

7.1.2 The board of directors noted this.

8. Date of next meeting

8.1 26th January 2021 at 2.00pm

8.1.1 The meeting closed at 4.05pm.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	26th January 2021

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. GIDS Judicial Review

1.1 We have been responding to the impact of the JR judgment and change in NHS England's specifications. A key part of this is planning for the clinical review of cases of existing patients currently receiving endocrine treatment or very recently referred to clinics. This will be in advance of decisions to seek best interest orders in cases where a clinical decision has been taken to continue treatment.

1.2 We aim to start these reviews by the end of the month.

1.3 We learnt on 18th January that we had been successful in our application to seek permission to appeal against the JR judgment. It is not yet clear when an appeal will be heard.

2. Race Equality

2.1 We are continuing to work with the Race Equality Strategy Steering Group to develop a refresh of our Race Equality Strategy. The group, which I co-chair with Irene Henderson the Trust's Race Equality Champion, is proving an effective way of taking this work forward.

2.2 The Group has now signed off an updated specification to appoint an external agency to conduct a review into the culture of the Trust and experiences of BAME staff. This will be going out very shortly and a sub-group of the Steering Group will be involved in appointing an agency to carry out the work.

2.3 The Group will also play a key role in helping to lead consultation across the organisation around the development of the strategy.

2.4 My aim would be to bring a refreshed strategy to the Board by no later than the May Board meeting.

3. Current Covid Position

3.1 The health and social care system continues to struggle from the ongoing wave of the pandemic. The numbers of admissions to acute hospitals have meant that the use of surge capacity across inpatient settings has been required. The situation also led to the opening up of the Nightingale facility for both management of cases and vaccination. On a more positive note, recent data suggests that London may now have passed the

peak of this wave and several key lead indicators have shown a downward trend in the last week.

3.2 The Trust continue to deliver all its services, including in clinical settings using a mixed model of delivery, flexing face to face delivery as needed. We continue to monitor safety and keep to infection prevention and control (IPC) requirements in our settings using a number of SOPs. The Trust Level Gold command EPRR continues to meet on a once weekly basis. Our educational service delivery has remained primarily remote through this quarter.

3.3 Various senior executives are also involved in system calls and actions to ensure continuing delivery of services. The Trust seeks to respond to calls for support from acute and MH provider Trusts and the emergency CAMHS pathway.

4. Vaccination

The Joint Committee on Vaccination and Immunisation (JCVI) has advised that the first priorities for any COVID-19 vaccination programme should be the prevention of COVID-19 mortality and the protection of health and social care staff. The Trust has been organisationally linked with the Royal Free Hospital for the purpose of vaccination. Staff have been booking onto vaccination links provided by RFH. We have also recently agreed more ad hoc arrangements with other vaccination hubs, including CLCH and there is potential for other such opportunities in the coming weeks.

The priority has been to vaccinate front-line staff, but everyone who works for the Trust, including bank staff, student placements, contractors and visiting lecturers will be included in vaccination opportunities. We have now been able to make the vaccine locally available to staff based in Bristol and Birmingham and hope to be able to be able to do the same for staff in Leeds very soon. Our aim remain to allow staff to have as many possibilities of accessing vaccination, as possible.

5. Registration with the Office for Students

5.1 We have learnt at the end of December that our application to be registered with the Office of Students, the official regulator of Higher Education had been successful.

5.2 Being included on the register of providers brings a number of key opportunities and benefits for the Trust and our education activities. It shows recognition that our courses are well-designed, and deliver a high-quality academic experience. It shows that our awards will hold value over time. It also confirms that we have the management, governance and financial resources available to deliver our courses as advertised. The Tavistock and Portman is unique among NHS providers in our

approach to education and training, and we are the first NHS Trust to be listed on the OfS register.

5.3 For the Trust as a sponsor of international students, being on the register brings additional benefits. To date, without being listed on the OfS register, our permissions as a sponsor of international students have been more limited. For example, our international students have had limited opportunities to find work while studying with us. We have been limited in the duration of studies that international students can take with us as sponsor – an important factor given that our routes of study often require several years to complete. Now that we are included on the OfS register, these restrictions no longer apply going forwards – news which is especially welcome in the wake of Brexit and the recent changes to immigration rules. We will be working with our current international students to ensure they receive the correct advice and, where possible, we will ensure they can also benefit from these changes.

5.4 Achieving this status has taken significant preparation and effort to demonstrate our eligibility. In particular I would like to thank Brian Rock and colleagues in the DET Training Executive, along with Simon Carrington and Bhavna Tailor.

Paul Jenkins
Chief Executive
21st January 2021

Report to	Date
Board of Directors	26 January 2021

RESULTS FOR PERIOD ENDED 31 DECEMBER 2020

Executive Summary

This paper provides an overview of the results for the Year To Date period, December 2020. Key points to note are:

- Trust is showing a £106k positive net deficit variance compared with the plan submitted to NCL STP in September. YTD deficit is £951k (after £3.6m of top up payments).
- Income is higher than plan due, primarily, to higher than plan income from DET (notably long courses)
- Expenditure is also above plan reflecting higher levels of activity in DET; provisions for legal costs; and an increase in the accrual for annual leave
- Cash balances of £13m are 'inflated' by early receipt of block payments (a month in advance, whereas usually cash would be received in arrears)

Recommendation to the Board

The Board is asked to note the contents of the report

Trust strategic objectives supported by this paper

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 9 Dec-20

Section

Period 9
Dec-20

	20/21 Actual YTD £'000	20/21 Plan YTD £'000	Variance Actual v Plan £'000	Variance Actual v Budget %
Operating Income	40,323	39,239	1,084	**3%**
Top-up payments	3,615	3,505	110	
Total income	**43,938**	**42,744**	**1,194**	
Staff costs	(33,293)	(32,534)	(759)	**(2)%**
Non-staff costs	(9,989)	(9,677)	(312)	**3%**
Operational costs	**(43,283)**	**(42,211)**	**(1,072)**	**(3)%**
EBITDA	**656**	**533**	**123**	**19%**
- Margin	**2%**	1%		
Interest receivable	2	2	(0)	(14)%
Interest payable	(27)	(35)	8	(22)%
Depreciation / amortisation	(1,209)	(1,071)	(138)	13%
Public Dividend Capital	(372)	(486)	114	(24)%
Net surplus / (deficit)	**(951)**	**(1,057)**	**106**	
- Margin	**(2)%**	(3)%		

COMMENTARY

The Trust is currently showing a YTD deficit of £951k vs the NHSI revised Covid planned deficit of £1,057k
Educational income has been far less effected by Covid than was assumed in the plan

However this favourable income variance is offset, partially, by additional costs within Estates, IT and HR.

A greater level of Relocation expenditure is being expensed than planned, reflecting the move away from the PDPA approach and to an updated OBC

Some IT costs have been expensed, rather than capitalised, due to the capital cap imposed by NHSE/I, however, some of this may be reversed later in the year - depending upon total out-turn capital spend

Additional HR costs include the interim HR director and higher legal provisions, most notably relating to the Judicial Review appeal

The annual leave accrual has been increased by £358k

FINANCE AND PERFORMANCE REPORT **BALANCE SHEET**

Period 9

Dec-20

	Prior Year End £'000	YTD Dec-20 £'000	Comments
Intangible assets	95	60	
Land and buildings	20,755	22,612	
IT equipment	2,680	1,912	
Property, Plant & Equipment	23,435	24,524	
Total non-current assets	23,531	24,584	
Trade and other receivables	6,394	4,824	
Accrued Income and prepayments	3,177	5,253	
Cash / equivalents	9,761	13,333	Cash balances inflated by £4m, being block payments received in advance
Total current assets	19,332	23,410	
Trade and other payables	(2,867)	(3,366)	
Accruals	(3,524)	(4,995)	
Deferred income	(5,756)	(9,997)	Block payments on account
Long term loans < 1 year	(445)	(445)	ITFF loan - repayments within 1 year
Provisions	(72)	(72)	Pension provisions
Total current liabilities	(12,664)	(18,876)	
Total assets less current liabilities	30,198	29,118	
Non-current provisions	(322)	(415)	Legal cost provisons
Long term loans > 1 year	(3,110)	(2,888)	ITFF loan
Total assets employed	26,766	25,815	
Public dividend capital	(3,724)	(3,724)	
Revaluation reserve	(12,171)	(12,171)	
I&E reserve	(10,871)	(9,920)	
Total taxpayers equity	(26,766)	(25,815)	
	(0)	*(0)*	

MONTHLY FINANCE AND PERFORMANCE REPORT **0**

Period 9

Dec-20

	Cashflow	
	Actual Dec-20 £'000	Notes
Operating cashflows	(2,960)	Underlying operating shortfall
Top Ups / Covid Payments	3,615	Approved top-up funding and Covid revenue reimbursement
Cash flows from operating activities	**656**	
(Increase)/decrease in receivables	1,571	
(Increase)/decrease in other current assets	(2,076)	
Increase/(decrease) in trade and other payables	499	
Increase/(decrease) in other liabilities	5,712	Block payments received in advance - deferred
Increase/(decrease) in provisions	93	
All other movements in operating cash flows	(65)	
Net cash generated from / (used in) operations	**6,390**	
Cash flows from investing activities		
Interest received	2	
Purchase of property, plant and equipment	(2,298)	
Net cash generated from/(used in) investing activities	**(2,296)**	
Cash flows from financing activities		
Loans from Department of Health and Social Care - repaid	(222)	ITFF Loan repayment - Aug 20
HIE funding	0	
Interest paid	(17)	ITFF Loan interest - paid in Aug 20
PDC dividend (paid)/refunded	(282)	Payment to Oct 20, taken in Nov 20
Net cash generated from/(used in) financing activities	**(521)**	
Increase/(decrease) in cash and cash equivalents	**3,573**	
Cash and cash equivalents at start of period	9,761	
Cash and cash equivalents at end of period	**13,333**	
	0	

MONTHLY FINANCE AND PERFORMANCE REPORT
Period 9
Dec-20

Capital Expenditure Summary

PROJECT	YTD £000 Actual	Jan-Mar £000 Forecast	Full Year £000 Forecast	Comments
Endpoint Replacement	179	102	281	Includes capitalised laptop spend
Endpoint Procure/Config/Compliance/Monitor		62	62	Slippage likely
Cyber Essentials	-	12	12	
Health Information Exchange	134	-	134	Final "Go Live" end of Sep. (£60k) consultancy, £18k staff. Excludes potential STP funding £133k
SITS Project 20/21	97	4	101	
ICT Cyber Security Compliance	-	82	82	Slippage likely
DET Record Management System	(27)	-	(27)	Prior year adjustment
Scheduling & Robotic Process Automation	79	-	79	Project paused - £40k saving staff on Robotics, £50k saving staff Scheduling
IT	**462**	**262**	**724**	
Safety	-	35	35	
PC Compliance		10	10	New projects sanctioned to fill NCL capital slippage
TC Compliance		178	178	New projects sanctioned to fill NCL capital slippage
GH Compliance		119	119	New projects sanctioned to fill NCL capital slippage
Finchley Road	820	-	820	
BUDGET - PROJECTS CANCELLED	-	-	-	
ESTATES	**820**	**342**	**1,162**	
RELOCATION - Cost	778	632	1,410	NCL sanctioned increase in costs to deliver NHSI business case by Mar 21, slippage now likely
RELOCATION - Expense Transfer	(200)	(300)	(500)	Reduction in capitalisation rate based on analysis of spend
RELOCATION	**578**	**332**	**910**	
Digital Academy	185	21	206	Assumes £60k saving on internal costs for course development
DIGITAL ACADEMY	**185**	**21**	**206**	
Coronavirus	**177**	**117**	**294**	Approved costs - unclear on timing of capital reimbursement
TOTAL	**2,222**	**1,074**	**3,295**	

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: January 2021

Report to	Date
Board of Directors	26 January 2020

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q3 quality metrics for the Trust. The Commentary section provides service updates on waiting times and 'DNAs'. 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**:

- There has been a small increase of 60 referrals between Q2 and Q3 to 2377 with marked decreases specific to Other CAMHS, Adult Complex Needs and GIC and a gradual decrease in Adolescents. Regionally there has been a greater focus on acute mental health crises which may account for this.
- Compliance with targets for first appointment and treatment appointment were mixed. Camden Camhs and Other Camhs continued to see 90% of patients for first appointment within the contracted waiting time, but Adolescents compliance dropping back down to Q1 level at 79.5%. Compliance with referral to treatment appointments increased in Adolescent services but decreased across Camden Camhs and Other Camhs.
- Trustwide we continue to maintain a good DNA rate with overall compliance at 7.43%. This is the lowest rate for the last 8 quarters. GIC rates increased in Q2 and 3 despite text reminders continuing. Additional individual administrator contact with patients was refocused after Q1.
- The number of incidents reported in the Trust increased in Q3 to 74 from Q1&2
- Q3 saw a marked decrease in reported complaints compared to Q2, from 40 complaints to 15. The decrease was in both AFS and the Gender Services. Please note that the Q2 complaint data has been corrected – both CYAF and AFS data had been incorrectly transposed but is now showing correct details.
- Among our outcome measures, CORE improvement rates are now 77% against a target of 70%. The form reminder and collection process is under review to focus on improving return rates.
- The NHS Staff survey went ahead from Sept to Nov 2020. The Trust achieved its highest completion rate to date. Report information has been received and is being reviewed.
- The applications cycle for long courses in DET opens annually in November. Data shows the number of applications remain buoyant, despite the pandemic. Short course activity is showing an increase in the average number of students per activity from last year.

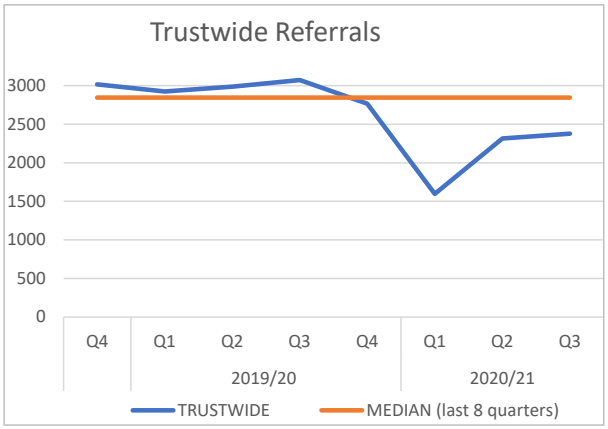
There are also details of continuing **Challenges**:

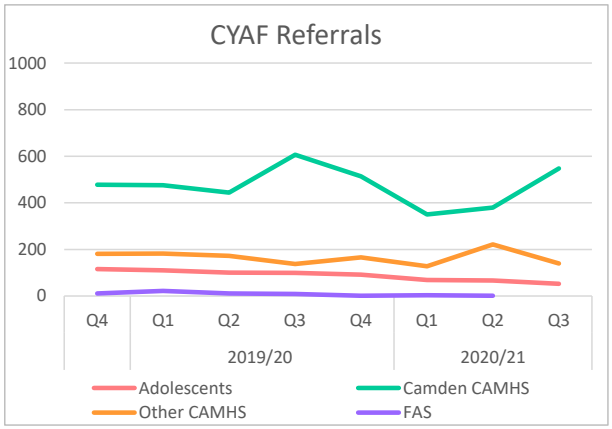
- Trust patient contacts decreased by a further 48 to 19 for Q3, with small increases in Camden CAMHS, Adult Complex Needs and FCAMHS.
- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthy. TAP has seen a continual drop in compliance from Q1 2019/20. It now stands at 7%. Adult Complex Needs waits have dropped in Q3 from referral to first appointment to 20% and referral to treatment to 25%.
- Outcome measures continue to remain a focus of work, as greater efforts are needed towards collection methods and staff engagement. Among our outcome measures Time 1 and Time 2 Goal Based Measure completion rates have increased slightly in Q3 but are based on low response numbers. Compliance continues to be under target. Work is being done to improve GBM Carenotes reminders and data completion.
- MHSDS collection rates are from September 2020 and continue to show an ongoing small decrease in ethnicity and accommodation status (adults). However, it should be noted that Adolescents, Camden Camhs, City & Hackney and Portman services all meet ethnicity data requirements and Adolescents and the Portman both have increasing trajectories for accommodation status data collection. Adult Complex Needs and Gender Services have both introduced different processes to verify data with patients to try and make improvements.
- HR information shows an increase in staff sickness in Q3 with Estates and Facilities staff having 9.91% sickness rate. Mandatory training compliance has been challenging though has been increasing in Q3 with the deadline for staff completion extended to 31 January 2021. A light touch staff appraisals process ran until Dec 2020. Not all data has been sent to HR to update compliance.
- There was a lot more media coverage in Q3 compared to the previous quarters. This related to the Judicial Review judgment handed down on 1 December 2020. Articles mainly held negative sentiments.

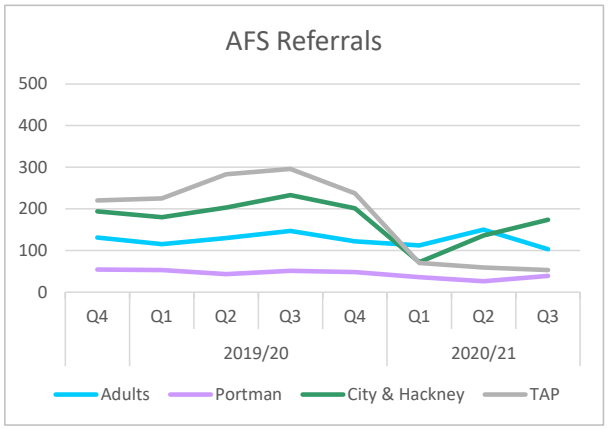
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.
Trust strategic objectives supported by this paper
Finance and Governance

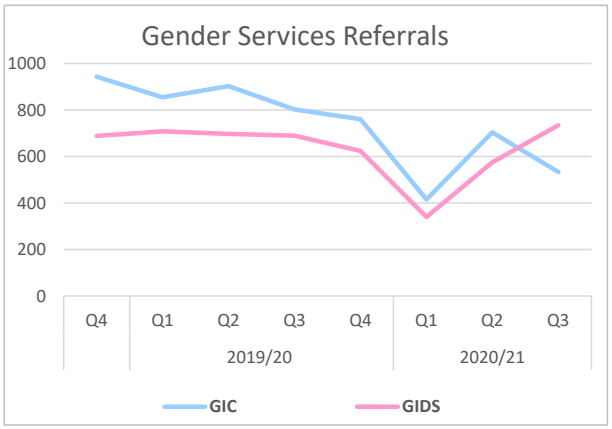
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q3 2020/21: Trust Reach – Access









Data source: Q3 data as recorded on 07/01/2021 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.

Number of Referrals Received:

In the data below we include 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, in Q2 those number have increased and now in Q3 there is a second slight increase. However, we are still under previous averages. In Q3 the trust received 2377 which is lower than the 2938 quarterly average number of referrals over the last financial year.

Adolescents: in Q3 received 52 referrals, 14 fewer than Q2 – the quarterly average of referrals received during last financial year was 100.

Camden CAMHS: in Q3 received 548, 169 more than in Q2. This is the second quarter where the number of referrals have increased. The quarterly average of referrals during last financial year was 510.

Other CAMHS: in Q3 received 139 referrals, 82 fewer than in Q2. The quarterly average of referrals during last financial year was 166.

Family Assessment Service: this service has been decommissioned.

Adults Complex needs: in Q3 received 103, 47 fewer than in Q2. The quarterly average number of referrals received during last financial year was 128.

Portman: in Q3 received 39, 13 more than in Q2. The quarterly average last financial year was 49.

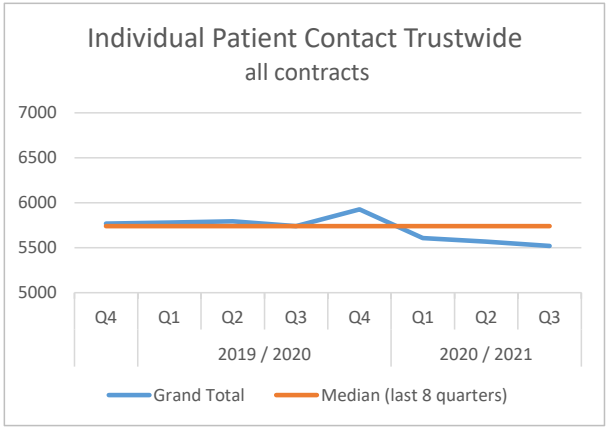
C&H PCPCS: in Q3 received 174, 38 more than in Q2. The quarterly average last financial year was 204.

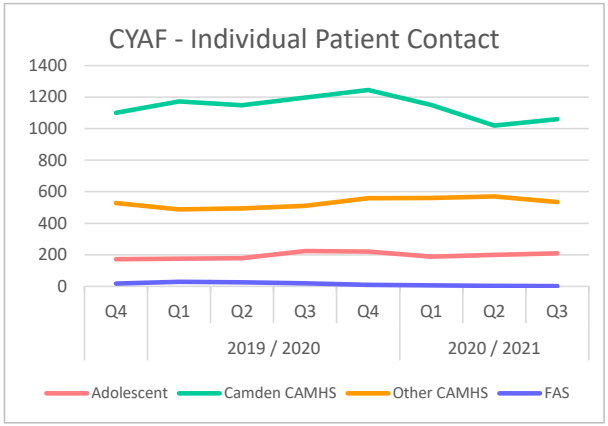
Team Around the Practice: in Q3 received 53, 6 fewer than in Q2. The quarterly average last financial year was 260.

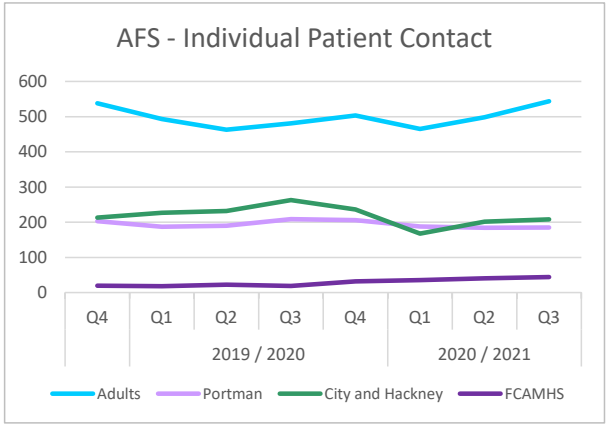
GIDS: in Q3 received 534, 170 fewer than in Q2. The quarterly average last financial year was 680.

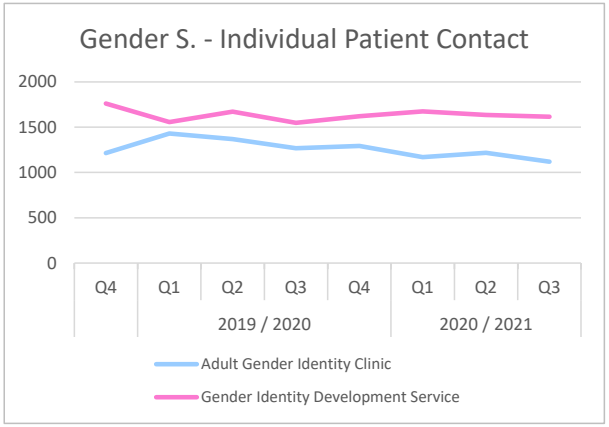
GIC: in Q3 received 735, 160 more than in Q2. The quarterly average last financial year was 830.

Q3 2020/21 : Trust Reach – Access









Data source: Q3 data as recorded on 07/01/2021 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.

Individual patients in contact with our services

In the data below 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 Q3 continued to be undertaken through the use of zoom. Q3 patient contact data is compared with Q2 and 2019/20 average quarterly contacts

Trust-wide, we saw a slight decrease in the individual number of patients seen in Q3. In Q2 the trust saw 5667 individual patients, and 5519 in Q3, which is 290 lower than the average number of contacts over the last financial year.

Adolescents: in Q3 saw 210 individual patients, 11 more than in Q2. The average of number of patient contacts during last financial year was 199 per quarter.

Camden CAMHS: in Q3 saw 1059 patients, 40 more than Q2. The average of number of patient contacts during last financial year was 1191 per quarter.

Other CAMHS: in Q3 had contact with 535 patients, 35 fewer than in Q2. The average of number of contacts during last financial year was 513 per quarter.

Family Assessment Service: : this service was decommissioned in December 2020.

Adults Complex Needs: in Q3 saw 544 patients, 46 more than in Q2. This is above the average of number of patient contacts during last financial year was 480 per quarter.

Portman: in Q3 had contacts with 185 patients, 1 more than in Q2. The average of number of patient contact during last financial year was 198 per quarter.

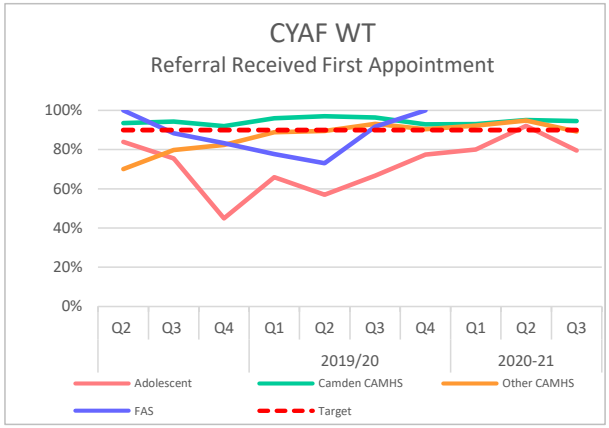
C&H PCPCS: in Q3 made contacts with 208 patients, 6 more than Q2. The average number of patient contact during last financial year was 239 per quarter.

