The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 18th May 2021

Please refer to the agenda for timings.

Meeting held online

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 18TH MAY 2021, 2.00pm – 4.15pm, 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
2.3	Minutes of the meeting held on 30th March 2021	Chair		1
2.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	3
2.4	VfM Self-assessment	Deputy Chief Executive / Director of Finance	2.40pm	4
3 Items for discussion				
3.1	Board Assurance Framework (BAF)	Chief Executive	2.50pm	5
3.2	GIDS Transformation Programme	Divisional Director Gender Services	3.00pm	6 - late
3.3	Quality Accounts 2020/21	Associate Director Quality and Governance Quality Directorate	3.10pm	7
3.4	Guardian of Safer Working Report	Medical and Quality Director	3.20pm	8
3.5	Quality Dashboard (Q4)	Medical and Quality Director	3.30pm	9
3.6	Clinical Thematic Case Review	Medical and Quality Director	3.40pm	10
4 Items to note				
4.1	Serious Incidents Annual Report	Medical & Quality Director	3.50pm	11
5 Board Committee Reports				
5.1	Training and Education Committee	Committee Chair	4.00pm	12
5.2	Audit Committee	Committee Chair	4.05pm	Verbal
5.3	Equality, Diversity & Inclusion Committee and Annual Report	Committee Chair	4.10pm	13

6 Any other matters				
6.1	Any other business	All		
8 Date of Next Meeting				
	27th July 2021, 2.00pm – 4.00pm – Online meeting			

Board of Directors Meeting Minutes (Part 1)
30th March 2021, 2.00pm-4.30pm, via Zoom

Present:			
Paul Burstow Chair	Dinesh Bhugra Non-Executive Director	Chris Caldwell Director of Nursing	Deborah Colson Non-Executive Director
Helen Farrow Non-Executive Director	Sally Hodges Clinical Chief Operating Officer	David Holt Senior Independent Director	Rachel James Divisional Director CYAF
Paul Jenkins Chief Executive	Tim Kent Divisional Director AFS	David Levenson Non-Executive Director	Terry Noys Deputy Chief Executive / Finance Director
Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Shalini Sequeira Associate Non-Executive Director	Dinesh Sinha Medical and Quality Director	Ailsa Swarbrick Director of Gender Services
Ian Tegerdine Interim Director of HR			
Attendees:			
Fiona Fernandes Business Manager Corporate Governance	Will Fitzmaurice Operations Director, Education & Training (item 4.6)	Badri Houshidar Governor - Staff	Laure Thomas Director of Marketing & Communications
Helen Robinson Interim Director of Corporate Governance	George Wilkinson Lead Governor - Public		
Apologies:			

Action Log

AP	Item	Action to be taken	Resp	By
1.	1.3.1	Amendments to the minutes of the previous meeting	FF	Immed
2.	5.1.3	Thematic Case Review to be circulated to the Board	DS	End of April

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 draft 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 reported that he had attended a North Central London (NCL) Integrated Care System (ICS) meeting relating to the recent publication of the Government's White Paper concerning the legislation for Integrated Care Systems (ICS).

2.1.2 Prof. Burstow reported that he had met with Mike Cook, Independent Chair of the ICS for North Central London (NCL), they discussed the implications of the White Paper and the Mental Health Review for adults and children. There will also be some changes in key personnel across the ICS for example the 'doubling hatting' of Chairs across the NCL.

2.1.3 Prof. Burstow referred to meetings of the NCL Provider Alliance where discussions would take place in relation to the shared initiatives of the alliance and determining what the priorities would be. The NCL will be focussing on waiting times on acute Trusts however all the Mental Health Chairs want the NCL to have equal focus on the Mental Health Trusts. The other areas of focus will be workforce and various lead roles.

2.1.4 Prof. Bhugra advised that he had attended a meeting of the Cavendish Square Group for Trust Chairs where the challenges of the White Paper and the issues of targets for mental health services had been discussed.

2.1.5 Prof. Burstow noted that he, along with a number of Chairs of Mental Health Trusts belonging to the NHS Confederation's Mental Health Network, had signed a letter to the Secretary of State requesting that mental health to be prioritised in the membership of ICS Board.

2.1.6 Mr Levenson noted that he had met with Mr Rex, Director of IM&T, who had updated him on the full migration of the Trust exchange and e mail services to the Cloud. Between the 6th and 7th March there had been a cyber security threat which had been identified and successfully dealt with.

2.1.7 The Board of Directors noted the verbal reports.

2.2 Chief Executive's report

2.2.1 Mr. Jenkins presented the report and highlighted:-

- The Trust's response to the ongoing Covid pandemic. The staff Covid vaccination programme has been positive and 80.9% of the Trust's frontline staff have been vaccinated. There was however a variation between the number of White and BAME staff choosing to be vaccinated. This hesitancy amongst some BAME staff is a concern across the sector.

- Education and training continue to be delivered remotely and the clinical services continue delivering a blended model, with some services delivering face-to-face. The Trust is working generally to a blended model and has benefitted in some ways from the flexibility.

- As part of the recovery planning for post the easing of lockdown restrictions in April 2021, several areas were under investigation. These include space utilisation of the building, review of the Trusts' Infection, Prevention and Control (IPC) and Standing Operating Procedures (SOPs), and the assessment of need for face-to-face work.

- Following a tender process led by the Race Equality Strategy Steering Group, Dr Yvonne Thompson has been appointed to lead on the external review of race equality in the Trust. She is leading a consortium of organisations with expertise in qualitative and quantitative research as well as policy and process analysis.

- The consultation of the Race Equality Strategy across the Trust has been launched with the aim of becoming an anti-racist organisation. This commenced with the all staff meeting last week which had been very well attended. Members of the Steering Group, Dr Tosin Bowen-Wright and Ms Anglin D'Christian (Staff Governor), had presented the background and principles of the work. Members of the group will follow this up with presentations to other key groups in the Trust including discussions at the April Board seminar.

- The Centenary Festival had concluded with an event chaired by Prof. Burstow with talks by Dr Jacquie Dyer, MBE and Julia Erwin. In excess of 7000 attendees had attended across all the festival events. This level of participation indicates a significant interest nationally and internationally in the work and reputation of the Trust. The qualitative feedback from post-event surveys indicated that there was an interest for more events.

- As Mr Levenson had noted earlier, the Cloud Migration had been completed successfully. Mr Jenkins thanked the IT team on a job well done.

- The Annual General Meeting (AGM) is proposed to take place on 20th October 2021 with the proposed theme of Race Equality.

2.2.2 Mr. Holt queried how the Board were being kept abreast of planning and decisions relating to the anticipated return to face-to-face working and vaccination hesitancy. He also asked if there was any central NHS guidance related to frontline staff who had not been vaccinated.

Responding to Mr. Holt, Dr. Sinha stated that there was a need to balance the vaccination hesitancy with the organisation's plans for the next phase. Staff engagement and communication continued to be a priority. Discussions are taking place centrally as to whether the vaccination should be mandatory for certain groups of staff.

Mr. Tegerdine added that a week of promoting the vaccination specifically targeting the ethnic minority staff groups was taking place. The risk assessment exercise is to be repeated for all staff and will be used as part of the planning. Information from the Centre includes the possibility of redeploying un-vaccinated

frontline staff to non-patient facing roles. He noted that the Social Care sector was being more assertive, including the dismissal and re-engagement of staff. It was reiterated that the Trust's performance on vaccinations was good and the need to ensure that a balanced approach is taken.

2.2.3 Responding to a query from Ms Sequeira on the precise levels of vaccinated staff, Mr. Tegerdine noted that overall figures are 86.8% (White staff group) and 69.5% (Ethnic Minority staff group)

2.2.4 The Board of Directors noted the report.

2.3 Finance and performance report

2.3.1 Mr. Noys presented the report, noting the ongoing uncertainty about the finances within the NHS system with an overall aim of break-even across the NHS and at individual Trust level. The Trust had recently been informed of £1.8 million additional funding and of further ICS funding. It is anticipated that the Trust would break even at the end of this financial year with a small surplus. The underlying deficit remains and is one of the challenges being addressed by the Strategic Review.

2.3.2 The Board of Directors noted the report.

3. Items for decision and approval

3.1 Quality Priorities 2021/22

3.1.1 Dr. Sinha presented the report and highlighted:-

- The fact that the requirements and deadlines for the Quality Accounts are prescribed in regulation and that he Trust was working to the 30th June 2021 deadline in the absence of any notification of revision of this date.
- The year-end timetable for 2020/21 had confirmed the continuation of the revised arrangements that were put in place last year 2019/20.
- NHS Foundation Trusts were no longer required to include the Quality Report in the Annual Report and Accounts or to commission assurance on their Quality Report 2020/21. With effective from 2021/22 this assurance exercise would be optional for all providers.
- There were renewed priorities for the coming year-improving job planning (linked to the Strategic Review), improving collection of Race Equality data which will be (also to be linked to the Strategic Review); improving waiting times and meaningful Outcome Measures.

3.1.2 Responding to a query from Ms Sequeira, Dr. Sinha agreed that having a baseline on patient experience ethnicity data would be useful. He noted that the baseline figures on MHSDS data remained unchanged in the high 50s. Dr Sinha noted that he would need to look further investigate this issue.

3.1.3 Mr. Holt asked whether the workforce priorities had been cross checked to ensure that they linked with NCL. Dr Sinha noted that there were plans to do so in the future and that there was ongoing consultation with the commissioners.

3.1.4 Dr. Hodges noted that a good half of the clinical services were outside the ICS but have links with them and reinforced the need for alignment at ICS level.

3.1.5 Dr. Colson welcomed the two new priorities and sought clarity on how, recognising the revised job planning within clinical services, the Clinical Effectiveness measure overview targets 1 and 2 in quarter 1 would link with the Strategic Review. She also asked if the Trust had an understanding of the key issues impacting the collection of Outcome Measures.

3.1.6 In response, Dr Sinha noted that the aim for job planning was alignment with the Strategic Review and this had driven the timelines. In relation to Outcome Measures, the Quality Assurance Board are aware of the issues on informatics and there are remote ways of filling out the measures but a lack of clarity remains.

3.1.7 Dr. Hodges noted that work on job planning had been ongoing for some time but in a silo way and that it had been brought together to align with the Strategic Review. In relation to Outcome Measures, part of the process is investigation of the issues. There had been significant drop-offs in outcome data collection.

3.1.8 Dr. James added that there was an ongoing programme of work to increase data collection.

3.1.9 Mr. Kent stressed the importance of technology in relation to the monitoring of outcomes and the need to ensure that staff were using this when seeing patients in a room. There was a need to improve data collection in relation to demographics, ethnicity and experience of service.

3.1.10 The Board of Directors noted the report, and unanimously approved the Quality Priorities for 2021/22.

4. Items for discussion

4.1 NHS Staff Survey 2020

4.1.1 Mr. Tegerdine presented the report and highlighted:-

- The fact that the survey had been undertaken in September and November 2020 with a good response rate of 66.6%.
- The Trust had performed better than average on three themes – health and wellbeing, bullying and harassment and violence against staff.
- The Trust had been categorised as average for the fourth theme regarding immediate managers. A development programme for line managers has been implemented.
- The Trust's performance had declined in six of the ten themes and compared to other Trusts, we were below average on equality, diversity and inclusion, morale, quality of care, safety culture, team working and staff engagement.
- In relation to staff engagement, this was the third consecutive year that it was below average.
- The Friends and Family Test - recommendation as a place to work, there had been a significant fall dropping from 71.4% in 2018 to 63% in 2020. We are

one of two Mental Health Trust which showed a drop and are positioned 45th out of 54.

- There had been a decrease in bullying for ethnic minority staff groups and, and increase for non-ethnic minority staff.
- There was a significant decrease in ethnic minority staff believing that the Trust provides equal opportunities for career progression or promotion.
- There was a 10.6% increase-almost double the average- in ethnic minority staff experiencing discrimination at work from managers, team leaders or other colleagues.

Reflections on the results

- Despite the context in Autumn 2020 of the early exploratory stages of research forming the Strategic Review, and the emerging financial, operational, system, data and impact and diversity challenges causing much rumour and anxiety, the Trust had a very high response rate which is positive.
- There was an ongoing impact of the hostile press and social media coverage related to Gender services that the Trust run on behalf of NHS England.

Points to note for the future

- The 2021 NS staff survey will launch in September 2021 which will be in the middle of the Strategic Review and therefore the Trust would need to be prepared for potentially further decreasing results.

Next steps and actions

- The Trust needed to take an organisation-wide approach in relation to the following:-
  - Openness of the recruitment process.
  - Clarity of processes and protection surrounding the Freedom to Speak Up Guardian.
  - Encouraging managers to advertise promotion and re-banding opportunities.
  - Leadership and Management skills development – already underway.
  - Implementation of the findings from the race equality review and the promotion and support of diversity, equality and inclusion.

- The Trust needs to refresh the existing People Plan to capture the strategic aims and actions.

- Focus on the Trust's values through the Strategic Review and to use this opportunity to engage staff in improving staff experience.

4.1.2 Ms Sequeira commented that it was positive that so many staff completed the survey, however it was concerning about the equity in the organisation and supported immediate actions to address these concerns.

4.1.3 Mr. Tegerdine noted that the use of internal communications needed to be reviewed and the policy changed on how recruitment is monitored to ensure external competition. The process on rebanding existing jobs needed amending to show equity and fairness.

4.1.4 Ms Houshidar asked whether there was data on how many ethnic minority staff were promoted and, if the jobs were advertised externally instead of rebanding, how equity for ethnic monitory staff would be ensured including that the

advertisements have been accessible. She questioned whether staff within the organisation should be prioritised to improve retention.

4.1.5 Responding to Ms Houshidar, Mr. Tegerdine noted that the Workforce Race Equality Standard (WRES), required the Trust to look at the recruitment data by race. Those from ethnic minority backgrounds were less likely to get short listed or progress to the interview stage. He stressed the importance of competition within a fair and transparent recruitment process. A Trust pool of diversity representatives who participate on interview panels exists, although due to work pressures, such participation was not always possible.

4.1.6 Mr. Kent stated that the formality of the reporting route was part of the problem. Ms Henderson is likely to receive more concerns as a trusted employee than through the defined process.

4.1.7 Mr. Levenson noted that the Trust has had a challenging year which was reflected in some of the survey data and queried to what extent an understanding existed of the stories underlying the data.

4.1.8 Responding to Mr. Levenson, Mr. Tegerdine indicated that evidence exists of staff trusting the organisation to act on the findings of the survey and noted that as a Board there was a need to make the necessary cultural changes.

4.1.9 Responding to Mr Kent's statement (4.1.7), Mr Tegerdine noted the importance of ensuring that staff have confidence in the reporting systems.

4.1.10 Dr. Colson queried the use of benchmarking in the survey. Mr. Tegerdine advised that benchmarking was based on all other Trusts that were surveyed at the same time including other Mental Health Trusts and did not therefore take into account specific characteristics of individual trusts.

4.1.11 Prof. Burstow noted that the diversity representatives on interview panels were not a sufficient mechanism to address the Trust's performance on workforce race equality. He agreed that it was encouraging that more staff had taken part in the survey. Staff communications needed to reassure staff that they had been heard and what actions are being taken. It was of concern that staff still did not feel comfortable to speak up. The issues raised were deepseated and would not be fully resolved before the next survey in September 2021, however, the Board had to demonstrate that we are taking this seriously to ensure we deliver the change that staff were expecting of us.

4.1.12 Mr Jenkins concurred with and echoed what Prof Burstow noted in 4.1.11 and added that the investment in the Strategic Review would bring meaningful change.

4.1.13 The Board of Directors noted the report.

4.2 Board Objectives & Board Assurance Framework (BAF) 2021/22

4.2.1 Mr. Jenkins presented the report and advised that the opportunity had been taken to reset the objectives. This was the first draft of the strategic objectives for consideration. A framework had been set out mapping the risks against the Strategic Aims and Challenges and what we have to achieve in the next year. A fully worked up Strategic Risk Register will be brought to the May Board.

4.2.2 Mr. Jenkins thanked Mr. Tegerdine and Ms Shipman for the work that they had done on this.

4.2.3 Mr. Holt commented that the weighting given to DET represented a significant portion of income and was a complex area to get right.

4.2.4 Prof. Burstow noted that the NHS were planning to issue guidance on the People Plan – he stressed the importance of diversity and the need to consider the psychological impact of the past twelve months on the Trust's staff. He also suggested that the Board would need to refresh the objectives in view of the outcomes of the Strategic Review.

4.2.5 Responding to Ms Sequeira's challenge, Mr. Jenkins noted that the Strategic Review was a starting point which would be followed by review of the Trust's People and other strategies.

4.2.6 The Board of Directors noted the draft objectives.

4.3 Operational Risk Register

4.3.1 Mr. Noys presented the report and noted that the main risks identified were located within GIDS.

4.3.2 Dr. Colson welcomed the inclusion of noted that she was pleased to see that issues about the waiting time figures for the Adult Gender Services waiting time figures had been picked up.

4.3.3 Dr. Sinha noted that there was an ongoing piece of work on assurance within all the clinical services.

4.3.4 The Board of Directors noted the report.

4.4 GIDS Transformation Programme

4.4.1 Ms Swarbrick presented the report and noted that the Transformation Programme is a significant wide ranging programme of complex work.

4.4.2 Ms Swarbrick thanked all those involved. To date, significant work had been undertaken to ensure the appropriate the governance arrangements were in place.

4.4.3 Ms Swarbrick advised that the key issues were:-

- Responding to the CQC and Judicial Review requirements to ensure a highly demonstrable clinical service.
- Having good management
- Having good governance
- Being data driven
- Having external and internal expert input
- Reconvening the PPI group in the light of concerns
- Risks-staff capacity, morale, waiting list numbers

4.4.4 Dr. Colson noted that she is the Non-Executive Director (NED) member of the GIDS Oversight Committee which meets fortnightly and scrutinises the papers. A huge amount of work had been done using the programme management approach. The focus was on getting things done right and the staff, children and young people and their families were at the forefront.

4.4.5 Ms Swarbrick advised that the Judicial Review was principally about Gillick Competence and whether a child could give consent to endocrine treatment. A court ruling on Friday had ruled that the parent could consent. The implications for the service of the ruling and NHS England's revised specifications were being addressed.

4.4.6 Dr. Sinha expressed thanks to the staff working through these challenging circumstances and to Ms Swarbrick for her work and leadership in this area.

4.4.7 The Board of Directors noted the report.

4.5 Academic Freedom Policy

4.5.1 Mr. Fitzmaurice was in attendance for this item, and together with Mr Rock, presented the report. This policy was a requirement of the Office for Students (OfS) and had been in the process of being drafted when the Trust had been conferred status as a higher education institution. The draft policy had been considered at the February meeting of the Education and Training Committee meeting. The policy had also been discussed by the Clinical Operations Board and had been reviewed by Human Resources, the Freedom To Speak Up Guardian and the Executive Management Team.

4.5.2 Mr. Rock advised that, should the policy be approved, a communications plan would be developed for the policy launch. The development of a policy for external speakers is also planned.

4.5.2.1 Prof. Burstow noted that the Education and Training Committee had discussed the changes made following the discussion at the Clinical Operations Board to expand the scope of the policy, with adaptations having being made to ensure the policy covers activities across the Trust, including within clinical divisions. Clarification had also been provided on the method of confirming any viewpoint as the official view of the Trust.

4.5.3 Mr. Jenkins noted that this was a very important policy and it should be trust wide as it covers all areas of the work the Trust does. There should be freedom of expression for staff whilst demonstrating respect for peers and those with protected characteristics.

4.5.4 Mr. Jenkins thanked Mr. Fitzmaurice for his work developing the policy

4.5.5 Prof. Burstow recommended that the Board adopt the policy.

4.5.6 The Board of Directors noted the report, and unanimously adopted the Academic Freedom and Freedom of Speech Policy.

4.6 Board Appointments and Roles

4.6.1 Prof. Burstow presented the report and highlighted that the Council of Governors had approved the use of the executive search agency Odgers Berndtson for the recruitment process for two new NEDs.

4.6.2 These appointments will take the total number of NEDs to six not including the Chair. To allow these appointments the Trust's Constitution would need to be amended, requiring the approval of the Board of Directors, the Council of Governors and members. This will be ratified at the Annual General Meeting in October 2021.

4.6.3 The Board of Directors was in agreement with the proposed constitutional amendments.

4.6.4 The Board of Directors noted the report and approved the constitutional amendments to be submitted to the AGM for ratification.

5. Items to note

5.1 Serious Incident Annual Report

5.1.1 Dr. Sinha presented the report and highlighted:-

- During quarter three, 28 clinical incidents had been reported including 12 which had bene escalated to the monthly incident panel.
- There had been three patient deaths in quarter three and a further death had been reported at the beginning of quarter four.
- One of the deaths was a patient in Adult and Forensic Service (AFS) which had been reviewed at the November 2020 incident panel and was logged on StEIS.
- The other two deaths were within the Adult Gender Identity Clinic (GIC) and both had been reviewed at the December 2020 incident panel with no further action having been required. In both cases, the duty of candour had been appropriately followed.
- There had been three attempted suicides, one is the CAISS team and two from GIDS.
- Several Learning Lesson events had taken place which continue to be well attended and during the pandemic more staff were able to access the events remotely.
- Thematic Case Review had been completed and the report had been shared with the Commissioners.

5.1.2 Dr. Caldwell welcomed the increased attendance at Learning Lesson events and suggested that it would be useful to have a more detailed discussion in part two of the meeting of the evidence of learning to see the improvements. Dr. Sinha concurred with this suggestion.

5.1.3 Dr Caldwell asked the report on the Thematic Case Review could be shared with the Board. Dr Sinha responded that an anonymised version of the report would be circulated.

Action: Dr. Sinha to circulate to the Board an anonymised version of the Thematic Case Review report.

5.1.4 The Board of Directors noted the report.

6. Board Committee Reports

6.1 Integrated Governance Committee (IGC)

6.1.1 Dr. Sinha presented the report and highlighted the ongoing review of the RAG ratings for Estates by the Interim Director of Estates, Facilities & Capital. Mr. Jenkins had undertaken to standardise RAG ratings across the Trust.

6.1.2 Dr. Caldwell corrected the rating on patient experience to green from amber.

6.1.3 Mr. Noys stated that the Estates review of RAG ratings was specifically the Estates items at the request of the Estates Committee.

6.1.4 The Board of Directors noted the report.

6.2 Education and Training Committee

6.2.1 Mr. Rock presented the report which related to both the February and March meetings. There had been discussions at both meetings concerning student recruitment and the strong performance of the recruitment cycle.

6.2.2 Prof. Burstow informed the Board of his intention to step down as Chair of the Education and Training Committee. Following discussions with Mr Levenson who is an existing member of the Committee, Prof. Burstow nominated Mr. Levenson as Chair.

6.2.3 The Board of Directors approved the nomination of Mr. Levenson as Chair of the Education and Training Committee with immediate effect**.**

6.2.4 The Board of Directors noted the report.

6.3 Strategic and Commercial Committee

6.3.1 Ms Farrow presented the report and noted that the main focus of the Committee was the Strategic Review. Business development opportunities remained extremely limited due to the external pandemic environment.

6.3.2 The Board of Directors noted the report.

6.4 Audit Committee

6.4.1 Mr Holt highlighted the discussions about the need for consistent RAG ratings across the organisation.

6.4.2 Mr Holt sought delegated authority from the Board to the Audit Committee to sign off the Annual report and Accounts 2020/21.

6.4.3 The Board of Directors noted the report and granted delegated authority to sign off the Annual Report and Accounts 2020/21 to the Audit Committee.

7. Any other matters

7.1.1 Prof. Bhugra advised that the report from the Equality, Diversity and Inclusion Committee would be brought to the next Board meeting. He also advised that Ms Henderson, Race Equality Champion, was stepping down from this role after four years.

7.1.2 The Board noted their thanks to Ms Henderson for all her hard work.

8. Date of next meeting

8.1 18th May 2021 at 2.00pm

8.1.1 The meeting closed at 4.30pm.

Report to	Date
Board of Directors	18th May 2021

Chief Executive's Report

Executive Summary

This report provides a summary of key issues affecting the Trust.

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. Strategic Review

1.1 The Strategic Review continues to be a major focus for the organisation. We have now completed consultation on the Vision and Principles document and are proceeding with the development of a further wave of engagement with staff in June. Based on a set of "compass points" this will aim to explore some of the key issues in more depth ahead of producing proposals for formal consultation.

1.2 In parallel we have been developing a specification for an externally led Board Governance Review to review the work of the Board and its Committees alongside the Strategic Review.

1.3 We will be discussing the Strategic Review later in the agenda.

2. NCL MH Commissioning Review

2.1 The NCL CCG is undertaking a review of the commissioning of mental health service across North Central London. An associated review of community health services is also underway.

2.2 The review has the aim of developing a core mental health offering across North Central London. This would aim to provide consistency in service delivery and tackle health inequalities while recognising that there will be some variation in how that offer is deployed depending on local need. The CCG has commissioned Carnall Farrar to support the review. The Trust is engaging closely with the review recognising its significance for the future of local services.

3. Covid19 Update – May 2021

3.1 The Trust has been closely following the review and relaxation of social restrictions by the Government. Schools and other educational settings have reopened since March and presentations in CAMHS and adult pathways have been high. All mental health Providers, including our own services have reported increasing activity and demand for services, as the service users have sought help for their needs.

3.2 The Trust, its clinical services and all our staff and trainees are now preparing for a significant return to Trust premises. There are significant reasons to return in greater

numbers to face-to-face settings in a phased return for improved communication, working within teams, team building, offering patient choice, staff wellbeing, confirming future patterns of working in all our pathways etc.

3.3 In proactively responding to the changing scenario, we have created a guidance for teams working for the next phase for our clinical services and similar planning is ongoing for Trust educational services. We are not expecting to return to pre-pandemic patterns of work/ delivery, though we expect to use the forthcoming period from June 2021 to trial a more permanent blended model of delivery. We expect educational services to return to Trust buildings in the next quarter to some degree and DET will be preparing a specific guidance, which will be in line with overall organisational plans.