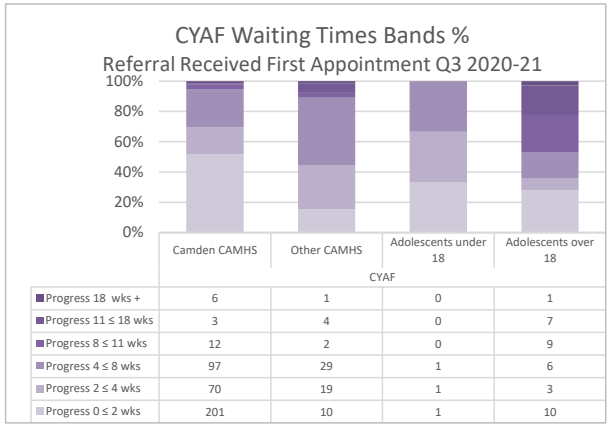
GIDS: in Q3 contacted 1615 patients, 19 fewer than in Q2. The average last financial year was 1599 per quarter.

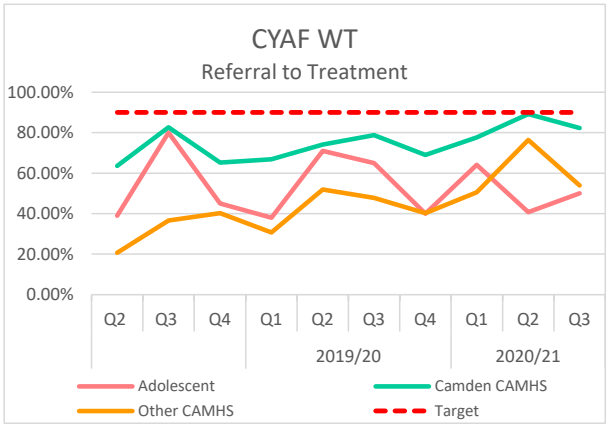
2

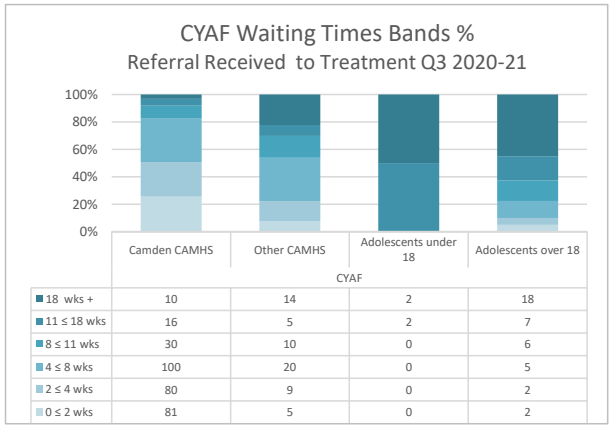
GIC: in Q3 contacted 1118 patients, 99 fewer that in Q2. The average of

Q3 2020/21 : Quality Responsive – Access









Data source: Q3 data as recorded on 08/01/2021 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.

CYAF Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations, Zoom sessions and face to face activity.

Referral to 1st Appointment: In Q3 CYAF saw 93% of patients within the contractual waiting times. This is a slightly lower rate compared to 95% in Q2. **Referral to Treatment:** In Q3 CYAF saw 75% of patients within the contractual waiting times. This is a lower rate compared to 81% in Q2.

Adolescent services

Referral to 1st Appointment – in Q3 the whole service line saw 79% of patients within contractual waiting times, a decrease on the 92% in Q2.

- Adolescents under 18 - 100%
- Adolescents over 18 - 78%

Referral to Treatment– – in Q3 the whole service line saw 50% of patients within contractual hours, a compliance improvement compared to 41% in Q2.

- Adolescents under 18 - 0%
- Adolescents over 18 - 55%

Camden CAMHS

Referral to 1st Appointment – has consistently done well since 2017/18. The compliance rate in Q3 was 95%, same as in Q2.

Referral to Treatment– in Q3 82% of the patients had an appointment within 8 weeks, a slight decrease in compliance compared to 89% in Q2.

Other CAMHS

Referral to 1st Appointment – In Q3 they achieved 89%, just under the target. In Q2 the compliance rate was 95%.

Referral to Treatment– in Q3 54% of the patients had an appointment within the contractual waiting times, a decrease in compliance compared to 76% in Q2.

Family Assessment Service (FAS) this service was decommissioned in December 2020

For further comments from service leads please see the commentary part of the report Page 21

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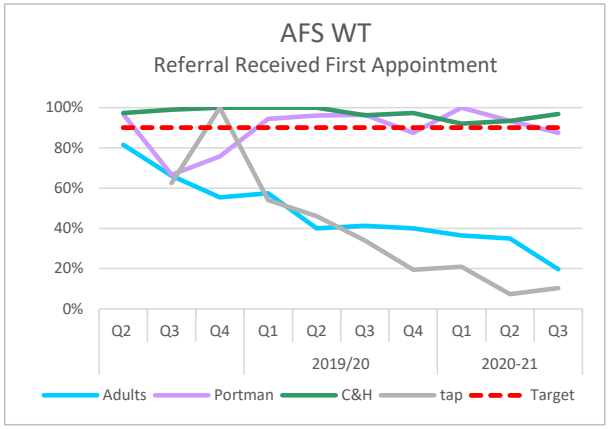
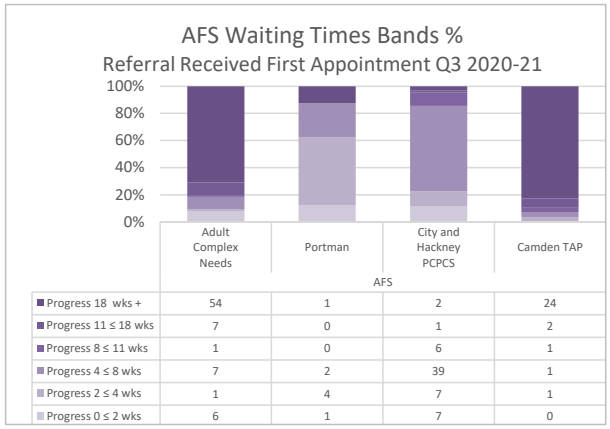
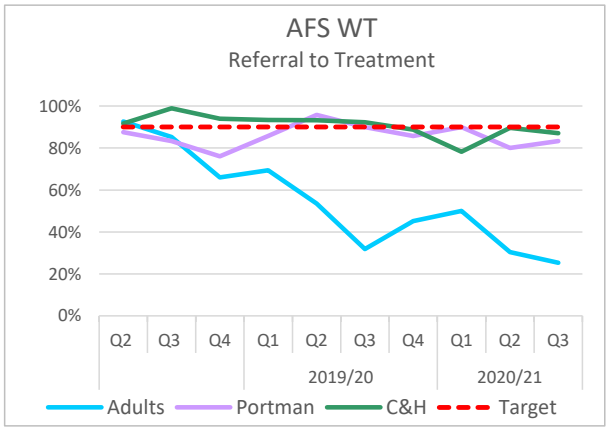
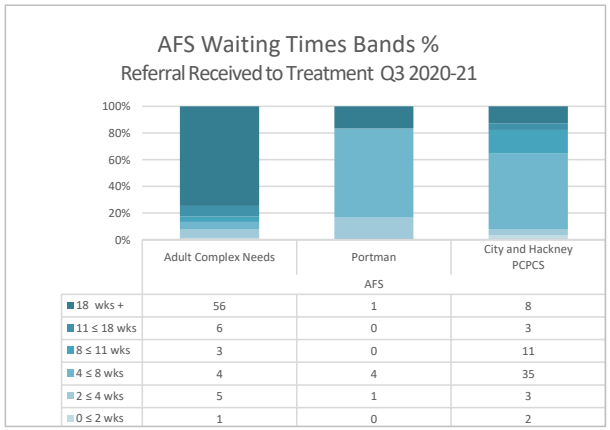
Q3 2020/21 : Quality Responsive – Access





	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
Progress 18 wks +	54	1	2	24
Progress 11 ≤ 18 wks	7	0	1	2
Progress 8 ≤ 11 wks	1	0	6	1
Progress 4 ≤ 8 wks	7	2	39	1
Progress 2 ≤ 4 wks	1	4	7	1
Progress 0 ≤ 2 wks	6	1	7	0





	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	56	1	8
11 ≤ 18 wks	6	0	3
8 ≤ 11 wks	3	0	11
4 ≤ 8 wks	4	4	35
2 ≤ 4 wks	5	1	3
0 ≤ 2 wks	1	0	2

AFS Waiting Times:

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

Referral to 1st Appointment: In Q3 AFS saw 49% of patients within the contractual waiting times. In Q2 this compliance was to 51%.
Referral to Treatment : In Q3 AFS saw 55%. of patients within the contractual waiting times. In Q2 this compliance was to 66%.

Adult Complex Needs
Referral to 1st Appointment –in Q3 they had 20% compliance, a decrease on Q2, when 35% compliance was achieved.
Referral to Treatment– in Q3 they had 25% compliance, a decrease on Q2, when they had 30% compliance.

Portman
Referral to 1st Appointment – in Q3 they had 88% compliance, a slight decrease on Q2, when they achieved 93% compliance.
Referral to Treatment– in Q3 they had 83% compliance, a slight increase on Q2, when they had 80% compliance.

C&H PCPCS
Referral to 1st Appointment – in Q3 they had 97% compliance, a slight increase on Q2, when they had 93% compliance.
Referral to Treatment– in Q3 they had 87% compliance, a decrease on Q2, when they had 90% compliance.

Team Around the Practice:
Referral to 1st Appointment – in Q3 the percentage of patients seen on time increased to 10%, in Q2 compliance was 7%.
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 20

Data source: Q3 data as recorded on 08/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
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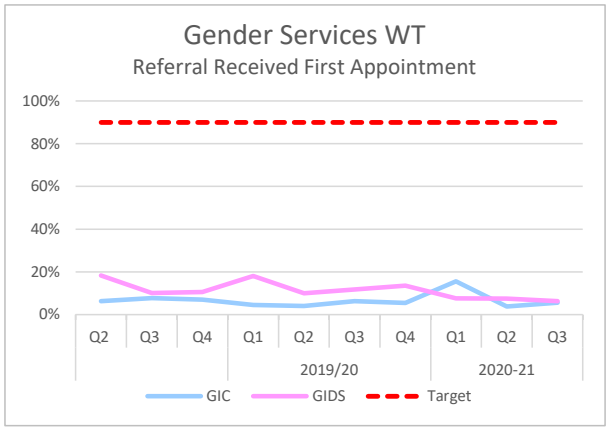
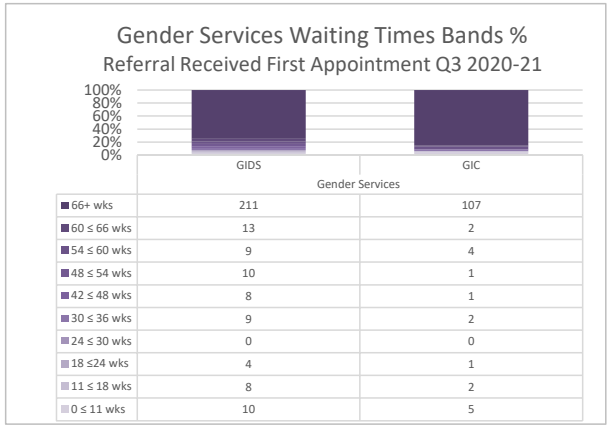
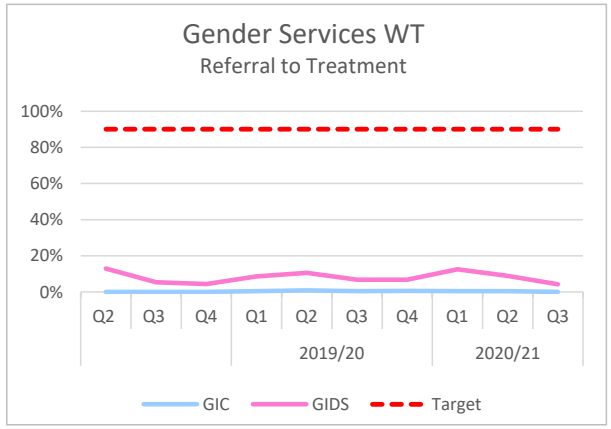
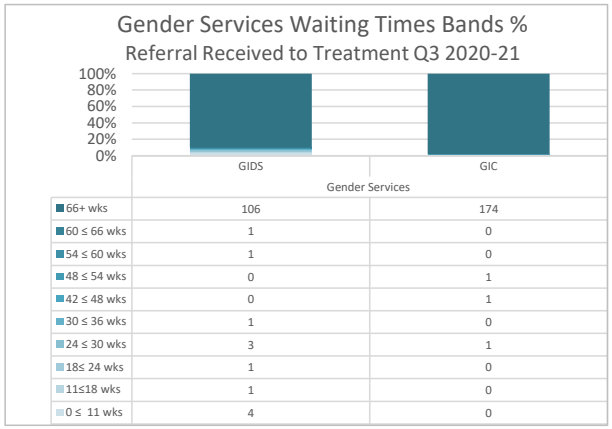
Q3 2020/21 : Quality Responsive – Access









Data source: Q3 data as recorded on 08/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

Gender Services Waiting Times:

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

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 Q3 6% of patients within the contractual waiting times. This is stable compared to also 6% in Q2.
Referral to Treatment : Gender Services Directorate saw in Q3 2% of patients within the contractual waiting times. This is a slightly lower rate compared to 4% in Q2.

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.

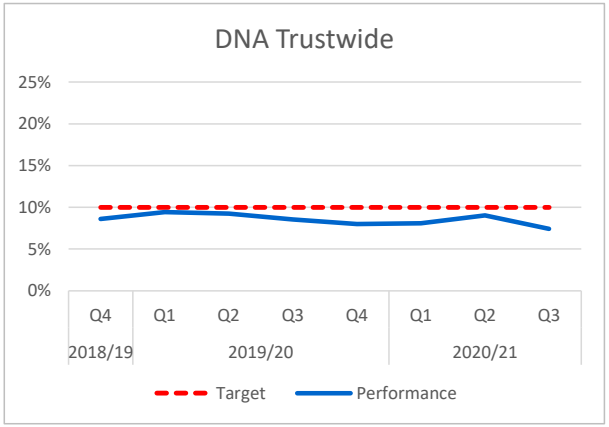
Referral to 1st Appointment – in Q3 had 6% compliance, a decrease on 7% in Q2.
Referral to Treatment – in Q3 had 4% compliance, a decrease on 9% in Q2.

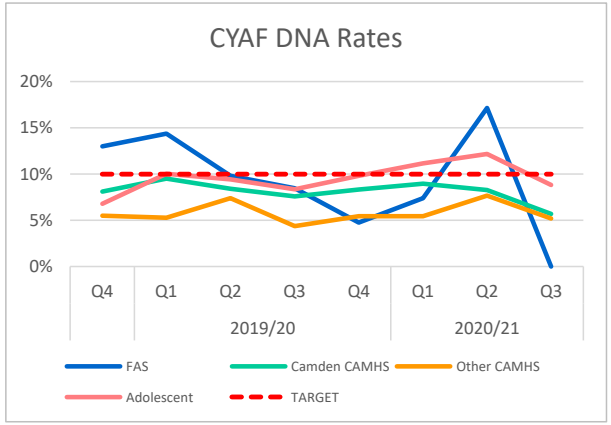
GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.

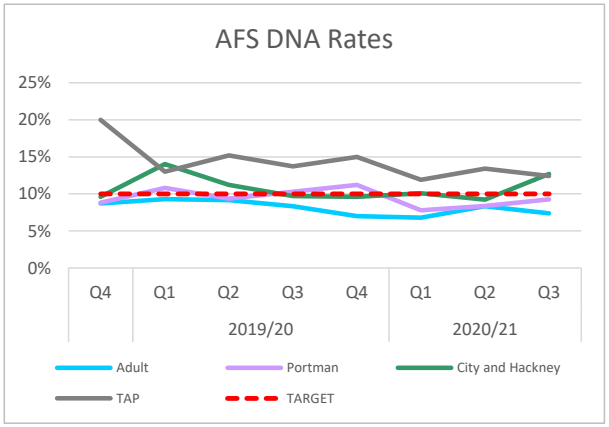
Referral to 1st Appointment – in Q3 had 4% compliance, a decrease on 6% in Q2.
Referral to Treatment– in Q3 had 0% compliance, and 0.5% in Q2.

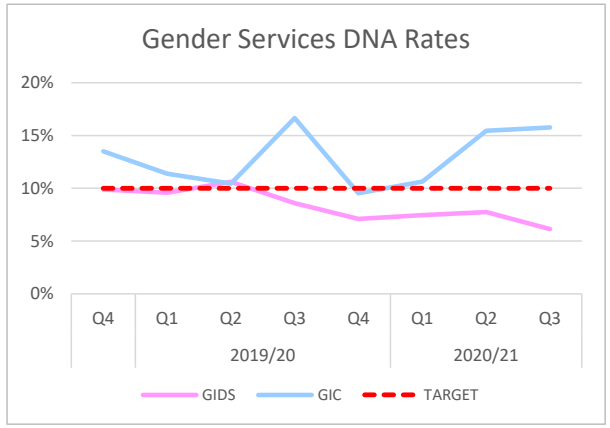
For further comments from service leads please see the commentary part of the report Page 22

Q3 2020/21 : Quality Effective – Access









Data source: Q3 data as recorded on 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

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 Q3 our compliance rate was 7.43%, this is the lowest rate in the last 8 quarters.

Adolescents: in Q3 had an 8.83% (134 DNAs and 1343 attended appointments) meeting the target for first time this financial year. The DNA quarterly average during last financial year was 9.4%.

Camden CAMHS: in Q3 had a DNA rate of 5.71% (389 DNAs with 6634 attended appointments). Target has been met for the last 2 years. The DNA average during last financial year was 8.5%.

Other CAMHS: in Q3 had a DNA rate of 5.21% (163 DNAs and 2885 attended appointments), Target has been met for the last 2 years. The average during last financial year was 5.6%. an increase on Q1 5.45%.

Family Assessment Service: this service has been decommissioned.

Adults Complex Needs: in Q3 had a DNA rate of 7.39% (283 DNAs and 3472 attended appointments), a decrease of 0.93% from Q1. Target has been met for the last 2 years The average during last financial year was 8.5%.

Portman: in Q3 had a DNA rate of 9.25% (147 DNAs and 1434 attended appointments), an increase of 0.87% from Q2. The average during last financial year was 10.4%.

C&H PCPS: in Q3 had DNA rate of 12.7% (118 DNAs and 749 attended appointments), this is an increase of 3.49% from Q2. The average during last financial year was 11.1%.

Team Around the Practice: saw a slight decrease in DNAs in Q3, resulting in a 12.4% DNA rate compared to a 13.40% rate in Q4. The average during last financial year was 14%.

GIC: in Q3 had a 15.77% DNA rate (284 DNAs and 1391 attended appointments) This signifies a slight increase of 0.33% from Q2. The average during last financial year was 12%.

GIDS: in Q3 had a 6.14% DNA rate (256 DNAs out of 3546 attended appointments). The average during last financial year was 9%.

For further comments from service leads please see the commentary part of the report Page 23, 24 & 25

Q3 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 most recent published DQMI is for Sep 2020, 95.7% against a target of 95%.

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 Group (QAG) 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.

	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	Month 4 July 2020/21	Month 7 October 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%	98.99%	99.16%
Valid Postcode	95%	99.80%	99.70%	99.80%	99.80%	99.80%	99.80%	99.70%	100%	99.72%	99.71%	99.79%	99.70%	99.72%
Valid Date of Birth	95%	100%	100%	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%	99.13%	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%	98.28%	98.33%
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%	98.80%	98.50%
Ethnicity	85%	79.60%	78.40%	77.30%	76%	75.80%	76.10%	80.60%	81.88%	78.76%	77.79%	75.94%	75.82%	73.88%
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%	55.94%	54.92%
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%	54.69%	53.63%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%	99%	99.00%	99.00%	
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%	46%	48.00%	56.00%	
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 above is for March.							88.90%	94.10%		95.60%	95.70%	

Data source: Data warehouse, informatics team 07/01/2021

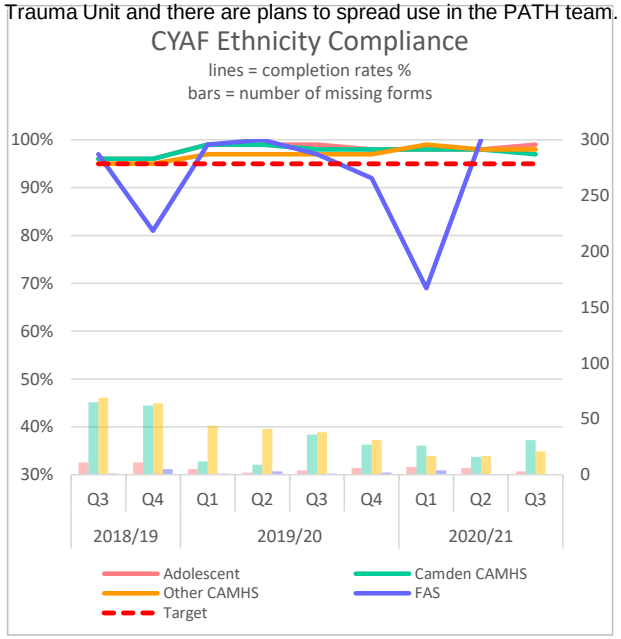
Q3 2020/21: Single Oversight Framework – Access

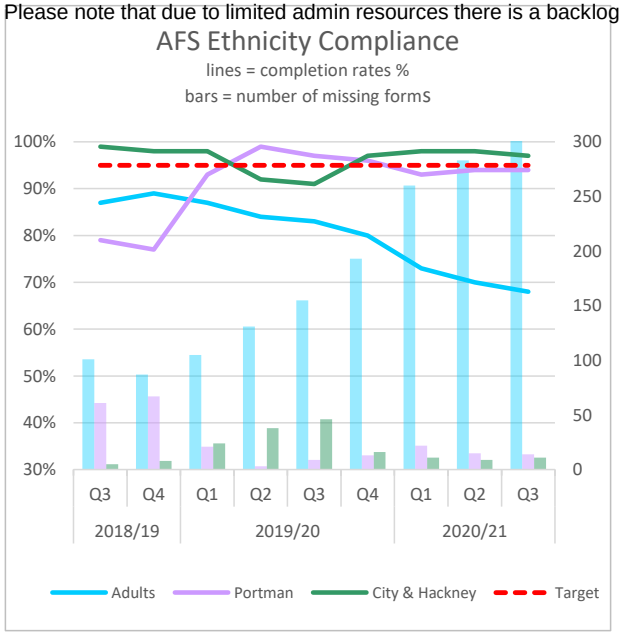
Ethnicity Rates

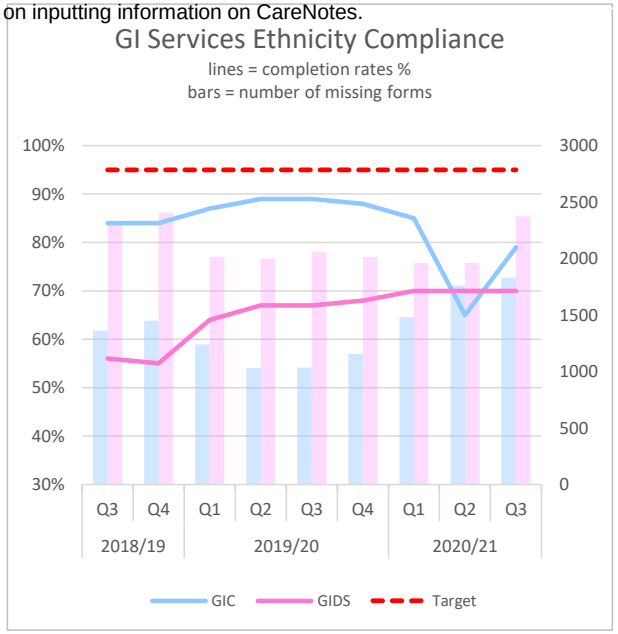
Ethnicity completion rates has been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%, in April last year. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. A significant aspect in not reaching the target is the large number of patients open to teams who have not been seen. The Quality Assurance Team (QAT) continue to work with teams in the Quality Assurance Group (QAG), raising awareness of the situation in order to improve this data further.

The trust has developed a report is called 'Basic Contact Details and Demographic Print-out ' - it allows teams to validate with patients the current information held in CareNotes and to collect missing pieces of information in our system. This process would work best where services have a reception as administrators can ask patients to review the form. We have started a small scale test within the gender services, for face to face updates. Unfortunately testing this change has been slow as most care is being delivered remotely as a result of Covid-19.

The Adult Complex Needs service have reviewed the best point to request this data and as a result have begun to introduce a new communication tool, called the acceptance letter. This is sent before any appointment is offered, in order to improve communications and expectations and includes the Patient Information Form, where demographic data is requested. It has been implemented at the Trauma Unit and there are plans to spread use in the PATH team. Please note that due to limited admin resources there is a backlog on inputting information on CareNotes.

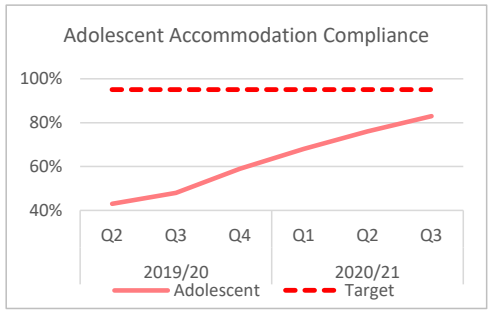


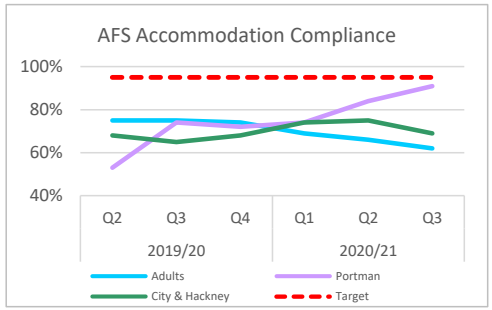


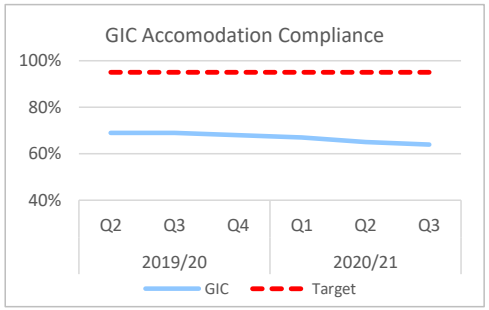


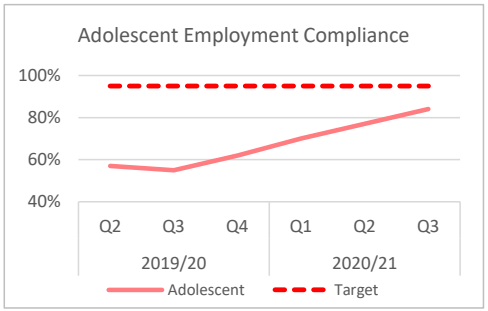
Data source: Q3 data as recorded on 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

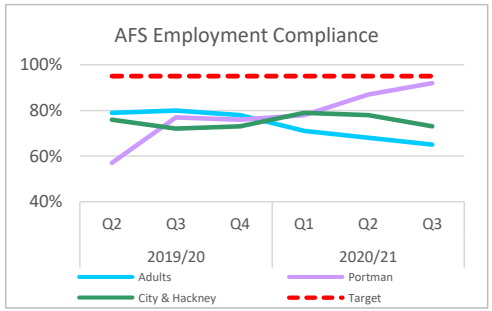
Q3 2020/21: Single Oversight Framework – Access

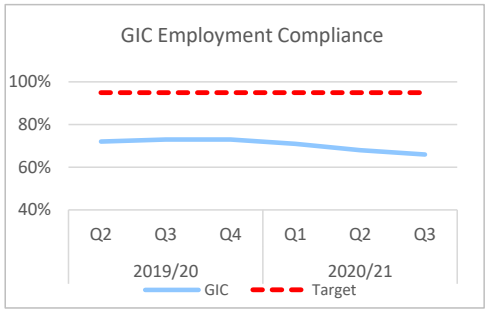


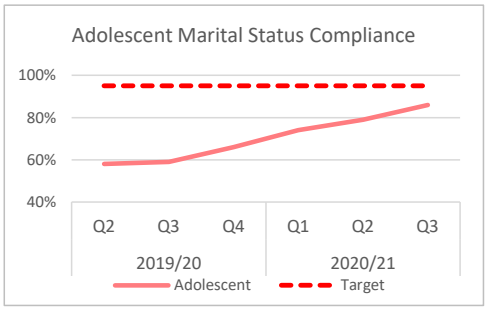


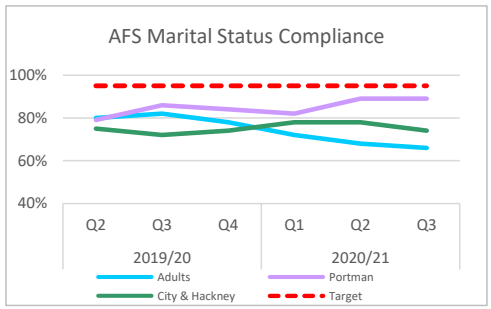


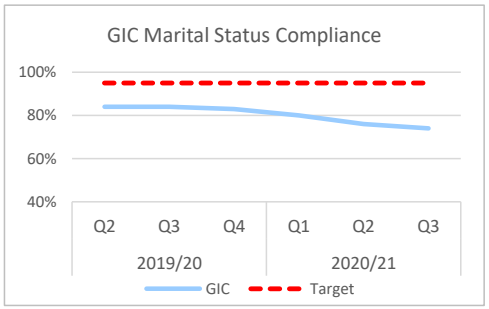












Data source: Q3 data as recorded on 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

Accommodation, Employment and Marital Status Rates

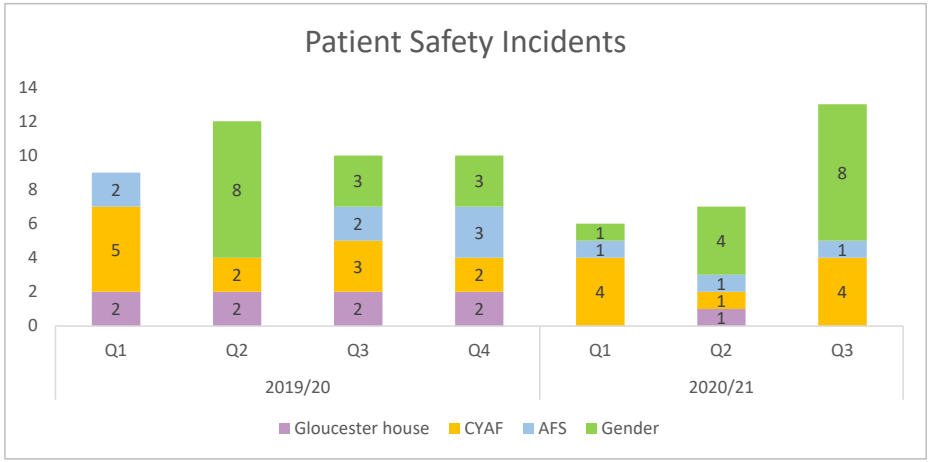
These parameters are only required for patients over 18 years of age.

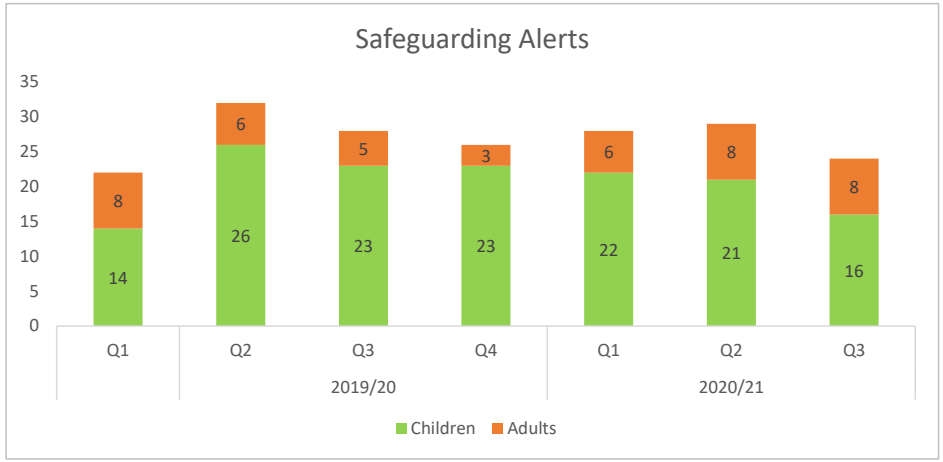
Please note the remarkable and sustained improvement of Adolescents over 18's Services data collection. It is also worth noting that the Portman have improved over the last two/three quarters for recording accommodation and employment.

The Trust has reviewed the GP referral forms, these forms now request all the relevant demographic parameters. As the trust develops the usage of these forms we are expecting to see improvement in our data quality.

Information on the new 'Basic Contact Details and Demographic Print-out report' Gender Service testing and Adults Complex Needs project on acceptance letter are covered on the previous slide.

Q3 2020/21: Quality Safety – Care





There were 13 clinical NRLS reportable incidents this quarter. Seven went to the incident panel and were discussed and a further three will go to the next meeting. The rest did not qualify for discussion as the score was low. There were no IG NRLS reportable incidents this quarter.

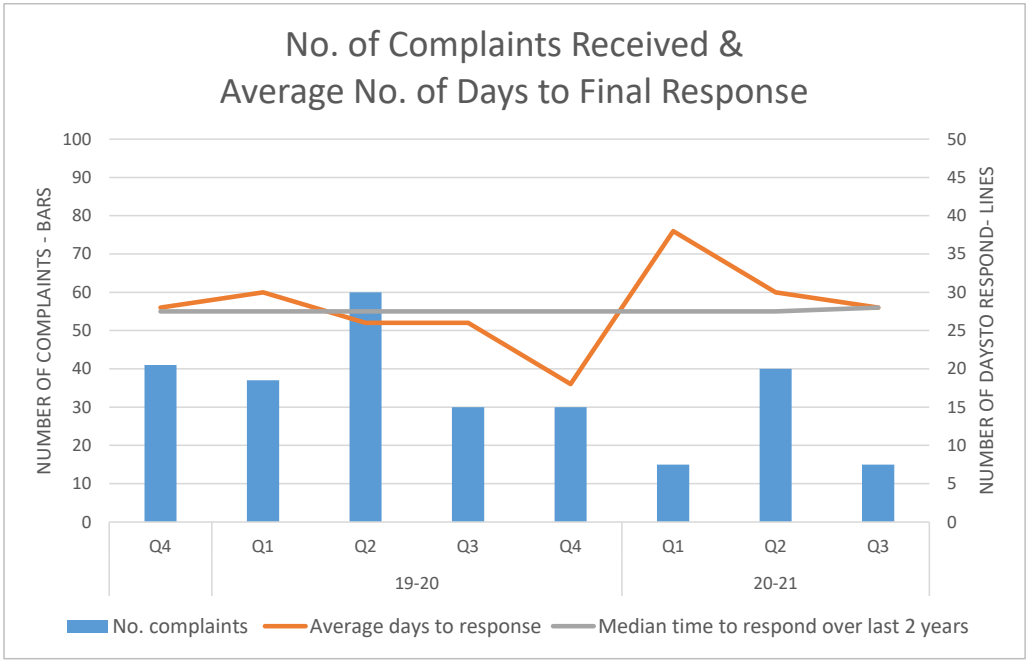
Some cases have more than one type of concern and were counted as one for accurate reporting.

Data & commentary source: Clinical Governance 12/01/2021

Incidents Reported by Risk Level – Trust wide	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3
1-4	82	101	65	65	60	37	34	32
5-8	23	28	27	28	30	11	19	29
9-12	9	3	11	12	18	3	3	13
15+	1	0	2	0	1	1	2	1
Total	115	132	105	106	109	52	58	75

Data & commentary source: Health & Safety Department 14/01/2021

Q3 2020/21: Quality Responsive – Care

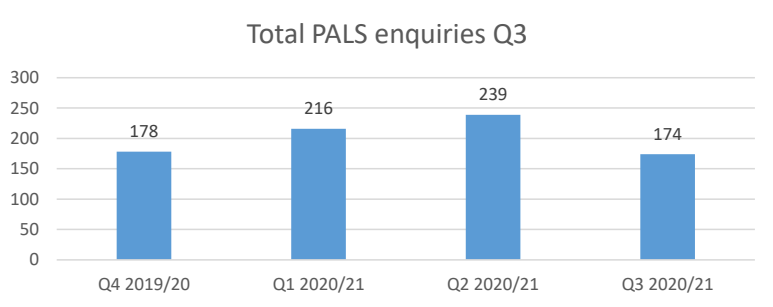


Directorate	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
Children Young Adults and Families	4	4	0	1	0
Adult and Forensic	2	4	3	11	3
Gender	24	21	12	25	11
Corporate	0	1	0	3	1
Total complaints	**30**	**30**	**15**	**40**	**15**

During Q3 a total of 15 complaints were received, this is a decrease from the last quarter. Although the complaints investigations have re-started, following the pause during the first lockdown in 2020, there is still a backlog of complaints to be investigated and responded to. Four complaints in Q3 have been responded to, none of these were upheld.

See Slide 31 for further KPI complaints information

Data & commentary source: Complaints Department 04/01/2021



Main enquires received related to Communications and Access to Treatment or Drugs.

Data & commentary source: PALS department 15/01/2021

Q3 2020/21: Quality Responsive – Care

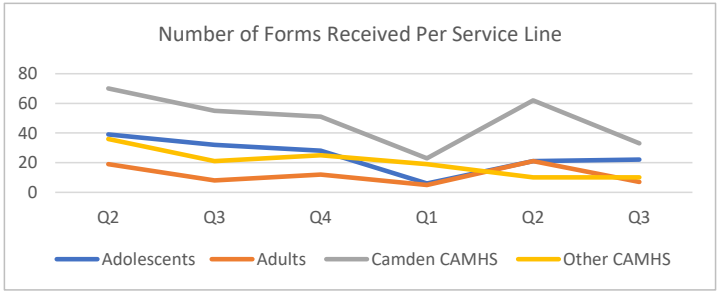
Quality Key Performance Indicators																		
KPI – London Contracts	Monitoring	Target %	2020/21												RAG Progress			
			Q1			Q2			Q3			Q4			Q1	Q2	Q3	Q4
			N	D	%	N	D	%	N	D	%	N	D	%	Q1	Q2	Q3	Q4
Q4 from ESQ 'Views and worries were taken seriously'	Quarterly	n/a	43	43	**100%**	100	102	**98%**	71	71	**100%**							
Q6 from ESQ "The information I received about the Trust before I first attended was helpful."	Quarterly	75%	35	33	**94%**	73	78	**94%**	47	49	**96%**							
Q11 ESQ 'If a friend or family member needed this sort of help, I would suggest to them to come here'	Quarterly	80%	43	41	**95%**	91	91	**100%**	66	68	**97%**							
Q12 from ESQ "Options for my care were discussed with me"	Quarterly	n/a	28	28	**100%**	49	55	**89%**	48	49	**98%**							
Q13 from ESQ 'Involved in important decisions about my care'	Quarterly	n/a	26	26	**100%**	48	53	**91%**	48	50	**96%**							
Q15 from ESQ "Overall, the help I have received here is good"	Quarterly	92%	42	42	**100%**	106	106	**100%**	72	72	**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, however we feel that the number of forms returned could be higher. The trust is piloting a new shorter form which aims to improve the collection rates. 'ESQ Implementation' is one of our current year Trust Quality Priorities and the schedule is progressing well and feedback is positive. It is worth noting that the current trialled forms are anonymised and not included on the above report as they cannot be input into CareNotes. Current information also does not allow link to a specific contract. Further developments are being considered to support reporting requirements.

Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team 07/01/2021

*ESQ % = (Certainly true + Partly true)/(Certainly True + Partly True + Not True)



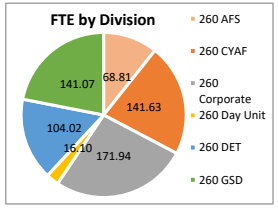
Q3 2020/21: Quality Well-Led

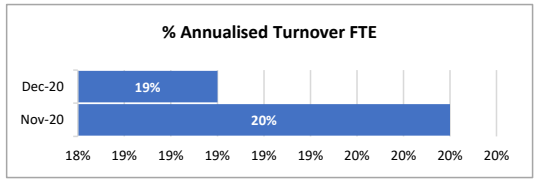
Workforce Headcount

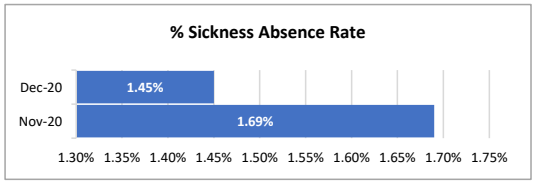
792 Total Headcount

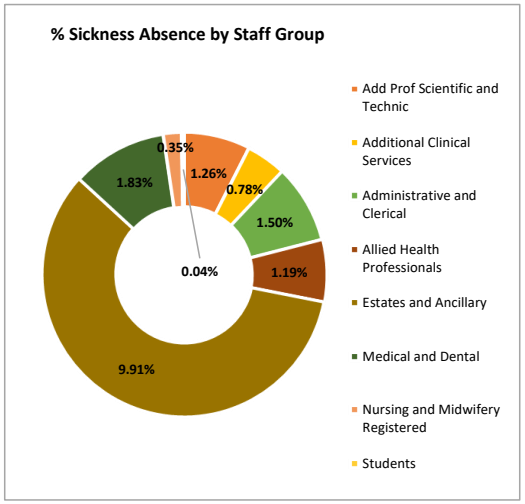
594 Female

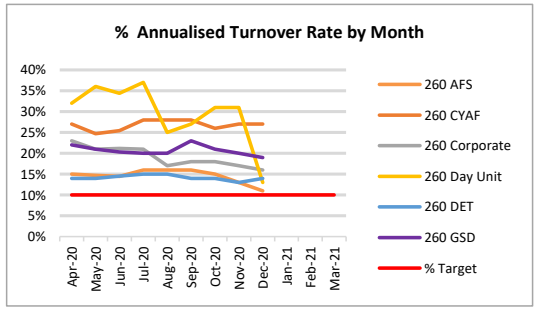
198 Male

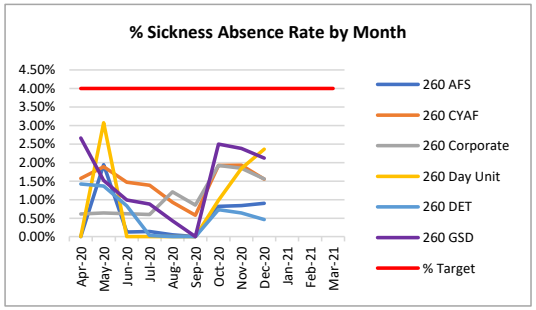


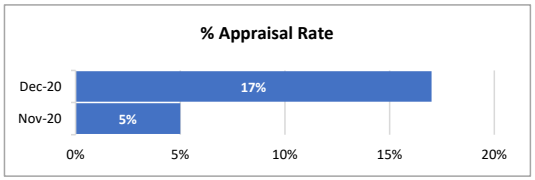


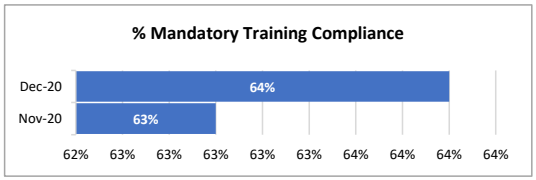


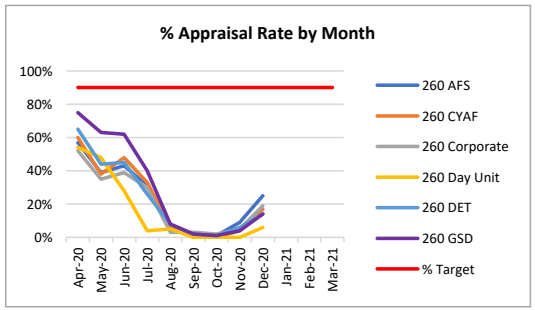


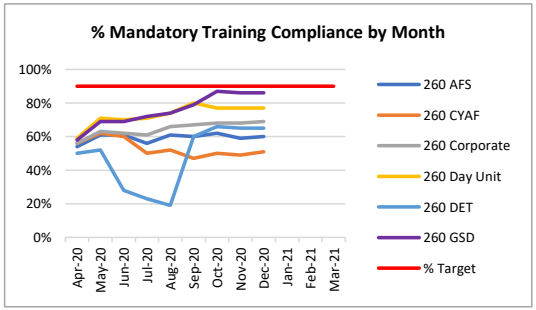


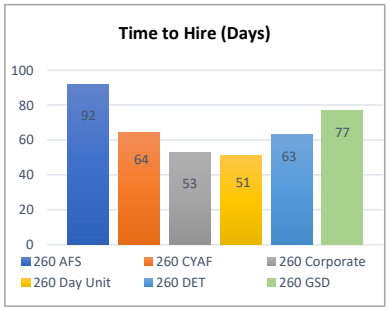


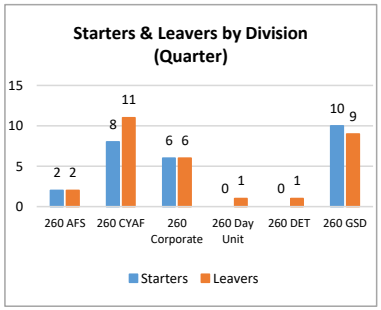










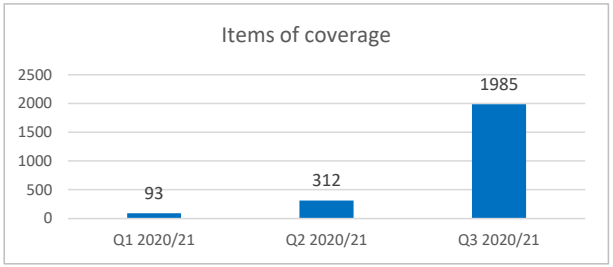


The Staff Friends and Family Test reporting was additionally suspended in Q2 2020/2021 due to Covid-19. However, the NHS Staff Survey went ahead as planned and ran from September to November 2020. The Trust achieved its highest completion rate to date. A light touch appraisal process ran from September to December 2020. Statutory and mandatory training has a compliance target of 95% and the deadline was extended to 31 January 2021 to allow staff to complete their training."
Data source: Human resources 12/01/21

13

Media overview

There was a lot more coverage in Q3 2020-21 compared to the previous quarter. The extra coverage is related to the judgment from the Judicial Review which was handed down on 1 December, which had considerable national media interest and wider syndication. Articles appeared in outlets including the *Mail*, *Times*, *Guardian*, and *Telegraph* with mainly negative sentiment.



Top stories mentioning us by reach

**average number of people who see this type of content in a given media outlet*

Platform	Title	Reach	Sentiment
BBC Online	Puberty blockers: Parents' warning as ruling challenged	698515004	Neutral
BBC Online	What are puberty blockers?	698515004	Neutral
BBC Online	Puberty blockers: Under-16s 'unlikely to be able to give informed consent'	698515004	Negative
Press Association	Under-16s can consent to puberty blockers if treatment understood, court rules	Syndicated	Negative
Thompson Reuters	UK court rules against trans clinic over treatment for children	Syndicated	Negative

Digital overview

Traffic to our main site is slightly up compared to the same quarter last year. Across our social channels followers continue to grow, impressions and engagement remain steady.

- Website users up 6%: 108,601 vs 102,589
- Page views up 13%: 349,236 vs 307,840
- Sessions up 10%: 158,479 vs 143,797

Most-visited news stories:

- "The baby who is born pink learns to become white", 1,662 views
- Update on GIDS Judicial Review and timetable for clinical reviews 22 December 2020, 1,526 views
- Referrals to the Gender Identity Development Service (GIDS) level off in 2018-19, 824 views

Most-visited course pages:

- Working with children, young people & families: a psychoanalytic observational approach (M7 Daytime), 4572 views
- Child and adolescent psychoanalytic psychotherapy (M80), 4098 views
- Systemic psychotherapy (M6), 3791 views

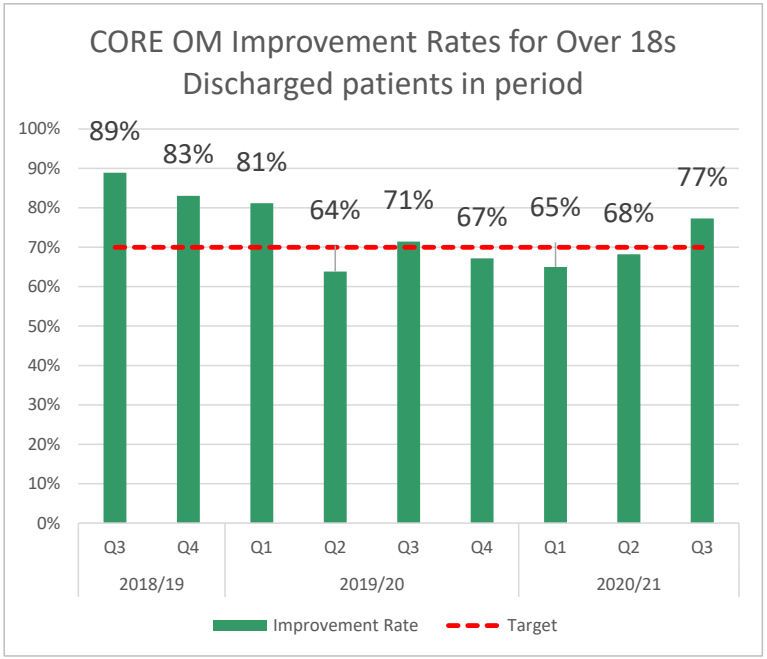
Social channels – followers compared to last quarter

- taviandport twitter: 7587 vs 7102
- tavitraining twitter: 5288 vs 5176
- Facebook: 6304 vs 6028
- Instagram: 676 vs 551

Data & commentary source: Communications Department 13/01/2021

Q3 2020/21: Quality Effective – Outcome Measures

A F S and Adolescents over 18



The CORE OM improvement rates include all patients discharged in period with a minimum of two completed CORE OM forms. In Q3 we had the same number of discharged patients than in Q2 – 44. However, the number of patients showing improved problems scores across the two completed forms increased by 4, with 34 (77%) patients. We are reviewing the form reminder and collection process in order to focus on improvements to the return rates.