3.4 The key strategies for keeping staff and service users' safe during COVID 19 are to perform regular hand hygiene, screen service users before attending, use PPE in accordance with guidance, decontaminate resources after use, and keep separate toy boxes for each child attending as well as screening the patient/family before they attend. We will continue to provide services in line with government advice for health and/or education services as appropriate.

3.5 There continue to be concerted efforts to promote the highest possible rates of vaccination for Trust staff, using several opportunities for vaccinations with local partners including RFH, CLCH and C&I.

3.6 There have also been significant efforts to address vaccination hesitancy, including through information on our intranet pages, message from the Medical Director, discussion at all staff meetings etc., to allay concerns and promote take up of vaccination. These have all had positive impact and the current figures for frontline staff vaccination have increased to 82.3% of all staff (84.1% of front line staff) and these measures will be continued in the coming period. There has also bene a significant increase in the number of staff who have received a second dose of the vaccine.

3.7 We are now embarking on the implementation of changes for the next phase of the pandemic. The hope is of continuing lower prevalence of Covid infection and higher levels of vaccination.

3.8 However, we will continue to exercise caution and pay due regard to continuing IPC measures. The process of seeking exemptions for mask use continues and each exemption is an exception, which shall be regularly reviewed and only permitted with all other aspects of IPC. Several individual mask exemptions were agreed by operational leads and the DipC (Medical Director).

3.9 Other key actions are as below:

- Increase in offer of F2F work in our clinical teams
- Teams to meet at regular intervals face to face
- Group work at Trust sites to continue using appropriate social distancing, PPE etc.

- Review of SOPs and IPC procedures to ensure service user and staff safety
- Use of space within our premises, especially the use of larger rooms for team meetings

3.10 The Trust EPRR Gold group meets weekly to take stock of the changing situation and modify communications to the Trust using a variety of methods including all staff briefings, communication messages etc. Any relevant information is also shared with the EMT and brought to the Trust Board, as appropriate. We have created a dedicated page on the intranet collating various IPC resources and procedures/ instructions, as issued and do regular messaging to maintain engagement and compliance.

4. Equalities

4.1 We have launched at the all staff meeting on 26th April, the External Review of the Trust's culture in respect of race.

4.2 The first wave of work has included promotion of workplace race survey which has been distributed to all staff in the organisation. This will provide a crucial level of quantitative data for the organisation on attitudes across the organisation towards race equality. We are organising a series of qualitative 1:1 and focus group interviews with the review team.

4.3 The aim is that the External Review will report to the Board in July.

4.4 At the same time, we have been undertaking consultation across the organisation on the next iteration of our Race Equality Strategy including our public commitment to become anti-racist organisation. This included a presentation at the Board seminar on 27th April.

4.5 We are in the process of recruiting an Associate Director for Equalities. This reflects the urgent need for senior resource to address the work of developing the refreshed Race Equality Strategy and other emerging equalities issue. The post has been advertised as a one-year fixed term appointment in recognition that we will want to review our governance and leadership arrangements for work on equalities in the light of findings from the external review.

4.6 We are also looking at work on other equalities issues. Given the Trust's role as a major provider of gender services we are looking to start some work on issues relating to trans people. We would aim to bring some thinking on this to the June Board seminar.

5. GIDS

5.1 There continues to be a lot of ongoing work in relation to GIDS and a report on the GIDS transformation programme is on the agenda later.

5.2 Following our CQC Inspection report, we attended, on 5th May, a Quality Summit to report on our plans for addressing the requirements set out by CQC and to highlight areas where we needed the support of the system in achieving improvements.

5.3 We are working with NHS England on the details of their plans for establishing panels to review decisions made to refer patients aged under 16 to endocrine services. This follows the recent judgment made in the Family Court. The panels will aim to review the robustness of the process followed in reaching decisions, not the clinical decisions themselves. They will not consider cases aged 16-17 where it is recognised that a different legal framework applies.

5.4 We are continuing our preparations with our legal team for our appeal against the JR judgment in December. The hearing is due to be held on 23-24th June.

Paul Jenkins
Chief Executive
12th May 2021

PAPER 3

The Tavistock and Portman NHS Foundation Trust

Report to	Date
BOARD OF DIRECTORS	18 May 2020

FINANCE AND PERFORMANCE REPORT

Executive Summary

Attached is a summary of the financial performance of the Trust during 2020/21.
The result shows a net surplus for the year of £0.7m, after NHSE and NCL ICS top up payments of £5.9m. Excluding these payments the position would have been a net deficit of £5.2m

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Udey Chowdhury, Director of Financial Operations	Terry Noys, Deputy CEO and Director of Finance

Financial Performance for the year ended 20/21

	2020/21 £'000	2019/20 £'000		2020/21 £'000	2019/20 £'000
	Excluding Top-up / PSF	Excluding Top-up / PSF		Per Accounts	Per Accounts
Income					
Patient Services	41,199	35,275		41,199	35,275
Education and Training	18,934	24,088		18,934	24,088
Research	466	612		466	612
Other	676	1,007		676	1,007
Top-Up Funding				4,165	0
FRF/PSF Funding					700
Total	61,227	60,982		65,442	61,682
Expenditure					
Pay	(47,056)	(43,799)		(47,056)	(43,799)
Non-Pay	(15,498)	(15,690)		(15,498)	(15,690)
Total	(62,553)	(59,489)		(62,553)	(59,489)
EBITDA	**(1,277)**	**1,493**		**2,889**	**2,193**
Depreciation and amortisation	(1,628)	(1,383)		(1,628)	(1,383)
Bank interest	3	54		3	54
Other finance costs	(11)	(38)		(11)	(38)
Dividend to the DoH	(578)	(608)		(578)	(608)
Retained surplus before restructuring costs	(3,491)	(482)		675	218
Impairment of fixed assets	0	0		0	0
Retained surplus / (deficit)	**(3,491)**	**(482)**		**675**	**218**

EBITDA margin	(2.08%)	2.45%		4.41%	3.56%
Net surplus margin	n/a	n/a		1.03%	0.35%

Commentary

The Trust achieved a net surplus for the year of £675k, an increase of £457k compared with the prior year. Control totals were not set during the financial year, but instead the Trust net surplus was managed in conjunction with wider North Central London Integrated Care System (NCL ICS) and NHS England priorities. During the Covid pandemic all NHS trusts have been in receipt of central top-up funding to ensure financial issues did not impede the delivery of patient services.

The amount received by the Trust has been £5,927k. Without this funding, the Trust would have had a deficit of £5,252k.

A breakdown of support funding from either NHS England or the NCL ICS is shown below: -

	£'000
Top-up funding – NHS England	4,165
Top-up funding – NCL ICS	660
NCL ICS redistribution of reserves	1,107
Total	**5,927**

In addition, the Trust received £1,298k of funding to support Covid-related activity.

The tables below show the major movements in income and expenditure during the year.

Income bridge from 19/20 to 20/21

	£000	
19/20 Totals	**61,682**	
Top-up Funding – from NHS England	4,165	
NCL ICS redistribution of central reserve	1,107	
NCL ICS Top-up funding	660	
Covid Reimbursement – direct costs and cash for annual leave provision	1,298	
Loss of FNP revenue from 19/20	(2,545)	
Other losses (Westminster, Hammersmith, Fulham, North West London ICS, Named Patient agreements not reimbursed directly)	(919)	
20/21 Total	**65,442**	

Staff Costs bridge from 19/20 to 20/21

	£000	
19/20 Totals	**43,799**	
Increase in annual leave due to Covid	1,084	
Directly related Covid costs	502	
Inflationary increases and full year effect of new starters from 19/20	1,558	
Increase in agency costs	116	
20/21 Total	**47,056**	

Non-Pay Costs bridge from 19/20 to 20/21

	£000	
19/20 Total	**15,690**	
Provision for overpayments and other legal costs	567	
Increases in Premises' business rates costs – full year of Lief House	133	
Savings on Educational delivery	(273)	
Savings on travel	(450)	
Other savings on property and establishment	(169)	
20/21 Total	**15,498**	

BACKGROUND AND INTRODUCTION

Background

1. This self-assessment has been produced to assist the Trust's external auditors – Mazars LLP("Mazars") – with their assessment of the Trust in terms of the value for money assessment.
2. It has been produced by the Trust's senior directors, notably the Director of Finance, Medical Director, Clinical Chief Operating Officer and Director of Education, with assistance from key members of the teams which they manage.
3. The self-assessment was reviewed and approved by EMT at its meeting of 27 April 2021.
4. Owing to its timing, the self assessment was not approved by the Board before being presented to Mazars, however, the intention is to present the paper to the May Audit Committee and May Board meetings.

Introduction

5. The Trust is, relatively, a small organisation with a flat management structure.
6. This means that key executives within the Trust often sit on the same committees / groups; have access to much of the same information (often in more than one forum); and are able to communicate, quickly, any known or potential changes to the Trust's activities.
7. Whilst, primarily, a provider of services commissioned on a national basis, the Trust takes a very active role in the STP with the Trust's Chief Executive, Medical Director, Clinical Chief Operating Officer, HR Director and Director of Estates all playing active roles.
8. In addition, the Trust's Director of Nursing plays an active role in the Trust's dealings with Health Education England (a key commissioner of Trust services).

MAIN DEFINITIONS

9. The following definitions are used throughout this document:

"Trust"	Tavistock and Portman NHS Foundation Trust
"Board"	Board of Directors
"Council"	Council of Governors
"EMT"	Executive Management Team
"DET"	Directorate of Education and Training
"STP"	The North Central London Sustainability and Transformation Partnership / Integrated Care System of which the Trust is a member
"CQC"	Care Quality Commission

A) FINANCIAL SUSTAINABILITY: HOW THE TRUST PLANS AND MANAGES ITS REOURCES TO ENSURE IT CAN DELIVER ITS SERVICES

The Annual Budget

10. The Trust sets out its Budget annually. This is the key financial report of the year, covering income and expenditure (both revenue and capital), cash flow and balance sheet movements. Typically, the Budget for a year is produced before the end of the previous year, with formal approval - by the Board - usually taking place in March of the year prior to the year to which the Budget pertains.
11. The Budget is based on the most recently available full year forecast for the year prior to which the Budget relates. This forecast is updated for any known changes to income and revenue expenditure, such as service lines which are being closed or new service lines which are being added, or other major initiatives. Assumptions are also made regarding increases in income and costs. For clinical income, the Trust will follow NHSE/I and STP guidelines. For DET income, the Trust will reflect the terms of its contract with Health Education England. In addition, DET income will reflect known / forecast student numbers (for long courses) and forecast income for short courses. DET income for long and short courses will reflect proposed price increases (agreed, in line with the Trust's SFIs /and Scheme of Delegation) by the Director of Finance and the Director of Education. An element of contribution from new (but as yet, not secured) income will also be included.
12. Staffing costs represent approximately 74% of addressable costs (ignoring depreciation and PDC). Accordingly, a lot of effort goes into ensuring staffing costs are accurate. For the Budget, initially, a full complement of staff is assumed (that is, all posts are filled for the full year), before a staff 'efficiency' factor is applied. (This efficiency factor reflects staff turnover and represents the fact that some posts will be vacant for some of the year).
13. Non-staffing costs are usually assumed to stay at the same level as the prior year, unless there are specific known changes (either upwards or downwards).
14. With regards to CIP ("Continuous Improvement Programme"), the Trust varies its approach. In some years it has a formal CIP programme, however, in the most recent years the Trust has not adopted a formal CIP programme, relying instead on contribution from new business activities. This approach is well understood and approved by the Board.
15. The Trust's new business activities are generated from 4 main areas, as follows:

- Revisions to existing contracts, which are overseen and controlled by the Contracts Team
- New service wins, delivered by the Business Development Team, which reports into the Chief Executive and is monitored by the Business Development Group (a sub-committee of EMT) and the Strategic and Commercial Committee, a sub-committee of the Board:
- Health Education England monies bid for by DET (particularly through NWSDU)
- Increased students attending long and short courses.

16. Once the first draft of the Budget has been put together, the Finance team meet with budget holders to discuss the assumptions and make sure that there are no obvious errors or omissions. This is usually done at service line level for clinical budgets; team level for corporate service functions; and at directorate level for DET.

17. The draft Budget, which contains a section on key risks and opportunities, is then presented to EMT for review and comment, being refined (for any further known changes) before being presented to the Board for approval. The Budget is also presented to Council (for information).

18. It should be noted that in each of the past 3 financial years (2017/18, 2018/19 and 2019/20) the Trust has met / exceeded its Budget. Given the revised financial arrangements for 2020/21 this measure (actual versus Budget) has little meaning.

19. A capital expenditure (Capex) budget for the year is also produced. Senior members of the Trust (EMT, Directors) are asked to put forward proposals for any project which may be capital in nature. A list of such projects is then compiled and prioritised. This prioritisation is based on a basic ranking system, as follows:

    - Level 1 - Projects required to meet health and safety or other compliance or regulatory requirements
    - Level 2 – Projects required to maintain the existing infrastructure of the Trust
    - Level 3 – Strategic projects which are already 'in flight' and which require on-going financing
    - Level 4 – Other projects.

20. Other projects usually consist of a range of clinical, DET, IT, Estates and corporate projects. Clinical projects are prioritised according to the view of senior clinical staff, DET projects according to DET staff etc. A final prioritisation is then agreed balancing a range of factors, but most notably:

    - The funds available for the Trust to invest in Capex (given the agreed STP limits)
    - The project management resource required
    - The likely financial and non-financial benefits to be derived from projects
    - STP or NHS priorities.

21. For 2021/22, this prioritisation process is carried out by the Change Board (a sub-committee of EMT), reviewed by EMT and then approved by the Board. (Also, for 2021/22, Level 2 projects were included with Level 1).

22. During 2020/21, the Trust's Capex plans were significantly disrupted by changes required by NHSE/I, notably a requirement to substantial cut back the Trust's original Capex Budget plus the need to bid for COVID-related Capex. In addition, the overspend on Leif House required Capex priorities to be reassessed.

23. The required changes to the Capex Budget were agreed by discussion at EMT and, despite this disruption, the Trust was still able to deliver on its core Capex programmes, notably Digital Academy and Relocation. It should be noted that an internal audit into COVID-related IT Capex resulted in a substantial assurance opinion.

Long Term Financial Plan ("LTFP")

25. The Trust utilises a LTFP, primarily for the purposes of Relocation and for the annual review of Going Concern. The LTFP is updated, at least once annually, and takes into account the latest in year forecast and the Budget for the following year. Subsequent years are driven by standard assumptions plus any known changes.

26. As noted above, the LTFP is used to assist in the Going Concern assessment required when producing the annual accounts.

Management Accounts

27. Each month the Trust produces detailed management accounts ("MA"). These compare the year to date results against the Budget. As well as income and expenditure, balance sheet and cash flow, the MA includes detailed service level reporting. The latest set of MA is presented to EMT and at each meeting of the Board and the Council. MA are also presented to the Operations Board.

28. Reviews of the MA are undertaken, at service level, each month.

In Year Reforecasts

29. The Finance team produces a monthly rolling in year reforecast. These reforecast the full year out-turn based on actual year to date results and the Budget for the remainder of the year, adjusted for any other known changes. The reforecasts are informed, in particular, by the detailed review of MA undertaken at service level but also by information flowing out of the Trust's key operational bodies (noted below).

30. Several times during the financial year, these reforecasts are formally presented to the Board and the Council.

Operations Board ("OB")

31. The OB is a sub-committee of EMT and is the senior oversight body in terms of the management of the Trust's clinical activities.

32. MA and reforecasts are presented to the OB, which enables the OB to raise queries on the information supplied and provide insight into actual or potential future changes to clinical activities.

Education and Training Committee ("ETC")

33. ETC, which is a sub-committee of the Board, is the senior oversight body in terms of the management of the Trust's educational and training activities. Financial information relevant to DET is presented to ETC. This financial information will include excerpts from the MA but also more detailed reports on short course profitability and long course recruitment. This information helps to inform the in-year reforecasts and annual Budget.

Business Development Group ("BDG")

34. The BDG is a sub-committee of EMT responsible for reviewing the Trust's performance in terms of income generation. BDG thus reviews reports from the Contracts and Performance ("Contracts") team on existing activities and approves any significant proposed new business initiatives. As part of the latter process, any requirements for additional (non-Budgeted) resources is identified.

35. The work of BDG (and many of its papers) are submitted to the Strategic and Commercial Committee which ratifies (or not) the decisions of BDG.

Change Board

36. Each year the Trust has a number of significant projects in progress. Each of these projects has a project board, with formal terms of reference, which is responsible for monitoring the performance (operational and financial) of the project. The Change Board was established to provide additional oversight on such projects. Accordingly, the project manager of each project provides the Change Board with a Highlights Report summarising the status of the project. The project senior responsible officer / sponsor also attends the Change Board. In this way, any over or under spend on any project can be taken into account and appropriate actions taken.

Strategy Day

37. The Trust holds a strategic planning day at least once per annum. This usually involves both EMT and the Board and provides a formal forum in which short / medium / long term strategic issues facing the Trust can be discussed. Where relevant, any matters arising from this activity are reflected in the Trust's financial plans.

STP Inter-Action

38. As noted under the Introduction section above, the Trust plays a very active role in the STP and its leading executives attend and actively contribute to a range of STP forums. In addition, either or both the Director of Finance and the Director of Financial Operations attend the weekly STP CFO meetings.

39. This means that the Trust is made aware of any national / STP initiatives which may impact on the operational or financial performance of the Trust.

NHSE/I and STP Reporting

40. The Trust has to make a range of annual, monthly and ad hoc reports to NHSE/I and the STP, most notably around its actual or projected performance. Many of these reports require triangulation of financial, workforce and activity data.

B) GOVERNANCE: HOW THE TRUST ENSURES THAT IT MAKES INFORMED DECISIONS AND PROPERLY MANAGES ITS RISKS

Introduction

41. The Trust Staff Handbook sets out the Trust's key governance arrangements and flows of assurance across the organisation.

42. The Trust's system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It, therefore, only provides reasonable and not absolute assurance of effectiveness.

43. The Trust's system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust; to evaluate the likelihood of those risks being realised and the impact should they be realised; and to manage them efficiently, effectively and economically.

Capacity To Handle Risk

44. The Trust has in place a Risk Management Strategy and Policy, supplemented by a Risk Management Procedure, which clearly sets out the accountability and reporting arrangements to the Board for risk management within the Trust. Operational responsibility for the implementation of risk management is delegated to executive and other named directors.

45. Risk management is a core component of the job descriptions of senior managers within the Trust. A range of risk management training is provided to staff and there are policies in place which are available to staff via the Trust intranet and public website.

46. The Trust learns from good practice through a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit, learning lessons seminars, application of evidence based practice and inter-professional events. The Trust also seeks to learn from the work of other organisations, notably those within the STP.

The Risk And Control Framework

47. The risk management strategy and policy set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

48. The Trust has recently moved to an online risk management system, away from the previous paper / Excel based arrangements and a risk management matrix is used to support a consistent approach to assessing and responding to all risks and incidents.

49. To provide oversight and assurance the Integrated Governance Committee ("IGC"), a sub-committee of the Board, is responsible for seeking assurance on the organisation's quality governance structures and systems of control.

50. During 2020/21 the IGC undertook a review of its governance arrangements (including its sub-committees). As a result a number of changes were made and the IGC now has sub-committees covering:

    - Risk and patient safety
    - Organisational development and people
    - Research and development
    - Estates and facilities
    - Data security and protection
    - Patient experience and quality care.

51. Within its remit it is an integrated governance forum (the Data Security and Protection sub-committee of the IGC) which is responsible for seeking assurance on all matters of risk, safety, experience, data security and other corporate compliance requirements that impact quality.

52. The IGC is also responsible for seeking assurance that the Trust's plans for complying with CQC regulatory requirements are delivered and, where there are deficits, that mitigating actions are in place.

53. The Board and EMT have undertaken a comprehensive process for assessing and agreeing the organisation's appetite for risk. This process was implemented following a Board development session to support the development of an appropriate internal framework to discuss, challenge and agree the level of risk which the Trust will accept.

54. Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level.

55. The Trust has an established Incident Panel ("IP") which is chaired by the Trust's Medical Director. A sub-committee of EMT, the IP is the senior group within the Trust which reviews all clinical incidents in the Trust and any learning from them. The IP directs the process for conducting reviews, escalates and coordinates responses and thematic improvements in various parts of the organisation.

56. The Risk and Patient Safety sub committee reports on all incidents of risk and patient safety to the IGC. The minutes of the IGC are shared with the Board. There are also quarterly and annual Safety / Incidents reports to the Board.

57. The Trust's board assurance framework ("BAF") supports the process for monitoring ongoing compliance with the requirements for registration set by the CQC and licence conditions set by NHS England and NHS Improvement. The BAF sets out the principal risks to delivery of the Trust's corporate objectives and identifies the assurances available to the Board in relation to achievement of the objectives and these are also mapped to key controls. The director with responsibility for managing and monitoring each risk is clearly identified.

58. The BAF is presented to the Board three or four times per annum.

59. The Trust has not identified any risks to compliance with the NHS Foundation Trust condition 4 (FT governance).

60. The Council approves the quality priorities for the Trust. The priorities include a number of indicators agreed with stakeholders, together with national indicators of quality.

61. The Board reviews an extensive number of metrics and performance data through its quarterly quality dashboard report, which is presented to the Board four times each year, normally after each quarter end.

62. A range of methods have been put in place to ensure that the Trust complies with the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which are set out in the CQC's five domains. Approaches include service visits, quality improvement projects, effective systems of supervision and regular team meetings.

63. See also comments under Audit Committee below.

Major Risks In 2020/21

64. The key risks to delivering the Trust's strategic objectives are recorded in detail in the BAF and monitored three or four times a year by the Board.

65. For 2020/21, the Trust identified 11 risks which could impact on the delivery of the strategic objectives, these were the risk that:

- The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.
- The risk that the pandemic and pressures on leadership have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.
- The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England
- If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy
- The risk of insufficient staff capacity to keep activity within contracted levels across all services and manage all regulatory requirements because of a range of factors including morale, staff sickness, staff shielding and system pressures. This may also lead to poor engagement with the quality agenda with a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care
- The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.
- The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the ICS and the delivery of the Trust's wider objectives

- If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19.
- The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.
- The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision
- If the Trust fails to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation and the quality of patient and student experience.

66. Against each of these strategic risks a responsible director is assigned to the risk who is tasked with identifying control measures to mitigate the risk, identify gaps in control measures and take appropriate actions. A number of the risks relate to factors in the external environment which are outside of the Trust's control.

67. EMT regularly reviews the risks identified on the BAF and considers any new and emerging issues which may impact on the delivery of the strategic objectives. The BAF is refreshed each year to reflect new strategic objectives and to provide the opportunity to reflect on the current and any emerging risks which need to be captured.

Care Quality Commission / Gender Identity Development Service ("GIDS")

68. The Trust is fully compliant with the registration requirements of the CQC.

69. The Trust engages with the CQC through ongoing engagement meetings and any risks or concerns in clinical services are shared in these meetings, as appropriate.

70. The Trust has regard for the CQC well-led framework and underwent a planned inspection in this domain area in 2018 achieving an overall 'Good' rating. The framework is applied routinely through operational management and the standard is reviewed regularly through the Trust's established systems of control and assurance.

71. During 2020, the GIDS service underwent a focused CQC inspection. The final rating given was "Inadequate", due to the ratings on waiting list and internal leadership.

72. The Trust is committed to delivering the actions recommended by the CQC and an extensive action plan is now being progressed through the interim management structure newly established within the service, which reports to a GIDS oversight group chaired by the Trust CEO.

73. As a result of an ongoing public campaign, the Trust has also been involved in a Judicial Review regarding the GIDS service and has subsequently acted to restructure the pathway through the service so that it is in line with the judgement. The Trust is currently engaged in the preparation of an appeal, which is due to be heard in 2021.

74. The Trust continues to look to work closely with both NHSE and the CQC (on the Trust's improvement plans), with EMT overseeing progress against the CQC action plan and IGC receiving assurances around the surrounding processes.

75. Issues with the GIDs service have been long running, with the Board being initially made aware of concerns – regarding waiting lists and work load in particular - in July 2018. These issues have been exacerbated by the media interest in and 'political' nature of the GIDS service, meaning that the service has been under intense scrutiny and external criticism.

76. Following the initial raising of concerns, an in depth review of the service was carried out by the Medical Director, and reported to the Board in February 2019. This included an extensive action plan. Further reports to the Board were made in March 2019, May 2019, July 2019 and again in November 2019.

77. In March 2020 the Board reviewed progress against the action plan and also reviewed the evidence base (in June 2020), underpinning the treatments offered by GIDS.

78. Further updates on the action plan, CQC inspection and judicial review were provided to the Board in July 2020, November 2020, January 2021 and March 2021.

79. With regards to the costs associated with the Judicial Review (and the subsequent appeal), the Board considered carefully the likely costs involved against both the public interest benefit and the costs associated with the alternative pathway proposed.

Education And Training

80. The Trust has recently been successful in securing registration with the Office for Students ("OfS"), the regulator in Higher Education, the first NHS body to be so registered. This has enabled the Trust to retain and build on its Tier 4 UKVI status. Hitherto the Trust was regulated by the Quality Assurance Agency for Higher Education.

81. The Trust is also monitored by OFSTED (for Gloucester House). Gloucester House is currently rated as "Good" by Ofsted,

Compliance Statements

82. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

83. As an employer with staff entitled to membership of the NHS Pension Scheme ("Scheme"), control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

84. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Audit Committee

85. The Board delegates certain of its duties and responsibilities and powers to the Audit Committee ("AC"), so that these can receive suitably focussed attention. The principal purpose of the AC is to ensure, on behalf of the Board, that financial reporting, the external and internal audit processes and the systems of internal control and risk management are appropriate and effective across the activities of the Trust.

86. The AC fulfils its responsibilities by reviewing the work and the reports of the internal auditors, external auditors and the local counter fraud specialist. The AC also seeks assurances from senior managers and reviews other relevant reporting, such as that on debtors and the work of the IGC.

87. The Deputy Chief Executive / Director of Finance, together with the Associate Director of Quality and Governance, present the annual report and accounts to the committee, which reviews and scrutinises these, in particular, through questioning the external auditors and senior managers.

88. During the period, the Trust used the services of RSM Risk Assurance Services LLP ("RSM") to provide its **internal audit** function, such services being designed to conform to the public sector internal audit standards. In setting the internal audit work plan for the year ahead, RSM (in conjunction with senior management and the AC) work within an overarching three year strategic plan and explicitly take into account the BAF. The Trust seeks also to use its limited, internal audit resources to focus on areas of actual or potential weakness.

89. During the year under review, the internal audit function covered a range of internal controls and potential risks, notably:

    - Refurbishment Project (Advisory)
    - Procurement and Accounts Payable (Reasonable Assurance)
    - Duty of Candour (Reasonable Assurance)
    - IT Equipment (Substantial Assurance)
    - Clinical Audit (Reasonable Assurance)
    - Risk Management Culture (Reasonable Assurance).

90. Management responses regarding any issues raised by internal audit are time-bound and monitored by the AC.

91. The Trust's Head of Internal Audit Opinion is graded as green /amber, that is, that the Trust "has an adequate and effective framework for risk management, governance and internal control. However, [RSM] has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

92. The Trust also uses RSM Tenon to provide its **Local Counter Fraud Service** ("LCFS"). Each year the counter-fraud plan is reviewed and approved by the AC to ensure that the Trust continues to develop its programme of deterrence, prevention and detection.

93. During 2020/21 there have been four investigations. One investigation concerned a fraud by (a now) former employee concerning overtime claims; a second related to a phishing scam (on which the Trust suffered no losses); a third related to the overspend on Leif House; and the fourth concerns a possible credit card fraud committed by a previous member of staff.

94. The Trust's external auditors are Mazars LLP (Mazars), who were appointed in 2019, following a competitive tender process.

95. External audit work during the year covered a range of potential risks, most notably: validity and accuracy of NHS contract income recognised but not yet settled by commissioners; accounting for capital expenditure; and management override of controls. Work in these areas is fundamental to providing assurance to the Trust and to outside stakeholders that financial management is robust and that sound corporate governance procedures are in place.

96. The AC has continued to develop its focus on risk management and corporate governance processes in accordance with guidance from NHS Improvement and others. This has included in-depth reviews and presentations by management to the AC of a number of significant risks on the BAF.

97. During the year the Trust continued to review and refine its approach and attitude towards risk management including (minor) revisions to its risk strategy, policy and procedures; an in-depth examination of the Trust's approach to risk appetite; regular reviews of the BAF; and, with assistance from RSM, further development of the Trust's use of assurance mapping. During the year, the Board has been provided with formal training on both managing risk and on local counter fraud.

98. As part of its annual cycle, the AC undertakes a 'deep dive' of operational risks by interviewing one or more service line managers. During 2020/21, the AC met with the Estates Consultant used by the Trust to understand how risk is managed on a strategic project (Relocation) and to hear how project risk management might be improved.

99. Regular subjects of review by the AC throughout the year have been tender waivers, aged debtors and data quality. The AC has paid particular attention to the changes in the approach and make-up of the IGC, noting its increased emphasis on ensuring that lessons learned from incidents are cascaded effectively through the organisation.

100. In the latter half of the year, the AC has questioned management with regard to its preparations and activities in relation to COVID-19, although key assurances around this subject have been dealt with, primarily, at Board level.

101. The AC gets a report at each of its meetings on any 'tender waivers', whether or not due to the use of framework agreements or for other reasons.

102. The Trust carries significant non-NHS related debt and the AC, therefore, receives a report on debtors at each of its meetings.

C) IMPROVING ECONOMY, EFFICIENCY AND EFFECTIVENESS: HOW THE TRUST USES INFORMATION ABOUT ITS COSTS AND PERFORMANCE TO IMPROVE THE WAY IT MANAGES AND DELIVERS ITS SERVICES

Introduction

103. The Trust uses a variety of strategies, policies, procedures and processes to oversee its performance, as detailed below.

Financial Reporting

104. As noted above the Trust produces regular financial reports on which it is able to assess its historic and projected financial performance, at both a service and Trust level.

105. The use of this data led, expressly, in January 2020 to the raising of concerns regarding the future financial sustainability of the Trust and to the identification of an underlying financial deficit of around £5m. This in turn, led to the Strategic Review ("SR") exercise currently being conducted by the Trust, under which all activities of the Trust are being scrutinised, under 4 dimensions being:

- Finance (performance and stability)
- Workforce
- Operations
- Value.

106. The SR uses the 2019/20 year end management accounts as the base financial data on which to evaluate financial performance. The Vision and Principles of the SR are incorporated into a Board approved document which was shared across the Trust.

107. Regular financial reports are supplemented by ad hoc financial reporting. This may be produced by the Contracts team (reviewing the performance of a particular service) or by the Finance team, for example, the Finance team maintains a programme profitability model which measures the profitability of the long courses run by DET. This is typically updated once a year (to reflect the new student intake and price increases) and is used, in part, to help DET determine its pricing for its long courses. The model was used, extensively, as part of the Task and Finish Group run to examine the issues around DET profitability (in 2019/20) and has also been used to help inform the SR.

Contracts Reporting

108. The Contracts and Performance team is responsible for negotiating and monitoring the performance of on-going contracts. In doing so, the team produces a wide range of support for internal and external stakeholders. A summary of performance activity is provided to the Operations Board, Business Development Group and Strategic and Commercial Committee.

109. The team keeps records of all individual contracts and their monitoring requirements. Data is validated and monitored monthly against the expected clinical activity and finances for each service.

110. The team monitors waiting lists and patient flow to assess actual or potential issues within services and any future income pressures. Issues are relayed back to commissioners and highlighted internally, with action plans put in place to address key risks.

Procurement

111. The Trust has a Procurement Strategy and Procurement Policy, supplemented by a No PO, No Pay procedure, which provide operational underpinning to the Trust's SFI's and Scheme of Delegation.

112. The Trust utilises an external consultant to provide procurement advice and all procurements are required to be signed off by the consultant (using a Procurement Sign Off form). All contracts – regardless of size – are required to be signed off by either the Chief Executive or the Director of Finance (the exception being certain agency arrangements via HR).

113. Procurements which fall outside of the Trust's normal rules and regulations are required to be approved by both the Chief Executive and the Director of Finance and are reported to each AC (the Tender Waiver report).

Recruitment Of Permanent Staff

114. Appointment of permanent staff requires approval of the Budget holder, HR and Finance (to confirm that the role is within Budget). In addition, the Trust has recently set up a Recruitment Approval Group ("RAG"). The Chief Clinical Operating Officer, Director of Education and Training and the Director of Finance form the RAG (assisted by representatives of HR and Finance). All permanent appointments must be approved by RAG before proceeding.

Temporary / Agency Staffing

115. The use of any temporary / agency staff must be signed off by one of the HR Director / Chief Executive or (in the absence of those) by the Director of Finance.

116. In addition, any temporary / agency staff or bank appointments must now also be approved by RAG.

117. Returns on agency staff are reported to NHSE/I every two weeks. The Finance team also maintains a schedule showing actual and projected agency spend. This is reviewed with HR on a monthly basis.

D) OTHER

Strategic Review

118. As noted above the Trust is in the middle of a Trust-wide strategic review ("SR").

119. The purpose of the SR is set out in the Vision and Principles document. The aim of the SR is to reorganise the activities of the Trust in order to ensure that clinically, academically and financially, these activities are sustainable in the long term.

120. Updates on the SR are presented at each Board meeting.

121. Papers of the SR Programme Board are available on request.

Relocation

122. The Trust has been looking at the possibility of relocating its core services from the current site (Belsize Lane) to a new site (Jamestown Road).

123. The project is supervised by the Tavistock Centre Strategic Review Committee (Relocation Committee), which is a committee of the Board.

124. In agreement with the external auditors, certain costs associated with Relocation are capitalised. By the end of March 2021, such costs total around £4m and are accounted for as an asset under construction. The Board has regularly reviewed its position regarding Relocation from a value for money perspective and determined that the project is worth pursuing given that the alternatives to Relocation – refurbishment or 'do minimum' – are either more expensive than Relocation and / or involve a degree of disruption to service users which the Trust would find nearly intolerable.

125. The project has encountered and had to overcome a wide range of issues. Both the Relocation Committee and the Board regularly assess the risks associated with the project and the probability of it completing.

Other Capital Projects

126. During 2020/21, as well as Relocation, the Trust undertook a number of other capital projects. All of these projects, with one exception, have been delivered within budget.

127. The main strategic projects were the Digital Academy and the refurbishment of Leif House. The Digital Academy is the Trust's new online platform for delivering DET short and long courses. As at 31 March 2021, the project had met or exceeded its Business Case objectives.

128. Leif House is a newly leased building, provided to house the Adult Gender Identity Clinic. The refurbishment of this project went substantially over budget. This reflected, primarily, a poor initial assessment of the work required. Of more concern, however, was that the work was carried out without the requisite formal approvals. This was the result, fundamentally, of a senior member of staff (since left) – the Director for Estates, Facilities and Capital Planning – ignoring Trust procedures. As a consequence of the overspend and the failure of certain procedures to be followed, the internal auditors were requested to undertake a specific review of the project. Their report and findings were reported to the Audit Committee and to the Board.

129. As a consequence of this incident, Trust management has instituted additional procedures to try and reduce the possibility of a similar issue arising in the future.

Report to	Date
Board of Directors	18 May 2021

Board Assurance Framework

Executive Summary

1. The following BAF is a working document which will be reviewed at the Board awayday and may result in amendments.
2. Strategic objectives for 2021/22 and key risks to achieving these, without detail, went to the March board for initial consideration. Individual risk assessments are included in the following report.
3. The **Trust's Risk Appetite Statement and assessment** is generally agreed annually by the Board each July but owing to the Covid-19 pandemic was not reviewed until the November 2020 Board of Directors. The Risk Appetite Statement was unchanged but it was recognised that the covid-19 pandemic had had a significant impact on Trust operational policies and practice which might not be consistent with the current Risk Appetite priorities. Changes to this matrix are currently unchanged with the exception of the new 'External System Engagement' strategic aim.
4. There are 10 risks with three carried forward from 2020/21. These are indicated and former risk scores are presented. There are three red risks with the rest 'amber'.
5. **Risk assessment scoring information** is presented for discussion to understand for possible future amendments which may better reflect the position of a risk or incident, and inform actions which need to be taken. The current risk assessment scoring is a straight forward multiplication. However, this does not give the opportunity to amend the level of risk and therefore treatment required, where the likelihood is low, but the consequence or impact is high. Changes would impact on the incident and risk systems equally, and would require changes within the electronic quality management system, and associated policies and procedures.

Recommendation to Board

The Board are asked to discuss the board assurance framework which will be reviewed in detail at the June Board away day:

- Confirm the BAF risks
- Confirm the Risk Appetite statement and ongoing assessment levels
- Agree the approach for risk assessment scoring

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
All Directors, AD Quality & Governance	Medical Director

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

1.2 The following Framework and approach are in line with the Risk Management Policy and Strategy, and Risk Management Procedure. The approach is outlined in Appendix 1.

1.3 Strategic objectives for 2021/22 are included in Appendix 2 and are presented alongside relevant Strategic Aims, Challenges from the Strategic Review and associated risks for an overview.

1.3 The BAF Heatmap on page 6 presents all current Strategic risks on a single page as an overview of the current position.

1.5 The new electronic risk management system is now in use across the Trust for operational risks. Strategic risks will be added to the system once confirmed at May Board.

2 RISK SUMMARY [risk descriptions are shortened]

2.1 Ten risks are identified within the BAF with three carried forward from 2020/21 with amendments namely:

- Risk 6 – data systems and processes. Increased risk score from 6 in Nov to 9. The Director of Education and Training has been added to this risk and wording amended to reflect this.
- Risk 9 – RES – current score remains as 12. The target score has increase from 4 (1x4) to 6 (2x3).
- Risk 10 – people's strategy – current score remains as 12

2.2 There are two risks rated 16 and one rated 15 as follows:

- Risk 1: The risk that poor management of the strategic review may not deliver sustainable financial and operational models
- Risk 2: The risk that in the efforts to modernise internal processes, not prioritising attention to staff risks losing them and jeopardising future strategy.
- Risk 8: The failure to adapt the delivery of services and programmes sufficiently and respond more quickly to new opportunities to grow risks trust sustainability.

4. RISK APPETITE

4.1 The **Trust's Risk Appetite Statement and assessment** is generally agreed annually by the Board each July. The 'risk appetite' matrix confirms the level of risk which the Trust will accept and supports discussion and robust challenge of risks. The Risk Appetite Statement is unchanged from the November review where it was recognised that the covid-19 pandemic had had a significant impact on Trust operational policies and practice which might not be consistent with the current Risk Appetite priorities. Changes to this matrix are currently unchanged with the exception of the new 'External System Engagement' strategic aim.

4.2 Risk Appetite Statement:

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

Agreed Board, July 2019

Overarching risk appetite descriptions

Appetite level	Described as:
Negligible (1)	Avoidance of risk and uncertainty
Low (2)	Preference for ultra-safe delivery options that have a low degree of inherent risk and limited reward potential
Moderate (3)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
High (4)	Willing to consider all potential delivery options and choose while also providing an acceptable level of rewards (and VfM)
Significant (5)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Appetite assessment against Strategic Aims

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

5.Risk Assessment Scoring

The following information is presented for discussion to understand for possible future amendments which may better reflect the position of a risk or incident, and inform actions which need to be taken. Changes would impact on the incident and risk systems equally, and would require changes within the electronic quality management system, and associated policies and procedures.

5.1 Current Risk Assessment Scoring

The current risk assessment scoring is a straight forward multiplication. This does not give the opportunity to amend the level of risk and therefore treatment required, where the likelihood is low, but the consequence or impact is high.

Likelihood	Risk Matrix		Consequence/Impact				
			Negligible	Minor	Moderate	Severe	Extreme
			1	2	3	4	5
	Very unlikely to occur	1	1	2	3	4	5
	Unlikely to occur	2	2	4	6	8	10
	Could occur	3	3	6	9	12	15
	Likely to occur	4	4	8	12	16	20
	Almost certain to occur	5	5	10	15	20	25

5.2 Risk Assessment Scoring - proposed

Non multiplication methodology which provides greater weight to the Consequence / Impact

Likelihood	Risk Matrix		Consequence/Impact				
			Negligible	Minor	Moderate	Severe	Extreme
			1	2	3	4	5
	Very unlikely to occur	1	1	3	6	10	15
	Unlikely to occur	2	2	5	9	14	19
	Could occur	3	4	8	13	18	22
	Likely to occur	4	7	12	17	21	24
	Almost certain to occur	5	11	16	20	23	25

Information taken from NHS Partners and modified

ow Risk Moderate Risk High Risk Extreme Risk

6. CONCLUSION

The Board is invited to discuss the board assurance framework and:

6.1 Approve the new risks and comment on whether, with the action plans as set out, the risks are tolerated;

6.2 Approve the Risk Appetite Statement and assessment;

6.3 Consider the matter of risk assessment scoring and agree the approach.

May 2021 BAF HEAT MAP

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

Board Assurance Framework 2021/22 – Summary –

Strategic Aims 2021: Finance and Governance, Services: Clinical; Services: Education; External system engagement; Growth and Development; People.

Current Risk Score

	Risk	Risk Lead	Strategic Aim	Corporate Objective	Nov 2019	Mar 2020	May 2020	July 2020	Nov 2020	May 2021	Target Risk L=likelihood C=consequence Risk = L x C
1	If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	**CEO**	Finance & Governance	1						15 (3x5)	Yellow (2x5)
2	If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.	**DoHR**	Finance & Governance	1						16 (4x4)	Amber (3x4)
3	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	**DoF**	Finance & Governance	2	15 (3x5)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Yellow (2x5)
4	Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.	**MD/COO/ DoE&T**	Finance & Governance	4						9 (3x3)	Green (2x2)

	Risk	Risk Lead	Strategic Aim	Corporate Objective	Nov 2019	Mar 2020	May 2020	July 2020	Nov 2020	May 2021	Target Risk L=likelihood C=consequence Risk = L x C
5	If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts	**DoF&E**	Finance & Governance	5						9 (3x3)	Green (2x2)
6	The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings. (updated 2020/21 risk)	**MD/COO/ DoE&T**	Services clinical	4	6 (3x2)	6 (3x2)	6 (3x2)	6 (3x2)	6 (3x2)	9 (3x3(	Green (2x2)
7	If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	**DoE&T**	Services education	6						9 (3x3)	Yellow (2x3)
8	If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will be at risk of becoming unsustainable and not be in a position to benefit from growth	**CEO**	Growth & Development	8						16 (4x4)	Yellow (2x3)
9	The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services. (updated commentary 2020/21 risk)	**CEO/DoHR**	People	9	8 (2x4)	8 (2x4)	8 (2x4)	12 (3x4)	12 (3x4)	12 (4x3)	Green (2x3)
10	The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. (updated commentary 2020/21 risk)	**DoHR**	People	10	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Yellow (2x3)

Strategic Aim: Finance and Governance

RISK 1): If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	
Risk Owner: Chief Executive	Date reviewed: May 2021
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The Trust faces a number of challenges to ensure it is financially sustainable and that its work is relevant and aligned to the needs of the ICS. A Strategic Review has been launched to address this.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 3 x Consequence 5 = 15	TARGET risk rating 2 x 5 = 10
Rationale for current score: The Trust has an underlying deficit of £5.3m. This and other challenges will require a significant programme of change.	
Controls/Influences *(what are we currently doing about this risk?)*: Well-structured programme with focus on agreeing clear "compass points" for the direction of travel. Strong programme of staff engagement.	Assurances received *(independent reports on processes; when; conclusions)*: Programme Board chaired by CEO (+) Board reports and monthly Board seminar (+) Input of critical friend (+)
Gaps in controls/influences: NCL MH Commissioning review Changes in wider NHS financial regime post H2	Action plans in response to gaps identified: Strong engagement with NCL Review

RISK 2): If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.	
Risk Owner: Director of HR	Date reviewed: May 2021
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The implementation of the Strategic Review will have far reaching impact on the way we employ and communicate to staff. The process of the Strategic Review and subsequent staff consultation for change will require broad and deep communication and engagement with staff.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4= 16	TARGET risk rating 3 x 4=12
Rationale for current score: We are just completing the early discovery stage of the Strategic Review and at this stage it is difficult to judge whether our communication and engagement plans will prove to be adequate in prioritising attention to the staff impacted by the Strategic Review.	
Controls/Influences *(what are we currently doing about this risk?)*: Strategic Review Programme Board Board oversight Clear programme structure with clearly defined workstrands in the key areas Appointed external 'critical friend' to scutinise the process Close engagement with staff side unions	Assurances received *(independent reports on processes; when; conclusions)*: Strategic Review Programme Board reports and minutes (+) Board reports on the Strategic Review (+) Regular meetings with unions and clear engagement in strands of work (+)
Gaps in controls/influences: Understand impact of work on staff	Action plans in response to gaps identified: Review communication plan (ongoing)

RISK 3): If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy.	
Risk Owner: Director of Finance	Date reviewed: May 2021
Corporate objective 2: In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Centre site	
Background / Context The Tavistock Centre ("TC") is an old building with serious issues around its mechanical and electrical systems. The way the building is laid out is also old fashioned and does not meet current requirements for patients and students. Repairs to the TC would be disruptive to patient / student experience. Accordingly, the Trust is looking to relocate its main activities from TC to a new site – Jamestown Road ("JR") – to which end a contract for sale and purchase of the site has been exchanged with the owners of JTR.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x 5=10
Rationale for current score: The Trust has now got active engagement with NHSE/I and the NCL ICS. The Relocation project is also treated as a priority project within the NCL estates stream. However, NCL has not yet determined which projects will be formally supported and the bridging financing required for Relocation has not been identified. The Relocation project also assumes that a Registered Provider (yet to be identified) will provide some of the funding required. With regard to the TC itself, recent surveys have confirmed the potential fragility to the electrical systems in the building.	
Controls/Influences *(what are we currently doing about this risk?)*: Established Programme Board with NED and Governor representation Estates & Facilities Compliance and Risk sub-committee of the IGC Regular contact with NHSE/I and NCL ICS	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of the Programme Board (+/-) Minutes of the sub-committee (+/-)
Gaps in controls/influences: Detailed plan for repairs to key building elements of the TC Post COVID working arrangements in TC Formal NHSE/I approval of Relocation project Bridging finance unidentified	Action plans in response to gaps identified: 6 Facet survey being undertaken by Rider Levett Bucknall (June 21) New Estates work stream of Strategic Review to be established (May 21) Outline Business Case being prepared (October 21) NHSE/I Regional team to approach National team (June 21)

RISK 4): Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.	
Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: May 2021
Corporate objective 4: To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance	

Background / Context There are a number of contextual factors that are impacting on capacity including the pandemic and the strategic review. Analysis of clinical leadership provision through the strategic review process has highlighted a large variation in performance and capacity in leaders. This will need to be addressed through the strategic review process if we are to be fit for purpose going forward	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 TARGET risk rating 2 x 2 = 4 CURRENT risk rating: Likelihood 3 x Consequence3 = 9	
Rationale for current score: The variation in sessions and training/capacity in clinical leaders varies significantly and they are not able to meet current leadership requirements consistently. There is both variation in management capacity and skills evident across our teams CQC inspection and JR transformation have heightened capacity challenges in the gender division	
Controls/Influences *(what are we currently doing about this risk?)*: This will be reviewed through the SR process Interim capacity challenges are being mitigated through operational and other forums A GIDS governance flow has been set up to follow through and support ongoing transformation linking it with Trust level structures	Assurances received *(independent reports on processes; when; conclusions)*: High level principles documents shared and agreed to guide restructure of teams and functions (+) Good feedback from recent Quality Summit from CQC and other stakeholders (+)
Gaps in controls/influences: There are continuing issues with staff engagement with SR There are continuing issues with staff attrition and engagement in GIDS transformation	Action plans in response to gaps identified: SR process improvements allow for a good engagement plan in the upcoming period for required changes Continuing engagement and involvement of GIDS team including recruitment of various external seniors to support delivery

RISK 5): If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts	
Risk Owner: Director of Estates, Facilities and Capital Projects	Date reviewed: May 2021
Corporate objective 5: To develop a Green Plan for the Trust, with a clear action plan and measurable objectives	
Background / Context This follows on from the launch of the campaign *For a Greener NHS* January 2020 and from the requirement for all organisations to have a Green Plan by 2021. The NHS recognises that the climate emergency is also a health emergency. As the largest employer in Britain the NHS is responsible for around 4% of the nation's carbon. For the emissions we control directly (the NHS carbon footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. For the emissions we can influence (the NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. This activity is a requirement for the relocation OBC.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 TARGET risk rating 2 x 2=4 CURRENT risk rating: Likelihood 3x Consequence 3 = 9	

Rationale for current score: The Trust does not have a Green Plan as yet and is due to complete a green plan by the end of July 2021.	
Controls/Influences *(what are we currently doing about this risk?)*: Have engaged with the Royal Free Hospital NHS Foundation Trust to test their approach to the development of their Green Plan and how they undertook staff engagement e.g are using the environment group who are an active engagement group to ensure a common set of objectives are agreed.	Assurances received *(independent reports on processes; when; conclusions)*: Relocation programme board oversight of Green Plan outcome (+) Environment Group stakeholder engagement group in place (+)
Gaps in controls/influences: Green Plan to be developed including objectives to be set over a defined period and monitored	Action plans in response to gaps identified: The Green Plan is being developed by the same team as used by the Royal Free, and will ensure a common benchmark (TBC) Green Plan NHS questions - review underway by third party (July 2021)

Strategic Aim: Services Clinical

RISK 6): The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings (updated 2020/21 risk)	
Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: May 2021
Corporate objective 4: To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance	
Background / Context The strategic review discovery work and staff feedback suggest that we have inadequate systems, structures and processes for managing data. We are aware that there continue to be issues at all points in the system; data entry, data tools and system outputs.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 2 = 6 CURRENT risk rating: Likelihood 3 x Consequence 3 9	TARGET risk rating 2x2=4
Rationale for current score: We are making significant strategic decisions on data that we do not feel confident in unless we have completed a manual review. Data entry is a significant issue for us, and without being able to properly represent the work we do, we risk reputational and financial consequences.	
Controls/Influences *(what are we currently doing about this risk?)*: The strategic review has provided a much clearer analysis of the issues and we will be using the change process to ensure that we are able improve confidence in data through improvements at all points in the data journey	Assurances received *(independent reports on processes; when; conclusions)*: Notwithstanding identified issues there have been significant improvement in understanding of gaps in the input, use and understanding of data Data led discussions now inform various forums including Quality Assurance Board, Trust Board etc. Dashboards have been developed for CYAF and AFS clinical divisions.
Gaps in controls/influences: Cultural challenge such as evident challenges in timely data input onto Trust platforms which remains a challenge ex. care notes Technical capability in collecting and using data in certain domains Fragmented ownership of data leading to confusion and lack of confidence	Action plans in response to gaps identified: We will continue to improve structures and processes for easing input, use and understanding of data across our services The Strategic review has already indicated possible interventions to reduce duplication and clearer ownership of data. We will continue our efforts to engage and empower staff in using data to achieve better outcomes in their interventions

Strategic Aim: Services: Education

RISK 7): If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	
Risk Owner: Director Education & Training	Date reviewed: May 2021
Corporate objective 6: To develop and deliver high quality, outcome focused and financially sustainable educational services which are data informed and responsive to changing requirements.	
Background / Context	

We have increased our year 1 student enrolment figures consistently over time and have also adapted our provision to meet the challenges of the pandemic and have also established and completed three ways of development in the Digital Academy. As difficult as the pandemic has been, it has also enabled and accelerated different ways of learning and teaching. However, it has been difficult to adapt our existing provision in more fundamental ways to significantly increase reach.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood x Consequence = 3x3=9	TARGET risk rating 2 x 3=6
Rationale for current score: Although there is evidence of successfully developing and delivering new provision it is often not well co-ordinated and sufficiently responsive to market need or opportunity, especially in the domain of long course development. Related factors include timely and relevant market assessment and external engagement, capability and capacity of teaching staff, PSRB requirements, resourcing and culture that can limit pedagogical range.	
Controls/Influences *(what are we currently doing about this risk?)*: Established Development Forum in DET with governance links to BDG Strategic review Positive exemplars	Assurances received *(independent reports on processes; when; conclusions)*: Adaptation and pivot through COVID-19 with online delivery (+) Pulse student surveys with high levels of satisfaction (+) Successful Digital Academy launch (+)