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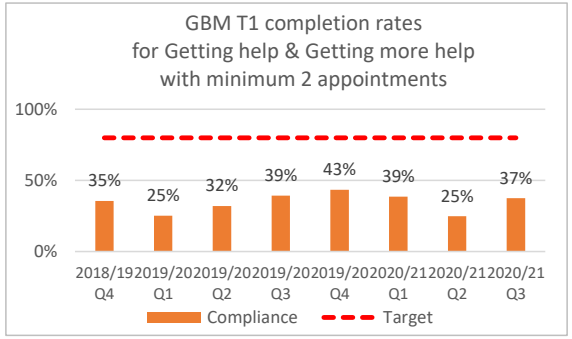
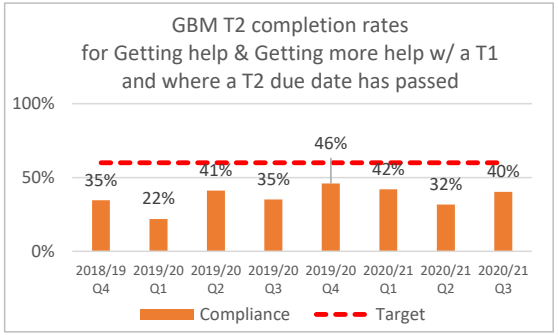
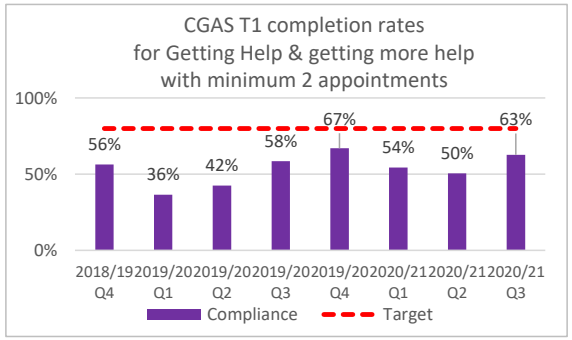
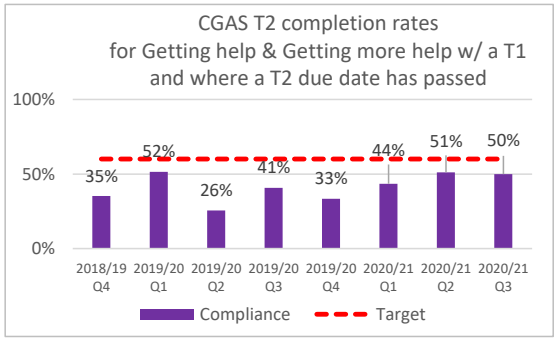








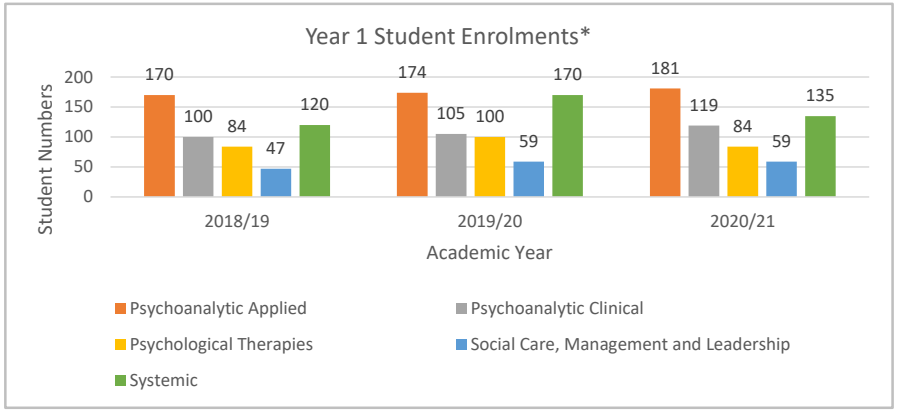
The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: GBM T1 form completion rates increased from 25% in Q2 to 37% in Q3. GBM T2 form completion rates also increased from 32% in Q2 to 40% in Q3. We have been testing a new reminder logic on the Carenotes system, to improve collection rates of GBM data. This was introduced to the Family Mental Health team in November. If the change is confirmed as successful we will apply it to other teams to continue to improve collection rates.
-CGAS rates: CGAS T1 increased in Q3, with 63% completion rates. CGAS T2 has decreased just 1% achieving 50% in Q3.

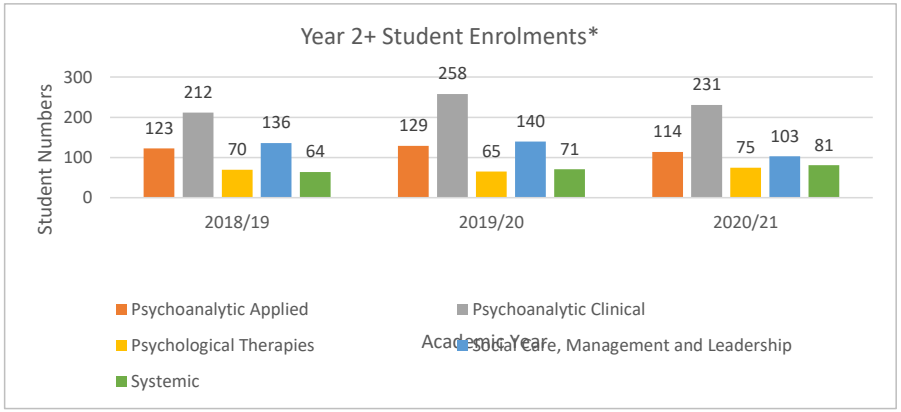
Data source: Q3 data as recorded on 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

See Slide 35 for further GBM and CGAS information

Q3 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Education and Training: Long Course Enrolment Summary By Portfolio (Validated and Non-Validated Courses)*





Year 1 Student Enrolments * as of December of each Academic Year

	2018/19	2019/20	2020/21
Portfolio	**Year 1**	**Year 1**	**Year 1**
Psychoanalytic Applied	170	174	181
Psychoanalytic Clinical	100	105	119
Psychological Therapies	84	100	84
Social Care, Management and Leadership	47	59	59
Systemic	120	170	135
Grand Total	**521**	**608**	**578**

** Student Enrolment for each academic year by December of each academic year. These figures exclude the associate centres*

An overall decrease of 5% in enrolled Y1 figures compared to 2019/20, but an increase of 4% and 12% respectively in enrolled Y1 figures for the Psychoanalytic Applied and Psychoanalytic Clinical Portfolios. The enrolled student number includes those who have reached both pre-enrolment (i.e. PE - fees paid and awaiting clearance of DBS checks) and full enrolment (C) stages, but excludes Associate Centres.

Data & commentary source: DET Department 11/01/2021

Year 2+ Student Enrolments * as of December of each Academic Year

	2018/19	2019/20	2020/21
Portfolio	**Year 2+**	**Year 2+**	**Year 2+**
Psychoanalytic Applied	123	129	114
Psychoanalytic Clinical	212	258	231
Psychological Therapies	70	65	75
Social Care, Management and Leadership	136	140	103
Systemic	64	71	81
Grand Total	**605**	**663**	**604**

** Student Enrolment for each academic year by December of each academic year. These figures exclude the associate centres*

An overall decrease of 10% in re-enrolled Y2+ (continuing students) figures compared to 2019/20, but an increase of 13% and 12% respectively in re-enrolled Y2+ (continuing students) figures for the Psychological Therapies and Systemic Portfolios. The enrolled student number includes those who have reached both pre-enrolment (i.e. PE - fees paid and awaiting clearance of DBS checks) and full enrolment (C) stages.

Q3 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

CEDU Activity and Financial KPIs, Q3 2020/21 FY
1 April – 31 December 2020

Q3 Activity	2020-21		2019-20		2018-19	
	No. actvities	No. students	No. activities	No. students	No. activities	No. students
Portfolio CPD	55	1100	68	1213	77	1760
Bespoke	25	457	45	1051	18	285
International	2	66	6	169	13	133
HEE funded activity	17	326	6	290	0	0
Total Q3	**99**	**1949**	**125**	**2723**	**108**	**2178**
Full Year (forecast for 20-21)	*163*	*3162*	160	3161	153	2193

Q3 Financials	2020-21			2019-20			2018-19		
	Income	Costs*	Contribution % *	Income	Costs***	Contribution %	Income	Costs***	Contribution %
Portfolio CPD	£334,439	£116,188	65%	£419,685	£181,749	57%	£533,597	£221,992	58%
Bespoke	£210,760	£117,436	44%	£274,929	£169,060	39%	£112,166	£72,275	36%
International	£87,085	£1,820	98%	£94,910	£48,101	49%	£130,547	£71,021	46%
HEE funded activity	£151,001	£62,596	59%	£138,869	£99,962	28%	£0	£0	0%
Total Q2	**£783,285**	**£298,040**	62%	**£928,393**	**£498,872**	**46%**	**£776,310**	**£365,288**	**53%**
*Full Year (forecast for 20-21**)*	*£1,194,209*	*£482,051*	*60%*	£1,156,859	£639,824	45%	£1,047,018	£480,423	54%

*direct costs only, not including staff costs; contribution before staff costs

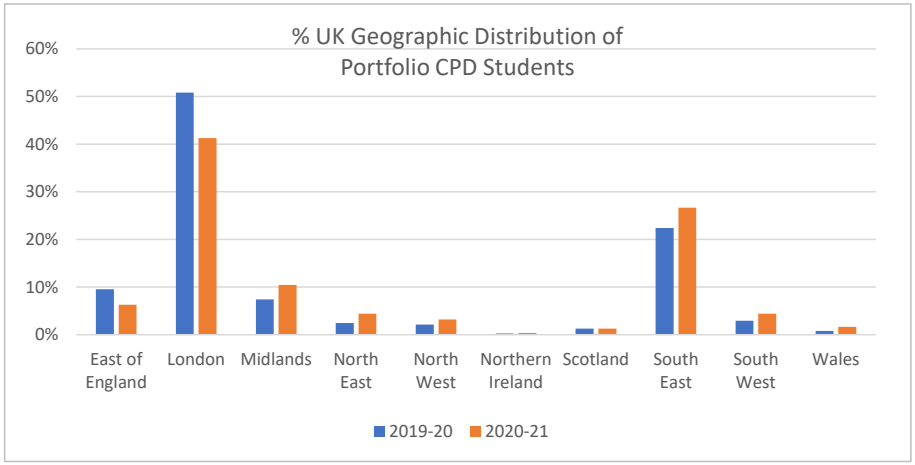
** Full year forecast for 20-21FY as at 31 December - all figures are subject to change as courses continue through the year and new commissions come in

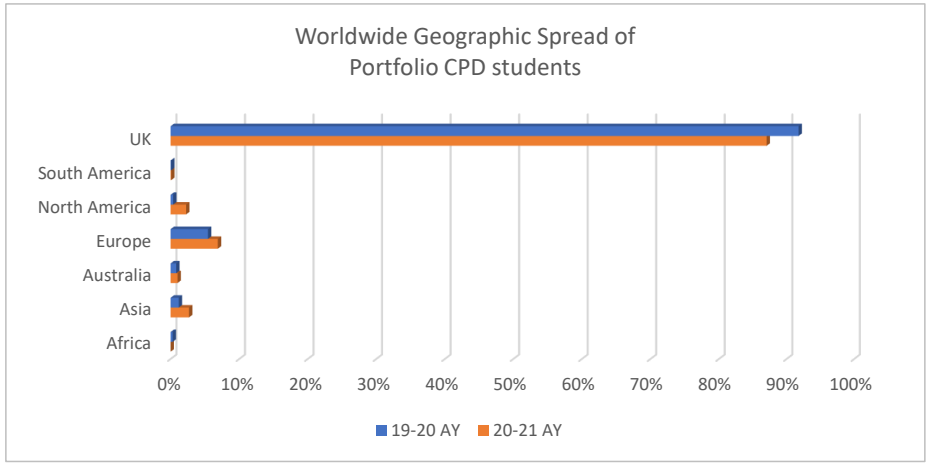
The CEDU KPI's are based on training activities that start within the reported timeframe (up to and including Q3). CEDU activities take place throughout the year and so the number of courses, student numbers, income and costs will continue to change throughout the full financial year and will be reported 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 external, paying individuals to book onto. This has remained relatively stable in this period. Whilst the number of activities has reduced slightly, we are showing an increase in the average number of students per activity to 20, up from 17 last year. All delivery has been successfully moved online due to the onset of Covid-19 and we are starting to see an increase in delegates attending from overseas and from other regions of the UK outside of London as a result of this.

Data & commentary source: DET Department 11/01/2021

Q3 2020/21: Directorate of Education and Training (DET) – Access/Recruitment





Bespoke activities are those commissioned by organisations for their staff either through a direct approach to us or through a tender process. Data for Q3 is showing a marked increase in requests, activities and student numbers from Q2 although still lower in comparison to the same period last year. This is still in part due to the impact of Covid-19 and the postponement and rescheduling of a number of activities and higher numbers from 19-20FY to later in the year.

However, the current full year forecast for confirmed bespoke activity for 2020-21 FY, as outlined below, is showing an increase in income from 2019-20FY figures.

	Activities	Income
2018-19*	33	£243,820
2019-20*	53	£290,765
2020-21	43	£303,481

HEE funded activity consists primarily of HEE funded perinatal training programmes, including the London Perinatal Training Programmes for 19-20 and 20-21FY. The 19-20 FY plan was also affected by the pandemic, with some activities delayed and rescheduled.

The majority of our **International** work has been impacted and put on hold by the pandemic, with the exception of a new collaboration with WWYY 'Seeing Psychology' online platform in China, through which we are selling our 'Families and Beyond' and 'Understanding Development– Adolescence' online courses. The financials for this are included in the KPI figures, but not equivalent student numbers as the income is derived from digital downloads only - as of the end of July, there had been over 3000 downloads of the course material from across China.

Data & commentary source: DET Department 11/01/2021

Quarterly Quality Report Commentary Q3 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 Q3	Objective / plan for next Quarter
Adolescent /AYAS	The service continues to implement the assessment timeliness strategy. This quarter we saw a drop below the 90% expected due to a number of patients having specific requirements and a slow responses from patients and referrers post referral which delayed their acceptance into the service probably due to the impact of the pandemic.	To continue to offer PAC (pre-assessment consultations) appointments within the timeframes and monitor impact of these appointments.
Camden CAMHS	Referral to First Appointment indicates that we are above target for Q3 the same figure as Q2 95% of patients. Although, the time bands data suggests that combined in the wait period 11 week – 18 weeks + = 9% of our patients in this period waited for a first appointment. The interpretation of the wait time here for the first appointment due to staff resources in our clinical intake service where staffing levels were low due to sick leave. Our screening process picks up the allocation of patients as mentioned below. Referral to treatment has decreased from the last quarter from 89% to 82% seeing a 7% decrease which has due to staffing levels due to long term sick and a reduction of staff turnover in our clinical intake service. We are hoping that with our current service line processes which includes; job planning, staff returning from long term sick leave and our additional recruitment of clinicians. We hope to see an increase in meeting our target for the next quarter for the Camden CAMHS service line.	We acknowledging that our Camden CAMHS Clinical Intake Service is now fully staffed and having identified that staffing resources have now increased in this service. We have also identified some newly recruited clinicians with our Camden CAMHS Service who will support our waiting times and pick up our referrals from Referral to 1st appointments and 2nd appointment to treatment this will increase our waiting time figures in order to meet our target for Q4. During Q4 we will continue to monitor and analyse our waiting times within our Camden CAMHS clinical services on a month by month basis. Our Data Quality team will continue to send us monthly data so that we can track our targets during Q4.
Other CAMHS	Despite a slight drop in Q3 in First Appointments, we are only just under target and have been over target for the last 4 quarters. When the patients are seen via ASF (Adoption Support Fund) often breach as the application for funding from ASF is made at the same time as referral. For referral to treatment, we have stayed above the previous financial year, showing an improvement and are trying to understand the reasons behind the drop in Q3.	We will continue to try to understand and review the wait to second appointments in all teams. We will continue to monitor the impact of Covid 19 pandemic on waiting times. Increases in staff absence over the coming months may affect our ability to meet this target.

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

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adult Complex Needs	Waiting times within the Complex Needs Service have been high for some time. Contributing to that is the long standing issue of resources in some units, especially the specialist ones, with availability of clinicians able to do assessments. This has continued to be a challenge during the pandemic, with some patients requesting face to face only and therefore wanting to delay their first appointment. Added to this some patients have had their sessions extended, due to increasing anxiety about ending therapy, without resuming a face to face session with the clinician, leading to additional capacity challenges to conduct assessments. The service is aware of these issues and has put a plan in place to address wait times for first and second appointments.	The service has engaged three clinicians with 8 additional sessions amongst them; for the next three months; to address the wait time for assessment appointments. This extra capacity created will start from the 4th January 2021 until the 31st March 2021. We have also changed the process around reminders to clinicians responsible for allocating cases; so that they will receive a reminder from the intake co-ordinator twice a month about cases that need to be allocated to avoid breaching. And admin teams have been reminded that any patients offered first appointments via remote means and turn it down due to wanting a face to face appointment only, still have to be added to CareNotes.
Portman	Only one patient breached the waiting time of 11 weeks for first appointment, which we are pleased about. This was due to an issue relating to moving to face to face working, and this was not reflected properly on the system as the timeline on CareNotes did not accurately reflect what had taken place. This will be rectified on the system. In general we have worked well to ensure that all patients are seen within the necessary timelines despite the complexities of moving to online working.	In view of the positive data regarding waiting times, we will continue to monitor our performance in this domain but do not need to change our current processes at present.
City and Hackney PCPCS	PCPCS is broadly satisfied with our waiting times in Q3. The vast majority patients were seen for 1st appointments and 2nd appointments (RTT) within the 18 week target. While we have not met the target % for RTT, the % of patients seen for 1st appointment within 18 weeks has continued to improve from its drop in Q1, during the first lockdown. Engaging patients in a first and subsequent contact can take longer while remote working. Patients do not always answer their phone or, if they do, are not free to talk at that time, which can cause delays in bookings. The number of referrals to PCPCS has also increased, adding to pressure on bookings and available clinics. However, given the wider situation and stresses on the health services, it is rewarding to see that most PCPCS patients were seen within a safe and appropriate timeframe.	Seeing patients within an appropriate timescale, particularly within a Primary Care setting, can reduce risk, result in better patient experience, mean less mental pressure on staff, and encourage GPs to make mental health referrals as they can expect their patients to be seen by our service in a safe and timely manner. PCPCS are currently able make patients a substantial assessment and treatment offer, through phone and video appointments. We will continue to offer these as standard, as well as limited face-to-face appointments when clinically necessary and when a safe, suitable location can be found.
TAP	Factors that have affected the above: uncertainty over the future of the service, staff reduction following the staff consultation in January 2020 as well as the pandemic impacted substantively on clinical capacity and service activity. Three additional staff left the service in late summer (one trainee psychologist, an honorary clinician on placement and one of the B8a clinicians), and inevitable gaps in recruitment affected the above further.	The long wait for first appointment has been influenced by the following factors: • Changes in staff with inevitable gaps in provision • Internal decision to increase treatment ratio (due to the length of the waiting list) which resulted in a decrease in slots available for assessment

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

Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q3	Objective / plan for next Quarter
GIC	The wait times for first appointments is an ongoing problem for all of Gender Services. We are working on service developments to think about how to make a patient's wait more active and less stagnant. As well, we are considering the types of patients waiting and is there a possibility of service development for specific sections of patients who need less support. We continue to struggle with narrowing the gap between appointments. We were making progress before the pandemic, but have lost ground due to repeat appointments.	We hope to roll out a new plan to support the waiting list next quarter. This will not necessarily reduce the time, but will plan to make the wait more active.
GIDS	Waiting times continues to be both far above target. The only deviation from 66+ weeks, we believe, is exclusively in the case of rebookings, DNAs and cancellations.	We have developed a waiting list plan which commences this month with specific actions which try to reduce wait or reduce risk inherent in the wait.

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

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adolescent /AYAS	The DNA rate in AYAS has returned to below 10%. This is due to targeted work undertaken to reengage and offer face to face appointments to those who found remote working difficult and unhelpful.	It is very possible that the DNA rate will go above 10% if the current lockdown (3) remains in place in particular for face to face appointments as we find that patients feel anxious about leaving their house for medical care. In addition some patients find the enforced restrictions very difficult and despite choosing to have remote treatment do not have sufficiently private spaces in their homes where they can engage. In these instances we will work to find individualised solutions to accommodate them.
Camden CAMHS	Q2 DNA Target was 8.29%, this quarter has decrease from last has reduce to 5.72%. This improvement suggests that patients are attending appointments due to face to face and zoom appointments being available during the Covid pandemic.	We will continue to offer appointments in our service using our Face to Face and Zoom appointments for our patients. However, we could see a possible increase in DNA's due to the current lockdown and increase in the new Covid variant.
Other CAMHS	Our DNA rate has now remained below target for two years. We are pleased that we have been able to maintain this and continue to monitor it.	Maintain low DNA rate into the new year and address any increase.

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

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adult Complex Needs	In looking at the data from the Q3 report there does appear to be a significant number of group therapy patients that have DNA'd their appointments for a variety of reasons over a number of weeks and months; with documented attempts from the clinician to re-engage them. Some of the reasons for the level of DNAs appear to centre on a lack of private space for the patient to join their session or technical difficulties with Zoom appointments, which is also the case for individual therapy. We also note that clinically there is difficulty in running group therapy remotely over a long period; as commitment to the therapy in a group setting is more challenging than individual therapy.	The plan for the next quarter is to look in more detail at the reasons patients are giving for DNA-ing their appointments, on a monthly basis and put plans in place to address some of the issues. In relation to appointments being sent via Zoom, clinicians will be encouraged to send one recurring link that can then be saved to the patient's CareNotes record; ready for the admin team to resend if the patient rings during their session with difficultly joining or finding the link. The admin team have already had some success with helping patients join their remote sessions in this way. We will also need to assess if a more detailed guide is needed for patients using Zoom. Further discussion on DNA rates for group patients, which is significantly higher, will be taken forward at the services' clinical team meetings going forward.
Portman	As for the previous quarter, we are pleased that our DNA rates have remained below the 10% limit. This has been despite the challenges of working online, and is remarkable considering that we have now moved all therapy groups online, which tend to bring higher DNA rates.	We will continue to monitor DNA rates but there is no indication for a review of processes relating to this parameter for now.
City and Hackney PCPS	While PCPCS's remit is to see hard-to-engage patients, it is disappointing to see the service's DNA rate rise above the Trust's target of 10%. The rise may be due to group treatments starting again, now remotely, in Q3. These sessions tend to have a higher DNA rate that individual sessions, especially in their early weeks. The wider context of COVID-19 should also not be ignored, with another lockdown in November and changes to the Tier system throughout. This may more negatively impact patients who may already feel overwhelmed or suffer from health anxieties and/or medically unexplained symptoms. The team works hard to keep DNAs to a minimum, but some level of non-attendance is to be expected. PCPCS uses telephone contact, letters, email, and SMS reminders to inform patients of their appointment details and encourage engagement with their treatment. This has been especially important while face-to-face interaction has not been possibly.	We hope to lower the rate in Q4, and continue to use the means available to us to sustain patient engagement in their treatment. The service has continues to provide therapies remotely, and the response from patients has been positive. We will continue to place importance on clear and regular contact with our patients, as we believe this creates mutual respect and trust, positively impacting outcomes and engagement.
TAP	The DNA rate benefitted from a QI project that was set up in the service (which looked at how we record DNAs) and appears to have remained stable although not quite meeting the target. There were proposals to look at DNA rates more in-depth which could involve making contact with patients who have disengaged with the service and offer a brief telephone interview to explore reasons but this is on hold due to lack of resources.	Based on the above target, we could consider directing resources towards looking at DNA rates more in depth, for example does length of wait affect DNA rate or other characteristics to the presentation but we currently have no specific staff available to do this.

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

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q3	Objective / plan for next Quarter
GIC	Our DNA rate has risen over the las over the last few quarters. We have tried different approaches to bring this number down. We are unsure of the reasoning behind this, but will continue to work on different approaches.	We are trailing being more strict with those who have multiple DNAs going forward to see if this encourages individuals to attend appointment or cancel in good time.
GIDS	GIDS DNA rate has reduced this quarter, which is good news. We feel this is primarily due to the continued flexibility regarding remote appointments which adds convenience to those who find travel to site difficult.	We plan to continue to offer remote appointments due to constrictions of the current pandemic. However beyond that, the positive impact on our DNA rate suggests a rationale for utilisation beyond these circumstances – i.e. we should consider long term provision of remote appointments where it increases access to the service and where it is clinically appropriate.

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 3 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	This was completed in Q2 and there were no further audits undertaken in Q3. As described below, we are planning a review audit in Q4.	Ongoing
Agree parameters for when CareNotes Alerts should be used across the Trust	Agreement has been reached on what is an appropriate use of an alerts and a plan made for the evaluation of all existing alerts. This has been shared and is being rolled out in CYAF, GIDS, Adult Complex Needs and PCPCS. Some further work needs to be undertaken to cover some small amendments needed at the Portman Clinic	Ongoing
Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review	See above	Ongoing
Implement guidance and re-audit across the directorates to assess adherence to the new guidance.	A re-audit will be undertaken in Q4	Ongoing

3.2 **Quality Priority 2**

Quality Priority	2 - Experience of Service Questionnaire (ESQ) implementation	Quality Priority
Key Workstreams	**Quarter 3 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	Feedback with Adult Directorate for consideration.	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	The collection numbers for the first 2 tests are gathered, and were for teams that do not have a standard test, nor collect data – so all collections increased data. 30 for Mosaic and 22 for TAP. The Q3 test will both have comparable data from our reporting systems with the data quality team to compare return rates. This will be completed in Q4 when forms are returned to PPI.	Ongoing
Work with teams to increase use of the ESQ data to improve and develop services	The PPI team are working with North Camden and Learning Disability/Autistic Spectrum Disorder team Managers in Q3 to make sure data is being meaningfully shared in team meetings. The LD/ASD team are doing some further comparative work which we hope to make available in Q4.	Ongoing

3.3 **Quality Priority 3**

Quality Priority	3. Improve Waiting Times Across the Trust	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice	Progress as originally planned on this has been delayed due to other pressing priorities. However, CYAF are progressing work with informatics to allow them to manage waits for specialist treatments (e.g. waits for child psychotherapy rather than first or second appts) using Carenotes. This will put an end to the myriad of systems currently used across teams (spreadsheets, word docs etc) to have a central way of managing our waits and to provide accurate reporting on them. In addition, GIDS has submitted an action plan to CQC for addressing waiting times, which has required detailed analysis of range, variation and areas of good practice. In some cases this builds on existing QI projects on, for example, parity of wait times between teams and intake procedures. A focused piece of work is also under way across GIDS and GIC to analyse and make recommendations for future practice in relation to demand, capacity and waitlist management.	On hold
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)	Unfortunately progress on this has been delayed due to other pressing priorities. However, work is now being taken forward in priority areas as identified above.	On hold
Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 & Q4)	See comments on workstream one. This work is being reconfigured, with a strong focus and comprehensive plans over the course of the next year. As good practice is identified and lessons learned, this will be applied across the Trust.	On hold

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback	In quarter three we have confirmed agreement to a more substantive trial of the Qualtrics software which should help the trust to work towards electronic OM in a simplified form. The intention is to reduce the majority of paper based OM and increase visibility and accessibility of OM by automating its application, this in turn should remove the responsibility and workload from clinical teams in distributing (and remembering) OM. We hope it will also increase the ease of return (no stamps or envelopes). There are issues to attend to including the degree of anonymity that any remote system can allow. Some experts by experience (service users) have indicated a tension between true anonymity / freedom of expression and the trusts contractual / corporate need for identifying details.	Ongoing
Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications	Informatics are working on co-ordinating all outstanding requests relating to improving Carenotes functionality when it comes to reporting on Outcome Measures. Meetings held during Q3 to identify and update outstanding requests and making subsequent workforce plans for actioning requests and feeding back on where there are technical limitations that will inhibit progress in certain areas. Work has been undertaken between the Informatics team and CYAF management to improve and refine the logic with GBM forms on Carenotes to ensure that subsequent forms are reliably and sensibly linked to previous forms (e.g. ensuring subsequent forms ask for the same number of goal updates as were listed in the first form, having information from the first form be auto-populated into subsequent forms etc..) More work undertaken in relation to GBM logic to ensure that GBM's reliably generate for patients who are re-referred. Technical codes altered during Q3 to resolve this issue.	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	Informatics have produced a new report which allows local admin teams to quickly run reports to identify which outcomes measures are due for patients, and so the hope is that the introduction and use of this report will result in an increase in forms being completed. New logic has been added to the Carenotes system that adjusts the way that 'due' forms are flagged up, which will make it clearer to teams which is the most recent due form that requires completing. Aims for next Quarter: • To consider Qualtrics pilots across directorates and take to the trust wide forum for co-production.	Ongoing

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures	**CYAF Update** Work has been undertaken with the informatics team to adjust the cohort required to complete GBM forms according to their recorded thrive category. Technical rule set has been adjusted so that for patients with 'getting advice' and 'risk support' thrive categories, clinicians will no longer be required to constantly complete a series of forms marked as N/A. Hopefully the streamlining of these requests will mean that due forms will be completed more diligently now that requests are all meaningful and appropriate. **AFS Update** The Adult Complex Needs Department is currently carrying out the second PDSA cycle of the Outcome Monitoring quality improvement project. Within the second PDSA cycle the CORE-10 has replaced the CORE-34 to see whether a shorter version of the CORE form will increase return rates. Patients were sent this prior to Christmas break, and we are still collating responses. A reminder will be sent out in a few weeks. Portman – when the clinic was working from the Portman building a receptionist would consistently hand out measures before clinical sessions. This proved to be the most reliable & best method in ascertaining a good return rate. However, this isn't possible anymore as working remotely therefore returns have gone down. Many Portman patients do not have email, or they cannot download documents in order to complete them and email them back. As such, it would be best for them if they could complete the measures online and we would email them a link. The new Qualtrics system could be considered for this purpose. The QI project has also highlighted further Carenotes reporting issues. This is to be presented at the Exec meeting later this month to further explore service improvement options Primary Care – we note that PCPCS (Hackney Primary Care) has the consistently highest use and return of OM in AFS which suggests, from its own history, that success is partly cultural in accepting the necessity and value of OM. Not all patients or clinicians accept this and whilst we must not become preoccupied with 'instruments' i.e. they can be used defensively, there is a clear need for solid data to evidence our claims of providing effective treatments which seek resources. The Quality Assurance team have been working with Informatics on the production of a dependable report for measuring both the rate at which multiple CORE OM forms are completed for adult patients, but also for measuring the change in scores between completed forms. This will allow for the sharing of both completion and improvement rates. It is the team's hope that being able to share information on improvement rates (previously unavailable) can act as a motivator for completing forms, as teams will be able to receive feedback based on the forms they complete. **Gender Services Update** GIDS - we note some drop in ESQ returns since employing Qualtrics (which has not been the case with our other psychosocial questionnaires used for clinical and research purposes). Our hypothesis is that the anonymous nature of these means that individuals cannot be sent reminders to complete and so rates are low (also not having access to older service users email addresses to send on remains a challenge). GIC - It is important to note that this clinic is not a mental health service and as such does not use routine OM in the form of Psychological testing used by CYAF and AFS, but does focus on. GIC are looking into alternatives to the ESQ form to allow them to digitally capture meaningful outcome/experiential data from their service users I am pleased to report and have been greatly impressed by the wide range of medical, occupational and speech related monitoring and testing that the clinic uses in its ambition to provide a caring and humane service that is not predicated on a psychiatric model of care.	Ongoing

Section Five: Trust Targets – KPI

Quality Key Performance Indicators										
Target See Slide 11 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%	93% 1/15	87.5% 35/40	100% 15/15					
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%	36% 5/14	25% 1/4					
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	100%	100%	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	All quarterly reports will be uploaded to Trust website	All quarterly reports will be uploaded to Trust 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	Yes, action plans are drafted for all complaint which are fully or partially upheld	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	7 outstanding complaints. Delays due to not being able to complete investigations due to COVID19	10 outstanding complaints. Delays due to not being able to complete investigations due to COVID19					
ii) Number of complaints reported to CQC	Quarterly	n/a	none	none	none					
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	none	none	none					
iv) Number of re-opened complaints.	Quarterly	n/a	none	none	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%	2.22%	2.36%					
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		See attached clinical audit paper Document						
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	Q2 & Q4			See attached clinical audit paper Microsoft Word Document						
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		See attached clinical audit paper Microsoft Word Document						

Section Five: Trust Targets – KPI

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target See Slide 13 on HR for graphical representation	Monitoring	Target%	% Progress Q3 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%	45%	17%					
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%		0.50%	1.5%					
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%	59%	64%					
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%	97%	97.69%					
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 Q3 20/21	RAG Progress			
					Q1	Q2	Q3	Q4
CAMHS Transformation Targets Run for London Contracts only	80% initial completed care plans	Q1-Q4	80%	**Q3 compliance 49% compliance (52% in Q2)** 161 assessment summaries were completed, out of those 79 initial care plans were created It is disappointing that the rate for Care Plan completion has dropped this quarter, this is not something we can identify and obvious reason for. As with OM we do now include the rates of completion in our monthly dashboards at a team level and there seems to be a delay in completing these and there is wide variance across the teams. We will develop an action plan for Q4 to look into the following areas 1. Are the reports on Care Plans sent as expected 2. Are they used by team managers 3. What other factors are driving the continued low rate of compliance				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	**Q3 compliance 30% compliance (46% in Q2)** 281 Assessment Summaries completed, of those, there were 83 Review Care Plans created/shared . The percentage of those care plans completed with in 6 months of the initial Assessment Summary was 8% See above				
	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 Q3 there were 44 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 44 responses, 40 patients answered 'certainly true' and 2 answered 'partly true' **giving a compliance rate of 95%** We are pleased that we consistently deliver on this target. We are exploring ways to increase the rate of completion of ESQS which will mean we have more data to use.				

Data source: 07/01/2021 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 Q3 20/21 See Slide 15 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 Run for London Contracts only	GBM Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q3 compliance 37% compliance (25% in Q2)** **61 GBM T1's out of 163 due in period were completed** We are pleased to see an improvement in our compliance this quarter. We have in this quarter implemented team level reporting on GBM time 1 and 2 at a team level through our dashboards. This indicated that GBMs are used but are often completed late, this is something we are following up with teams. We have also implemented a new report that allows clinicians and teams to see what OM they have due for completion, though not all staff can access reporting services at this point. We have identified a number of issues with the Carenotes assist panel that are in the process of being resolved – one of these was that GBM's did not generate for patients that were re-referred which is quite a large number of our caseload. Further the system seems to have a number of issues with the number of goals it requires to be completed, these are being addressed but the problems impact staff feelings about the use of OM.				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q3 compliance 63% compliance (50% in Q2)** **96 CGAS T1's out of 153 due in period were completed** We are pleased to see a significant improvement in CGAS completion this quarter. Please note the comments made in regards to GBM				
	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%	**Q3 compliance 40% compliance (32% in Q2)** **21 GBMs T2's out of 52 due in period were completed** As per T1				
	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%	**Q3 compliance 50% compliance (51% in Q2)** **54 CGAS T2's out of 108 due in period were completed** As per T1				

Data source: 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Report to	Date
Board of Directors	26th January 2021

CQC – focused inspection of GIDS

Executive Summary

This report covers the outcome of the CQC focused inspection of GIDS which was published in Wednesday 20th January and resulting action.

Recommendation to the Board

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

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

CQC – Focused Inspection of GIDS

1. Introduction

1.1 As the Board is aware the CQC carried out a focused inspection of the Trust's Gender Identity Development Service (GIDS) in October 2020. They published their report on 20th January. This is attached at **Annex A**.

1.2 In their report rated the service as "inadequate". It had been previously rated as Good in 2016. The overall "inadequate" rating was driven by "inadequate ratings" for the responsive and well led domains. Safe and effective domains were rated "requiring improvement" and the service was rated "good" for the caring domain with CQC and the patients and families they talked to giving positive feedback about the understanding, compassion and kindness of staff.

2. Waiting times

2.1 CQC made a number of areas of criticism in their report. Their biggest concern related to waiting times and this was the key reason for the inadequate rating for the responsive domain. As previously shared with the Board, they have already imposed an enforcement action on the Trust in relation to waiting times.

2.2 We accept the serious nature of issues around waiting times and the distress that delays in treatment cause patients awaiting treatment.

2.3 In response to the enforcement notice we submitted on 17th December a plan to CQC on the actions we can take to reduce waiting times. This is attached at **Annex B**.

2.4 As part of this we are also in discussion with NHS England, our commissioner about how we manage our referral criteria. CQC's report recognises that demand has increased beyond the capacity of the service.

3. Other major areas of criticism

3.1 The report highlights a number of other important areas of criticism. These include the need for:

- Improvements in record keeping including better and consistent capturing of risk and care plans.
- A more standardised approach to assessment and other aspects of the work with the aim of reducing unjustified variation in practice.
- Consolidation of the changes we have already made with the introduction of the standard operating procedures (SOPs) on safeguarding and consent. This includes a requirement for a retrospective audit of live cases assessed before the introduction of the SOP on Consent in January 2020.

- Further action to support the service around culture and leadership including addressing issues about the raising and handling of concerns.

3.2 In total we have given 10 "must do" actions and 6 "should do actions" which will need to be addressed in our Action Plan. We are required to submit this to CQC by 17th February.

3.3 These issues develop themes identified in the GIDS Review and in subsequent plans for improvement. They also continue to reflect the difficulties the service has experienced in managing its dramatic increase in scale and in operating in such a contested space. While CQC recognise some of the progress which has been since the GIDS Review their report and ratings do, however, mean we should significantly accelerate the pace of change.

4. Management and Governance

4.1 In response to the CQC report and the breadth of existing actions flowing from the Judicial Review judgment we are proposing to take immediate action to strengthen management arrangements for the service and increase our clinical and operational capacity to deliver change.

4.2 **Annex C** sets out these arrangements in more detail. The key elements are:

- To set up a new Interim GIDS Management Board, chaired by the Divisional Director for Gender. This will replace existing senior management structures in GIDS and will provide a single point of accountability for both improvement programmes and existing service delivery. The Board will be accountable to a new GIDS Oversight Committee which I will chair and on clinical governance issues to the Integrated Governance Committee.

- The establishment of 6 work programmes which will report to the Interim GIDS Management Board. These include:

    - Work on the New Endocrine Pathway including the completion of clinical reviews and associated best interest orders as required by the JR judgment.

    - Wait List Reduction.

    - Clinical governance, safety and practice development

    - Organisational Development

    - Data strategy

    - Current GIDS clinical operational delivery

- The recruitment of a range of clinical and operational experts from outside the service, and in most cases from outside the Trust to increase our capacity to manage

and deliver change at pace. They will work alongside existing GIDS clinicians and operational staff in taking forward the identified workstreams. We are also investing in programme management capability to ensure we can effectively support all the work programmes and report to key internal and external audiences.

4.3 It is proposed to start these new arrangements from 1st February. We anticipate the interim arrangements will last for between 6-12 months. Alongside this we will develop and implement plans for a longer-term restructuring of the service.

5. Staff Support and Communications

5.1 The CQC report coming on top of the JR judgment and the ongoing coverage of the service is very difficult and there is a real risk of it destabilising the staff group. We have had a series of briefing meetings with staff at all levels in the service to prepare them for the news and to discuss our response.

5.2 Communications will be key going forward, in particular given the need to move at pace. While we cannot consult at length on all the changes required it will be important we ensure there is a good level of focused involvement from the existing staff group in all of the areas of improvement work.

5.3 The good rating for caring has been an important consolation for staff. It will be crucial that we ensure we respect and retain the key aspects which have underpinned this while at the same time taking forward required actions to improve the consistency and structure of our processes and our clinical practice.

5.4 We will also need to involve patients and families. Our initial communications to patients and families, including an open letter and video message form have focused on acknowledging criticisms, in particular in relation to waiting times and setting out our commitment to make improvements while building on the caring quality of clinical work which is clearly appreciated by patients and families.

6. Conclusion

6.1 The Board are asked:

- To consider and note the content of the CQC report.
- To note the Trust's plan for improving waiting times.
- To the note timeframe and issues to be addressed in the Trust's Action Plan responding to CQC's "must do" and "should do" actions.
- To consider and agree the proposed interim management arrangements for GIDS.

Paul Jenkins
Chief Executive
21st January 2021

Tavistock and Portman NHS Foundation Trust

Gender identity services

Inspection report

The Tavistock Centre
London
NW3 5BA
Tel: 02074357111
www.tavistockandportman.nhs.uk

Date of inspection visit: 14 October 2020 to 6 November 2020
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Inadequate
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Our findings

Gender identity services

Inadequate 

This was an announced, focused inspection of the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust.

The Gender Identity and Development Service (GIDS) is provided by the Tavistock and Portman NHS Foundation Trust. In October 2020, the service was working with 2093 young people. The service is based at the Tavistock Centre in London. The service has a regional centre in Leeds and satellite clinics in Exeter, Bristol and Birmingham. Most of the referrals to the service are from GPs and child and adolescent mental health services. The service also accepts referrals from other health, social care and education professionals and from voluntary organisations. Referrals are made for people under the age of 18 with features of gender dysphoria. Gender dysphoria describes a sense of unease that a person may have because of a mismatch between their assigned sex at birth and their gender identity. The gender dysphoria leads to clinically significant distress and/or social occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The service is commissioned by NHS England. The service is commissioned to provide assessments of young people, refer young people for medical treatment when appropriate and provide some continuing support when this is required. It is a national specialist service and is the only service available in England for children and young people with gender dysphoria. The service also treats children and young people from Wales.

The Tavistock and Portman NHS Foundation Trust provide outpatient psychosocial services only, and GIDS provides outpatient services for gender dysphoria. Any medical treatment is provided by other acute healthcare providers and the Tavistock and Portman NHS Foundation Trust refer into these as required. Medical treatment involves the prescribing of medicines that pause the physical changes of puberty and hormones that alter characteristics of gender. This medical treatment is provided by the endocrinology departments at University College Hospital London and Leeds General Infirmary. The CQC inspected and published reports on these services at the same time as the inspection and publication of GIDS.

Our last inspection of GIDS was in 2016. This took place as part of an overall inspection of the Tavistock and Portman NHS Trust. Following the inspection, we rated the trust as good overall. The domains of effective, caring, responsive and well-led were rated as good. The domain of safe was rated as requires improvement, although the improvements we said the trust must make related to a different service within the trust.

We undertook this inspection due to concerns reported to the CQC by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures and assessments of capacity to consent to treatment. This inspection focused on the Gender Identity Development Service (GIDS) only.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent at the service to prevent cross infection. Four inspectors and a CQC specialist advisor visited the service at the Tavistock Centre on 14 and 15 October 2020 to review patients' records and complete essential checks. Two inspectors visited the service

Our findings

in Leeds on 20 October 2020. Whilst on site we wore appropriate personal protective equipment (PPE) and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included interviews by telephone, the use of video conferencing facilities and analysis of evidence and documents. Our final staff interview was completed on the 6 November 2020.

Separate from our inspection the High Court made a ruling on the 1 December 2020 around capacity and consent of children receiving hormone intervention for gender dysphoria. This ruling has not impacted on our findings. Our findings and judgements are based on the legal position at the time of our inspection.

Prior to, and during, the inspection we received intelligence from former members of staff and healthcare professionals not directly associated with the service. During the inspection visit, the inspection team:

- visited the service to look at the quality of the environments
- spoke with 22 young people who were using the service
- spoke with 13 parents of young people using the service
- reviewed information from 23 people who contacted the CQC through our website to share their experience of using the service
- reviewed information from six people on the waiting list who contacted the CQC through our website
- reviewed information from six service users and parents who wanted to share their experience via an independent organisation
- spoke with four members of the GIDS clinical executive team, the GIDS safeguarding lead, the GIDS service manager, the divisional director for gender service, the medical director, human resources director and a staff governor.
- spoke with 30 other staff members across the multidisciplinary team
- looked at 35 patients' records
- looked at a range of policies, procedures and other documents relating to the running of the service.

Overall summary

Our rating of this service went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4600 young people on the waiting list. Young people waited over two years for their first appointment.
- Staff did not always assess and manage risk well. Many of the young people waiting for or receiving a service were vulnerable and at risk of self-harm. The size of the waiting list meant that staff were unable to proactively manage the risks to patients waiting for a first appointment. For those young people receiving a service, individual risk assessments were not always in place with plans for how to manage these risks. The number of patients on the caseload of the teams, and of individual members of staff, were high making caseloads difficult to manage and placing pressure on staff.
- Staff did not develop holistic care plans for young people. Records of clinical sessions did not include any structured plans for care or further action. Staff did not sufficiently record the reasons for their clinical decisions in case notes. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.

Our findings

- Staff had not consistently recorded the competency, capacity and consent of patients referred for medical treatment before January 2020. However, since this date these decisions had been recorded.
- The teams did not always include the full range of specialists required to meet the individual needs of the patients. Staff did not always work well together as a multidisciplinary team.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.

However:

- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Feedback from young people and families currently being seen at the service was overwhelmingly positive about the care and support staff had provided.
- Staff referred young people to other providers for medical treatments that were consistent with good practice.
- Managers ensured that staff received training, supervision and appraisal. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Clinical premises where patients were seen were safe and clean.

Following the inspection, we took enforcement action against this provider under the Health and Social Care Act 2008 by imposing a condition upon their registration. This requires the trust to report to us on a monthly basis so we can monitor their progress with improving their waiting times.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement because:

- Many of the young people waiting for or receiving a service were very vulnerable and at risk of self-harm. Despite this staff often did not assess the risks presented by young people and their families. Staff did not create plans to manage risks. The size of the waiting list meant that staff could not proactively monitor the risks to all patients waiting for their first appointment. However, in a few cases, where patients presented a particularly high risk, staff worked effectively with child and adolescent mental health services and children's social care services to ensure that young people were safe.
- Staff did not always work well with other agencies to safeguard young people. Most records did not include plans, agreed with other agencies, on sharing information and protecting young people.
- Not all staff had completed an appropriate level of training in safeguarding adults.
- The number of young people on the caseload of the teams, and of individual members of staff, was high and varied considerably between different members of staff, causing caseloads to be stressful and difficult to manage.

However:

Our findings

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Clinical premises where patients were seen were safe and clean.

Detailed Findings

Safe and clean environment

Interview rooms were not fitted with alarms. Staff considered that the risk presented by interviews was low and did not require alarms to be installed.

The waiting area provided a comfortable space for young people to wait for appointments. There were four chairs in the waiting room all suitably distanced from each other.

All areas were clean, had good furnishings and were well-maintained. Interview rooms were bright with comfortable chairs.

Staff adhered to infection control principles, including handwashing. Between the onset of the Covid-19 pandemic in March 2020 and October 2020, the service conducted 6360 consultations. Only 7% had involved face-to-face meetings. Forty-one percent had been carried out by telephone. Fifty two percent had been carried out using video call facilities. Face-to-face consultations were only arranged for specific reasons, such as if a patient was particularly vulnerable. The service did not refer young people to the endocrinology service unless the young person had met a therapist in person. Therefore, some young people needed to attend the service in order for a referral to be made. When staff, young people and visitors attended the service, they were required to wear a face mask at all times. Hand sanitising gel was provided at the entrance to the building, at the entrance to all the corridors and in the toilets.

Safe staffing

The established number of clinical psychologists and psychotherapists for the service was 66.3 whole time equivalents (WTE). The established number of assistant psychologists was 6.6 WTE. The service employed 15 administrators, 1.8 consultant psychiatrists and 1.8 specialist nurses. The service also received support from service managers, project managers, research assistants and divisional level staff. The vacancy rate for the service was 17%. This included vacancies for 9.2 psychologists or psychotherapists, six administrators and three assistant psychologists.

During 2019/20, the staff turnover for the service was 23.5%. This is very similar to the total turnover for the trust which was 23.68%. During the same period, the sickness rate for the service was 2.19%. This is very similar to the overall rate for the trust of 2.5%.

The provider had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. The level of staffing was based on the budget for the service agreed with the commissioners. The staffing allocation had been calculated to take account of the waiting list and the current caseload for staff.

Our findings

The caseload for each member of staff varied considerably. Ten members of staff had a caseload of less than 10 young people. One member of staff had a caseload of over 100. Sixty-five percent of staff had a caseload over 40, including 34% of staff who had a caseload over 60. The overall average was 45.53. This increased to 52.5 when staff with a caseload under ten were removed from the calculation. This meant that staff were working with high numbers of clients which could be stressful and difficult to manage.

Cover arrangements for sickness, leave and vacant posts ensured patient safety. Staff worked on each case in partnership with a colleague. If a member of staff was off work due to leave or sickness, the case would be covered by their partner.

The service used bank and agency staff appropriately. Between April and June 2020, the service had not used any agency staff. The service had used bank staff to deliver 2% of the service during this time, meaning that permanent staff had provided 98% of the service.

The service had rapid access to a psychiatrist when needed. The service had an urgent concerns protocol. This protocol included arrangements for an on-call rota for psychiatrists who could see young people urgently.

Staff were not up-to-date with all appropriate mandatory training. The trust had designated 17 courses as mandatory for some or all their staff. Overall compliance with mandatory training was 86%. The service achieved compliance of over 90% for courses on equality, diversity and human rights (95%), infection prevention and control (96%) and safeguarding children level 3 (95%). However, compliance fell below 75% for training on preventing radicalisation (74%), resuscitation (70.21%), and adult basic life support (54%).

Assessing and managing risk to young people and staff

We reviewed the assessment and management of risk in 29 care records. Twenty-eight of these records included details of risks that were relevant to the young person. However, the recording of risk and of plans to manage these risks varied considerably. Some records demonstrated good practice, such as completing risk assessments jointly with child and adolescent mental health services. Others had limited information. For example, one record had very little information about risks, despite the referral letter stating that the young person had frequent suicidal thoughts and had previously harmed themselves by cutting.

Assessment of patient risk

Staff recorded the risks presented by the young person at the initial appointment, either in the record of the appointment or on a standard form. Staff had identified many young people as being vulnerable to specific risks. We found examples of young people who had made suicide attempts, young people who were vulnerable to sexual exploitation and young people who had a history of inappropriate or high-risk sexual behaviour. Records of risks were based on information provided by young people, parents and the person making the referral. Staff did not routinely update the risk assessment form, although updated information relating to risks was recorded in the notes of meetings with young people.

Staff used a recognised risk assessment tool. The service had introduced a standard risk assessment form in April 2020. This form had been completed on most of the records we reviewed. However, on some records, staff only completed very brief details. The risks were not always assessed by staff in relation to the impact of the risk and the likelihood of risk incidents occurring. On some risk assessment forms, staff had not recorded all the risks discussed in the notes of meetings. This meant that someone unfamiliar with the patient may find it difficult to identify the risks quickly.

Our findings

Staff did not create crisis plans for young people. However, both young people and their parents said they would contact their counsellor if they had any problems or their situation deteriorated.

Management of risk

Staff usually managed significant risks appropriately, although their approach was not always structured or consistent. The primary approach for managing risk was known as the 'network model'. Through this model, clinicians liaised with the young peoples' local services, including child and adolescent mental health services (CAMHS), children's social services, GP and special needs co-ordinators in schools, to ensure that risks were being appropriately managed. We saw some evidence of this model working well. For example, one record showed evidence of joint working with the patient's CAMHS and voluntary sector organisations. This included sharing information in accordance with an agreed protocol. Another record included a joint assessment by GIDS and CAMHS. When young people were subject to high levels of risk, several other agencies were involved in supporting and protecting them However, the approach was not always consistent. On some records, the management of risk was poorly documented. Some records did not include a risk management plan to show how risks were being managed and which agencies were responsible. Two records for patients presenting a high level of risk did not include evidence to demonstrate that GIDS staff were fully involved in multi-agency meetings.