Strategic Aim: Growth & Development

RISK 8): If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will be at risk of becoming unsustainable and not be in a position to benefit from growth	
Risk Owner: Chief Executive	Date reviewed: May 2021
Corporate objective 8: To maximise the potential of our historical relevance to current and emerging business pre-occupations for the purpose of business growth and organisation profile	
Background / Context The Trust has historically relied on new business development to support its financial sustainability. The move to new integrated care structures and the immediate impact of the pandemic has led to a reduction in opportunities. To address this a number of priority areas have been identified including new opportunities outside traditional markets.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	TARGET risk rating 2 x 3 =6
Rationale for current score: The move to integrated care and the pandemic has had a significant impact on new opportunities.	
Controls/Influences *(what are we currently doing about this risk?)*: Workstream plans for new priorities. Exploration of partnership opportunities with GOSH	Assurances received *(independent reports on processes; when; conclusions)*: Targets for new income growth Monthly BDG meeting chaired by the CEO Oversight by SCC
Gaps in controls/influences: Availability of external opportunities Diversion of resources due to the Strategic Review	Action plans in response to gaps identified: Short term additional resourcing for the business development

RISK 9): The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services	
Risk Owner: Chief Executive/Director of HR	Date reviewed: May 2021
Corporate objective 9 To set a clear direction for the Trust as an anti-racist organisation with key supporting actions	
Background / Context: The Trust faces a significant challenge on diversity. Unless addressed this will have a negative consequence on staff engagement and the quality of services.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3= 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x3 =6
Rationale for current score: Staff and student surveys and a narrative of negative staff experience highlight that the Trust has a long way to go to ensure equality of opportunity and experience for all staff. Unless addressed this will impact negatively on the attractiveness of the Trust as an employer and the quality and effectiveness of its services for patients and students.	
Controls/Influences *(what are we currently doing about this risk?)*: Declared ambition of becoming an anti-racist organisation. Race Equality Strategy Steering Group Consultants commissioned to lead external review of Trust culture Race Equality Staff Network; Race Equality Staff Allies Group Equality Diversity Inclusion Committee Workforce Race Equality Strategy (WRES) and action plan	Assurances received *(independent reports on processes; when; conclusions)*: Race Equality Strategy Steering Group minutes (+) Appointment of Associate Director for Equalities (+) Equality Diversity Inclusion Committee minutes (+)
Gaps in controls/influences: Engagement of all staff	Action plans in response to gaps identified: Report of External Review (July 2021) Work to produce a refreshed Race Equality strategy (July 2021)

RISK 10): The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. . (updated 2020/21 risk)	
Risk Owner: Director of HR	Date reviewed: May 2021
Corporate objective 10 Develop a People Strategy for the Trust with a focus on future workforce needs and addressing staff engagement, welfare and morale.	
Background / Context With the well researched link between staff engagement and service quality and delivery, the Trust has lower engagement indicators than it would aspire to as seen in the staff survey.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x3 =6
Rationale for current score: The lack of an in date comprehensive People and Organisational Development strategy and plan 'People Plan'.	
Controls/Influences *(what are we currently doing about this risk?)*: Links to WRES actions Planned development of the Trust People Plan over Q 1 to 3 Integrated Governance Committee (IGC)	Assurances received *(independent reports on processes; when; conclusions)*: Reports to IGC (+) Board scrutiny of staff survey (+)
Gaps in controls/influences: Lack of OD and People sub committee to scrutinise progress on people agenda Lack of in date people and OD strategy and plan	Action plans in response to gaps identified: To develop OD and People sub committee (Sept 2021) To develop People plan (Dec 2021)

Appendix 1

APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

Appendix 2
Strategic objectives and risks 2021-22

Strategic Aims	Challenges (strategic review)	Objectives (2021/22)	Risk 2021/22
Finance & governance	Financial	**1.** To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust. **CEO** **2.** In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Clinic site. **DoF** 3. To ensure that the Trust manages its cash balances in a robust and effective manner. **DoF**	1.If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work. **CEO** 2.If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy. **DoHR** 3. If Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience. resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy **DoF**
Finance & Governance	Data and Impact	**4.** To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance **MD/COO/DoE&T** 5. To develop a Green plan for the Trust, with a clear action plan and measurable objectives. **DoF&E**	4 .Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact. **MD/COO/ DoE&T** 5.If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts. **DoF&E**
Services clinical / education	Operational	Linked to objective 4	6.The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings. **MD/COO/DoE&T** (updated 2020/21 risk)

Services education	Operational	**6.** To develop and deliver high quality, outcome focused and financially sustainable educational services which are data informed and responsive to changing requirements. **DoE&T**	7. If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services **DoE&T**
External system engagement	System	7. To ensure that the internal process review is aligned with equivalent externally focused activity to enable the Trust to position itself effectively internally and externally for future success. **CEO**	
Growth & Development		8. To maximise the potential of our historical relevance to current and emerging business pre-occupations for the purpose of business growth and organisation profile **CEO**	8.If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will be at risk of becoming unsustainable and not be in a position to benefit from growth. **CEO**
People	Diversity	9. To set a clear direction for the Trust as an anti-racist organisation with key supporting actions – **CEO/DoHR** **10.** Develop a People Strategy for the Trust with a focus on future workforce needs and addressing staff engagement, welfare and morale. **DoHR**	9.The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services **CEO/DoHR** 10.The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. **DoHR**

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	18/05/2021

Guardian of Safer Working Hours 2021 Quarter 3

Executive Summary

Since February 2021- May 2021 (till 13th may 2021) there have been 14 exception reports. Due to the current pandemic restrictions the trainees have not been able to spend majority of the fines accrued. They have now arranged to attend a DBT course with the GOSWH funds. They have been provided support and guidance via their educational/clinical supervisors and medical support forum meetings. I met with the trainees on 19/01/20 and 26/04/21 in regards to the exception reports, fines and there disbursement.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Gurleen Bhatia	Dinesh Sinha

Guardian of Safe working hours Q2 May 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 third report in role.

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
February	4	2	4	-
March	3	0	3	-
April	6	2	4	-
May	1	1	0	-

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.

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.

The trainees are now paid the new locum rate and do 1 locum shift/month in addition to their normal working schedules and on call rota. .

2.5 Fines

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
	hrs	hrs	£	£	£
February 2021	-	10.5	1274.28	477.855	796.42
March 2021	-	12	1456.32	546.12	910.20
April 2021		10.5	1274.28	477.855	796.42
May 2021	-	-	No fines till 13th May	-	-
Total		33	4004.88	1501.84	2503.04

This is the amount of money which would have been leftover in the GOSWH fund after the payment of the fines to the trainees. Hence I have given a breakdown from month to month.

May 2021- No fines till 13th may 2021

April 2021- £ 796.42 (yet to come)

March 2021- £ 910.20

Feb 2021- £ 796.42

January 2021 £ 1157.455

December 2020- no fines issued

November 2020- £557.155

October 2020- £ 303.40

September 2020- £ 341.325

August 2020- £299. 645

July 2020- no fines

June 2020- £265.475

May 2020 - £ 1626.77

April 2020 - £ 1457. 005

3. Junior Doctors Forum (JDF)

Backlog of fine payments has been resolved by HR/finance department. However a recent meeting with trainees highlighted 2 trainees not being paid the fines till date

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.

The amount in GOSWH fund has been agreed to be used for the DBT course.

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. We have been monitoring the impact of the second pandemic lockdown on the exception reports.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors: May 2021

Report to	Date
Board of Directors	18 May 2021

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q4 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 an overall Trust increase of 368 referrals between Q3 and Q4 accounted for by a small increase in Adult Complex Needs of 28 and 458 in GIC. All other services have seen decreases.
- Compliance with targets for first appointment and treatment appointment were mixed for first appointment with City and Hackney seeing 100% and the Portman Clinic and Camden Camhs seeing 90% of patients within the contracted waiting time to first appointment. Adult Complex Needs compliance improved to 36% from a dip in Q3 of 20%. Adolescent services increased referral to treat compliance for a second quarter along with all AFS services.
- Other Camhs compliance dropped from 90% to 67% compliance this quarter for first appointment and along with Camden Camhs also saw a drop in compliance from referral to treatment. All Adult services saw an increase in compliance from referral to treatment.
- Trustwide we continue to maintain a good DNA rate with overall compliance at 7.78%. Following DNA increases in Q2 and Q3 within GIC rates have reduced from 15.8% to 14.3% in Q4.
- The MHSDS data for January 2021 shows increases in ethnicity, employment status and accommodation status with further increase in the ex-British armed forces indicator and the DQMI (96.6%). From February 2021 our gender services will not be included in the MHSDS data submissions although we will continue to monitor internal compliance.
- The number of incidents reported in the Trust increased in Q4 to 111
- Q4 saw an increase in complaints from 15 in Q3 to 43– particularly in gender services. Days to final response has gradually reduced over the year and is now an average of 23 days with the proportion of complaints being responded to within 25 working days 63% in Q4, increased from 25% in Q3.
- The applications cycle for long courses in DET opened in November. The monthly booking chart shows that bookings were largely on track against target for this month. Student satisfaction rates across all products are encouraging, with the majority of respondents scoring their experience highly.

- There was less than half the media coverage in Q4 compared to Q3. We have also had positive coverage when experts in our Trust gave advice about the effects of COVID-19 and lockdown. Digital traffic to the Trust main site is up notably compared to the same quarter last year

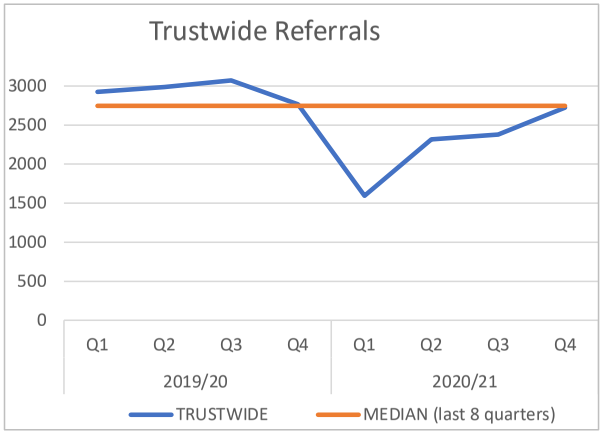
There are also details of continuing **Challenges**:

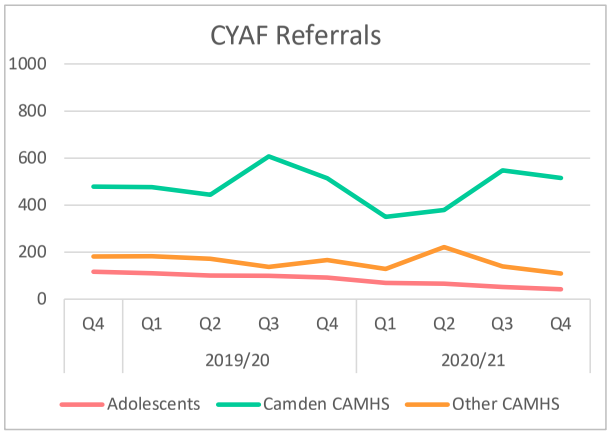
- The Staff Friends and Family Test for Q4 2020/21 went ahead as planned. The Trust was one of the poorest performers in the recommendations as a place to work. This score had dropped from 2018 at 71.4% to 63% in 2020.
- Statutory and Mandatory training has a compliance target of 95% and by the end of Q4 the Trust unfortunately did not meet its overall compliance target. Statutory and Mandatory compliance (70%) has been severely affected by the challenging period last year due to the pandemic.
- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthy. The TAP service is to be decommissioned this quarter.
- Outcome measures continue to remain a focus of work, as greater efforts are needed towards collection methods and staff engagement. Among our outcome measures, CORE improvement rates are now 78% against a target of 70% but Time 1 and Time 2 Goal Based Measure completion rates remain low.
- CAMHS care plan compliance continues to remain below the 80% target for completion (54%) and 6-monthly review (31%).

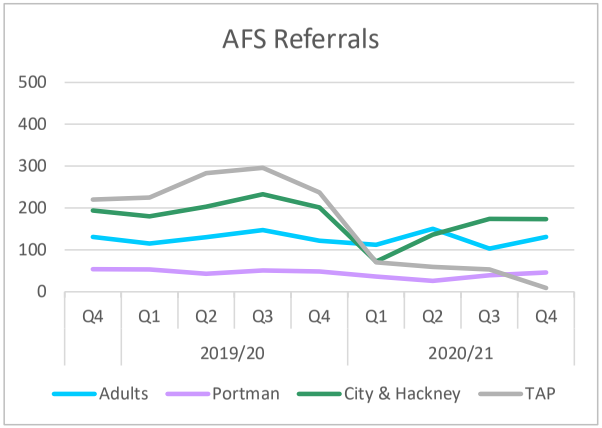
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.
Trust strategic objectives supported by this paper
Finance and Governance

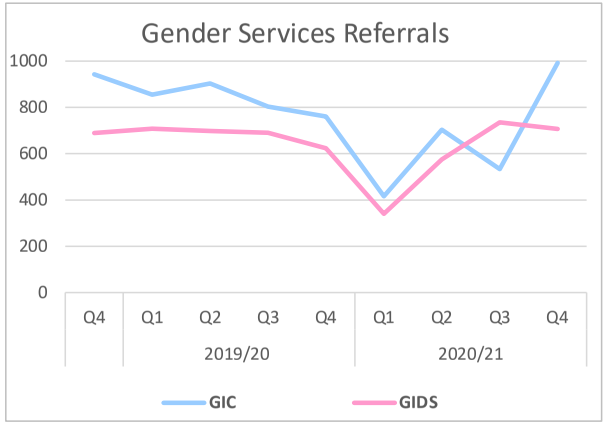
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q4 2020/21: Trust Reach – Access









Data source: Q4 data as recorded on 12/04/2021 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.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

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 a significant drop in referrals in Q1, those numbers increased gradually in Q2 and Q3. Now in Q4 we reached levels close to previous financial year. However, we are still under previous averages. In Q4 the trust received 2715, which is 223 lower than the 2938 quarterly average number of referrals over the last financial year.

Adolescents: in Q4 received 42 referrals, 10 fewer than Q3. The number of referrals has decreased over the last 4 quarters – the quarterly average of referrals received during last financial year was 100.

Camden CAMHS: in Q4 received 515, 33 fewer than in Q3. The quarterly average of referrals during last financial year was 510.

Other CAMHS: in Q4 received 109 referrals, 30 fewer than in Q3. The quarterly average of referrals during last financial year was 166.

Adults Complex needs: in Q4 received 131, 28 more than in Q3. This quarter the service was above the quarterly average number of referrals received during last financial year, 128.

Portman: in Q4 received 46, 7 more than in Q3. The quarterly average last financial year was 49.

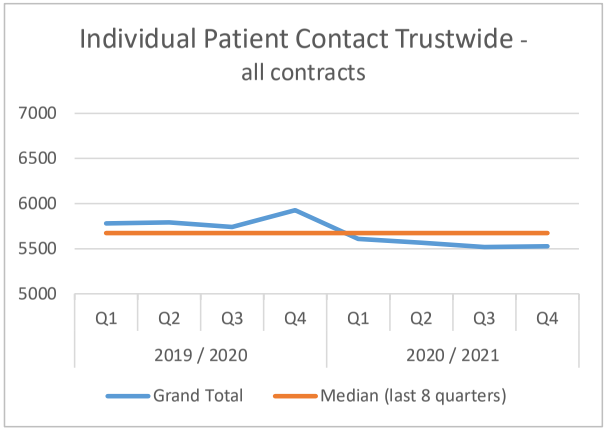
C&H PCPCS: in Q4 received 173, just 1 fewer than in Q3. The quarterly average last financial year was 204.

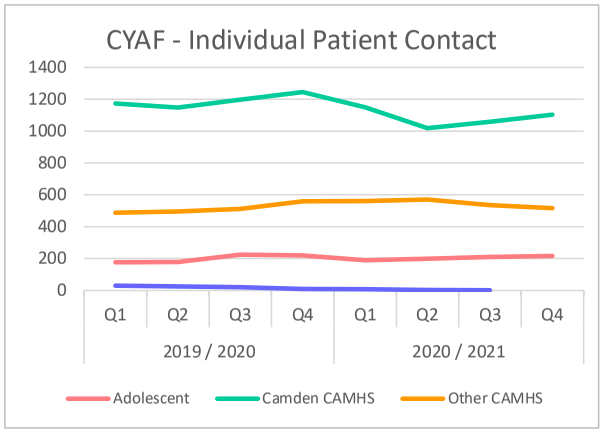
Team Around the Practice: in Q4 received 9, 44 fewer than in Q3. The quarterly average last financial year was 260. Service to be decommissioned this quarter.

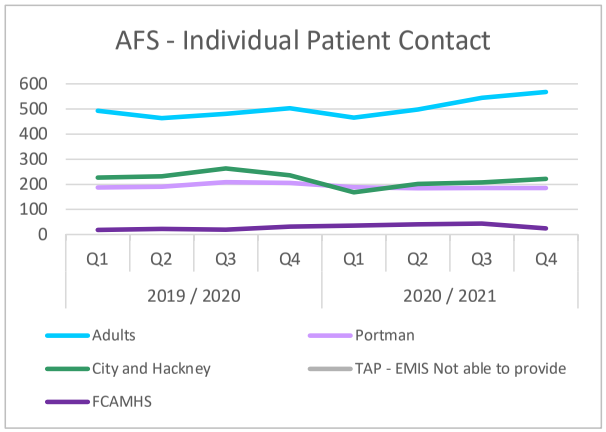
GIDS: in Q4 received 707, 28 fewer than in Q3. This quarter the service was above the quarterly average last financial year, 680.

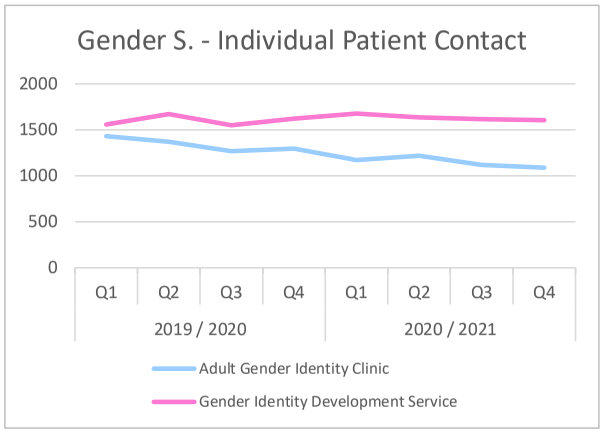
GIC: in Q4 received 992, 458 more than in Q3. The quarterly average last financial year was 830.

Q4 2020/21 : Trust Reach – Access









Data source: Q4 data as recorded on 12/04/2021 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.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

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 face to face, telephone and zoom contacts.

Trust-wide, in Q4 the number of individual patients seen had a marginal increase of 8 patients, so nearly the same level of activity. In Q4 the trust saw 5527 individual patients, 282 lower than the average of number of patient contacts during last financial year, when we had 5809.

Adolescents: in Q4 saw 216 individual patients, 6 more than in Q3, this represents a 3% increase. The number has been slowly increasing for the last 3 quarters. The average of number of patient contacts during last financial year was 199 per quarter.

Camden CAMHS: in Q4 saw 1103 patients, 44 more than Q3, an increase of 4%. The average of number of patient contacts during last financial year was 1191 per quarter.

Other CAMHS: in Q4 had contact with 517 patients, 18 fewer than in Q3, 3% lower. The average of number of contacts during last financial year was 513 per quarter.

Adults Complex Needs: in Q3 saw 568 patients, 24 more than in Q3, an increase of 4%. This is above the average of number of patient contacts during last financial year of 480 per quarter.

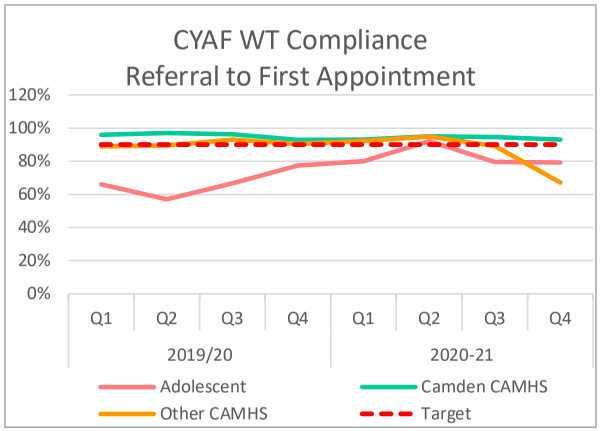
Portman: in Q4 had contacts with 185 patients, no change from Q3. The average of number of patients contact during last financial year was 198 per quarter.

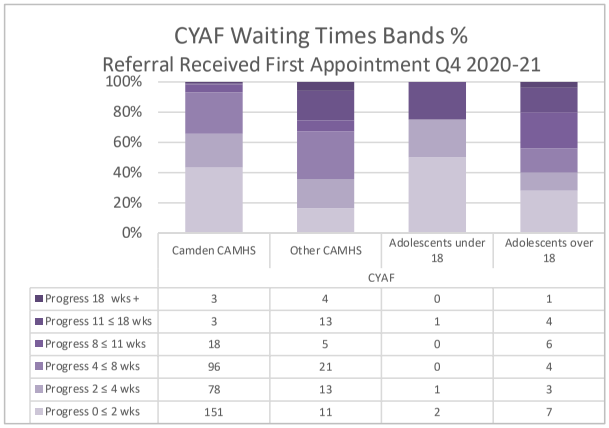
C&H PCPCS: in Q4 made contact with 222 patients, 14 more than Q3, this is a 7% increase. The average number of patients contact during last financial year was 239 per quarter.

GIDS: in Q4 contacted 1604 patients, 11 fewer than in Q3, 1% lower. The average last financial year was 1599 per quarter.

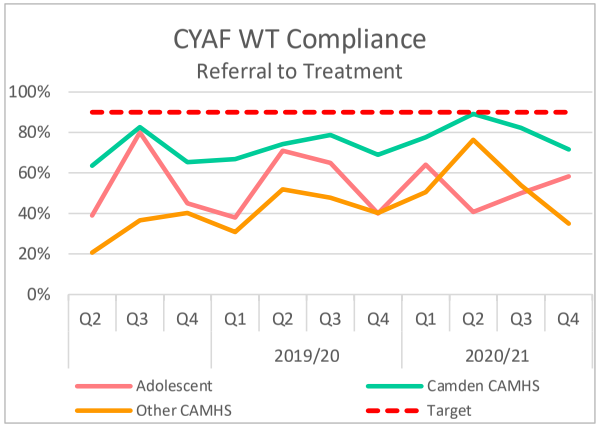
GIC: in Q4 contacted 1087 patients, 33 fewer that in Q3, 3% lower. The average of number of contacts during last financial year was 1340.

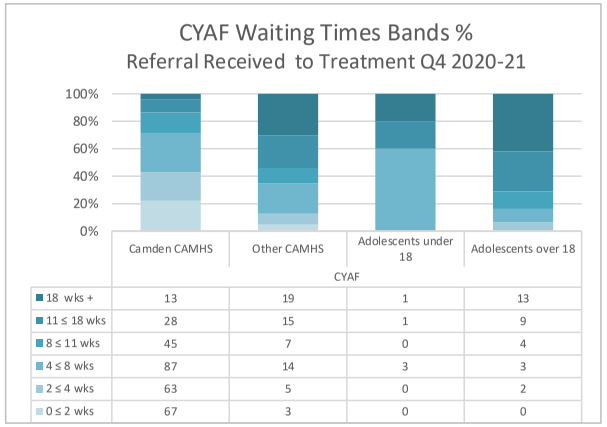
Q4 2020/21 : Quality Responsive – Access





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
Progress 18 wks +	3	4	0	1
Progress 11 ≤ 18 wks	3	13	1	4
Progress 8 ≤ 11 wks	18	5	0	6
Progress 4 ≤ 8 wks	96	21	0	4
Progress 2 ≤ 4 wks	78	13	1	3
Progress 0 ≤ 2 wks	151	11	2	7





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	13	19	1	13
11 ≤ 18 wks	28	15	1	9
8 ≤ 11 wks	45	7	0	4
4 ≤ 8 wks	87	14	3	3
2 ≤ 4 wks	63	5	0	2
0 ≤ 2 wks	67	3	0	0

Data source: Q4 data as recorded on 12/04/2021 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 Q4 CYAF saw 88% of patients within the contractual waiting times. This is a lower rate compared to 93% in Q3.
Referral to Treatment: In Q4 CYAF saw 65% of patients within the contractual waiting times. This is a lower rate compared to 75% in Q3.

Adolescent services
Referral to 1st Appointment – in Q4 the whole service line saw 79% of patients within contractual waiting times, same performance as in Q3.
- Adolescents under 18 - 75%
- Adolescents over 18 - 80%

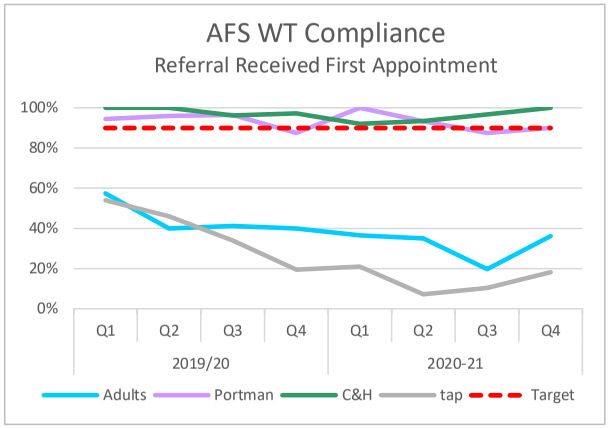
Referral to Treatment– – in Q4 the whole service line saw 58% of patients within contractual hours, a compliance improvement compared to 50% in Q3.
- Adolescents under 18 - 60%
- Adolescents over 18 - 58%

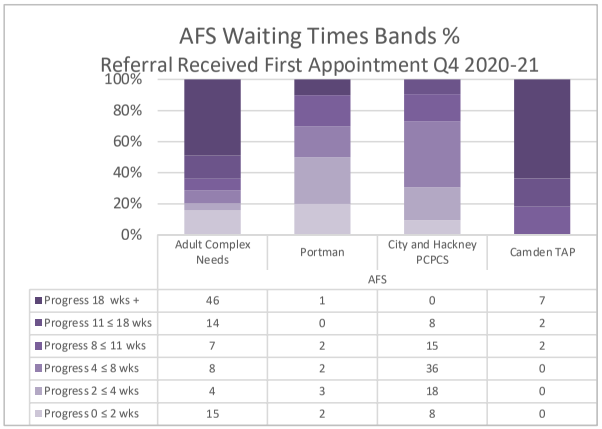
Camden CAMHS
Referral to 1st Appointment – has consistently met the target since 2017/18. The compliance rate in Q4 was 93%, a decrease compared to 95% in Q3.
Referral to Treatment– in Q4 72% of the patients had an appointment within 8 weeks, a slight decrease in compliance compared to 82% in Q3.