The service did not have the resources to sufficiently address risks associated with gender dysphoria of young people on the waiting list. The service had introduced an 'enquiries line' that young people on the waiting list or their parents could use to contact the service whilst waiting. This was to address the fact that the service could not proactively assess and manage all risks for the young person whilst they were waiting. The service relied on the child's local support agencies, such as CAMHS or the GP, to address serious risk issues that arose whilst the patient was waiting. However, some parents we spoke with said the support they had received from CAMHS was not relevant to their child's needs associated with gender dysphoria. Staff also said that the threshold to access CAMHS had increased, making it difficult for young people to access these services. The service had also carried out a pilot study to work with CAMHS to support young people on the waiting list, although this pilot had not demonstrated a significant impact. This meant that whilst serious risks to young people on the waiting list were managed by local services, who were in themselves stretched, young people's needs associated with gender dysphoria were often not being met and less serious risks were not addressed.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. The trust had a policy for lone working. This included guidance for staff working in isolation. Staff usually worked in pairs and met with young people and parents either at the trust's offices or using video conferencing facilities. None of the staff raised any concerns about working alone.

Safeguarding

Clinical staff were trained in safeguarding young people. Ninety-four percent of staff who were required to do so had completed level three training in safeguarding children. Three out of the four staff who had not completed this training had recently joined the service. However, non-clinical staff said they would find it helpful to have safeguarding training above the basic, level one training in order to become more confident in dealing with situations of possible abuse that had arisen through their daily contact with vulnerable young people.

Our findings

Safeguarding adults training was completed at level 2 for 68% of staff required to do so. This did not reach the trust target of 80% compliance. Records showed that some work with families involved supporting vulnerable adults at risk of abuse. This meant that staff may not be able to identify and respond to safeguarding matters relating to the parents they worked with. Staff providing safeguarding supervision had not received specialist safeguarding supervision training.

The trust had produced a standard operating procedure specifically for the Gender Identity and Development Service. Staff were required to report any safeguarding concerns to a supervisor, regional lead or senior clinician. The matter would then be reviewed by the trust's safeguarding team or the GIDS safeguarding lead and referred to the relevant multi-agency safeguarding hub if necessary. The GIDS safeguarding lead said that this procedure would be reviewed in November 2020. Most staff we spoke with gave examples of safeguarding concerns they had raised. For example, a clinician referred a patient to the multi-agency safeguarding hub following concerns about parental neglect and sexual abuse. Another clinician made a referral about a 17-year-old young person who was living independently in inappropriate housing, experiencing poor physical health and was not receiving any support.

Staff could give examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, one clinician gave an example of how they had worked with families that had held homophobic or transphobic attitudes. They explained that if this presented a risk to the young person, they would make a referral to children's social care services.

Staff knew how to identify young people at risk of, or suffering, significant harm. The service carried out work to support and protect young people in partnership with other agencies, such as CAMHS and children's social care services. We reviewed the records in relation to safeguarding young people for a sample of 22 patients. On 13 of these records, 60%, we found that there had been effective joint working with local agencies to support the young person. However, on three records we found insufficient evidence of multi-agency work. Two of these records involved patients who were at significant risk. The other six records showed some good practice and some areas for improvement. Clinicians said that the scope and quality of information sharing with multi-agency partners varied hugely depending on the local authority. Most records did not include any formal information sharing agreements with local services. This meant that whilst, in most cases, the structures and processes in place to safeguard young people worked well, there remained some risk that young people may not have been appropriately protected.

Staff access to essential information

Staff recorded all information on an electronic patient record system. Administrators scanned paper correspondence and uploaded this to the electronic record.

Information needed to deliver patient care was available to all relevant staff, although we found that staff kept records in an unstructured and poorly organised manner. This meant that it could be difficult to find important information quickly. For example, records did not include documents giving all the key information about young people such as details of the person or people with parental responsibility or professional contacts in other agencies such as schools and CAMHS. Records did not include care plans. Risk assessments did not include comprehensive risk management plans and some were not completed fully. Assessments were not recorded in a structured manner. This meant it would be difficult for someone unfamiliar with the young person to understand the work that had been carried out.

Track record on safety

Our findings

Between April 2019 and March 2020, there had been two serious incidents. Both of these incidents occurred in June 2019. In addition, there had been 64 reported incidents during this period. Between January and March 2020, there were 14 recorded incidents. One of these involved harm to a young person. This incident involved a young person taking an overdose of over-the-counter medicines after their therapeutic session evoked traumatic memories. One incident involved a member of the public posting abusive messages about the service on social media and one involved a member of the public leaving an abusive message on the service's voicemail. Other incidents related to information governance, communication and facilities.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record. Staff received training and information on incident reporting at a team meeting in July 2020.

Staff reported most incidents that should be reported. However, we found that some incidents identified during audits were not recorded in the electronic incident record. For example, an audit of capacity, competency and consent was carried out in March 2020. This audit found that assessments of capacity, competency and consent had not been recorded in accordance with the established procedures in eight of the 11 records reviewed. The absence of a structured assessment had not been recorded as an incident for any of these records, despite the absence of a formal record of assessment potentially leading to a risk of medicines being administered unlawfully.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when something went wrong. For example, a member of staff described an incident involving the young person's preferred name being written on a letter but their given name, which they did not like to use, was written on the envelope. The service sent the young person a formal apology for this.

Staff met to discuss feedback. For example, staff discussed cases where there were safeguarding concerns at regular case discussion forums, the monthly psychoanalytic forum, team meetings and reflective practice sessions. Staff discussed the suicide of a former patient and an information governance incident at a clinical governance meeting in July 2020.

Is the service effective?

Requires Improvement ↓↓

Our rating of effective went down. We rated it as requires improvement because:

- Staff's assessments of patients were unstructured, inconsistent and poorly recorded. Staff did not sufficiently record their reasoning in reaching clinical decisions. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.
- Staff did not develop care plans for young people. Many records provided insufficient evidence of staff considering the specific needs of young people, such as autistic spectrum disorders.
- Staff had only recently begun to record consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. The records of young people who began medical treatment before January 2020 did not include a record of their capacity, competency and consent. When staff identified records without a

written capacity assessment, they did not seek to address this or record it as an incident. However, staff had supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16.

- Staff did not consistently assess the physical healthcare needs of patients and how they could support them to access external services.
- The multi-disciplinary teams supporting the young people did not always include the specialists required to meet all the individual needs of patients under their care.
- Whilst staff were supported with ongoing supervision and appraisals it was not possible to see how these identified whether individual staff were performing in terms of meeting the requirements of the service and the young people they support.
- Whilst staff participated in clinical audit, they did not always act on the findings of audits to make improvements where needed.

However:

- Staff used some recognised rating scales to measure the impact of the service. They also participated in quality improvement projects.
- Managers provided an induction programme for new staff and there was access to ongoing specialist training.

Detailed findings

Assessment of needs and planning of care

We reviewed 35 care records. We found these records to be unstructured. Records did not provide evidence to show what staff were assessing. There was no clear rationale for clinical decision making.

Staff completed an assessment of each patient, although these assessments were completely unstructured. The specification for the service states that clinicians would assess young people during a course of between three and six sessions. Data from the trust shows that young people attended, on average, 10 assessment sessions. Eighteen percent of young people referred to an endocrinology service between March 2019 and March 2020 attended 25 or more assessment sessions. Although the trust had produced this data, it had not carried out any analysis to understand why there was such a high variation in the number of assessment sessions for each patient. Furthermore, there was no clearly defined assessment process. For example, there were no standard questions for staff to explore with young people at each session. Most records of assessment sessions were simply descriptions of conversations that had taken place between the clinician, the young person and their parents. None of the records included a clear statement of what the service was assessing. Whilst the criteria for considering referring young people for administration of hormone blockers was set out in the service specification, we saw no reference to this on any patient records. Although decisions about referrals to endocrinology were taken by at least two clinicians, it would be very difficult for the service to assess whether clinicians had made the correct decision in making a referral.

Although staff did not provide interventions for physical ill health, we did not see consistent evidence that staff routinely asked young people about their physical health, in order to refer them to external services if needed. We reviewed

physical health monitoring on 24 records. On 18 records (75%) there was no mention of physical health. Four records (16%) included a discussion of physical health at the initial meeting. This meant that staff were not consistently screening for physical health problems, unless these were included in the referral from the young person's GP or local CAMHS.

Staff did not develop care plans that met the needs identified during assessment. Some records included a short care plan in letters to the young person's GP, but these were usually very brief. For example, one of these letters simply stated that GIDS would continue to support the patient and refer to the adult service when the patient reached the age of 18. Records did not include plans for assessment and care that were specific to needs or circumstances of the young person. This meant that it would be difficult to someone unfamiliar with the young person to understand what assessments had been carried out or what the plans were for further assessment and treatment.

Best practice in treatment and care

We reviewed 35 care records. These records were not completed in a consistent or structured manner. This meant that many records did not demonstrate good practice.

Staff provided a range of care and treatment interventions suitable for the patient group. Care and treatment consisted of an assessment by clinicians followed by ongoing occasional contact with the service, more frequent input from the service approximately every three months or a referral to the endocrinology clinic with ongoing input from the service. The endocrinology clinic prescribed medicines used to block hormones and, therefore, inhibit hormonal changes that take place in puberty. The aim of this model was to provide support, advice and treatment to assist young people experiencing features of gender dysphoria in reducing behavioural, emotional and relationship difficulties. Twenty-eight percent of young people assessed by the service were referred to endocrine clinics for medical treatment. The decision to refer young people to endocrine clinics was taken by at least two clinicians and reviewed at a meeting of senior staff. However, records we reviewed did not sufficiently record the needs of patients with autistic spectrum disorders. The service did not record how many patients had a diagnosis, or suspected diagnosis, of an autistic spectrum disorder. We reviewed a sample of 22 records, more than half of which referred to autistic spectrum disorder or attention deficit hyperactivity disorder (ADHD). Discussions with staff about autistic spectrum disorders focused on the communication needs of these patients. Records we reviewed did not record consideration of the relationship between autistic spectrum disorder and gender dysphoria.

Staff used recognised rating scales and other approaches to rate the extent of young peoples' needs and to monitor outcomes. For example, the service used the Children's Global Assessment Scale to assess adolescent global functioning after psychological support and physical treatment. The service also used Patient Rated Outcome Measures to assess the progress each patient felt they had made as a result of interventions by the service. This included specific measures for gender dysphoria and a self-harm questionnaire.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, the service carried out an audit to see how many young people had received an assessment using the Children's Global Assessment Scale (CGAS). The audit found that 97% of young people who had been discharged between April and June 2020 had received an assessment using this tool. The audit showed a small increase in the average CGAS score from 63.1 at the initial assessment to 66.4 at a pre-discharge assessment. This meant there was, on average, a small increase in patient's global functioning during their treatment, although this did not indicate a significant change. In addition, the service completed quarterly audits of the completion of 'Safeguarding and Risk Forms' and the completion of safeguarding supervision forms to check that these forms were completed correctly. The service had begun work on a quality improvement initiative to improve consistency in managing waiting times.

Our findings

Skilled staff to deliver care

The staff team included clinical psychologists, psychotherapists, family therapists, specialist social workers and a counselling psychologist and assistant psychologists. The service also employed two psychiatrists, two specialist nurses and a large team of administrators.

Staff were experienced and qualified and had the right skills and knowledge to meet the primary needs of the patient group. However, staff did not necessarily have the skills or experience to meet the needs of young people with complex needs. For example, whilst some staff had previous experience of working with patients with autistic spectrum disorders, the service did not employ a specialist to focus on this area of clinical practice. This meant the service may not be sufficiently able to assess the needs of young people with complex needs.

Managers provided new staff with appropriate induction. The induction period for new staff was six months, although this could be extended to ten months if necessary. Clinical staff primarily learned from working alongside experienced colleagues. New staff received supervision once a week. The service had introduced an electronic platform where staff could access teaching materials, text and academic papers that new staff were required to read as part of their induction.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings. Data from the trust showed that clinical staff within the service had received supervision in accordance with the trust's policy. The service in Leeds had recently reintroduced supervision for administrative staff. Staff said that supervision was helpful, providing the opportunity to discuss complex cases and safeguarding matters. However, records of supervision sessions were held confidentially between the supervisor and supervisee. This meant that these discussions lacked transparency and made it difficult for senior staff to monitor the quality of line management. Managers conducted appraisals using a standard development and appraisal form. Completion of this form involved a discussion with the member of staff about their work over the past year, a review of their performance against objectives and a review of their personal development plan. Appraisals also involved agreeing objectives for the year ahead. The trust had developed a training presentation for staff and managers to help them conduct effective appraisals. The service also held discussion forums for staff including weekly team meetings, clinical discussion forums and complex case panels.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers created continuing professional development plans collaborative with staff at annual appraisals.

Managers ensured that staff received the training for their roles. The service provided staff with training sessions at regular team meetings. For example, staff had received training sessions on autistic spectrum disorders, sexual abuse, gender presentation and the Mental Capacity Act.

There was variation in how managers dealt with staff performance. Concerns about poor performance could be identified through supervision or joint working with colleagues. Systems were in place for managers to work with staff to identify and address their development needs by creating an action plan. Managers could be supported by the trust human resources department when necessary. However, staff told us that performance varied enormously. For example, staff said that one member of staff worked with two young people each week whilst other staff worked with 17. They said these types of discrepancies in performance were not addressed.

Multidisciplinary and interagency teamwork

Our findings

Staff held regular and effective multidisciplinary team meetings within the service. Staff held regional team meetings each week and meetings for all staff once a month. At regional team meetings staff discussed practical matters, such as leave and rotas, and complex cases. At meetings for all staff, there were discussions about waiting times, referrals, complaints, patient satisfaction surveys and patient involvement.

Staff usually shared information about young people although they did not always provide effective handover notes. Young people were assigned to a new clinician when the clinician they had been working with left the service. On one patient record, we found that the outgoing clinician had prepared comprehensive handover notes. However, on another record we found there were no handover notes. This meant it could be difficult for the new clinician to provide a consistent service.

The teams did not always have good working links with primary care, social services, and other teams external to the organisation. The service did have good relationships and regular meetings with the endocrinology departments that provided medical interventions. We also found some good practice, including an example of joint assessments with the young person's CAMHS. However, in some cases, work with other agencies was unstructured, inconsistent and poorly recorded. Two records showed that staff from GIDS were not fully involved in multi-agency meetings.

Good practice in applying the Mental Capacity Act

Staff had received training in the Mental Capacity Act 2005. This training included details of the five statutory principles of the Act. The service had provided training on the Mental Capacity Act to over 50 staff at a team meeting in July 2020. A further training session for staff on assessing competency in children under the age of 16 was held at the team meeting in October 2020.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act. When staff had any concerns about a patient's competency or capacity, they could discuss the matter with senior colleagues at the complex cases panel. If the staff required further advice, they could contact an independent legal service.

For young people who might have impaired mental capacity, staff had not always assessed and recorded competency or, capacity to consent appropriately, although the service had recently made some improvements. We reviewed 16 records of young people the service had referred to endocrinology services for hormone blockers. On six of these records where the patient had been referred for treatment before January 2020, there was no evidence of an assessment of the patient's capacity or competency. Some records showed that staff had discussed the effects of hormone treatment with the young people and recorded that the patient demonstrated an understanding of the potential benefits and side-effects, although these records still lacked a comprehensive, structured approach to the assessment of the patient's mental capacity. Since the introduction of a standard operating procedure for consent, capacity and competency, in January 2020 there had been improvements. This procedure had introduced a form for staff, young people and parents to sign confirming their consent to treatment. The procedure also introduced a checklist for staff to complete confirming that they have provided necessary information to young people and assessed all the components of young people' capacity, such as the ability to understand, retain and weigh up information, as well as being able to communicate their views. However, the absence of structured assessments prior to staff implementing the standard operating procedure in January 2020 meant that the service has not fully assessed the competency and capacity of some young people who were still receiving hormone blockers. At the time of the inspection we asked the trust to review this.

Our findings

Staff's approach to enabling young people to make their own decisions was unstructured and inconsistent although there was some evidence of good practice. Some records included very little information about the work carried out to help the young person make decisions. For example, on one record the evidence of capacity was limited to a statement that the young person was able to think about the pros and cons of treatment. Another simply said that the young person appeared to understand everything and is able to communicate their wishes. There were also some examples of good practice. For example, one record noted observations of family involvement. Also, in this record staff encouraged the young person to have a 'cooling off' period before proceeding with treatment to allow time for them to reflect on their decision. The service had produced a pictorial guide to the effects of hormone blockers. This had been designed for young people with autism or learning difficulties. Many young people said that staff had talked to them about their consent to treatment. Parents also said that decisions about treatment had been discussed at a number of sessions. This helped staff to assess young people's understanding and retention of the information provided. However, whilst staff demonstrated their work on helping young people to understand information about treatment, there were very few details on the records of staff engaging in the more difficult task of supporting young people weigh-up the foreseeable risks and consequences.

Staff audited the application of the Mental Capacity Act but did not always take action to address any learning that resulted from it. The service carried out audits of compliance with the standard operating procedure for consent, capacity and competency in March and September 2020. In the audit in March 2020, the service reviewed ten records of young people who had been referred to endocrinology for hormone blockers. Of these, only three contained a completed consent form and checklist for referral. Staff completing the audit had not recorded the absence of a structured assessment of capacity, competency and consent as a recordable incident. During our review of records, we found no evidence that staff had completed an assessment after the documentation was found to be missing. Again, this meant that staff had still not assessed the capacity and competency of young people receiving treatment, despite being aware that they had not done so. However, the audit carried out in September 2020 showed there had been improvements. This audit found that only three out of 29 referrals to endocrinology did not have a complete set of referral documents.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in their care and actively sought their feedback on the quality of care provided. They provided young people with details of organisations that could provide independent support and information.
- When appropriate, staff involved families and carers in assessment, treatment and care.
- Young people and parents could be involved in the design and delivery of the service.

Detailed findings

Our findings

During this inspection, we interviewed 22 young people receiving care and treatment from GIDS. We interviewed the parents of 13 young people using the service. Twenty-three people contacted the CQC through our website to share their experience of using the service. Feedback from these people was overwhelmingly positive. Six people on the waiting list for the service contacted us through the CQC website. These people were concerned about the length of time they had to wait.

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Throughout our interviews with staff they demonstrated a caring, supportive and understanding approach to patients. Clinicians talked about the importance of listening, engaging and understanding young people and families. Records showed examples of clinicians speaking with patients in a way that was supportive and appropriate to their age. Young people said that their clinicians always responded quickly if they contacted them between appointments.

Staff supported patients to understand and manage their care, treatment or condition. Throughout consultations, clinicians, young people and parents talked about how to manage the young person's situation. This involved, for example, discussion about problems at school as well as discussions about treatment.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff provided details of organisations that provided support and information to young people with gender dysphoria.

Patients said staff treated them well and behaved appropriately towards them. Feedback from young people about the staff was overwhelmingly positive. Young people described staff as knowledgeable, caring and understanding. Patients said they felt very safe with their clinicians and valued their non-judgemental approach.

Staff understood the individual needs of patients. However, there was no evidence of the service responding to young people's cultural and religious needs.

Staff maintained the confidentiality of information about patients. For example, clinicians routinely had consultations with young people and parents both jointly and on their own. This provided the opportunity for young people to discuss matters they may not have been comfortable discussing with their parents.

Involvement in care

Involvement of patients

Staff involved patients in discussions about their care and treatment. This included detailed discussions about possible medical interventions.

Staff communicated with young people so that they understood their care and treatment, including finding effective ways to communicate with young people with communication difficulties. Records showed that clinicians spoke with young people in a way that was supportive and appropriate to their age. The service had also provided an illustrated guide to puberty and hormone blockers for young people who may have found it difficult to read detailed text.

Our findings

Staff involved young people when appropriate in decisions about the service. The service had appointed a member of the executive team to be the lead in patient and public involvement. The service provided opportunities to train young people to sit on interview panels for the recruitment of new staff. There were also opportunities for young people to give feedback, to be involved in media activities, to take part in research and to be involved in other training and service development opportunities. At the time of the inspection, take up of these opportunities was low but staff were working to increase involvement.

Staff enabled young people to give feedback on the service they received. Young people and care givers were encouraged to complete an 'Experience of Service Questionnaire'. The questionnaire included 12 questions. This included questions about whether they felt listened to, were their views taken seriously and whether staff sufficiently explained the help available. Between January and March 2020, 44 young people and six parents had completed this questionnaire. The responses they provided were mostly positive. In response to the statement "Overall, the help I received here was good", 88% of young people and 86% of parents said this was certainly true. Respondents were also able to record comments. One young person said that staff were kind and listened to them. A parent said they trust the people they were working with and believed they had the child's best interests at heart. However, another young person said they found the process invasive and they felt staff had misunderstood what they were saying. A parent said they felt like they were being pushed into doing things they didn't want to do.

Young people could not access advocacy through this service. However, the service did give young people details of organisations that provided independent support and information.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. The service worked closely with the parents of young people using the service. Parents attended appointment with young people and were able to see clinicians in private. Feedback from parents was positive. Some parents described the service as being a 'life saver' and that they found a lot of the work to be family focused. Parents said that they were able to build positive relationships with their clinicians and that they trusted the staff to provide the right care, support and treatment for their child. The service also invited parents and siblings to 'Family Days' where families could meet with clinicians to learn more about the service. However, some parents said that they had had to wait a long time for an appointment and they did not receive any support whilst they were on the waiting list.

Staff enabled families and carers to give feedback on the service they received. Parents completed the 'Experience of Service Questionnaire'. Responses to this questionnaire were collated and reviewed by the trust.

Is the service responsive?

Inadequate ↓↓

Our rating of responsive went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4500 young people on the waiting list for the service. Young people often waited over two years for a first appointment.

Our findings

- The service did not have specific regard to the needs of all patients including those with a protected characteristic. Staff only completed ethnicity data for half the patients referred to the service. Work with young people did not include cultural and spiritual support.

However:

- Staff offered flexibility in appointment times and followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included facilitating transitions to adult gender identity services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service had a website that provided clear information to young people and parents and carers about the service. It had links to helpful information and resources and contact details for the service.

Detailed findings

The number of referrals to the service had increased from 77 in 2009/10 to over 2700 in 2019/20. Between 2010 and 2017, the number of referrals had, on average, increased by well over 50% each year. However, the rate of increase had slowed to 6% in both 2018/19 and 2019/20. During the year from April 2019 to March 2020, the service received 2736 referrals. The covid-19 pandemic had caused a reduction in referrals. Between January and March 2020, there was a small reduction from an average quarterly rate of 701 between April and December 2019, to 632. There was a more significant reduction between April and June 2020, with the number of referrals falling to 339. The service expected the number of referrals to increase as referral agencies adapt to covid-19 arrangements.

There was a long waiting list for the service. The service was commissioned as a single national provider and the growth in referrals had exceeded the capacity of the service. On 30 June 2020, there were 4509 patients on the waiting list for the service. This had risen to 4677 in October 2020. The service had introduced some initiatives to reduce the waiting list. For example, the service in Leeds had worked collaboratively with a local voluntary organisation to provide sessions on gender identity for young people on the waiting list. The service encouraged patients over 17 years and six months to be referred to the adult service. The service had also carried out work with child and adolescent mental health services to support patients on the waiting list. However, none of these initiatives had had a significant impact. There were not enough new patient appointments available to reduce the number of patients on the waiting list. The numbers of patients who were discharged or referred on from the service was consistently less than the number accepted on to the waiting list. For example, between January and March 2020, the service accepted 456 new patients onto the waiting list but only discharged 128. This meant the service continued to be unable to meet the needs of those young people waiting.

The service had clear criteria for which patients would be offered a service. The service accepted referrals from GPs, CAMHS, other health, social care and education professionals and from voluntary organisations for children and adolescents with features of gender dysphoria. The criteria did not exclude patients who needed treatment and would benefit from it. Between April 2019 and March 2020, the service accepted 90% of referrals made to the service. However, data from the trust showed that 33% of young person only attend one session.

Our findings

The provider did not meet its target for the time from referral to triage/assessment. The service aimed to see patients within 18 weeks from the date of referral. An 18 week wait target is set out in the NHS standard contract. Out of 1089 patients being seen by the service, only 13% were seen within 18 weeks. In total 64% of patients waited more than 66 weeks to be seen, including 26% who waited two or more years. Once patients had been seen at their initial appointment, their second appointment usually took place within the next 11 weeks.

It was possible for the team to see urgent referrals quickly, although regional teams took different approaches to the waiting list. Overall, the service did not provide urgent interventions for young people although it did provide support to local services if that was required.

Where possible, staff offered patients flexibility in the times of appointments. Since March 2020, the service had offered appointments to young people and their parents by telephone or using video conferencing facilities. This had increased the flexibility for appointment times and addressed the concerns of many families who had previously travelled long distances to appointments.

Since the start of the Covid-19 pandemic, staff have conducted appointments with patients using telephone and video facilities. This has led to an increase in the number of appointments provided by staff from 3519 between January and March 2020 to 4032 between April and June 2020.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Between April and June 2020, staff cancelled 2% of appointments. Staff rearranged these appointments as soon as possible.

Facilities that promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment and care. The waiting room had chairs for up to six people. Interview rooms had comfortable furniture and adequate soundproofing. Toilets at the London service were gender neutral. The service did not have facilities to carry out physical examinations.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education opportunities. Staff talked to young people about how to manage difficult situations at school to help them maintain a positive experience of education. The service provided information for schools on how to support young people with gender dysphoria. The service contacted the special needs co-ordinator at the young person's school if the young person was having specific difficulties, such as bullying or disengaging from education. One young person told us that the liaison between the school and the service had been very helpful and had led to staff and pupils having a better understanding of gender dysphoria.