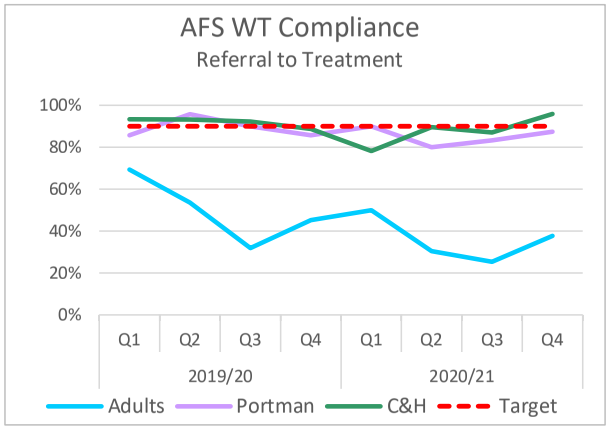
Other CAMHS
Referral to 1st Appointment – in Q4 they achieved 67%, a decrease in compliance compared 89% in Q3.
Referral to Treatment– in Q4 35% of the patients had an appointment within the contractual waiting times, a decrease in compliance compared to 54% in Q3.

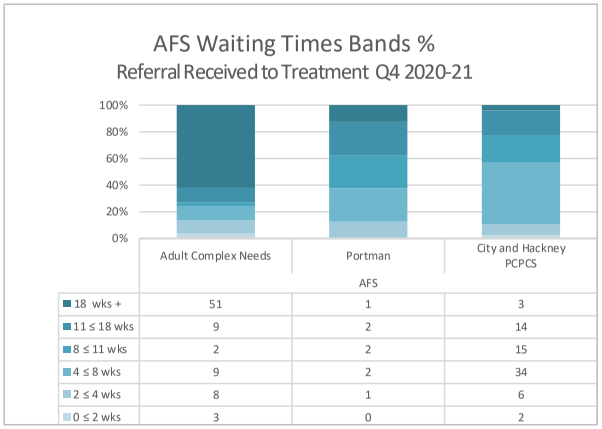
For further comments from service leads please see the commentary part of the report Page 21

Q4 2020/21 : Quality Responsive – Access









AFS Waiting Times:

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

Referral to 1st Appointment: In Q4 AFS saw 65% of patients within the contractual waiting times. In Q3 this compliance was 49%.
Referral to Treatment : In Q4 AFS saw 66%. of patients within the contractual waiting times. In Q3 this compliance was 55%.

Adult Complex Needs
Referral to 1st Appointment –in Q4 they had 36% compliance, an increase on Q3, when 20% compliance was achieved.
Referral to Treatment– in Q4 they had 38% compliance, an increase on Q3, when they had 25% compliance.

Portman
Referral to 1st Appointment – in Q4 they achieved 90% compliance, an increase on Q3 when they had 88% compliance.
Referral to Treatment– in Q4 they had 88% of patients were seen within contractual times, an increase on Q3, when they had 83% compliance.

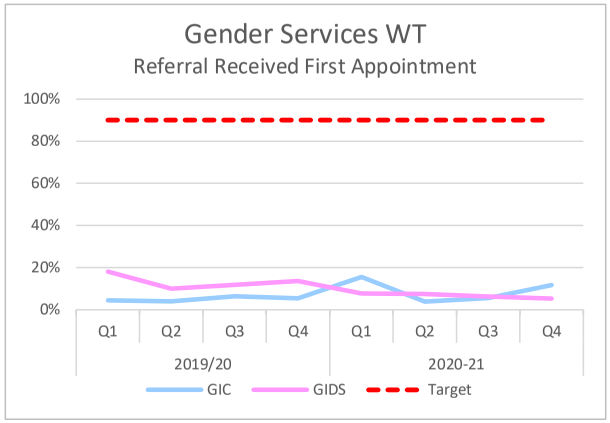
C&H PCPCS
Referral to 1st Appointment – in Q4 they achieved 100% compliance, an increase on Q3, when they had 97% compliance.
Referral to Treatment– in Q4 they had 96% compliance, an increase on Q3, when they had 87% compliance.

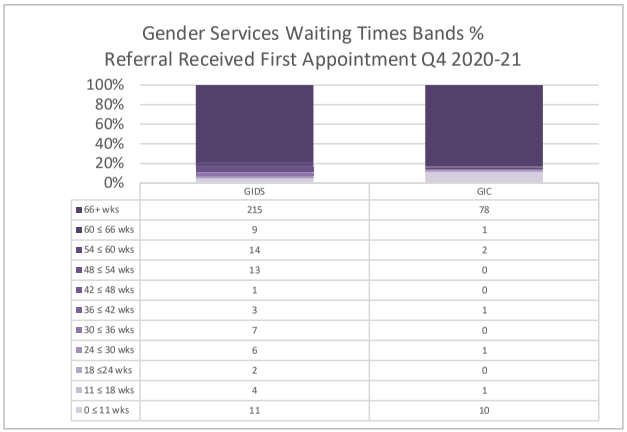
Team Around the Practice:
Referral to 1st Appointment – in Q4 the percentage of patients seen on time increased to 18%, in Q3 compliance was 10%.
Referral to Treatment– this service does not report on second appointments as their system (EMIS) is not able to provide the data. Service to be decommissioned this quarter.

For further comments from service leads please see the commentary part of the report Page 20

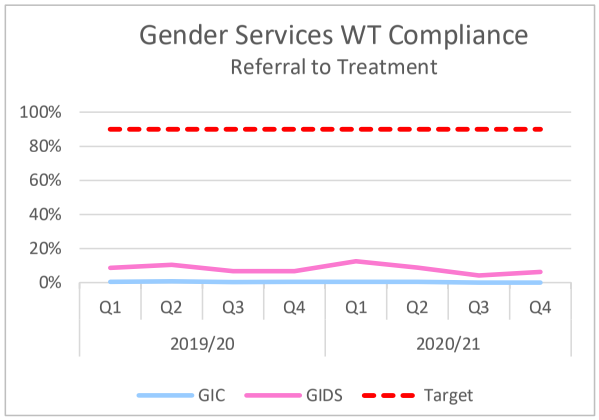
Data source: Q4 data as recorded on 12/04/2021 (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

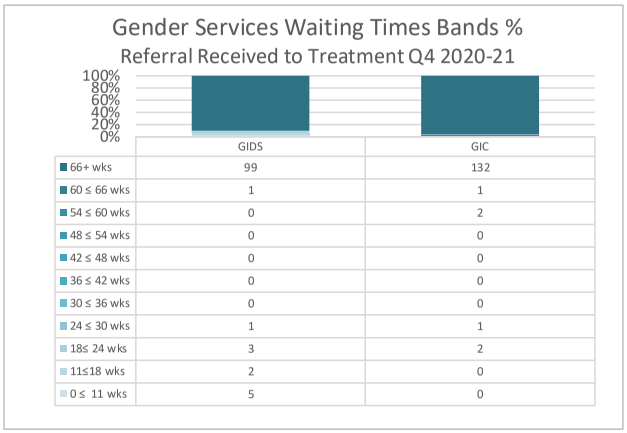
Q4 2020/21 : Quality Responsive – Access





	GIDS	GIC
66+ wks	215	78
60 ≤ 66 wks	9	1
54 ≤ 60 wks	14	2
48 ≤ 54 wks	13	0
42 ≤ 48 wks	1	0
36 ≤ 42 wks	3	1
30 ≤ 36 wks	7	0
24 ≤ 30 wks	6	1
18 ≤24 wks	2	0
11 ≤ 18 wks	4	1
0 ≤ 11 wks	11	10





	GIDS	GIC
66+ wks	99	132
60 ≤ 66 wks	1	1
54 ≤ 60 wks	0	2
48 ≤ 54 wks	0	0
42 ≤ 48 wks	0	0
36 ≤ 42 wks	0	0
30 ≤ 36 wks	0	0
24 ≤ 30 wks	1	1
18≤ 24 wks	3	2
11≤18 wks	2	0
0 ≤ 11 wks	5	0

Data source: Q4 data as recorded on 12/04/2021 (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

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 Q4 7% of patients within the contractual waiting times. This compares to 6% in Q3.
Referral to Treatment : Gender Services Directorate saw in Q4 3% of patients within the contractual waiting times. This is a slightly higher rate compared to 2% in Q3.

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.

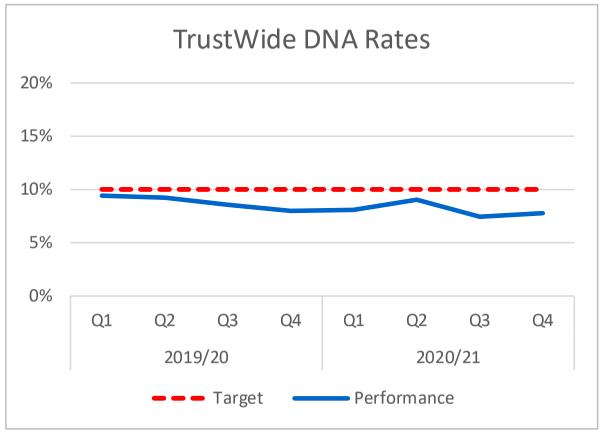
Referral to 1st Appointment – in Q4 had 5% compliance, a decrease on 6% in Q3.
Referral to Treatment – in Q4 had 6.4% compliance, a slight increase on 4.2% in Q3.

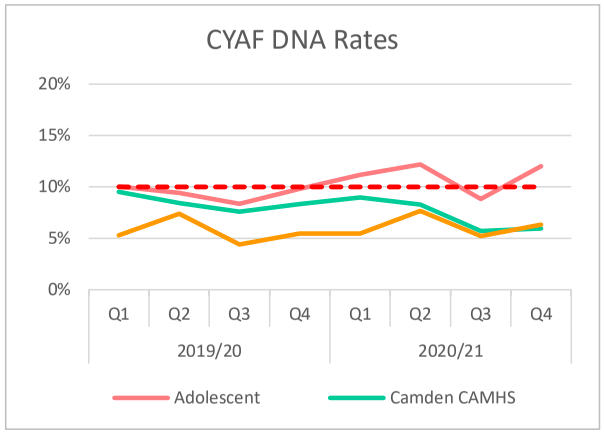
GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.

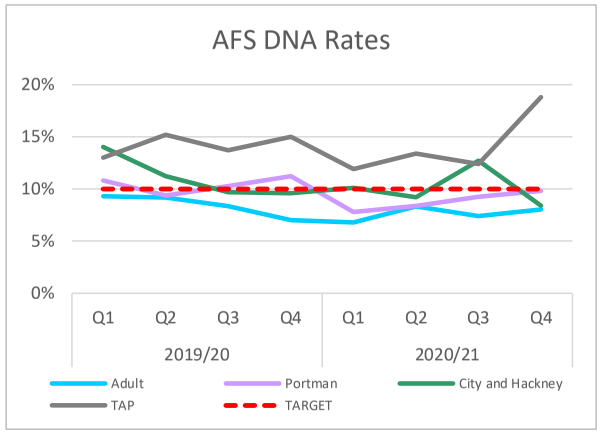
Referral to 1st Appointment – in Q4 had 11.7% compliance, an increase on 5.6% in Q3.
Referral to Treatment– in Q4 138 patients had the second appointment but out the contractual time frames, giving a 0% compliance rate. Q3 had the same performance.

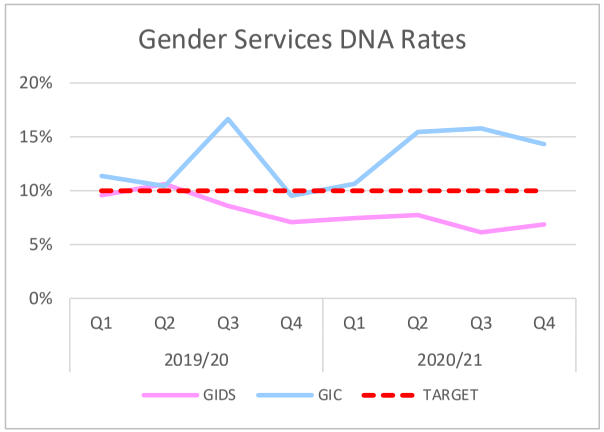
For further comments from service leads please see the commentary part of the report Page 22

Q4 2020/21 : Quality Effective – Access









Data source: Q4 data as recorded on 12/04/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

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 (excl. TAP), we continue to maintain a good DNA rate. In Q4 our compliance rate was 7.78%. Last financial year average rate was 8.80%. The trust has met this target over the last 3 years.

Adolescents: in Q4 had an 12.01% -190 DNAs and 1392 attended appointments. The DNA quarterly average during last financial year was 9.4%.

Camden CAMHS: in Q4 had a DNA rate of 5.96% - 478 DNAs with 7544 attended appointments. Target has been met for the last 2 years. The DNA average during last financial year was 8.5%.

Other CAMHS: in Q4 had a DNA rate of 6.32% -215 DNAs and 3187 attended appointments, Target has been met for the last 2 years. The average during last financial year was 5.6%.

Adults Complex Needs: in Q4 had a DNA rate of 8.03% - 372 DNAs and 4260 attended appointments. Target has been met for the last 2 years. The average during last financial year was 8.5%.

Portman: in Q4 had a DNA rate of 9.82% -158 DNAs and 1451 attended appointments. The average during last financial year was 10.4%.

C&H PCPCS: in Q4 had DNA rate of 8.39% -78 DNAs and 852 attended appointments. The average during last financial year was 11.1%.

Team Around the Practice: in Q4 had a DNA rate of 18.80% - 79 DNAs and 421 attended appointments. The average during last financial year was 14%. Service to be decommissioned this quarter.

GIC: in Q4 had a 14.34% DNA rate - 262 DNAs and 1568 attended appointments. The average during last financial year was 12%.

GIDS: in Q4 had a 6.87% DNA rate -278 DNAs out of 3768 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

Q4 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 January 2020, 96.6% against a target of 95%.

- From February 2021, our gender services will not be included in MHSDS data submissions although we will continue to monitor internal compliance rates.

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.

	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	Month 10 January 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%	99.60%
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%	99.53%
Valid Date of Birth	95%	100%	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%	99.13%
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%	99.12%
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%	99.98%
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%	88.77%
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%	66.98%
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%	66.59%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%	99%	99.00%	99.00%		100.00%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%	46%	48.00%	56.00%		64.00%
DQMI -Data Quality Maturity Index	95%	The DQMI Indicator is not submitted in the same intervals, hence we are still not able to provide January's data.							88.90%	94.10%		95.60%	95.70%	95.70 %	96.6%

Data source: Data warehouse, informatics team 12/04/2021

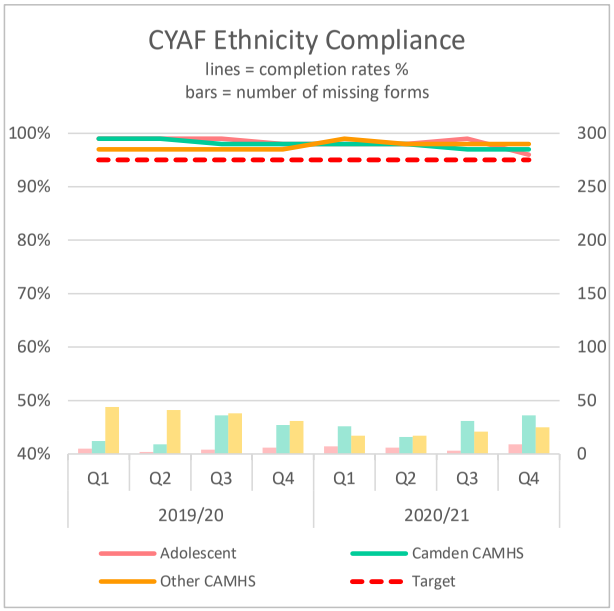
Q4 2020/21: Single Oversight Framework – Access

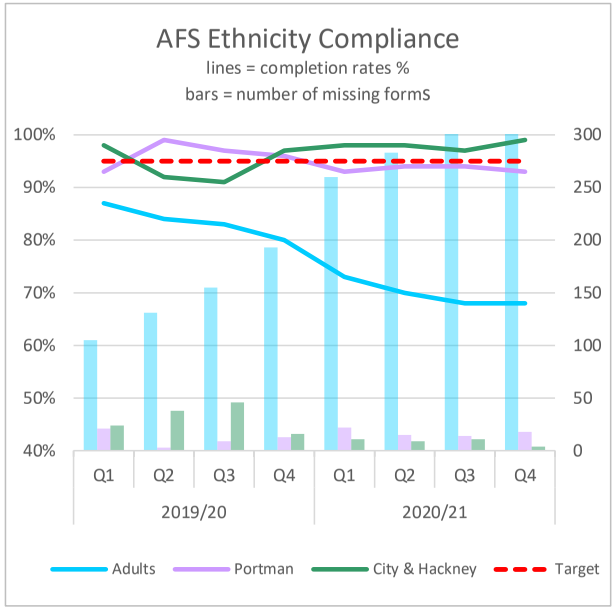
Ethnicity Rates Internal Reports

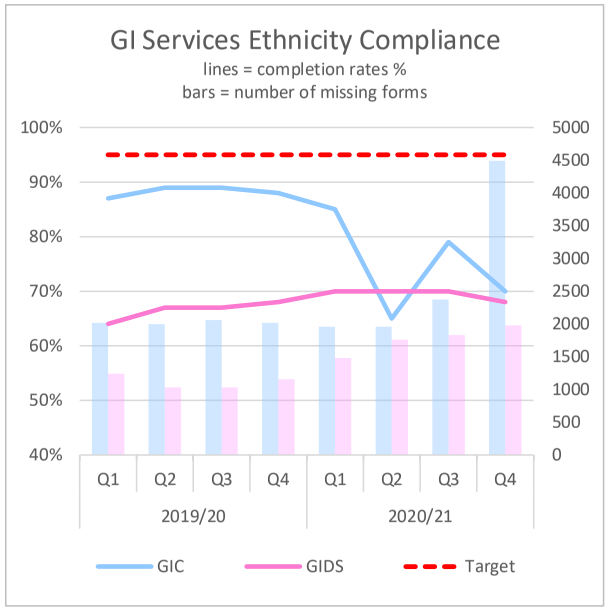
Ethnicity completion rates have been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%, in April last year. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services 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.

During Q3 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 NHS monitoring form, where demographic data is requested. It has been implemented within the Trauma and PATH Units and there are plans to spread the letter to other teams. This new initiative has helped stabilised in Q4 the continued growth of missing demographics in previous quarters. The service is continuing to explore new ways to improve the rates of missing demographic data as this is one of the Trust Quality Priorities for next financial year.

In Q4 GIC accepted a large number of pending referrals, this explains the big spike on their data. As mentioned earlier one of the Trust Quality Priorities for next financial year is improving collection of ethnicities data across the Trust, we are hopeful to see an improvement over the next few months.

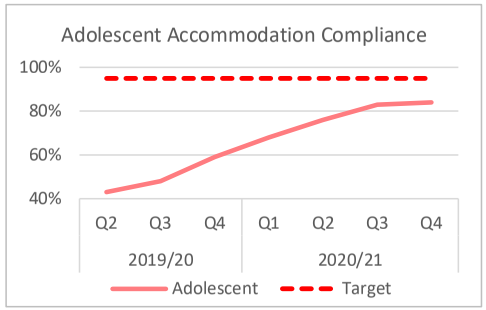


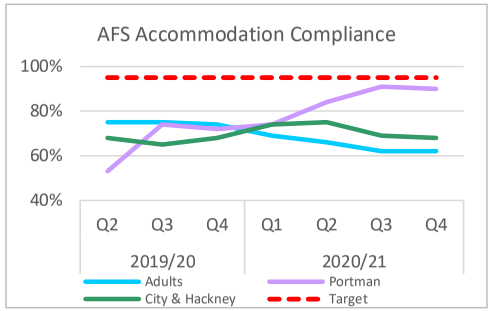


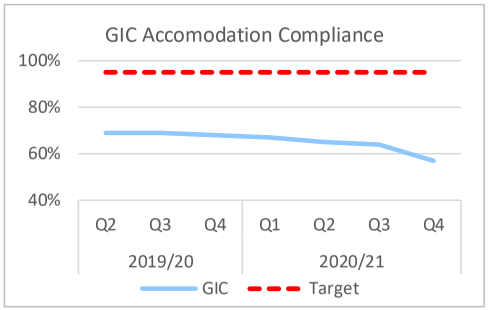


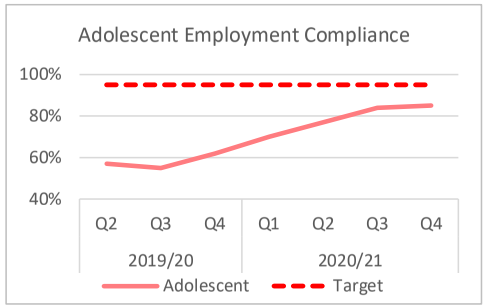
Data source: Q4 data as recorded on 12/04/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

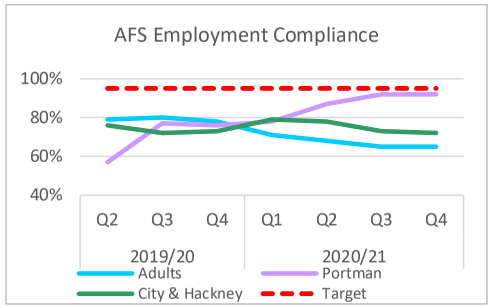
Q4 2020/21: Single Oversight Framework – Access

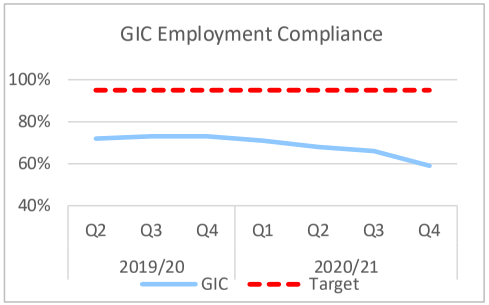


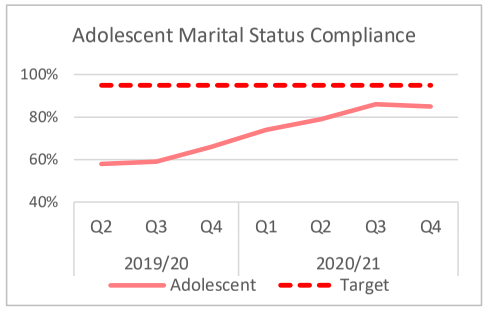


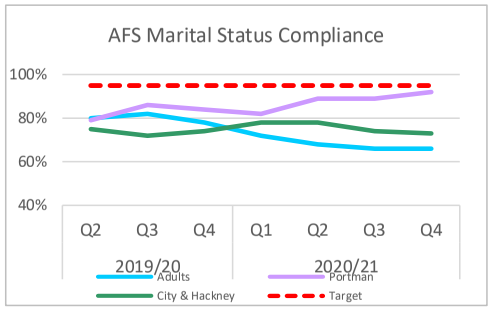


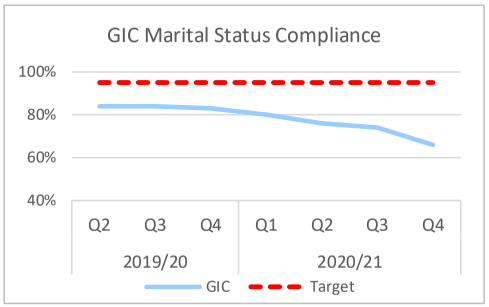












Data source: Q4 data as recorded on 12/04/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q4 data for AFS and Gender Services has been run without meeting the threshold on number of unoutcomed appointments.

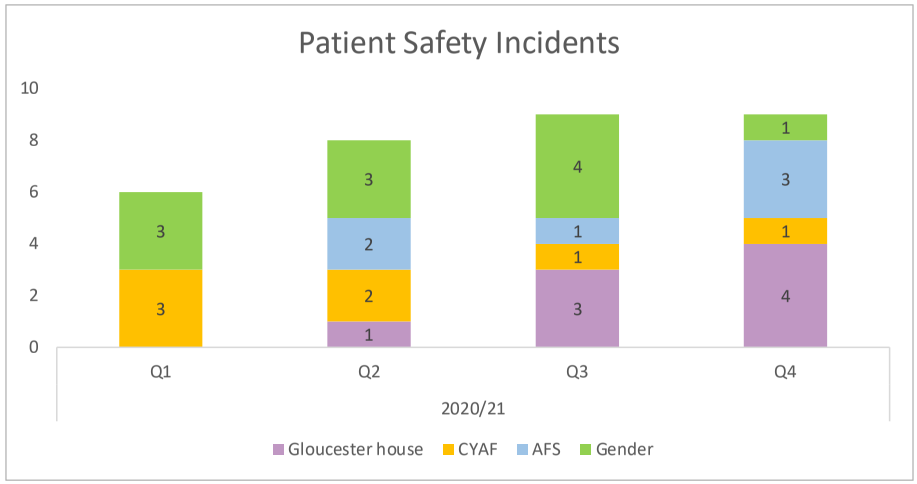
Accommodation, Employment and Marital Status Rates Internal reports

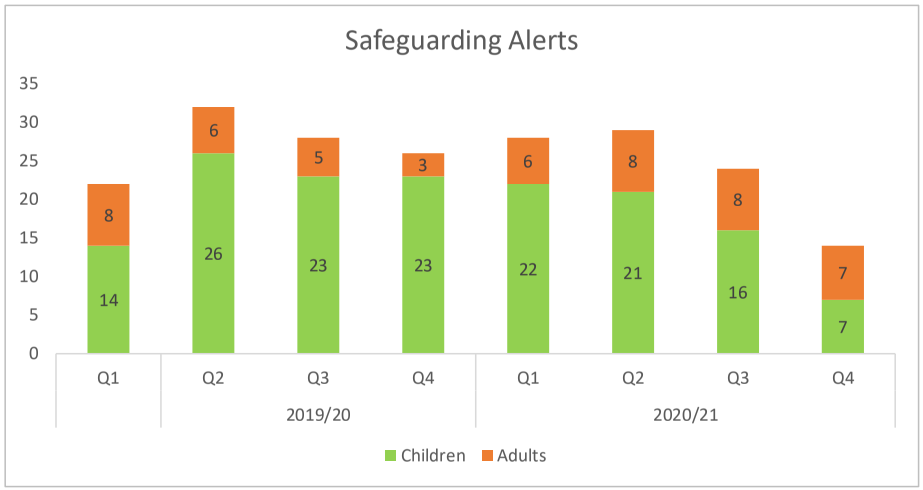
These parameters are only required for patients over 18 years of age.

Please note the strong 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.

We have recently raised awareness of a potential minor glitch in the CareNotes report with regards to the information held on the Social Inclusion From. We have found a few cases where information has been provided but not included on the last social inclusion form, and the report is not counting this data. If the project succeeds we are hoping see a slight improvement on our performance.

Q4 2020/21: Quality Safety – Care





Four of these Q4 incidents were discussed at the incident panel and the remaining incident has a score of four, therefore will not be coming for discussion.
The patient harm score for the Gloucester House incidents in Q4 was very low.

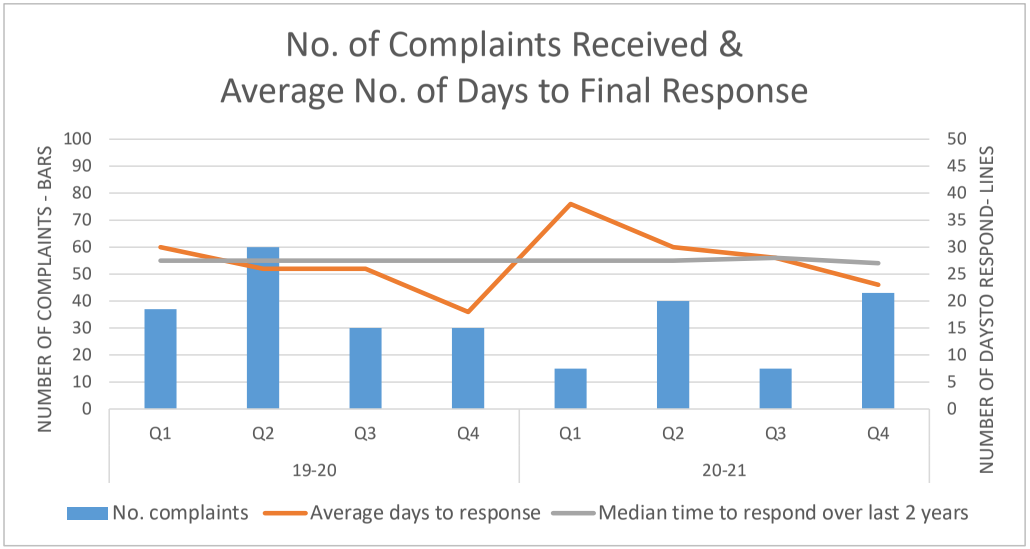
Some cases have more than one type of concern and were counted as one for accurate reporting.

Incidents Reported by Risk Level – Trust wide	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4
1-4	101	65	65	60	37	34	32	62
5-8	28	27	28	30	11	19	30	28
9-12	3	11	12	18	3	3	12	19
15+	0	2	0	1	1	2	1	3
Total	132	105	106	109	52	58	75	112

Data & commentary source: Clinical Governance 12/04/2021
Previous quarters' data as reported in relevant earlier reports.

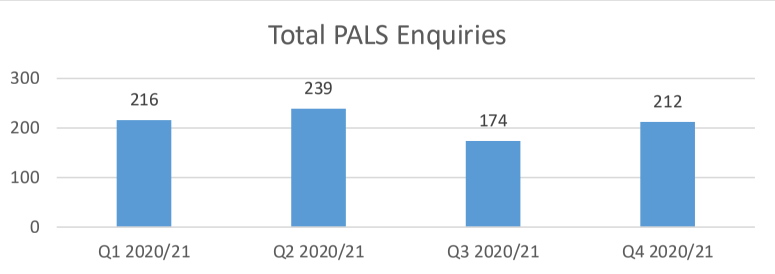
Q4 2020/21: Quality Responsive – Care

See Slide 29 for further KPI complaints information



Directorate	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Children Young Adults and Families	4	0	1	0	3
Adult and Forensic	4	3	11	3	7
Gender	21	12	25	11	27
Corporate	1	0	3	1	7
Total complaints	**30**	**15**	**40**	**15**	**43**

This is an increase in the number of complaints received in Q4 compared to the previous quarter. Of the 43 complaints received in Q4 11 have been responded to, leaving 32 open. Following the 'pause' in the complaints process in place from the end of March 2020 due to the coronavirus crisis a backlog of complaints has resulted. This backlog of complaints has not yet been cleared, as many staff are still working from home and are dealing with other urgent work related to the pandemic. All complainants have been advised to expect a delay in the response to their complaint and that it is not possible to say when we will be able to respond. Of the complaints that have been responded to one was upheld and nine were not upheld and one was partially upheld.



Accessing treatment and support issues, followed by communication issues are the top two categories, fairly equal across Gender/Adult/C&F and young people's services.

Data & commentary source: Complaints Department 12/042021
Previous quarters' data as reported in relevant earlier reports.

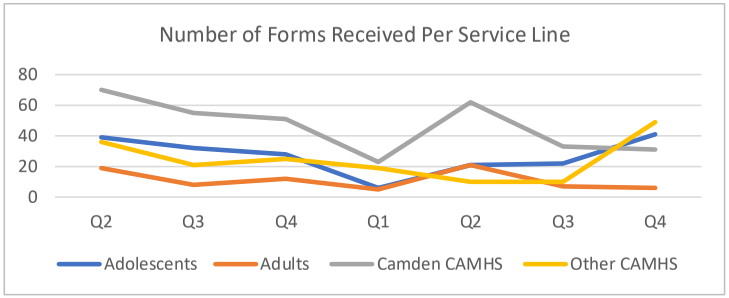
Data & commentary source: PALS department 19/04/2021

Q4 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%**	84	84	**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%**	58	60	**97%**				
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%**	76	77	**99%**				
Q12 from ESQ "Options for my care were discussed with me"	Quarterly	n/a	28	28	**100%**	49	55	**89%**	48	49	**98%**	51	51	**100%**				
Q13 from ESQ 'Involved in important decisions about my care'	Quarterly	n/a	26	26	**100%**	48	53	**91%**	48	50	**96%**	50	51	**98%**				
Q15 from ESQ "Overall, the help I have received here is good"	Quarterly	92%	42	42	**100%**	106	106	**100%**	72	72	**100%**	82	82	**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 has been piloting a new shorter form which aims to improve the collection rates. 'ESQ Implementation' is one of our Trust Quality Priorities for 2021/22. It is worth noting that the test forms trialled during this financial year were anonymised and not included on the above report as they cannot be input into CareNotes. Further developments to the form has been applied and the final form will be linked to our Patient Record and Reporting System.



Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team 12/04/2021
*ESQ % = (Certainly true + Partly true)/(Certainly True + Partly True + Not True)

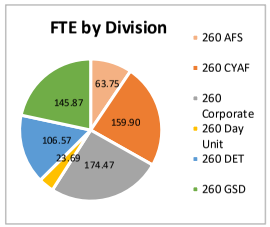
Q4 2020/21: Quality Well-Led

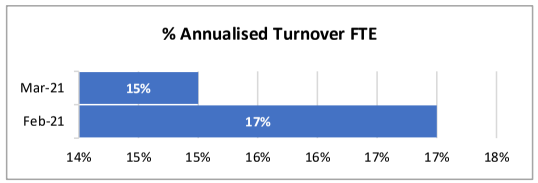
Workforce Headcount

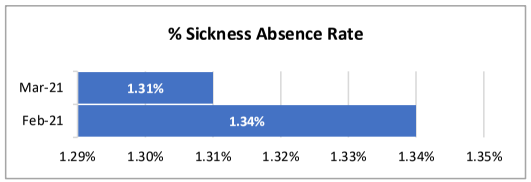
820 *Total Headcount*

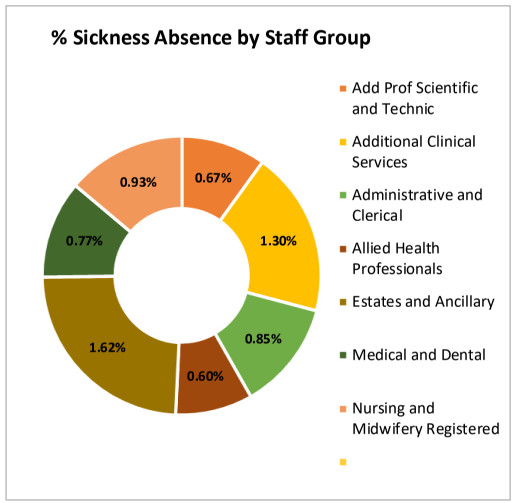
619 *Female*

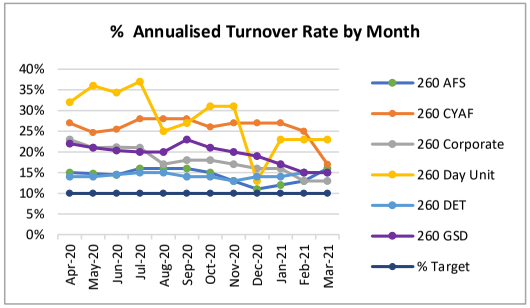
201 *Male*

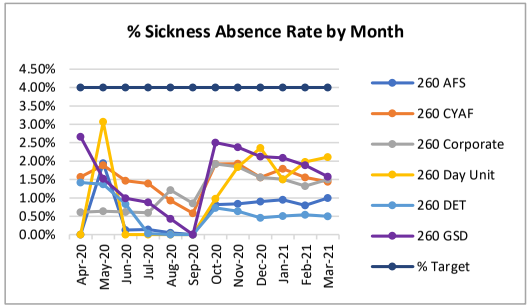


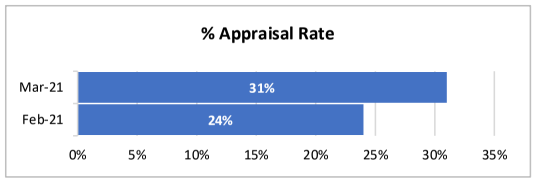


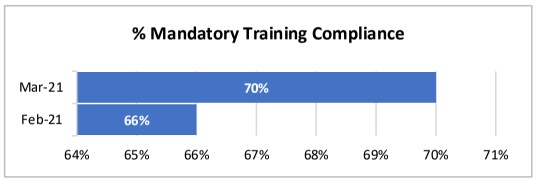


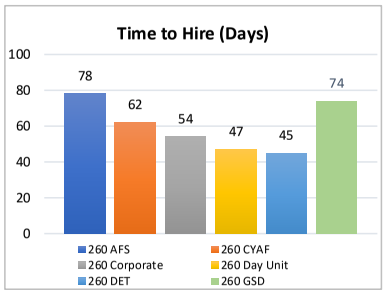


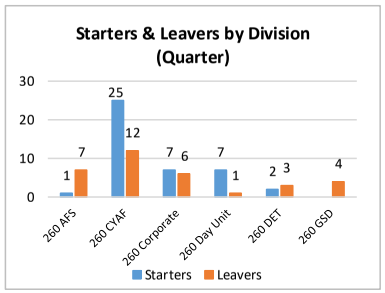


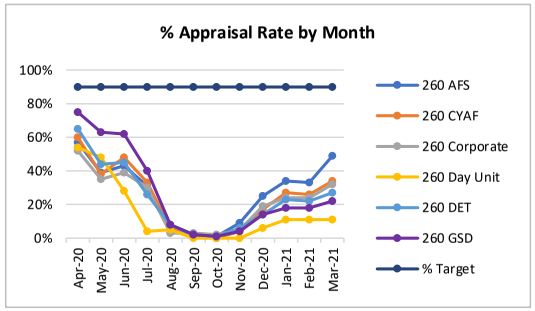


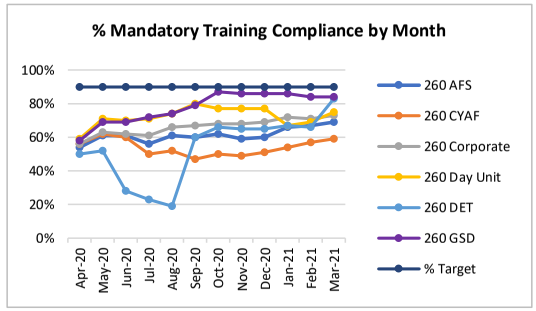










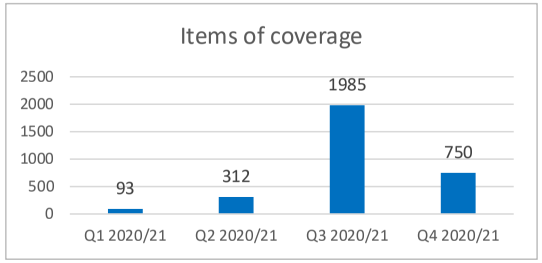


The Staff Friends and Family Test for Q4 2020/21 went ahead as planned. The Trust was one of the poorest performers in the recommendations as a place to work. This score had dropped from 2018 at 71.4% to 63% in 2020. The NHS Staff Survey for 2020 took place between September – November with 63% of eligible staff responding. This is an increase from 60% in 2019. The trust is above average for the mental health and learning disability trust which stands at 49%. Statutory and Mandatory training has a compliance target of 95% and by the end of Q4 the Trust unfortunately did not meet its overall compliance target. Statutory and Mandatory compliance has been severely affected by the challenging period last year due to the pandemic.

Data Source: Human Resources Department: 12/04/21

Media overview

There was less than half the coverage in Q4 2020/21 compared to Q3 (which had a spike related to the judgment from the Judicial Review) but more than twice that of Q2. This quarter featured the GIDS CQC report. Articles appeared in outlets including the *Mail* and *Guardian*, with mainly negative sentiment. We have also had positive coverage when experts in our Trust gave advice about the effects of COVID-19 and lockdown.



Top stories mentioning us by reach

**potential number of people who could have seen the coverage*

Platform	Title	Reach	Sentiment
BBC Online	NHS child gender clinic rated 'inadequate' by inspectors	803,000,000	Negative
BBC Online	Covid: Why I'm breaking lockdown rules [Laverne Antrobus's expert commentary on why people might, not advocating the position]	803,000,000	Positive
BBC Online	The crisis at the Tavistock's child gender clinic	710,000,000	Negative
Daily Mail	Gender clinic bosses removed after regulators highlighted a string of failures	384,000,000	Negative
Daily Mail	When your son says he wants to be a woman	384,000,000	Negative
Reuters	UK court rules in favour of parental consent in trans treatment row	Syndicated	Neutral
Reuters	UK regulator slams waiting times, patient records at trans clinic	Syndicated	Negative

Data & commentary source: Communications Department 14/04/21

Digital overview

Traffic to our main site is up notably compared to the same quarter last year. Social followers continue to grow.

- Website users **up 21%**: 129,145 vs 106,623
- Page views **up 27%**: 420,420 vs 328,681 (50% of page views, 210,209, were to the training section)
- Sessions **up 23%**: 188,572 vs 152,642

Most-visited news stories:

- "The baby who is born pink learns to become white", 1,010 views (also the top item last quarter)
- Statement in response to the CQC report, 922 views
- Help inform and develop our anti-racism work – invitation to tender research project, 824 views

Most-visited course pages:

- Working with children, young people & families: a psychoanalytic observational approach (M7), 6,213 views
- Systemic psychotherapy (M6), 6,063 views
- Child and adolescent psychoanalytic psychotherapy (M80), 5,120 views

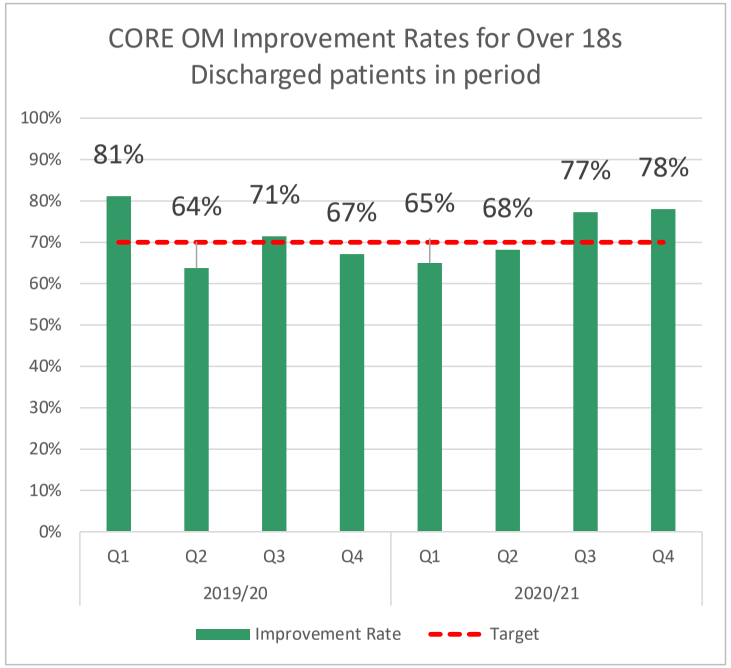
Social channels – followers compared to last quarter

- Twitter: **@taviandport:** 7956, up from 7,587, **@tavitraining:** 5,391, up from 5,288
- LinkedIn: 12,929
- Facebook: 6,470, up from 6,304
- Instagram: 832, up from 676

Q4 2020/21: Quality Effective – Outcome Measures

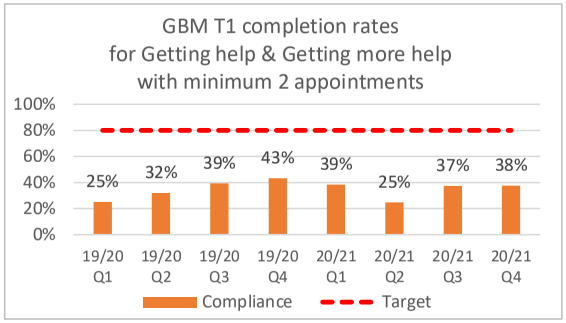
See Slide 33 for further GBM and CGAS information

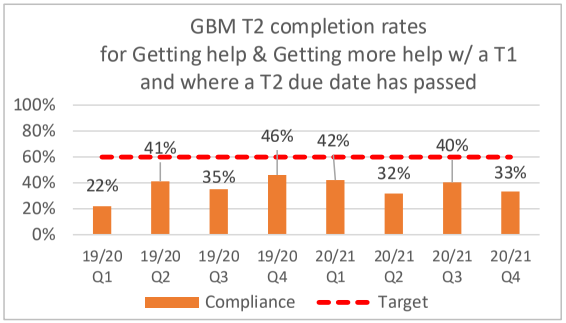
A F S and Adolescents over 18

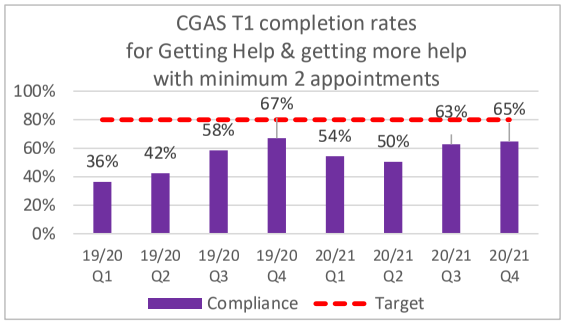


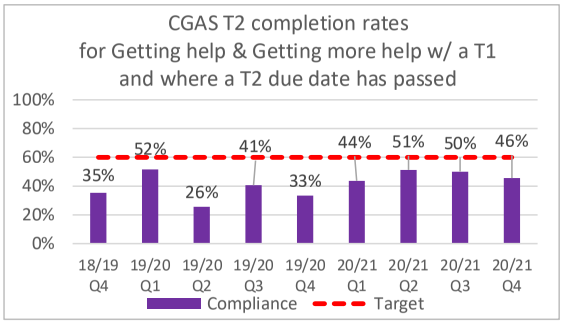
The CORE OM improvement rates include all patients discharged in period with a minimum of two completed CORE OM forms.
We are pleased to see the improvement rates have increased over 3 consecutive quarters, and stayed above the target in Q3 and Q4. We also would like to highlight that the ratio of discharged patients with more than two completed form increased this quarter by 3%.
We are reviewing the reminder system and collection process in order to focus on improvements to the return rates.

C Y A F





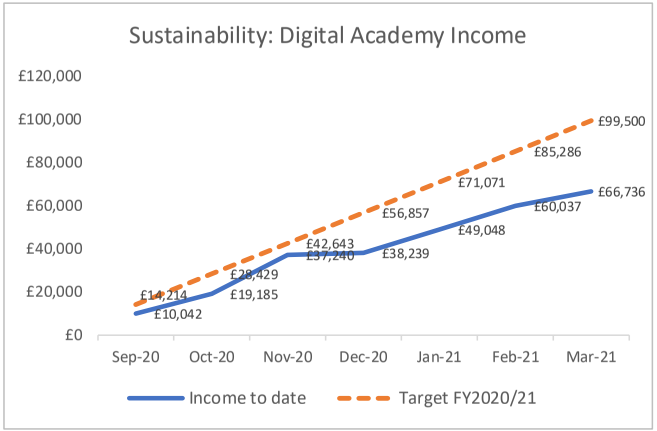


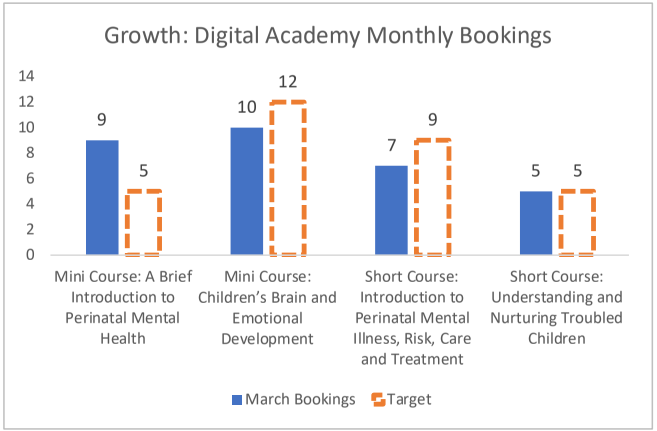


The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: GBM T1 form completion rates increased from 37% in Q3 to 38% in Q4. GBM T2 form completion rates decreased from 40% in Q3 to 33% in Q4. In Q2 we tested a new reminder logic to improve collection rates on the Carenotes system in the Adolescents Team. During Q3 this was also implemented within Family Mental Health Team. Feedback from teams has been positive and there are plans to extend the new logic across other services. We have also resolved glitches with the CareNotes interface which makes inputting the goals easier.
-CGAS rates: CGAS T1 increased in Q4, with 65% completion rates. CGAS T2 decreased to 46% in Q4. Also, it is important to highlight the increase in annual averages for CGAS T1 increased by 7% and T2 by 10% compared to 2019/20. This is encouraging news.

Data source: Q4 data as recorded on 09/04/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q4 data for AFS has been run without meeting the threshold on number of unoutcomed appointments.

Q4 2020/21: Directorate of Education and Training (DET)

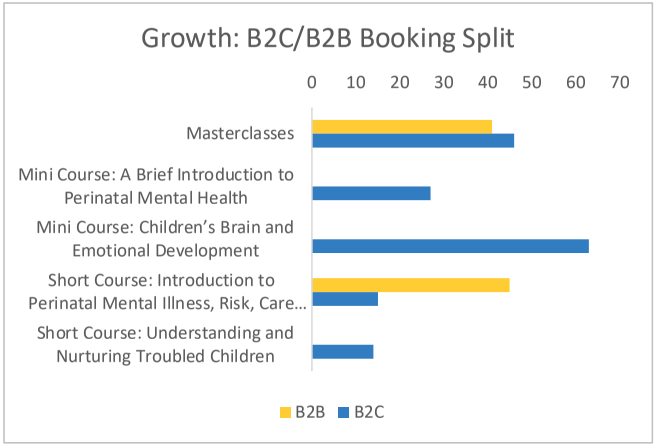


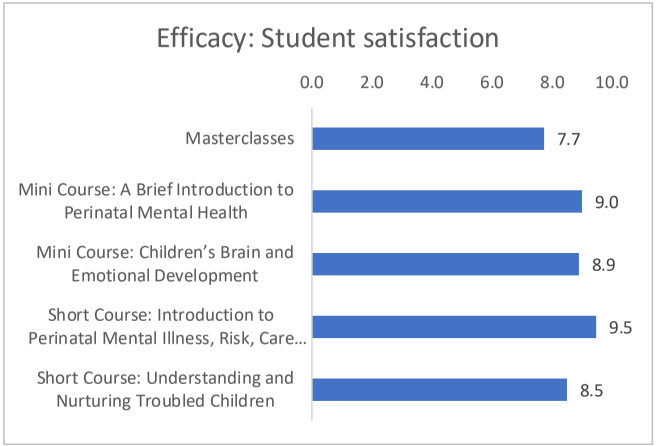


The income graph shows cumulative individual booking income for all Digital Academy products since launch, against the original business case target.

Not shown on this graph is the organisational group booking (B2B) income figure. As of the date of the reporting, invoiced B2B income stands at £38,768, taking total Digital Academy income above target to £105,504 since launch. Future iterations of the KPI report will show both sources of income.