Meeting the needs of all people who use the service

Of the 339 referrals made to the service between April and June 2020, 71% were from natal female patients. Staff had recorded the ethnicity of only 51% of patients. Of these, 89% were recorded as being 'White-British'. Only one patient was recorded as being 'Asian or Asian British' and one patient was recorded as being 'Black or Black British'. We reviewed the records of two young people from black or minority ethnic groups. There was no evidence to show that the service had explored the cultural context of these young people.

Our findings

The service made adjustments for disabled people. There was step free access to the service in London and accessible bathrooms available on the site.

Staff ensured that young people could obtain information on treatments, local services and patients' rights. The service provided information about treatments such as hormone blockers.

The information provided was in a form accessible to the particular patient group. For example, the service provided an illustrated guide to puberty and hormone blockers for young people who may find it difficult to read detailed text. This included information on the negative side effects of hormone blockers, such as low mood, fatigue, weight gain and reduced activity. The service had a website that young people who used the internet could access and read all about the service and find links to further information. Information was clear, young person friendly and up-to-date.

Managers could provide staff and patients with interpreters and make information leaflets available in languages spoken by patients. However, the service had not needed to do so. The service provided therapy and support in English.

Listening to and learning from concerns and complaints

Between April 2019 and March 2020, the service had received 17 complaints. Three complaints were upheld. Three complaints were partly upheld. Four complaints were not upheld. Seven complaints were still being investigated. There had been three complaints in September 2020. These related to the waiting time for a first appointment, concerns from a parent about their child's ability to give consent to treatment and concern from a young person about their treatment after their clinician had left.

Some young people and parents we spoke with did not know how to make a complaint, but they all said that if they had any concerns they would feel comfortable speaking to the clinician. Parents said they were confident they would be able to find out how to complain if they needed to. Information about making a complaint was available on the website for the service.

When young people complained or raised concerns, they received feedback. Complainants received a final letter from the Chief Executive setting out the outcomes of the complaint and findings of the investigation.

Staff knew how to handle complaints appropriately. The process for handling complaints was set out in the trust's complaints procedure. This included performance standards such as acknowledging complaints within three days and responding to complaints within 25 days. If the investigation lasted longer than 25 days, young people where kept informed of the progress of the complaint.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Staff discussed complaints at Clinical Quality and Governance meetings.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

Our findings

- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- Managers were not always able to deal effectively with professional disagreement amongst team members.

However:

- Leaders had a good understanding of the young people who used the service and were visible in the service. There were initiatives for young people to give feedback on care and be involved in service development.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Young people we spoke with said those values came across in how staff interacted with them.

Detailed findings

Leadership

The service was led by a service director along with senior clinicians who formed the Gender Identity Development Service (GIDs) executive team. All staff on the GIDs executive team had relevant qualifications and many years' experience of working within the service. Leaders recognised that demands on the service and the leadership team had increased considerably in recent years due to increase in the number of young people referred to the service.

Leaders had a good understanding of the services they managed and identified the challenges the service faced. They could explain clearly how the teams worked to provide the service. Leaders were fully aware of the many challenges, such as the substantial rise in demand, very long waiting lists and high levels of external scrutiny, particularly within the national media. They also highlighted some improvements such as introducing standard operating procedures for safeguarding and consent to treatment. All of the GIDS executive team continued to have a caseload of young people and engaged in the casework discussion forums. Members of the GIDS executive team also participated in complex case reviews.

Leaders were visible in the service and young people and staff knew who they were. The executive team led the clinical quality and governance meeting with all the staff once a month. The service director welcomed discussions and feedback from young people and parents.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values and ethos of the service focused on promoting non-judgemental acceptance of gender identities, taking a holistic approach and providing support to both young people and their families. Staff demonstrated these values throughout the inspection. Young people and parents told us that they valued and appreciated the supportive, non-judgemental approach taken by staff.

Culture

Our findings

Clinicians said they had developed collaborative and supportive relationships with their colleagues through supervision and staff forums. Staff also felt proud of the way service supported the young people they worked with. However, non-clinical staff did not always feel valued. These staff were often frustrated at being unable to make simple decisions without going through many layers of approval. This meant that it was difficult to make simple improvements to the service and have their voice heard.

Staff said they felt positive and proud about working for the provider and their team. Many staff said that they loved their work. However, some staff said high caseloads and constant external scrutiny meant they worked under relentless pressure. The service was subject to frequent media interest. The service had been subject to a judicial review in the High Court in October 2020. The service was also preparing for a thorough review by its commissioner, NHS England. Some staff said there was a sense of the team being 'under siege' from external pressures. Some staff also commented that although staff turnover was consistent with the average for the trust, it was still high at 24%. This turnover created pressure on long-standing members of staff to support new employees.

Staff did not always feel able to raise concerns without fear of retribution. Some staff, particularly those in non-clinical roles, said there was a fear of blame within the service. This meant they were reluctant to raise concerns.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The Speak Up Guardian presented an annual report to the trust board. In their report in May 2019, the Speak Up Guardian stated that staff at GIDS had raised concerns and that many of these staff felt worried about speaking in open groups.

Managers could deal with poor staff performance when needed, although there were examples of inconsistencies in performance that had not been addressed. Managers explained that when they identified poor performance, they agreed an action plan for improvement with the member of staff.

Teams worked well together although, when difficulties arose, managers did not always deal with them appropriately. Senior managers explained that there were a number of staff forums where clinicians had the opportunity to discuss concerns and differences of opinions. Some staff said that their team was good at challenging each other's clinical opinions. However, during the inspection, staff told us about situations involving differences of opinions between staff. These situations had led to a clinician resigning, a formal grievance, and a situation where staff felt it was difficult to engage with a senior member of staff.

Staff appraisals included conversations about career development and how it could be supported. At each appraisal, staff agreed their objectives and personal development plan for the year ahead.

The service did not provide any initiatives to promote equality and diversity in its day-to-day work. The trust's policy on equality, diversity and inclusion stated the trust's commitment and intent to creating an organisation that diverse, inclusive and provide opportunities for all. However, in relation to race equality, staff commented that the service predominantly employed white people. The workforce race equality standard report for the trust for 2019 showed that over 80% of staff were white.

The service's staff sickness and absence rates were similar to the average for the provider. During 2019/20, the turnover rate of 23.5% was the same as the turnover rate for the trust. The sickness rate of 2.19% was slightly below the sickness rate for the trust.

Our findings

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff could access the trust's 'Staff Advice and Consultation Service'. This service could give support to staff in coping with crises such as bereavement, relationship breakdown or experience of trauma.

The provider recognised staff success within the service. For example, at the regional team meeting in Leeds, staff reviewed compliments and thank-you cards that had been sent to the service. A member of staff was awarded the 'Star of the Month' award. At the meeting in September 2020, staff thanked a colleague for completing a particularly difficult piece of administrative work.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively to ensure that the needs of patients were met in a safe, structured and systematic manner. The GIDS service had a comprehensive action plan to address issues identified by the trust and improve service performance. This was written in March 2019. It contained seven areas of recommendation and over 55 specific actions. These covered areas of concern focused on during this inspection. While improvements were seen in some areas, such as introducing standard documentation for assessments of consent and capacity, there were still many areas where improvements had not been consistent. For example, actions to minimise variation in practice had not been fully achieved. There continued to be a wide variation in the number of sessions young people received, from two or three sessions to over 25 sessions, with some young people receiving more than 50 sessions. There also remained variation in assessments which were unstructured. Assessments did not demonstrate what staff were assessing or demonstrate clear criteria for decision making. There appeared to be no framework for discharge other than young people reaching the age of 18. Actions to manage the waiting list had not reduced the time young people waited, with current waits at 24 to 26 months. Record keeping was also poorly organised and it could be difficult to find important information.

There was a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service had an established structure for executive team meetings, meetings for senior staff, clinical quality and governance meetings and regional team meetings. Each meeting had a standard agenda of items that were discussed. For example, at clinical quality and governance meetings staff discussed waiting times, complaints, feedback from young people and opportunities for young people to be involved in the service. At regional team meetings, staff discussed practical arrangements, such as leave and rotas, and casework. These meetings also provided opportunities for staff to discuss any concerns.

Staff undertook or participated in clinical audits. In most cases the audits were sufficient to provide assurance and staff acted on the results when needed. One exception we found was that staff had not taken sufficient action after an audit on consent and capacity found cases were missing necessary paperwork.

The service did not have consistent arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. For example, records did not include risk management plans to show which agencies were responsible for or involved in managing the risks to young people. However, the service did have well-established arrangements for supporting young people to be transferred to the service for adults. The service also had regular meetings with endocrinology services.

Management of risk, issues and performance

Our findings

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. Two entries on the trust's risk register related specifically to GIDS. The risk register included details of the risk, a risk score and details of action being taken to mitigate the risk.

Staff concerns matched those on the risk register. Entries on the risk register related to stress placed on staff due to the level of internal and external scrutiny and the length of waiting times. Both these risks were assessed as being high.

The service had plans for emergencies, for example, adverse weather or a flu outbreak. The trust had developed a business continuity plan that provided details of what the trust would do in the event of a major incident.

Information management

The recording of information was insufficient to ensure safe and effective professional practice. Records of sessions with young people and their parents were often simply descriptions of discussions that had taken place. They did not include any analysis, structured assessment, professional curiosity or clinical decision making. One member of staff commented that clinicians often said they were too busy with direct patient work to complete records. Supervision notes were also held in confidence by the supervisor and supervisee. This meant the service did not have access to fundamental information about the competence of staff in respect of both work with young people and the provision of supervision.

The service used systems to collect data that could be over-burdensome for frontline staff and administrative support was not working efficiently. The service employed 15 administrators to support 66 clinical staff. Many staff said there was too much administrative work. One member of staff said the service would be improved if there was more time to think and less administrative work.

Information governance systems included confidentiality of patient records. Breaches of patient confidentiality were record as information governance incidents.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This information was prepared by non-clinical staff and accessed by the executive team in the form of a monthly dashboard. However, there were concerns that the executive were reluctant to engage in discussions about data.

Staff who left the service were routinely offered an exit interview with a line manager or executive team member. They could make a specific request for exit interview with a member of staff from trust human resources department if they preferred.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, the service provided updates and information in the 'News' section of its website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff encouraged young people and their parents to give feedback by completing the 'Experience of Service Questionnaire'.

Our findings

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The service collated reviewed feedback. Staff discussed this feedback at clinical quality and governance meetings. Collated feedback was included in the quarterly report to commissioners.

Directorate leaders engaged with external stakeholders. The service provided comprehensive reports to commissioners every three months.

Learning, continuous improvement and innovation

Some staff said they were given the time and support to consider opportunities for improvements and innovation. For example, staff had explored initiatives to reduce the waiting list. These initiatives had involved collaboration with CAMHS and voluntary sector organisations. Other staff said it could be difficult to embed improvements across the whole service and it was done at a local team level. They said it could be difficult to embed consistently and have their ideas considered by senior staff in other teams.

Staff used quality improvement methods and knew how to apply them. The service had provided training in quality improvement methods for non-clinical staff. The service was carrying out a quality improvement project to review the parity of waiting times in the different regional teams.

Our findings

Areas for improvement

Action the provider MUST take to improve

The service must ensure that it meets the needs of young people who are referred to the service. Regulation 9(1)(b)

The service must ensure that young people referred to the service do not have to wait unacceptable lengths of time for a first appointment. Regulation 9(1)(b)

The service must ensure that plans for care and treatment are established and clearly recorded on care records. Regulation 9(1)(b)

The service must ensure that appropriate staff with specialist skills are available to meet the needs of young people and that records of assessments include details of how care and treatment is planned in relation to those complex needs. Regulation 9(1)(b)

The service should ensure that it records the details of ethnicity for all young people and that it responds to young peoples' cultural needs. Regulation 9(1)(b)

The service must continue its work to ensure that assessments of capacity, competency and consent are recorded for all patients referred for medical treatment, including young people currently receiving treatment who were referred before January 2020. Regulation 11(1)

The service must ensure that staff assess the risks to all young people and record these risks appropriately. Regulation 12(1)(2)(a)(b)

The service must ensure that systems or processes are established and operated effectively to ensure compliance with regulations. The service must maintain securely an accurate, complete and contemporaneous record in respect of each young person, including a record of the care and treatment provided to the young person and of decisions taken in relation to the care and treatment provided. This includes ensuring that assessments and clinical decisions are structured and clearly recorded. Regulation 17(1)(2)(c)

The service must ensure that systems are in place so all staff are able to contribute to discussions about the service and that staff do not feel fearful that they will be blamed when they raise concerns. Regulation 17(1)(2)(e)

Action the provider SHOULD take to improve

The service should have effective systems in place to ensure that staff caseloads are kept to an equitable and reasonable level and to ensure that staff feel they have a manageable workload.

The service should ensure that staff are aware of young peoples' holistic needs including their physical health needs.

The service should continue its work with individual clinicians to review their competency and performance in terms of meeting the requirements of the service and the young people they support.

Our findings

The service should ensure that non-clinical staff have sufficient training to ensure they are confident in responding appropriately to potential safeguarding risks they encounter through their contact with young people using the service.

The service should ensure that all staff have completed an appropriate level of training in safeguarding adults.

The service should ensure that it continues to develop its multi-agency support and protection for young people, including the development of joint protocols and information sharing agreements.

Our inspection team

The team that inspected the service comprised of eight CQC inspectors, an assistant inspector, two inspection managers, two specialist inspectors of children's services, a head of hospital inspection and two specialist advisors with professional backgrounds in gender identity services. The lead of a current independent review of gender identity services for children and young people, commissioned by NHS England, attended all the interviews with the executive team, interviews with some other members of staff and participated in meetings to review the evidence collated during this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The Tavistock and Portman
NHS Foundation Trust

Tavistock and Portman NHS Foundation Trust

Report to CQC on GIDS Waiting times

December 2020

CONTENTS

1. SECTION 1: INTRODUCTION

The proposal letter dated 18th November 2020 stated that the Tavistock and Portman NHS FT (T&P) must provide a written report to the Care Quality Commission within four weeks, and on the last Friday of each month thereafter, setting out:

- The actions taken to ensure the system in place for the management of and reduction in the Gender Identity Development Service (GIDS) patient waiting list at the services in London and Leeds is effective;
- The results of any monitoring of the system undertaken by the Trust;
- A report of the number of patients on the waiting list, including monthly figures of new referrals awaiting an assessment, those assessed and receiving treatments, and patients discharged or referred onto another service.

The Trust have reviewed further the waiting lists, the actions to be taken and then the monitoring of these actions. This first report sets out the planned actions and monitoring. It also sets out 20-21 waiting times, to 14 December 2020, and historical data.

2. SECTION 2: PLAN TO MANAGE AND REDUCE THE WAITING LIST

The Trust has scoped out a range of waiting list management interventions, and has begun discussions with NHSE as the commissioner of the service with regards to the approach. With a view to analysing the effectiveness of these interventions, the Trust will submit in due course an indicative trajectory for key actions, to predict their impact. The actions fall into the following broad categories:

a) Referral, intake, waiting list
b) Safety/risk for current waiters
c) Patient journey while open to GIDS
d) Discharge: leaving the service is a timely and well managed way
e) Oversight and planning
f) Staffing and personnel
g) Contract management/other

In total, there are currently 27 listed change interventions across these categories, ranging in scale and potential impact. In a number of cases these build on and augment current improvement activities, to increase the timing and effectiveness of management of, in particular, the volume of referrals.

Each intervention has been listed against:

i. SMART action summary
ii. How impact will be evaluated
iii. Expected completion
iv. Expected stakeholder involvement (RAG rated) to estimate whether the Trust can implement the change independently of its collaborators or otherwise.
v. [Draft] Action lead
vi. Additionally, GIDS WL action ID and GIDS WL action category has been added to each.

As part of this activity, we have also formally requested from NHSE a change to existing referral criteria. This is in acknowledgement that the significant and growing waiting time for young people referred to GIDS where one cannot simply scale up the service to manage the dramatically increased referral numbers, needs a different approach to management.

In the meantime, the judgment from the Judicial Review, on the use of puberty blockers on under 16 year olds, has been handed down. The outcome of that judgment on our patient population, both currently in the service and those being newly referred to the service, will be profound. The clinical reviews and legal processes now required will also require reassignment of clinical resources to achieve what is now required, and this will serve to add further to the capacity required within this specialist and uniquely important service. There may be a consequential impact on capacity in the service and on waiting times, which we will monitor carefully to try to minimise the unintended consequence of the recent judgment.

The work will be taken forward by a dedicated project management team, which will sit within usual Trust governance structures. We propose that further details will be forthcoming on this structure in our January 2021 update.

3. SECTION 2: SYSTEM MONITORING PROPOSAL

Following review of the areas mentioned above, we plan to make the following interventions:

CQC-GIDS Action Plan in response to N

To ensure complete monitoring of the system, T&P request that we can align the regular report we are required to submit to the CQC with the reporting timelines for NHSE. Currently data reporting is run and completed by 3rd week of the month, following the end of month.

We recommend the following data items to be in the report each month:

a. Progress against action plan and any supporting narrative summary.
b. New referrals by month and GIDS regional team split.
c. New cases seen for first appointment by month and GIDS regional team split.
d. Patients discharged by month and GIDS regional team split.
e. Those transferred to adult gender identity clinics (GICs) by month and GIDS regional team split.

4. SECTION 3: 20-21 WAITING TIMES

The table below sets out the 20-21 position from 1st April to 14th December 2020, broken down by teams within the GIDS service.

It is important to note that new patients starting assessments take more time and are more intensive than patients who are already on the pathway. This is because clinicians work in pairs during the initial assessment phase of work and appointments may be undertaken at a higher frequency while a clinical assessment and care plan is formulated. That means that where patients are discharged it will not be possible to pick up an equal number of first appointments. Managing patient flow will be key to reducing waiting times.

	Waiting list 1st April 2020	Waiting list Dec 14 2020	Referrals Received 20-21 YTD	First Assessments 20-21 YTD	Discharges and Rejections 20-21 YTD
GIDS Birmingham	355	395	119	68	51
GIDS Bristol	269	295	72	34	46
GIDS COTP	3	1	0	1	1
GIDS Exeter	188	200	42	21	41
GIDS Intake	2	4	4	0	2
GIDS Leeds	1281	1404	459	269	451
GIDS London	391	429	146	78	143
GIDS Midlands	829	836	222	177	199
GIDS South East	1031	1101	343	200	281
GIDS South West	266	259	68	59	87
Total	4615	4924	1475	907	1302

5. SECTION 4: HISTORICAL DATA

The below data details historical data for key metrics over the last decade in GIDS, in order to provide context as our reporting develops. One of the areas that causes longer delays for the waiting list, is the length of treatment for patients. Some patients can be under our care for a number of years depending on their age at referral.

Referrals													
FY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2011-12	12	13	14	16	20	12	18	13	25	19	27	21	210
2012-13	19	17	24	26	38	21	25	39	31	21	28	22	311
2013-14	48	38	37	33	32	37	43	40	36	42	40	45	471
2014-15	56	51	55	60	55	52	65	53	53	53	64	74	691
2015-16	103	84	114	106	92	117	147	118	125	123	146	134	1409
2016-17	120	172	178	167	154	152	163	172	147	171	191	194	1981
2017-18	201	216	223	256	239	198	224	250	193	205	164	194	2563
2018-19	181	214	231	252	238	187	264	278	202	238	223	226	2734
2019-20	232	263	219	284	219	201	269	212	210	233	225	178	2745
2020-21	114	98	130	189	175	216	265	247	41				1475

Discharges and Rejections													
FY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2011-12	0	2	1	6	1	4	8	13	6	5	1	10	57
2012-13	4	5	5	13	7	4	4	5	19	9	21	8	104
2013-14	5	13	13	7	19	12	22	5	9	35	30	11	181
2014-15	22	20	26	42	37	45	55	40	65	39	9	23	423
2015-16	28	47	27	36	57	26	42	45	46	21	20	20	415
2016-17	85	27	30	78	33	49	54	67	54	77	74	86	714
2017-18	52	84	88	117	127	72	77	158	114	128	123	118	1258
2018-19	97	291	118	84	115	178	90	151	113	108	144	103	1592
2019-20	115	144	127	144	147	152	134	174	173	197	110	159	1776
2020-21	177	114	138	139	157	180	189	136	72	0	0	0	1302

First Assessments													
FY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2011-12	6	13	11	11	17	10	15	14	9	18	28	19	171
2012-13	9	13	18	21	23	20	15	23	21	29	22	30	244
2013-14	15	19	32	29	30	27	42	28	27	41	27	41	358
2014-15	22	35	40	51	38	42	61	54	32	44	58	46	523
2015-16	42	44	56	59	82	48	65	90	65	70	69	55	745
2016-17	51	32	47	62	69	92	113	190	86	149	176	156	1223
2017-18	76	167	111	82	69	63	58	102	53	94	73	63	1011
2018-19	60	76	51	63	49	57	92	97	46	96	116	100	903
2019-20	59	56	54	109	93	116	114	94	75	104	88	127	1089
2020-21	94	95	143	121	88	120	101	100	45				907

Action Plan Reference:	**1.0-3.0_GIDSWL**
CQC Reference	**RGP1-9895286599**
Account number	**RNK**
CQC Requirement:	The registered provider must provide a written report to the Care Quality Commission within four weeks, and on the last Friday of each month thereafter, setting out the following: • The actions taken to ensure the system in place for the management of and reduction in the Gender Identity Development Service (GIDs) patient waiting list at the services in London and Leeds is effective. (Recommendation ID: 1.0_GIDSWL) • The results of any monitoring of the system undertaken by the Provider. (Recommendation ID: 2.0_GIDSWL) • A report of the number of patients on the waiting list, including monthly figures of new referrals awaiting an assessment, those assessed and receiving treatments, and patients discharged or referred onto another service. (Recommendation ID: 3.0_GIDSWL)
Success Criteria:	1.0 A robust system of management and reduction in the GIDS patient waiting list. Clear communication with the regulator (CQC) and service commissioners (NHSE) on actions taken to manage and reduce patients wait and an evaluation of their success. 2.0 Evaluation as per each point in 1.0. 3.0 Contracts report by month specifying as above: new referrals received, those commencing assessment (first appointments) and ending assessment, treatment appointments, discharges and destination/onward referrals.
Timeframe	Reporting to CQC every 4 weeks on the last Friday of each month.
Responsible person(s)	Paul Jenkins, Chief Executive