The monthly booking chart shows that bookings were largely on track against target for this month. A B2B engagement plan and new referral relationships with partner organisations should continue to improve recruitment.





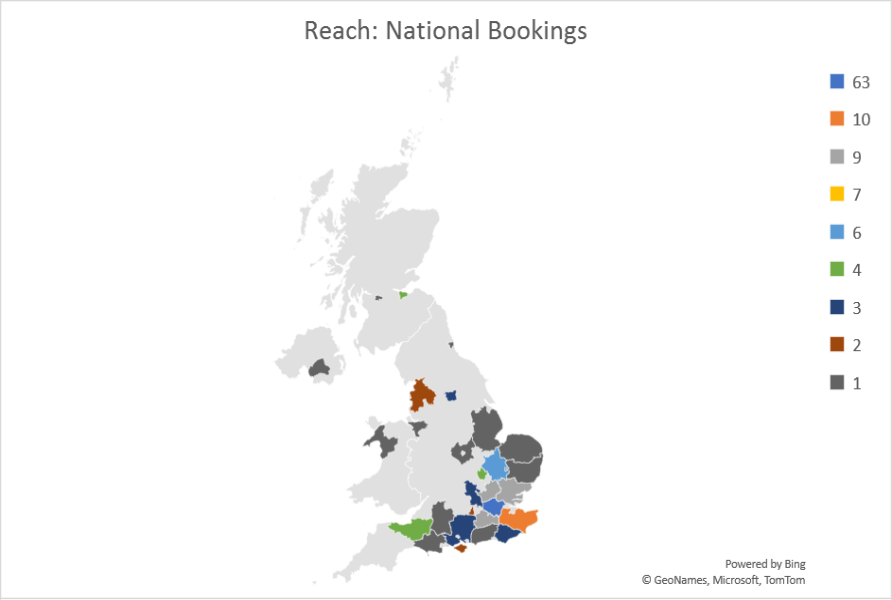
Commentary:
Individual B2C (business to consumer) bookings form the majority of our growth currently, although certain products (i.e. Masterclasses) and certain subjects (i.e. Perinatal Mental Health) have shown positive organic B2B growth.

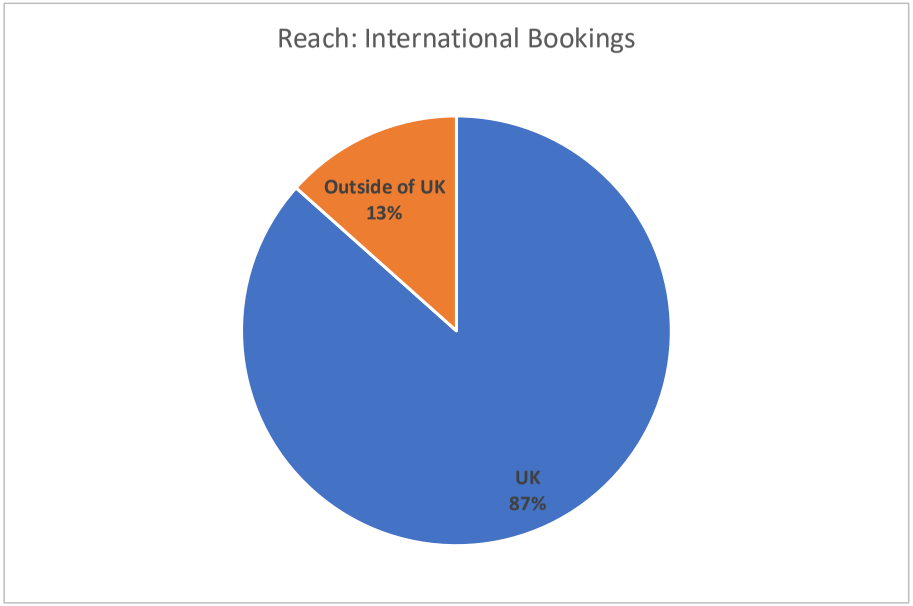
The Digital Academy team is launching a B2B engagement plan in April 2021 which should increase organisational group booking rates.

Student satisfaction rates across all products are encouraging, with the majority of respondents scoring their experience highly. We are investigating format changes to the Masterclass to improve student engagement and experience scores.

Data & commentary source: DET Department 12/04/2021

Q4 2020/21: Directorate of Education and Training (DET)





Commentary:
Digital Academy bookings are largely concentrated in London and the South East. This is perhaps unsurprising given brand awareness of the Trust is strongest here, and as this is where advertising has been concentrated in order to maximise our limited marketing budget.

As brand awareness increases, and new referral channels open we hope to grow recruitment across the UK.

International recruitment is largely organic at this stage, driven by learners searching for specific courses or the Trust, but the fact that over 10% of Digital Academy learners are international within 6 months of launch is an encouraging statistic and we intend to pilot market-specific advertising over the next year. The largest current international markets are Greece, USA, China, India and France.

Data & commentary source: DET Department 12/04/2021

Quarterly Quality Report Commentary Q4 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 Q4	Objective / plan for next Quarter
Adolescent /AYAS	AYAS has maintained its referral to first appointment at 80%. In this quarter it became apparent that a number of patients were going to breach and so changes were made to accommodate the patient with another clinician offering a first appointment sooner. This reduced the number of patients breaching to 20% and the wait for other patients to 12 weeks. One anomalous patient appears to be waiting a significant period of time for a first appointment but was being seen on a weekly basis for a long term family therapy treatment in the service.	An additional fortnightly meeting has been established with team managers and psychiatrists to ensure that 1st appointments are being offered in a timely fashion. In this meeting referrals will be shared across teams if it is apparent that they will breach. The WT to second appointment will now be a focus for intervention and will require a number of adjustments to ensure that this is occurs. A significant areas of delay in referrals coming through is a large amount of liaison occurring at intake and so we will look at these processes meaning that there is not enough time left on the clock to offer 2 appointments.
Camden CAMHS	The Q4 data indicates that compliance rates for first appointment have remained high at above 90% for the first appointment, but compliance for second appointment within 8 weeks has reduced. This has been impacted by increased staff absence due to leave arrangements as a result of staff not taking leave earlier in the year due to the pandemic. During Q4 there has also been an increase in staff turnover which has impacted on compliance with 2 appointments being provided within 8 week deadline. Also, during Q4 we became aware that waiting time reports were only being monitored for first appointments, and as such a new report has been developed and is being shared weekly with team managers and admin leads to ensure timely monitoring of the wait times to improve compliance.	We will monitor the reporting of waiting times to first and second appointments and improve feedback mechanisms with team and service managers across the directorate to improve compliance. We will work in collaboration with other directorates through the Waiting Time Quality Priority to improve compliance and experience of service for CYAF service users in 2021/22. In addition, we are working with partner providers across NCL to develop a web based platform to support service users whilst they are waiting to be seen.
Other CAMHS	As identified in Q3, we continue to try to understand and review the wait to second appointments in all teams to monitor the impact of the Covid 19 pandemic on waiting times. Increases in staff absence over Q4 has impacted our ability to meet this target. Additional factors include: - a new cohort of Haringey Children's Wellbeing Practitioners (CWPs) in January where 2 new members of staff replaced the previous 3 that left the service and needed to undertake training prior to starting clinical work in the Haringey CWP service – this accounts for 6 breached cases. - The impact of the taking of Adoption Support Fund cases in the FAKCT team where delays are caused by the necessary and unavoidable wait for confirmation of funding from the AS Fund in 4 cases. This is out of our control and we are seeing an increase in ASF funded cases. - There are some delays within the system e.g., waiting on further information from referrers, as well as within the teams e.g., delays in cases being allocated, and we are working to address these. - Of the 12 breaches in Q4 for the Autism Spectrum Conditions service, 9 are assessment/diagnostic cases and we are working to understand the specific pressures in this area. - increased pressures on the admin teams due to staff turnover and absence - within FMHT there are waits for some of the specific clinical interventions	To gain a clearer understanding of the waiting time compliance requirement for 2 appointments within 8 weeks and the impact on clinical service delivery. We have now implemented a new report that allows us to quickly see who is waiting for appointment two and this is shared with team managers on a weekly basis. Previously this was only available for appointment one. Improve system and processes for identifying the key issues regarding compliance to ensure timely action if required. Regarding the 12 breaches in the quarter for the Autism Spectrum Conditions service, we are trying to understand the specific pressures in this area and are also working with colleagues across NCL providers to improve waiting times across the ICS. In addition, the Team Manager has introduced a process whereby the clinician who is given a case/new referral are also given the breach date as soon as they have the case allocated with the aim of reducing breaches going forward.

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

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q4	Objective / plan for next Quarter
Adult Complex Needs	In the last quarter (Q3 2020/21) the referral received to 1st appointment and referral received to treatment was 20% and 26% of patients being offered appointments within the target dates set respectively, and well under the target of 90% for both measuring criterion. In this quarter (Q4 2020/21) we have seen an increase in the number of patient cases receiving their 1st appointment and treatment within the target date to 38% and 39% respectively. This is largely due to the objective and plan set at the last quarter to engage additional resource in offering assessment appointments to patients to reduce the number of individuals waiting for their 1st (assessment) and 2nd (treatment) appointments.	Although the additional resource engaged for the last quarter was for a limited period and has now ended, we have managed to address the majority of the backlog of patients waiting for 1st and 2nd appointments to a more manageable level, and plan for the trend to continue, within the generic treatment teams. This is in part due to the intake co-ordinator reminding clinicians responsible for allocating cases, twice a month, of patient cases that need to be allocated to avoid breaching the wait times. There are also plans in place to look at how waiting lists in Adult Complex Needs are managed, especially within teams that have historically long waiting lists due to the treatment model being offered, and are being taken forward by the General Manager for the service.
Portman	Only one patient breached the contractual target. At the time of writing this report, the Intake coordinator is on leave, so the reason for this is uncertain, but will be identified. As seen, the majority of patients are seen within the first 8 weeks of referral.	We will continue to ensure that patients receive their first and second appointments as soon as is possible.
City and Hackney PCPCS	We are pleased with PCPCS's waiting time figures for Q4. All our patients were seen for a 1st appointment within the 18 week target, and a large majority of patients received their 2nd appointment within the same timeframe. It is satisfying to see the service meet these targets and therefore know we offered patients the help and support they need in a timely manner.	PCPCS continues to aim to see patients within an appropriate timescale. Particularly within a primary Care setting, timely and regular contact can reduce risk, result in better patient experience, mean less mental pressure on staff, and encourages GPs to make mental health referrals.
TAP	The Tavistock & P made a decision to stop providing the service which resulted in a pausing of referrals in February. The waiting times for assessment i.e. first contact, had been on the increase anyway as the graph shows due to the following factors: cut to the service during the recommissioning cycle and consequent reduction in staff, staff deciding to leave the service due to low morale also connected to yearly cuts and inevitable gaps between this and new recruits. In the autumn we also decided to prioritise treatment appointments due to the long wait for treatment, which impacted on the waiting time for first appointment.	N/a TAP is being discontinued.

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

Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q4	Objective / plan for next Quarter
GIC	The waiting times continue to be too long. This is in line with the other services and is a national problem. The gap between appointments has suffered greatly during the pandemic and many people who have attended appointments on Zoom still need to be seen in the clinic before they can progress.	We have begun work with two consultants who are working across GIDS and GIC to look as waiting times and what we can do to improve. We are hoping that the waiting list consultants can help us look at the gap between appointments and help us devise a plan to narrow the gap. There is a draft action plan and we are hoping to be making improvements over the next financial year.
GIDS	We have recently been looking into very long waits. Where we have looked at individual cases, they can be due to patients who have left the waiting list, who are then subsequently re-referred. We've therefore emphasised to staff that re-referrals should be entered in accurately with new referral rates. We believe the long waiters are those whose age moves them out of the GIDS waiting list onto adult services elsewhere, who tend to have a needs-consultation with GIDS to determine the best route onwards. Where *aging out* is removed, we try hard to ensure our waits for first appointment are fairly offered.	Next quarter we will continue to observe the impact of the changes we have made in accordance with the CQC waiting list action plan. We will also be writing to those on the waiting list to ensure support is well signposted, and to GPs to suggest a needs assessment to those waiting to ensure their needs are met, considering the significant wait.

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

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q4	Objective / plan for next Quarter
Adolescent /AYAS	The DNA rate for AYAS patients has been above the 10% cut off throughout the lockdown periods of 2020 /2021 and was below during the Autumn when there were less restrictions. It is understood that the age group of 18 – 25 which is where the majority of our patients are, have been disproportionately impacted on by the pandemic educationally, emotionally and socially. This can have the impact of making it feel harder to reaching out for help and attending appointments, especially when appointments may have moved between remote and in person as required by the lockdown and patients having to self isolate. Patients who DNA are contacted after their appointment to check that they are OK and to remind them of their next appointment.	Having been provided with a list of all patients who DNA'd this quarter, the service manager contacted all clinicians whose patients had DNA's more than once to highlight this. Clinicians were asked to devise an intervention for patients who had missed more than 2, to discuss this with their supervisor and to feed this back to the service manager. In 1 or 2 cases a decision has been made to arrange the end of treatment due to persistent non- attendance. All clinicians contacted have complied with this request. It is also hoped that as the restrictions are eased patients will feel better able to attend their appointments.
Camden CAMHS	The DNA rate has now remained below target levels for over two years. We are pleased that we have been able to maintain this and continue to monitor on an ongoing basis to enable a timely response to any variation. Q4 data evidenced that the DNA compliance remained high with a very slight increase of 0.24%. It is noticeable that whilst the DNA rates have significantly improved as a result of an increase in the remote delivery of clinical sessions throughout the pandemic for most services, AYAS have seen an increase in DNA rates.	Maintain low DNA rate in 21/22 and address any variation in a timely way. Automated text reminders have been turned off during the pandemic due to confusion about face to face and zoom appointments. We are now looking at how we can start using this again in a way that continues to support our low DNA rate. AYAS have developed an intervention plan to reduce DNA rates across the service which is described in the separate commentary.
Other CAMHS	The 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 to enable a timely response to any variation.	Maintain low DNA rate in 21/22 and address any variation in a timely way.

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

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q4	Objective / plan for next Quarter
Adult Complex Needs	For this quarter although we are below the target set of 10% of appointments DNA'd, there is an increase of a few percent above the last quarter, and a significant increase in DNA'd appointments on the same quarter in the previous year. It's clear from the data that the switch to remote sessions has had an impact on attendance and engagement, particularly for patients having group sessions.	As in the last quarter, there is a clear preference for more face to face work with patients, rather than on line remote options, and where possible patients need to be given the choice of having face to face appointments if there are difficulties engaging remotely. A dill down into data will be discussed at the next complex needs executive meeting and a plan for improvement will be discussed.
Portman	Our DNA rate remains steady at around 9%, which is still within the agreed rate of 10%.	There is no indication for any immediate intervention to address DNA rates considering that we are still within agreed parameters, but we will continue to monitor this. The population of the patients we treat, especially those with antisocial personality disorder, are known to be 'hard to reach' and often are difficult to engage and miss appointments, and so our DNA figures are very reasonable.
City and Hackney PCPS	PCPCS are satisfied to see our DNA rate fall below the 10% target set for the Trust, in what continues to be a challenging time for the service and NHS as a whole. Our service's remit is to see hard-to-engage patients in a Primary Care setting and therefore, while the team works hard to keep them to a minimum, 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 vital while face-to-face interaction has been limited.	We firmly believe that patients relate to the whole institution -- not just their allocated clinician – so encourage all members of the team, clinical and administrative, to communicate clearly and in an open and straightforward manner when in contact with patients. Letters and emails are written in a simple, easy to understand way, and we encourage patients to contact us should they have any questions about their appointments and/or treatment. We hope to maintain a similarly low rate going into the next year, and will continue to use the means available to us to sustain patient engagement in their treatment.
TAP	It is unclear what may be affecting this but it is possible that the length of wait for both assessment and treatment may have had an impact.	N/a TAP is being discontinued

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

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q4	Objective / plan for next Quarter
GIC	The DNA trend has remained consistent over the last 3 quarters, however we are clear that we need to have a more strict policy around discharging due to multiple DNAs built into our model.	The DNA policy has been clarified and we are working within admin to ensure we are communicating with patients about being discharged due to multiple DNAs. Clinicians have been informed that they should clinically review any patient who has had multiple DNAs with a view to discharging if there is acceptable clinical risk.
GIDS	DNA appointments have increased against Q3, but are still relatively low compared to the year overall and within the target.	We are currently conducting an audit on DNAs with a view to refreshing our DNA policy. This is part of our action plan, reporting to the CQC on our waiting list management.

3. Quality Priorities

3.1 Quality Priority 1

Quality Priority	1. Standardise the use of Carenotes Alerts to enhance patient safety and communication	Quality Priority
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Complete audit of Carenotes Alerts within each of the clinical directorates (AFS, CYAF and Gender) to clarify current use of Alerts	*An audit has was completed on alerts in CYAF in Q1 and AFS in Q2 and the main uses were identified. It pointed to a reliance on alerts to compensate for issues with Carenotes or as poor practice for storing information. An audit was not been completed in Gender due to limited capacity and anecdotal evidence from the General Manager suggesting their use of alerts is similar to CYAF and AFS. The main themes were communication and risk and safeguarding concerns.*	**Achieved**
Agree parameters for when CareNotes Alerts should be used across the Trust	*Initially the plan was for the North Camden Community CAMHS team to run a QI project in Q1 to develop a protocol for the use of alerts and what the parameters of their use should be and then review across all CYAF teams before taking to AFS and Gender for their input. However the QI project in North Camden was unable to progress due to staff sickness. Therefore, the CYAF and AFS General Manager drafted guidance on the use and review of Carenotes alerts. This included systems for reviewing alerts and auditing compliance.* *This guidance was shared with managers and teams across all directorates in Q3 and agreement was 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, which will be completed in Q1 2021/22.*	**Partially achieved**
Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review	*Starting in Q2, the weekly Divisional Directors meeting included General Managers once a month to ensure consistency across the trust and to monitor progress on the QP's across the directorates.*	**Achieved**
Implement guidance and re-audit across the directorates to assess adherence to the new guidance.	*AFS and CYAF started working to clear all old or inappropriate alerts in Q4. With the exception of the Portman, AFS have now completed this work and a recent audit showed good compliance. The work was slightly delayed in CYAF due to staff sickness but is underway and expected to be completed in late April/early May 2021. The realistic timescale for Gender undertaking this work will be discussed in the next directors meetings as they have a number of competing priorities at present.*	**Partially achieved**

3.2 **Quality Priority 2**

Quality Priority	2 - Experience of Service Questionnaire (ESQ) implementation	Quality Priority
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Evaluate and review Q4 testing and test in 2 Adult and Forensic Services teams, reviewing and adjusting the form following these tests	The themes and feedback were shared by PPI director the Patent Experience Care Quality Sub committee, and at the PPI Trust wide forum.	**Achieved**
Identify and assess methods of streamlining collection of the information and obtain a consensus for delivery across the Trust	The PPI team have been made aware that the trust is exploring the possibility of using 'Qualtrics' a data analysis software that will enable easier delivery. Use of this software was trialled during the year and will be implemented fully in 2021/22 with involvement from clinical team leads.	**Achieved**
Evaluate effectiveness of the new form for increasing ESQ return rates and improving qualitative feedback	Information provided showing effectiveness of form.	**Achieved**
Work with teams to increase use of the ESQ data to improve and develop services	Due to covid there were limited resources for development of the use of data – however the PPI team have compiled data collected, explored themes and fed back to the teams who were able to participate. This information has been shared by the PPI director at EMT.	**Achieved**

3.3 **Quality Priority 3**

Quality Priority	3. Improve Waiting Times Across the Trust	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice	We have now rolled this Quality Priority forward to 21/22 to reflect work which has started on waitlist management in Gender Services.	**Not Achieved**
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)	See above.	**Not Achieved**
Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 & Q4)	See above.	**Not Achieved**

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback	Data collection, systems and software have been discussed in this quarters Board Meeting and one NED has challenged the staff teams to think with him about improving our data performance as a group exercise. This proved fruitful in bringing together and having a shared understanding of our strengths and weaknesses in relation to data reporting and application. At Q4 we have a more sophisticated and integrated understanding of the co-dependencies between the data gathering software (Qualtrics or other), the EPRS (Care Notes) and what software or human resource we need to convert raw data into meaningful statistics with clinical and organisational application. Our EPRS provider has agreed to enable the integration of data with CareNotes records from the autumn 2021.	**Partially achieved**
Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications	The CYAF & AFS General Manager has set up an OM group to systematically work through the Carenotes challenges with colleagues from data quality. He will also be adding CORE compliance and ESQ returns at a team level to the AFS dashboard (the CYAF dashboard already includes their OM data but ESQ will be added there too). The trust continues to trial Qualtrics, a data gathering software solution, and we will roll out using it to collect ESQ data across the Trust in Q1 and CORE OM in Adult complex needs in 2021/22. We will continue to report back on progress. It must be recognised that most of CYAF's mandated measures are not patient completed so they can't be completed via Qualtrics so more would need to be done to increase returns of clinician reported outcome measures GBM's and CGAS.	**Partially achieved**
To develop a robust and standardised system of user friendly reminders and follow up on missing OM through the EPR and team level reporting	Results of the quality Improvement project on use of Qualtrics to collect OM has been fed back to the Adult Complex Needs service as part of our plan to create a feedback loop between governance initiatives, staff doing front line clinical work and informatics/data quality. The aim of such QI projects has been to generate a better understanding of the value and applications of patient data and create stronger interest in its value. Some colleagues have continued to feedback their caution of using 'instruments' i.e. OM type tools / questionnaires as it can detract from the clinical & emotional focus, however it is an ever growing reality that external bodies, not least within the commissioning sphere as well as partner agencies expect some output that demonstrates impact and efficacy. Some our improvement figures e.g. CORE in AFS suggest good improvement rates but the sample is low which means our data is not as reliable as we need. There is also thought to adapt the use of OMs to the population served, e.g. the Trauma service has started a QI project on using measures specific to PTSD (such as the impact of Events Scale and others).	**Partially achieved**
To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures	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 design and apply more widespread Qualtrics electronic OM and patient level data communications to capture and improve on current returns rates.	**Partially achieved**

Section Five: Trust Targets – KPI

See Slide 11 for complaints graphical representation

Quality Key Performance Indicators										
Target	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	98% 44/45				
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	63% 7/11				
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	100%	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	Annual report to 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	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	7 outstanding complaints. Delays due to not being able to complete investigations due to COVID 19				
ii) Number of complaints reported to CQC	Quarterly	n/a	none	none	none	none				
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	none	none	none	none				
iv) Number of re-opened complaints.	Quarterly	n/a	none	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%	2.39%				
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q4	n/a				Microsoft Word Document				
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		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					Annual Report for 2020/21 to be provided Q1 2021/22				
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		See attached clinical audit paper Microsoft Word Document				

Section Five: Trust Targets – KPI

See Slide 13 on HR for graphical representation

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target	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%	31%				
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%		0.50%	1.5%	1.3%				
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%	70%				
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%	95%				
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 Q4 20/21	RAG Progress Q1	Q2	Q3	Q4
CAMHS Transformation Targets Run for London Contracts only	80% initial completed care plans	Q1-Q4	80%	**Q4 compliance 54% compliance (48% in Q3)** 147 assessment summaries were completed, out of those 79 initial care plans were created We have clarified that team administrators continue to send information regarding missing care plans to their teams as set by the CYAF data schedule, and that there are wide differences across the teams with care plan compliance. Where team managers closely monitor completion rates and support staff to self-manage their caseloads, compliance rates are higher. To make this process easier for team managers, a new report is being designed to simplify access to meaningful data. We are also considering ways to improve clinician and trainee capacity to self-monitor their caseloads to improve compliance in this area, such as through training and improving feedback mechanisms.				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	**Q4 compliance 31% compliance (30% in Q3)** 189 Assessment Summaries completed, of those, there were 59 Review Care Plans created/shared . The percentage of those care plans completed with in 6 months of the initial Assessment Summary was 6% 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 Q4 there were 27 responses from CYAF patients to the ESQ question 7: *'I feel that the people who have seen me are working together to help me'*. Of these 27responses, 22 patients answered 'certainly true' and 3 answered 'partly true' **giving a compliance rate of 92.59%** We are pleased that we consistently deliver on this target. However, we are exploring ways to increase the rate of completion of ESQ's across the trust with a revised shortened format in the hope of increasing the volume of feedback received. This may include automating the distribution of ESQ's electronically to remove the burden on clinicians and ensure all service users have the opportunity to provide feedback at regular intervals.				

Data source: 09/04/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Section Five: Trust Targets – KPI – London Contracts

See Slide 15 for OM graphical representation

Target	Detail of indicator	End of Year Target %	% Progress Q4 20/21	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%	**Q4 compliance 38% compliance (37% in Q3) -- 61 GBM T1's out of 162 due in period were completed** The CYAF Service Manager worked with the Quality Team, AYAS and the Family Mental Health Team in Q4 to re-design the logic for GBM's to appear in the assist panel. This moved from them appearing when they were contractually due to them being available at all times, allowing clinical staff greater flexibility and the ability complete a GBM according to patient need. Although overall compliance remains low there are some improvements in the completion rates for T1 in AYAS and FMHT and our intention to roll out the new logic to all of our clinical teams in CYAF with the goal of improving compliance for Q1 in relation to the completion rate for T1 GBM. In addition, there is work taking place across AFS and CYAF to explore digital ways of capturing OM data to improve compliance. This will potentially also enable the data collection to be service user led and enable a move away from paper based approaches to data capture which are needed as a result of the remote delivery of service through the pandemic.				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q4 compliance 65% compliance (63% in Q3) -- 101 CGAS T1's out of 156 due in period were completed** CGAS compliance has remained consistent for T1 throughout Q4 compared with Q3. We recognise that this has been an ongoing issue throughout 20/21 and we will work with the teams to support quality improvement projects and share learning across the directorate to improve our compliance in this area throughout 21/22.				
	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%	**Q4 compliance 38% compliance (37% in Q3) -- 61 GBM T1's out of 162 due in period were completed** The CYAF Service Manager worked with the Quality Team and AYAS and the Family Mental Health Team in Q4 to re-design the logic for GBM's to appear in the assist panel. This moved from them appearing when they were contractually due to them being available at all times, allowing clinical staff greater flexibility and the ability complete a GBM according to patient need. Although compliance is low we have noticed improvements in the completion rates for T2 in AYAS and FMHT and our intention to roll out the new logic to all of our clinical teams in CYAF with the goal of improving compliance for Q1 in relation to the completion rate for T2 GBM. In the teams who tested the new logic we have seen an increment on completion rates, especially noticeable in FMH GBM T2. In addition, there is work taking place across AFS and CYAF to explore digital ways of capturing OM data to improve compliance. This will enable the data collection to be service user led and enable a move away from paper based approaches to data capture which are needed as a result of the remote delivery of service through the pandemic.				
	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%	**Q4 compliance 46% compliance (50% in Q3) -- 57 CGAS T2's out of 57 due in period were completed** CGAS compliance has reduced slightly for T2 throughout Q4 compared with Q3. We recognise that the low rate of matched pair compliance this has been an ongoing issue throughout 20/21 and we will work with the teams to support quality improvement projects and share learning across the directorate to improve our compliance in this area throughout 21/22. South Camden CAMHS have identified a resource within the team to begin a QI project within the team in Q1 21/22.				