CQC Recommendation ID	GIDS WL Action ID	GIDS WL Action Category	SMART Actions	How impact will be evaluated	Expected Completion	External stakeholder involvement	Action lead	Progress Update	Evidence (in line with 2.0_GIDSWL)
3.0_GIDSWL	3.0A_GIDSWL	CQC Action Plan set up	Create report for monthly review internally as well as to send to CQC	Report submitted by month to CQC.	Jan-21	Internal	Associate director of contracts		
3.0_GIDSWL	3.0B_GIDSWL	CQC Action Plan set up	Ensure relevant governance structure in place to support CQC Action Plan	CQC Action Plan structure document signed off by T&P.	Jan-21	Internal	Gender divisional director		
1.0_GIDSWL	1.0A_GIDSWL	Referral, waiting list, intake	Review and improve (re-word) general comms (i.e. website or other literature) regarding referral routes into service, information required in order to refer, local support available, and information to professionals about what support they could provide.	Monitored by fewer referrals rejected, fewer patients dropping out after 1-2 appts. Increase quality of incoming referrals (measured qualitatively) and longer term reduction in number of referrals	3 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0C_GIDSWL	Referral, waiting list, intake	Analysis of patient drop-out rate (i.e. those who are are referred but do not engage with service) or those who disengage before completion of assessment to determine whether support for this cohort is more successfully managed elsewhere/outside of the waiting list system.	Reduction in discharges with 0-1 appointments	6 mos	Internal and dependant on analysis, NHSE	GIDS service manager		
1.0_GIDSWL	1.0D_GIDSWL	Referral, waiting list, intake	Review communication to patients on waiting list (including but not limited to standard letters to patients and referrers) to ensure communication is clear and timely, and support mechanisms are explicit and begin sending new agreed suite of communication.	Reduction in negative feedback/complaints from YP on wait list, reduction in incidents/serious incidents amongst waiting list cohort.	3 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0F_GIDSWL	Referral, waiting list, intake	GIDS waiting list is currently sub-divided into regions and sub-regions, and this can create inequity and processes can differ. This system is to be reviewed with an aim to create one waiting list system which is patient centred and places patient choice at the heart of operation.	Increase in parity of wait time, as currently being measured in ongoing QI project. Reduction in negative feedback from patients on wait list regarding inequity of wait time experience	6 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0G_GIDSWL	Referral, waiting list, intake	Review internal referral acceptance process. Promote equity by ensuring a uniform set of standards for intake and acceptance of each referral, and comprehensive communication about local support available. Ensure we adequately adhere to our own referral criteria.	Reduction in staff time spent obtaining information that should be submitted on the referral form. New SOP setting out agreed process for intake across the Service that can be subject to audit	6 mos	Internal	GIDS clinical director		
1.0_GIDSWL	1.0H_GIDSWL	Referral, waiting list, intake	Review GIDS booking process for all assessment appointments with a particular emphasis on those coming off of the waiting list and onto the caseload. Ensure the management of this process is smooth and regulated in the admin team.	Increase in parity of wait time and standardised process for YP coming off the wait list.	9 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0B_GIDSWL	Safety	GIDS request NHSE change referral criteria, to ensure the negative impact of the significant and growing waiting list can be locally managed as and if required and to mitigate risk. Will consider need to review this action as risks reduce accordingly.	Increased local mangement of risk, monitored via reduction in incidents/serious incidents amongst waiting list cohort.	6 mos	Internal, NHSE, Cass Review	GIDS clinical director		
1.0_GIDSWL	1.0E_GIDSWL	Safety	Regular request from GIDS to GPs responsible for those waiting for first appointment that in acknowledgement of long waiting times, and the impact this may have on a young person referred, they should undertake individual risk assessments (GIDS to consider appropriate methodology) to determine any additional needs (i.e. mental health, psycho social) and take appropriate action. Emphasis on curent waiters in first instance.	Management of risk for current waiters, monitored via reduction in incidents/serious incidents amongst waiting list cohort.	3 mos	Internal, NHSE	GIDS clinical director		
1.0_GIDSWL	1.0X_GIDSWL	Safety	Agree with NHSE queries that should be handled by GIDS; Review with NHSE how to safely engage with patients and professionals to ensure that risk is managed locally thereby minimising pressure on GIDS enquiries	Reduction in enquiries which should be managed locally, in line with service spec	9 mos	Internal, NHSE	GIDS Service Director		
1.0_GIDSWL & 2.0_GIDSWL	1.0I_GIDSWL	Patient journey in GIDS	Monitor numbers of assessment and treatment appointments offered per patient against service specification.	Monitor the # of assessment appointments (average and range) for compliance with NHSE Service spec. Monitor the number of treatment appointments (average and range) with aim to deliver outcomes agreed with NHSE for discharge	1 year (tied to Cass Review)	Internal, NHSE, Cass Review	GIDS service manager		
1.0_GIDSWL	1.0J_GIDSWL	Patient journey in GIDS	Review of 17.5 protocol, consider the manner in which waits for this group are managed.	Establish clear (auditable) view of YP who are approached using the 17.5 protocol with the aim of emphasising a patient centred approach. Separately monitor the disposition of those who reach 17.5 whilst on wait list from the overall group.	6 mos	Internal, poss. NHSE	GIDS Service Director		
1.0_GIDSWL	1.0K_GIDSWL	Patient journey in GIDS	Ensure appointments offered by GIDS are fully utilised by creating a system to offer last minute cancellations or short notice clinical availability to a reserve list.	Increase in numbers of attended appointments and reduction in % of non-attended appointments.	9 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0L_GIDSWL	Patient journey in GIDS	Improve implementation of DNA and cancellation polices with a view to more closely monitor wastage re patient facing time.	Audit adherence to existing DNA and cancellation policies.	3 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0M_GIDSWL	Patient journey in GIDS	Administration team to schedule in clinical contacts to ensure better oversight and management of flowthrough, as well as swift escalation of issues occuring in order to solve.	Increase in numbers of attended appointments and reduction in % of non-attended appointments. Increase in clinician patient-facing time through reduction in admin tasks undertaken by clinicians	1 year	Internal	GIDS service manager		
1.0_GIDSWL	1.0N_GIDSWL	Patient journey in GIDS	Agree safe and manageable caseload standards (per WTE and seniority) and monitor these on individual basis per staff member in supervision.	Audited view of caseloads across clinicians using agreed standard/parametres.	6 mos	Internal	GIDS clinical director		
1.0_GIDSWL	1.0O_GIDSWL	Patient journey in GIDS	Create and implement a clear dormant case process (for <18 and 18+) capturing updates/changes in existing Discharge SOP. Develop new SOP for dormant cases.	Measurable reduction in dormant cases.	9 mos	Internal	GIDS Service manager		
1.0_GIDSWL	1.0P_GIDSWL	Discharge: leaving the service in a timely & well managed way	Review and update discharge SOP to ensure consistent and timely discharge processes across Service	Increase in discharge numbers and increase in number of 1st appointments.	9 mos	Internal	GIDS clinical director		
1.0_GIDSWL	1.0Q_GIDSWL	Discharge: leaving the service in a timely & well managed way	Create service level view of operational delivery, including circulation of new cases, overall activity (split by assessment and treatment) and discharges, with accountability to operational team. Create governance structure through which performance is communicated to staff across the service.	Agreed governance plan to share performance data with all staff in the Service.	9 mos	Internal	GIDS service manager		
1.0_GIDSWL	1.0R_GIDSWL	Oversight & planning	Individual job planning of patient-facing tasks by clinician within line management structure and centrally held and reviewed.	Completion of individual job planning records by clinicians	1 year	Internal	GIDS clinical director		
1.0_GIDSWL	1.0S_GIDSWL	Oversight & planning	Create guidance for new case uptake of new starters (clinicians); standardise this process in the Service with aim of reducing wastage in the system.	New SOP agreed and measure adherence (audit) to the SOP	9 mos	Internal	GIDS clinical director		
1.0_GIDSWL	1.0T_GIDSWL	Oversight & planning	Review and agree circumstances in which pair working is required, both internally and with NHSE.	Agreed parametres for paired working. Audit activity against agreed parametres	1 year (tied to Cass Review)	Internal, NHSE, Cass Review	GIDS clinical director		
1.0_GIDSWL	1.0U_GIDSWL	Oversight & planning	Review and standardise handover process for when staff member leaves the Service; consider actions to ensure handover is consistent and timely. Produce updated management SOP	Adherence audit against the agreed SOP	9 mos	Internal	GIDS clinical director		
1.0_GIDSWL	1.0V_GIDSWL	Oversight & planning	Create system generated report/dashboard via the electronic care record which provides view of patient flow through GIDS, with appropriate detail. This will include the monitoring of waits into different parts of the pathway as well as the core waiting list with a view to understanding system bottlenecks.	Report/dashboard which summarises quantitative data on operational delivery metrics	6 mos (proposed deliberable of DSP, phase 2)	Internal	GIDS data support		
1.0_GIDSWL	1.0W_GIDSWL	Staffing	Work with HR to devise a long term action plan with key short term actions for GIDS staff retention	Increase in retention rates of GIDS staff, monitoring of staff sickness rates, staff surveys.	1 year	Internal	Gender divisional director		
1.0_GIDSWL	1.0Y_GIDSWL	Contract/ other	Minimise activity outside service spec.	Devise measurement of this actitivy and monitor reduction over time of activities outside service spec.	6 mos (tied to DSP phase 2)	Internal, NHSE.	GIDS data support		

Annex C

GIDS Interim Management Board

Introduction

1. This note summarises plans for:
    - A GIDS Interim Management Board, to oversee both a transformation programme and also current clinical operational delivery.
    - The associated aim, objectives and workstreams; and
    - Accountability and governance.

2. These arrangements will formally start on 1 February. The current GIDS Executive will be disbanded from that date.

Background

3. GIDS has grown dramatically in recent years amidst growing scrutiny and controversy. However, its practices, structures and governance have not kept pace with that change. An improvement programme was started following the 2019 GIDS Review and made some important changes but also encountered significant cultural and capacity barriers. Plans had been developed for governance changes, but more far reaching change is now required in view of the Judicial Review ruling (Dec 2019) and CQC findings (Jan 2021).

4. The scope and scale of change needed is reflected in consistent themes across the following past, current and future reports and reviews:

    - The 2019 GIDS Review, where there are some outstanding actions and where other changes need to be embedded and sustained.
    - The Judicial Review findings.
    - The CQC report.
    - The current Trust Strategic Review
    - The independent Cass Review, which will continue over this year.

5. This is alongside pressured business as usual clinical operations delivery, and other reviews such as those commissioned by NHSE into evidence for puberty blocker.

6. The Trust has concluded these changes cannot be achieved without more capacity and new skills in GIDS. We have recruited temporary senior clinical, operational and programme resource and expertise to help take forward the change and to stabilise the service; whilst a strong permanent team and leadership group is being designed and rebuilt.

Interim management board and transformation programme design

7. The changes required will eventually shape standard clinical delivery in GIDS. In order to get to that point, an interim management board will streamline the strategic approach; to have full oversight of both current and developing work, aligning and managing it effectively; and

to ensure clear governance and decision making. This would continue until the transformation programme is well established and a refreshed, permanent GIDS structure and governance is in place. We envisage this will take between six and twelve months.

8. The interim Board will be chaired by the Gender Services Divisional Director during that period. Membership will comprise the GIDS General Manager, the GIDS Service Director, GIDS Lead Doctor, the GIDS Transformation Programme Manager and secretariat support. Other relevant staff would be invited for specific agenda items. A parallel working group, chaired by the programme manager and including senior clinical and operational leads for each workstream, would ensure work is genuinely cross cutting and manage inter-dependencies.

9. The Board's purpose would be to ensure the highest possible quality of care to the young people and families GIDS serves, and to ensure that a transformation programme effectively responds to the findings of the JR judgement, CQC and other relevant reviews.

10. It would do this through:

    - **Programme management:** to shape, plan and deliver a Transformation Programme that responds to regulatory and governance frameworks and other requirements. To include co-ordinating, aligning and supporting programme projects and workstreams;
    - **Stakeholder management:** to work with relevant regulatory and governance bodies and stakeholders; including providing clarity on progress and strategy and seeking to collaboratively resolve shared problems;
    - **Governance and reporting**: to be accountable for and to oversee:
        i. robust clinical, financial and information governance;
        ii. staff management and development;
        iii. the development and delivery of excellent patient experience, including for those on the waiting list;
        iv. implementation of appropriate levels of project management (including dependency management, processes and systems), governance, financial management, risk management, and reporting, across the transformation programme and to governance and regulatory bodies;
    - **Performance and quality measurement*:*** to define measures and monitor progress against these to ensure clinical care and planned change meets identified quality objectives and is timely, where relevant.

<u>Projects/ Workstreams</u>

11. The Board would oversee the following projects/ workstreams:

    - <u>New endocrine pathway</u> - designing, implementing, reviewing and improving clinical reviews and applications for best interests orders, following the JR ruling.

    - <u>Waitlist reduction</u> in line with agreed CQC plan. This covers a range of actions, strategic and system wide (e.g. referrals); one off tasks (e.g. redesign of patient correspondence, and some analysis); and quality improvement projects.

- Clinical governance, safety and practice development, to carry forward or embed GIDS Review Action Plan (2019) recommendations, including on safeguarding, consent and pathway development; and to address concerns raised in the CQC report in relation to, for example, record keeping, decision making, assessments, managing risk and managing co-occurring difficulties.

- Organisational Development, to ensure a high performance culture while supporting staff during an intensely difficult time; for training, coaching and mentoring; to address capacity and retention needs; to scope new skills needs to respond to new demands; to ensure individual and team performance is effectively managed; improve internal communication; and, in the medium term, restructure.

- Data strategy further development and implementation, to enact improvements and changes to the GIDS data system (including changes to forms, processes and systems) which will allow ongoing accurate and clear reporting of patient flow through the Service, capturing changes as agreed in the new endocrine pathway.

- Current GIDS clinical operational delivery, to meet ongoing contractual commitments including continued delivery against the 2016 NHSE service specification; oversight of regional services including the Leeds base and the Birmingham and Bristol outreach clinics; research commitments; ongoing staff management and development; and stakeholder management and external communications.

12. A consequence of these arrangements is that the current GIDS Executive team will be disbanded. Its members will have roles in workstreams and projects relevant to their skills and experience, and will continue their current line management responsibilities. The Service Director will have a place on the GIDS Interim Management Board.

Staffing

13. New interim and consultancy support will help take forward this work. Currently this comprises three external senior clinicians (two paediatricians, and a psychologist); two senior clinicians from elsewhere in the Trust (a psychiatrist and a senior nurse); two operational consultants with expertise in demand, capacity, flow and waitlist management; and an experienced programme manager. These individuals will work part-time with the exception of the programme manager. We are also recruiting other new permanent staff.

14. In addition, we will draw in contributions from a cross section of GIDS staff, so they can be deeply engaged in and inform the transformation programme, along with contributions from relevant staff in the wider Trust.

Accountability

15. The Programme Board will report to the Trust Board via a new GIDS Oversight Group, chaired by the Trust Chief Executive and, in relation to clinical governance issues, via the Trust Integrated Governance Committee. Interim staff will report managerially to the Gender Divisional Director, and interim clinical staff will report professionally to the Trust Medical Director.

Next steps and timing

16. The Trust Board will be invited to approve these arrangements on 26th January, along with terms of reference for the GIDS Interim Management Board and associated working groups, workstreams and projects. They will then come into effect on 1 February.

17. There will then be further consideration and design of internal meetings and management forums within GIDS to best support the delivery of key workstreams and to support effective staff engagement across the service.

18 January 2021

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Trust Board	20/01/2021

Guardian of Safer Working Hours 2020 – 2021 Quarter 3

Executive Summary

There have been 17 exception reports since August 2019 until 20th of January 2020.
The trainees have been able to negotiate better locum rate and the backlog of fine payments has been resolved now. This was due to staffing issues within a HR/finance department. Due to the current pandemic restrictions the trainees have not been able to spend majority of the fines accrued. They have been provided support and guidance via their educational/clinical supervisors and medical support forum meetings.

Recommendation to the Board of Directors

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Guardian of Safer Working Hours	Medical and Quality Director

Guardian of Safe working hours Q3 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 Q3.

1.2. This is my second report in role.

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
August	4	1	2	2
September	4	1	2	1
October	1	0	1	0
November	2	0	2	0
December	1	1	0	0
January 2021	5	0	5	0
	17	3	12	3

The exception reports logged in by one trainee were actually submitted in January 2021 due to the trainees DRS logging on system not working since June 2020.
1 report from July 2020,
2 reports from October 2020 and
2 were from Jan 2021. Hence the total being 5 reported in January 2021 by the same trainee.
All these reports were verified by emails sent to me in this time frame and HR/finance department were also aware of this.

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. More recently there have been some changes and the provision now more closely resembles business as usual which is reflected in the number of exception reports coming down from last year.

2.2 **Work schedule reviews**

- The numbers staffing the non-resident out of hours on call rota is a 1 in 9.8
- There have been no formal requests for a work schedule review.

2.3 **Vacancies**

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

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

Total number of vacant locum slots calculated from august 2020 until February 2021 was 21 in total. All vacant slots was successfully filled by the specialist registrar's.

The locum rate for the local trainees doing locum shifts has been renegotiated.

2.5 Fines

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
August	5.5 hrs	-	487.41	187.765	299.645
September	-	4.5hrs	546.12	204.87	341.25
October	-	4hrs	485.44	182.04	303.4
November	4hrs	4.5hrs	884.23	327.075	557.155
December	-	-	No fines	-	-
January 2021	4.5hrs	12hrs	1855.11	697.655	1157.455
Total			4258.31	1599.405	2658.905

3. Junior Doctors Forum (JDF)

Backlog of fine payments has been resolved by HR/finance department.

No other issues have been highlighted in the last junior doctor forum.

A recent update has been requested for the current fine disbursement.

Well-being fund for trainees - £ 12,000 total (the trainees were unable to spend the money for courses or books due to pandemic restrictions).

On 19 January 2021 a few of the trainees participated in a RADA course which was funded from the well-being money.

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sheva Habel.

Conclusions and Recommendations

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

4.2. Changes implemented during the pandemic reverted back to a situation closer to "business as usual" in July 2020. However we have been monitoring the impact of the second pandemic lockdown on the exception reports.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	26th January 2021

Serious Incidents – Quarterly Report – Q3 2020-21

Executive Summary

This quarterly serious incident summary report for the Board covers Q3 2020-21.

During this period there were 28 clinical incidents ranging from patient deaths, attempted suicide, safeguarding, communication, appointments, waiting times, patient care, physical/verbal abuse, IT/IG, and patient in crisis. Sadly there were 5 patient deaths and 3 attempted suicides recorded during Q3.

There were no Information Governance serious incidents recorded in Q3.

Each of the deaths had a concise report completed with 1 of the deaths deemed to be from medical causes. This patient's death was recorded 7 days after his discharge from an acute hospital and our staff team have shared their concise report on their care for this patient via a joint safeguarding review meeting and also a full table top exercise to share the learning across involved services, which was led by the Black Country Healthcare NHS Foundation Trust.

Following discussion of each death at the Q3 Incident Panels it was agreed that 1 of the deaths was in fact a formal Serious Incident which would be led by us and an investigator was appointed to conduct a full root cause analysis investigation of the care provided to this patient by the Trust.

This report is due to be completed at the end of January in preparation for the coroner's inquest, initially scheduled for 10th February 2021. There were also 3 attempted suicides which again were all reviewed at the Q3 incident panels and where appropriate staff are working with the local CAMHS to review these cases. It was confirmed that where appropriate duty of candour had been followed in each case.

As previously noted in Q2, and in agreement with our Camden commissioners, Dr Caroline McKenna is conducting a thematic case review of three of our previous serious incidents which were linked to gang related violence. A draft report will be provided to the commissioners during the first week of February 2021.

As the Covid-19 pandemic continues to negatively impact the Trust has continued to provide regular lessons learned events, which is now done via online platforms and all relevant staff are invited and encouraged to attend. It is notable that the provision of this training online has enabled greater staff attendance at lesson learned events right across the Trust and will remain one of our future delivery methods. During Q3 the following lessons learned events took place:

- **15 October 2020 - Infection Prevention and Control (IPC)**
- **3 November 2020 - Adult Safeguarding / Domestic Abuse**
- **2 December 2020 - Suicide risk and suicide prevention during the COVID-19 pandemic – children, young people and adults.**

When incidents are discussed at each panel, any identified learning is shared appropriately across teams and the below is a snap shot of the learning from the Q3 Incident panels:

October Incident Panel

A more robust process to be put in place regarding patients returning for a review at TAP.

Referrals team at GIC have a system in place to review and request any information missing from referral forms however careful attention needs to be taken when there is a high number of referrals during a given period.

November Incident Panel
The importance of keeping the network informed about roles and responsibilities; it is important that all agencies involves in the care of a patient share information.

Relationship with St Mary's liaison A&E Team needs to improve to ensure community follow up care is better and safer.

December Incident Panel
Improvements at GIC regarding how appointments are booked and documented to Carenotes and clarity on current medications listed in respect to layout of clinical assessments.

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	Board of Directors
Report from	Education and Training Committee – 8th December 2020

Key items to note

The Education and Training Committee met in December 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 Trust's application to the Office for Students was at the time of the meeting being actively reviewed by the regulator. Further information was requested in relation to updated financial information for the period from the date of application (Aug 2019) with a focus on financial sustainability and short-term liquidity.

[Since the Committee met on 8th December, we have had the very good news of our success in being registered with the Office for Students. This has been the product of much thought and effort into considering and lodging our application and the work in navigating the requirements of the review team through the process of updating our submission, particularly to those who were most closely involved in the liaison and negotiation through each of the successive stages. We are now official recognised as an English Higher Education Institution, will retain and be able to expand our Tier 4 UKVI privileges, and be eligible for a larger range of funding opportunities. It will also mean a more direct relationship with the regulator. We have been very much supported in these developments by the University of Essex.]

Graduation

The committee noted the work of a small working group to develop our plans for the Trust's graduation ceremonies, both for the cohort of students whose graduation was cancelled because of the current Covid-19 pandemic and for those who graduated in the summer.

The recommendation by the Education & Training Executive to host two virtual ceremonies in the first part of 2021 using a combination of live and pre-recorded elements was approved by the Committee.

The committee noted the future proposal to include students who have completed non-validated Trust provision as part of the ceremony, and the opportunity presented to consider what a refreshed ceremony might look like, which will be discussed in due course.

DET Strategic Discussion.

The committee spent a large portion of the meeting discussing the development of a DET Strategy and what shape it might take, including consideration of the key interdependencies across the Trust, the impact of the strategic review, and internal and external factors.

Annual Student Survey Report

The committee received the full report on the Annual Student Survey which ran between 7th and 31st July and achieved a creditable response rate of 41% of eligible students. The committee noted the headline satisfaction for 2020 of 89%, compared to the 2019 satisfaction of 92%. As a benchmark, overall satisfaction from the national Postgraduate Taught Experience Survey,

published in 2019 was 82%. Considering the disruption that students experienced due to the COVID-19 pandemic and the changes and resulting impact on peoples' everyday and student experience, this is a very positive outcome.

The Committee supported the implementation of regular surveying of our students in light of the fact that teaching is online. That feedback continues to be positive and reinforces the opportunities going forward for online learning.

Student Recruitment and Enrolment

The Committee received an update on student recruitment and enrolment and noted the positive outcome of achieving 639 new Y1 student enrolments on our long courses based in London-based and at our Alternate Centres. This represents an increase overall of 6 percent against the previous recruitment cycle, in a year marked by the unique challenges of the pandemic. This achievement is thanks to the hard work of staff across DET, in faculty and professional services teams.

[Since the Committee met, further work has been undertaken to analyse the EDI data in relation to student recruitment. The overall recruitment gap and award gap have both reduced overall in DET, with the recruitment gap falling from 10% in AY2018/19 to 7% in AY2019/20, and the award gap falling from 18% to 8%. Further analysis will be undertaken to understand these trends.]

Academic Freedom Policy

The committee noted the development of an Academic Freedom Policy, which is a requirement of our registration with the Office for Students. An updated report and policy will come to the Board of Directors in due course.

Digital Academy Project Update

The committee received an update on governance as the project moves from phase 2 to phase 3. The level of interest in this early period since the launch of the DA in Sept 2020 is encouraging. Phase 3 will focus on learner recruitment and on the development and implementation of a B2B strategy. The committee noted that it would receive a report on the review of the business case forecast in July 2021. The plan is to close the project in September 2021 and integrate the DA into BAU.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Paul Burstow, Chair
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	04 February 2021

Report to	Date
Board of Directors	26 January 2021

Report on Audit Committee Meeting – 15 October 2020

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 14 January 2021.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Director
Terry Noys, Deputy CEO and Director of Finance	David Holt, Chair of Audit Committee

HIGHLIGHTS OF A MEETING OF THE AUDIT COMMITTEE HELD ON 14 JANUARY 2021

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 14 January 2021.

1.2 This note highlights matters which the Committee thought should be brought, explicitly, to the attention of the Board of Directors.

2. MINUTES OF THE INTEGRATED GOVERNANCE COMMITTEE ("IGC")

2.1 Report from Estates and Facilities sub-committee of the IGC had an overall red rating, reflecting the lack of an Authorised Fire Engineer ("AFE") being in place. Whilst the Committee noted that an AFE was now appointed, the Committee was interested in the debate at the IGC on this matter about how RAG (red, amber, green) ratings were determined and that this area had previously been rated amber.

2.2 It was further noted that, with Director of HR and Corporate Governance on secondment to NHE/I, the work around standardising the Trust's approach to RAG ratings would be delayed / deferred.

2.3 The Committee noted the concerns of the IGC that staff mandatory training continues to be an issue at the Trust.

3. REFURBISHMENT OF LEIF HOUSE / FINCHLEY ROAD

3.1 The Committee received a report from an independent expert which concluded that "the cost [incurred] is not unreasonable for the scope of works and that the actual costs were generally in line with industry standard costs."

4. RISKS AND ASSURANCE

4.1 The Committee undertook a 'deep dive' into the risk register of the Relocation Programme Board ("RPB") noting that several members of the Committee were also on the RPB and that the risk register provided the RPB with the appropriate assurances.

4.2 The Committee was also in receipt of an updated Assurance map. It was noted that this required significant additional work, notably input from the Executive Management Team ("EMT").

4.3 There was some discussion on how the Board assured itself with the full range of strategic, project and operational risks being managed by the Trust.

INTERNAL AUDIT WORK PROGRAMME: 2021/22

4.4 The proposed work programme by RSM (the Trust's internal auditors) for 2021/22 was approved.

4.5 The programme will focus on:

I. Estates and Facilities health and safety compliance

II. Data Security and Protection Toolkit ("DSPT") compliance

III. Payroll

IV. Board assurance framework and risk management

V. Equality, Diversity and Inclusion ("EDI").

4.6 There was a substantial discussion about the programme and alternate work around, for example, Safeguarding, cyber security and Freedom to Speak Up.

4.7 The Committee noted that DSPT compliance would cover cyber security; that Duty of Candour had been audited in 2020/21 and that both Safeguarding and Freedom to Speak Up had been audited in 2019/20.

5. ANNUAL QUALITY INDICATORS

5.1 The Committee briefly discussed the proposed indicators, noting that these had yet to be formally discussed by the EMT or the Board, nor yet approved by the Council of Governors.

6. EXTERNAL AUDIT STRATEGY

6.1 The external auditors, Mazars, presented their plan for auditing the annual report and accounts for 2020/21.

6.2 The Committee noted that the audit requirements for value for money were changing but, as yet, were still unclear.

7. CREDIT CARD FRAUD

7.1 The Committee heard that progress on this had stalled as a result of Action Fraud rejecting the application for this to be pursued by the police. The Trust's Local Counter Fraud Service has appealed this rejection.

8. OVERDUE DEBTS

8.1 Debtors overdue by 90 days or more were at their lowest (for at least 3 years).

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 26th JANUARY 2021, 2.00 – 3.45pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	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 24th November 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.05pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.10pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.25pm	3
2.4	Quality Dashboard (Q3)	Medical and Quality Director	2.35pm	4
3. Items for decision / approval				
3.1	GIDS - CQC report	Chief Executive/Medical and Quality Director and Divisional Director for Gender	2.45pm	5
4. Items for noting				
4.1	Guardian of Safer Working (Q3) Report	Medical and Quality Director	3.15pm	6
4.2	Serious Incidents Report (Q3)	Medical and Quality Director	3.25pm	7
5 Board Committee Reports				
5.1	Education and Training Committee	Committee Chair	3.35pm	8
5.2	Audit Committee	Committee Chair	3.40pm	9
6. Any other matters				
6.1	Any other business	All	3.45pm	
7. Date of Next Meeting				
	30th March 2021, 2.00pm – 4.00pm – Online / The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			