Data source: 09/04/2021 SRRS (Internal Reporting System) Reported by the Quality Team

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	

Clinical Thematic Case Review

Executive Summary

Knife Crime and Vulnerable Adolescents

The Board is asked to note the following thematic case review into knife crime and gang related violence and vulnerable adults.

The Trust agreed to conduct this review in agreement with our local Camden commissioners and has been shared accordingly.

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
Associate Medical Director	Medical Director

Knife Crime and Vulnerable Adolescents

Introduction

This review sets out to look at four incidents concerning young people all of whom were involved in knife crime and/or were stabbed/seriously injured in the context of gang violence. Sadly, in one case the young person died. There would appear to have been links between some of the young people involved.

Originally the format of the review had been to include external stakeholders but due to the Covid 19 pandemic this has not been possible. It is important to state that this review is therefore limited in scope. It is not an investigation or a reinvestigation of individual incidents rather the purpose within the revised terms is primarily to provide information and to consider the findings alongside three recently published reports. These include an analysis of statutory reviews of homicides and violent incidents, a thematic review of a case series of sixty vulnerable adolescents and a published taskforce report on youth safety. It is envisaged that learning from the case notes review and the published reports will be presented internally at a Trust interdisciplinary forum.

Young people and knife crime: recent statistics

Evidence suggests that the peak age for carrying a knife is 14-15 years

(Serious Violence Strategy, 2018).

Increasing numbers of children (10-17 years) have been given official warnings for/or been convicted of knife and offensive weapons offences. In 2019, 4547 children, aged 10-17 years, in England and Wales, received an official warning or conviction for knife and offensive weapons offences (in 2013 the figure was 2692), (MoJ, 12 March 2020).

In 2019, in England and Wales, 2723 cases of knife crime and offensive weapons offences, involving children who were aged 10-17 years resulted in immediate custody (526) a community sentence (2190) or a fine (down from 2,863 in 2018). (MoJ, 12 March 2020).

In the year ending March 2020, 256 people (all ages) were stabbed to death in England and Wales (ONS, 17 July 2020).

The government is funding Violence Reduction Units (VRU's) across the country to prevent serious violence through multiagency partnerships working together to understand the root causes of violence. VRUs will build on a public health approach to tackling violence and violent crime. (https://www.gov.uk/government/collections/violence-reduction-unit).

Format of review

The following three published reports were considered and have been summarised in the next section:

1. Analysis of statutory reviews of homicides and violent incidents: A report commissioned by the Mayor of London's Violence Reduction Unit. January 2020: https://www.scie.org.uk/safeguarding/reviews-of-homicides/london-2020;

2. Vulnerable Adolescents Thematic Review, Croydon Safeguarding Children Board. February 2019: https://croydonlcsb.org.uk/wp-content/uploads/2019/02/CSCB-Vulnerable-Adolescent-Thematic-Review-PUBLISHED-Feb-2019.pdf; This Thematic Review is based on the analysis of information pertaining to sixty individual young people.

3. Youth Safety Taskforce Report 2018 Camden Council (https://www.camden.gov.uk/documents/20142/0/download+%288%29.pdf/3b1a64e6-31db-01cc-c7c9-4d04b5450bc6. The Youth Safety Taskforce Report is not based on individual case reviews but its strength is that it includes primary research with young people.

Four sets of case notes were reviewed along with the corresponding concise review reports all of which were discussed at the Trust Incident Panel chaired by the Medical Director. A summary of each case is presented but the written narrative is restricted in order to ensure that none of the young people is identifiable given the small number. Risk factors identified in the three published reports including adverse childhood experiences are mapped for each set of notes – see table below.

Limitations of this review are discussed and recommendations made for learning.

Analysis of statutory reviews of homicides and violent incidents: A report commissioned by the Mayor of London's Violence Reduction Unit. January 2020

This report is a thematic review of homicides and violent incidents across London, commissioned by the Violence Reduction Unit (VRU) of the Mayor of London's Office. The purpose of the review was to look at underlying causal factors and common patterns. The findings on youth peer violence are of particular note and will be summarised briefly.

The review includes all cases of homicide and nonfatal violence in London meeting the criteria for either a Domestic Homicide Review, Independent Investigation Report (formerly Mental Health Homicide Reviews), Serious Case Review (now called Child Safeguarding Practice Review) or Safeguarding Adult Review published since 2016. The report looked at total of 64 reviews published in the last three years in London including youth peer violence in the 10–25-year-old age group.

The report highlights that the quality of learning across agencies is insufficient in supporting an understanding of the causes and patterns of serious youth violence in particular.

One of the key recommendations of the report is that "The VRU should continue its approach of addressing adverse childhood experiences (ACEs), alongside a focus on contextual and resilience factors, as a means of tackling serious youth violence (Recommendation 3 Page 3)"

The report highlights that addressing violence should be part of the 'core business' of a wide range of agencies including health, mental health, police , children's social care and others.

The report documented the contextual factors experienced by victims of youth violence: at home (including neglect/abuse, bullying, lack of parental capacity to safeguard, breakdown of parent-child relationships); in the wider family (lack of support networks, abuse by other family members); in peer groups (including being involved in offending behaviour and gang activity); at school. (including exposure to gang-affiliated young people and school exclusion) and in the local neighbourhood (including gang related activity)

The most commonly occurring victim characteristics in the eight youth peer violence reviews (8 homicides and suicides grouped together, age range 13 years-25 years) were absent parent, abuse or neglect as a child, experiencing domestic abuse, mental health difficulties and substance misuse problems .

Analysis of the youth peer violence reviews found that young people were exposed to multiple risks and that these were exacerbated by lack of single agency oversight. Adolescent risks particularly in relation to offending behaviour were often not seen within a safeguarding context so young people could be known by YOS for example but not necessarily to Children's Social Care.

The report identified key recurrent issues in relation to youth peer violence: understanding adolescent safeguarding and how multi-agency partners can be more effective by taking a contextual safeguarding approach;

the need for holistic assessments including consideration of the impact of early trauma; responses to missing young people; the role of schools as a protective factor but also recognising that schools could provide young people with a context in which to meet others involved in gang affiliated/gang related behaviour; strengthening responses to domestic abuse and safeguarding children within domestic abuse environments.

Vulnerable Adolescents Thematic Review, Croydon Safeguarding Children Board. February 2019

This thematic review of 60 cases (23 females, 37 males) of vulnerable adolescents who either had evidence of poor outcomes or who were of considerable concern had as a central focus identifying any patterns in the young people's experiences which could inform and improve future planning.

Five of the sixty young people had died. Black males of Caribbean heritage and white females of British heritage were the two largest groups in the cohort. 71.67% of the young people were identified as being from BAME backgrounds.

This thematic review set out to understand the cohort – who they were and what happened in their lives and what could be learned from their experiences. The information gathered about this cohort of young people involved multiple agencies reviewing and learning together.

The summary chapter of the review details the main findings:

- Young people in the cohort had been known to agencies early. More than 50% of the young people in the cohort were known to Children's Services before the age of 5 years and nearly 75% of the known by the age of 12 years

- 5 young people were deceased (3 died of stab wounds, 1 died following a crash and 1 died following ingestion of a highly toxic drug)

- Initial concerns were addressed through short term interventions but there was a lack of appreciation of underlying trauma or of presence or multiple adverse childhood experiences (ACEs).

- Many children continued to come to the attention of Children's Services;

- At age 14 there was a peak of young people in the cohort coming into care. The review suggested that the young people's situations had deteriorated and interventions that had been provided up to then had been unsuccessful.

- There was evidence of a range of parental factors, such as absent parents, substance misuse, mental health problems, parental criminality and domestic abuse.

- For some in cohort their aggressive and disruptive behaviour throughout primary school remained of concern. 19 of the cohort received fixed term exclusions in primary school. All 19 of those children subsequently received criminal convictions.

- For many there was poor transition between primary and secondary school and deteriorating behaviour throughout secondary school. More than 50% of the young people in the cohort received exclusions, managed moves, and placements in pupil referral units or alternative education provision.

- Behaviour had to get worse to be able to access some services. The impact of trauma not addressed.

- Multi-agency response was reactive and agencies struggled to effectively engage families to keep children safe.

- More than 75% of the young people in the cohort were frequently reported missing (included 100% of the girls). Average number of missing episodes/young person was 16.

- 55% (33) of the cohort had links to known gangs/gang associates.

- 14 males were victims of knife crime, 38% of the male cohort. 39 young people (65%) (9 females, 30 males) were themselves suspected of committing knife crime.

- Of the 60 children, 44 (73%) were known to the Youth Offending Service.

- 50/60 (83%) of the young people had either police cautions, criminal convictions or both.

- 22 (37%) of the cohort were exposed to Child Sexual Exploitation (CSE). 16 (27%) of the cohort were exposed to Child Criminal Exploitation (CCE) and 4 (7%) were exposed to both CSE and CCE.

- 42 (70%) were referred to CAMHS for help. 16/23 females, 26/37 males. The youngest referral was at age 4 and the eldest at age 17.

- There was no formal mental health diagnosis in 18/42 and in the remained a mixture of ADHD/conduct disorder/emotional disorder suggesting underlying psychosocial vulnerability factors rather than the severity of mental health problems alone. There was variable length of contact with CAMHS and problems with lack of engagement.

- 15 of the young people in the cohort had Education Health and Care Plans (EHCPs) predominately for behavioural related disorders. A link is suggested between these 15 young people and an increase in their risk-taking behaviour during their teenage years.

- On 31 January 2019, 23/60 children (38%) were held in either prison, YOI, or Secure Units. 5 children (8%) remained looked after in foster care or in a children's home. 12 children (20%) had and moved to independent types of accommodation and 17% (6 females and 4 males) had moved to fully independent accommodation. 14 of the cohort (23%) were living with their families.

This thematic review identified five key multi-agency findings to inform future service developments:

Finding 1. Early help and prevention is critical

Finding 2: Greater recognition of, and response to, children's emotional health and wellbeing is needed.

Finding 3: An integrated, whole systems approach, is needed across agencies, communities and families.

Finding 4: Schools should be at the heart of multi-agency intervention.

Finding 5. Disproportionality, linked to ethnicity, gender and deprivation, requires attention and action.

Recommendations (total of 15 recommendations) were made in relation to each finding.

Youth Safety Taskforce Report 2018 Camden Council

This taskforce was set up in December 2017 as a response to a significant increase in youth violence in the Borough of Camden in the previous year. The aim of the taskforce was to understand the underlying causes of youth violence in the borough and to determine what more could be done to keep young people safe. There was extensive engagement with young people, their families and communities as well as with professionals in statutory and the voluntary sectors.

The taskforce evidence was underpinned by a literature review and responses to three main questions: Why do some young people carry knives, what are the main causes of youth violence and what can be done to address the problem?

Risk Factors identified in the report i.e. for young people becoming involved in gang and youth violence:

- Poor school attendance and school exclusions
- Lack of things to do
- Lack of employment opportunities
- Lack of trusted relationships
- Need to make money makes involvement in gangs and drugs attractive
- Negative view of police
- Stop and search practice – young black men feeling they are disproportionately and unfairly targeted.
- Parents fearing involvement of Social Services if they ask for help, worry about being stigmatised as a bad parent
- Gap in support or provision for those over 18-25 years old.

- Youth violence as a broad public health issue , not just a law and order issue
- Transition from primary to secondary school recognised as a time of increased vulnerability to involvement in youth violence
- Fear is a key factor as to why some young people carry knives.
- Boys in particular are groomed into gangs and the drug trade from an early age
- Young people affected by youth violence are likely to have suffered early childhood trauma.
- Young offenders are often also victims

The taskforce developed 17 recommendations under 5 themes - Prevent, Identify, Support, Disrupt and Enforce taken up by all relevant partners and communities in the borough and turned into actions.

Case notes reviews

A balance has to be struck between ensuring that enough detail is presented to give a context and meaning to the information that emerges while at the same time ensuring that none of the young people is in any way identifiable.

Case 1. 16-year-old male.

This young person was convicted of grievous bodily harm having stabbed another young person causing very serious injuries. There was multiagency involvement at the time of the incident including Children's Safeguarding, YOS and Police. The young person was subject to a Child Protection Plan at the time of the stabbing (emotional abuse). There was long standing involvement of Children's Social Care with his family.

This young person witnessed domestic violence and abuse over lengthy period and he had also been assaulted by a relative.

The young person's living arrangements were unstable and he moved between family/extended family/friends. It is recorded that there was non-cooperation by family with a range of services.

The young person had been excluded from school because of violence and anti-social behaviour. There was an account of escalating violence and involvement with gangs and knife crime. There were possible links with county lines. The young person was a victim of serious assault (knife crime) several months before he caused very serious injuries to another young person.

A younger sibling was also thought to be involved in knife crime.

The young person had been referred to CAMHS following an episode of deliberate self-harm and he was assessed as being depressed at the time of the first appointment. An account of past suicide attempts emerged at that time.

There was subsequently persistent non-engagement with CAMHS by both the young person and his parent and the case was closed several months after initial referral and prior to the incident of grievous bodily harm.

Case 2. 15-year-old male

This young person was accused of stabbing another young person who sustained non-life-threatening injuries. He received a YOS order following this incident.

There were broad concerns that the young person was linked to antisocial and gang-related activity and that he was at high risk of criminal exploitation and serious youth violence. There had been a prior allegation of assault with a knife. There were difficulties in accessing support in relation to gang involvement which then became available following a YOS order.

There was a history of school exclusion and of repeatedly going missing – possibly involved in county lines. Several months after the stabbing incident the young person's friend was fatally stabbed.

There was early adversity and significant trauma related to domestic violence.

This young person was known to CAMHS for several years. There was ongoing involvement and monitoring of medication.

Case 3 .17-year-old male

This young person was shot and stabbed by a group of males known to be gang involved. The young person was not known to be involved with gangs. He had known another young person who was fatally stabbed a few months before the incident described.

There was an account of possible subsequent involvement in knife crime and he was at risk of gang involvement and being a victim of gang violence. There was a history of violence to property. The young person was subject to a Child Protection Plan and a Child Criminal Exploitation Plan.

There was clear evidence of early and significant social adversity. There was a history of domestic violence, parental substance misuse and incarceration. Children's Social Care had been involved with the family throughout the young person's life.

His attendance at school/college fluctuated.

He had been referred to CAMHS in early teenage years with a history of low mood and repeated overdoses. He was being treated for depression.

Case 4. 16-year-old male

This young person was stabbed to death.

He was known to two of the young people discussed above.

He had been known to CAMHS but the case had been closed a few years previously. He had been referred because of anger and aggression at school and home. His behaviour improved during the time he was being seen.

The information available in the case notes is therefore only until the time of case closure. Prior to the CAMHS referral the young person had been known to YOS following a physical altercation in the street. The young person had previously been subject to a Child Protection Plan because of domestic violence and violence to the young person.

It was evident following contact with agencies after the young person's death that there were gaps in knowledge about previous agency input. The young person had moved a number of times and it would seem that not all prior agency input was known or handed over.

Mapping relevant factors

Factors	Case 1	Case 2	Case 3	Case 4
Gender	M	M	M	M
Age at time of reported incident	16	15.5	17	16
Ethnicity	Black British	Mixed	White British	White/Black Caribbean
Multi-agency involvement at time of incident	Y	Y	Y	Y
History of self-harm	Y.	N	Y	n/k
Mental health diagnosis	Depression, Conduct Disorder	ADHD Post trauma	Low mood	No formal diagnosis
Poor educational outcomes	Yes	Initially, then improved	Fluctuating attendance	Yes
Bereavement	Not known	Yes	Yes	Not known
County Lines/Gang involvement	Likely	Vulnerable to exploitation	Vulnerable to exploitation	Not at time case open to CAMHS – became gang involved
Abuse (ACE)	Y	Y	Y	n/k
Neglect (ACE)			Y	
Household Mental Illness (ACE)	n/k	n/k	Y	Y
Household Incarceration(ACE)			Y	
Domestic violence (ACE)	Y	Y	Y	Y

Household Substance Misuse (ACE)	n/k	n/k	Y	n/k
Divorce/Separation / Absent parent(ACE)	Y	Y	Y	Y

Adverse Childhood Experiences (ACEs)

ACEs are experiences that occur during childhood that directly hurt or harm a child/young person or affect them through the environmental context in which they grow up. ACEs can have a detrimental effect on all areas of health and development and are also linked to adult health behaviours and outcomes (Bellis, 2013).

Adverse Childhood Experiences
Parental Separation
Household Domestic Violence
Household Mental Illness
Household Drug Misuse
Household Alcohol Misuse
Household Member incarcerated
Physical Neglect
Emotional Abuse and Neglect
Physical Abuse
Verbal Abuse
Sexual Abuse

Comment on mapping and findings

As only 4 case notes from one organisation were reviewed robust statements cannot be made about the findings. General statements can be made and linked to other reports.

All the young people were males. There was evidence of a number of adverse childhood experiences particularly domestic violence as well as parental divorce/separation in each case. All young people were involved in youth peer violence/knife crime and they were known to several agencies. School was unstable. There was evidence of contextual risk factors across home, peer group, school and neighbourhood (this was less well evidenced in the case notes but one young person, for example, was afraid to be seen in Clinic A preferring Clinic B for safety reasons). It was striking that in this small group one young person was separately known to two others. Several of these findings were also identified in groups having poor outcomes in both the Analysis of statutory reviews of homicides and violent incidences

https://www.scie.org.uk/safeguarding/reviews-of-homicides/london-2020;) and in the Vulnerable Adolescents Thematic Review

(https://croydonlcsb.org.uk/wp-content/uploads/2019/02/CSCB-Vulnerable-Adolescent-Thematic-Review-PUBLISHED-Feb-2019.pdf;

Recommendations for Trust learning

The main recommendation for learning is that there should be an overarching theme of exploring the relationship between youth peer violence and young people's mental health with the aim of increasing knowledge and skills within teams. (PHE, Jan 2015). This is likely to be facilitated by a rolling programme of learning to include:

- Trust wide learning on the relationship between youth peer violence and mental health and on how Trust services can support gang-involved youth, or those at risk of exploitation from gangs.

- Increasing knowledge about and awareness of the key factors to consider when seeing young people involved in knife crime/youth peer violence.

- Enhance understanding of safeguarding during adolescence and greater recognition of peer violence between young people as a form of abuse.

- Identify opportunities to collaborate with other agencies in a learning forum

- Consideration of ACEs. – looking at each young person's life and circumstances. Review training on Adverse Childhood Experiences and use of ACE-Questionnaire. (Finkelhor, D., 2018).

- Review cases of youth peer violence once every 2 years

- Increasing clinician's knowledge and awareness of link between range of risk factors related to knife crime/youth peer violence.

- Enhance clinician's knowledge of contextual safeguarding i.e. an approach to safeguarding children and young people by understanding and responding to a child/young person in the context of their environment (Working Together 2018).

Limitations of this review.

This is a review of four cases, one of which had been closed to the service for more than 2 years and for which the service did not have information on any antecedents.

Information was obtained from Trust case notes only, not from multiple sources which would have added much more to the narrative about these young people.

The families and other agencies were not involved in the preparation of this report. The findings can be considered in relation to the published reports described and to others but the case sample is too small to generalise the findings.

Conclusion

No one organisation can draw up themes and identify opportunities for prevention/early intervention in youth peer violence. This is a very large task and if it is to be done thoroughly it would require a multiagency audit.

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The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	

Serious Incidents – Quarterly Report – Q4 2020-21

Executive Summary

This quarterly serious incident summary report for the Board covers Q4 2020-21.

Clinical Incidents

During Q4 there were 27 clinical incidents reported including four patient deaths and two serious incidents investigations, one internal and one external. The reported incidents included patient deaths, patients in crisis, safeguarding, appointments, access to treatment, waiting times and IT & IG incidents.

The first serious incident investigation involves a patient death, whereby the Learning Disability service was informed that one of their patient had taken his own life early in March 2021. This incident is being investigated with an internal concise report which is due to be reviewed at the April Incident Panel.

The second serious incident investigation involves a young person who was arrested for breaching their bail conditions and whilst in custody revealed their involvement with a fatality. This incident has been logged externally on StEIS and an investigator has been appointed to undertake this work, which will be reviewed by the May or June Incident panel.

Of the 27 reported incidents, 15 reached the threshold for review at the monthly incident panels including the below 4 x patient deaths:

A TAP service patient suffered a cardiac arrest and died in the Royal Free Hospital. After review there was no further action required.

A relative called City and Hackney reception to inform that the patient died of what is believed to be Covid-19. We are awaiting the mortality review to be sent to incident panel for discussion.

The Lifespan team has been informed that a young patient took his own life. A concise report was completed and will be discussed at the incident panel in April 2021. It was agreed that Hertfordshire CAMHS will lead the main investigation and will report externally on STEIS.

There is one mortality review is due to come to the April incident panel which will be reported on further in Q1, 2021-22.

Learning from incidents
Although there were no lessons learned events during Q4, there are more being planned for Q1 2021/22. However, over the year there has been numerous events, as evidence below to encourage and share learning and good practice, with the new approach of online learning enabling greater remote attendance. Topics for learning over the year have included:

The role of the Coroner, giving evidence at Coroner's Court and supporting those in such circumstances – delivered 4th February 2020
National reports have in recent years repeatedly called for additional support for staff involved in serious incidents, which may include involvement with inquests and attending Coroner's Court. This learning lessons event included a presentation on the role of the coroner, giving evidence at Coroner's Court and supporting those in such circumstances. Learning was linked to a serious incident investigation.

Gang-related violence, knife crime and county lines – delivered 18th June 2020
There have been a number of serious incidents over the last year linked to gang related violence, knife crime and county lines. These issues are of serious concern in the local area at present, as well as

nationally, and affect many young people seen in the Trust. This event was an opportunity to hear about some of these cases, to share the learning and to think together about how we can best support young people in these situations. This was an opportunity to discuss challenges in clinical practice and participants benefitted from being in a multi-disciplinary forum to maximise learning.

Infection Prevention and Control (IPC) – delivered on 15th October 2020
Infection Prevention and Control (IPC) occupies a unique position in the field of patient safety and quality since it is relevant to healthcare staff and patients at every single health care encounter. The current Covid-19 pandemic underscores this reality, as we recognise that strict infection prevention and control practice in our workplaces is essential in order to stop the development or further spread of infection. This learning lessons event will be an opportunity to learn from other organisations who had recent outbreaks, hear from Trust staff members about the impact of IPC on clinical practice and who have been engaged in IPC work. It will be a forum to consider the ways we are likely to work in the foreseeable future and learn lessons.

Adult Safeguarding – delivered on 3rd November 2020
This will be an opportunity to discuss key issues in adult safeguarding practice linked to case presentations.

Suicide Prevention – delivered on 2nd December 2020
This event will discuss recent evidence and guidance on suicide prevention including around Covid-19. The presentation will draw particularly on the resources available from University of Manchester, National Confidential Inquiry into Suicide and Safety in Mental Health.

All relevant services continue to feed into the work around the action plans identified in the 2018 CQC inspection, and these action plans are regularly monitored by the Executive Management Team.

Identified learning via the Incident Panel
The following are learning lessons from incidents discussed at the incident panel in Q4 2020-21:

Incident Panel	Lessons Learned
February 2021 Incident Panel	Ensuring adequate time to check through detailed communication. Consider ways in which existing systems might compliment work and reduce opportunities for administrative errors, e.g., by utilising care notes letter auto populate
	GIDS service: information about accessing support in an emergency is now included in automatic out of office hours email replies.
March 2021 Incident Panel	Clarify escalation routes for agreement to local capacity management decisions, so risk across the service can be assessed, monitored and addressed. Need to progress GIDS Transformation Programme actions, particularly in relation to staff recruitment and retention and capacity management.

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

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	

Annual Serious Incidents Report – 2020-21

Executive Summary

Clinical Incidents 2020-21
This report summarises the annual clinical incidents reported during 2020-21. There were 96 clinical incidents reported across the Trust, some of which had an information governance (IG) and clinical element so those incidents were reviewed by both teams in IG and clinical governance. The annual report does not include five incidents previously recorded in Q1, which have now been removed via the IG team upon their review, so the final report records 96 clinical incidents overall for 2020/21, where our quarterly reports below shows the originally recorded 101 clinical incidents.

Quarterly overview
During Q1 there were 22 clinical incidents, one of which was logged externally on STEIS and subsequently de-escalated with agreement from our commissioners. During Q2 there were 24 incidents, and again, one was logged externally on STEIS and subsequently de-escalated with agreement from our commissioners. During Q3 there were 28 incidents, which included one serious investigation, which has been investigated and the final report with action plan is now with our commissioners. Finally, during Q4 there were 27 clinical incidents, one of which was a fatality, resulting in a serious incident investigation, which is currently underway.

Learning from incidents
During 2020/21 there have been numerous lessons learned events, which have been provided via online platforms. This new approach has enabled and increased greater staff remote attendance and topics for shared learning this year included the below:

Gang-related violence, knife crime and county lines – delivered 18th June 2020
There have been a number of serious incidents over the last year linked to gang related violence, knife crime and county lines. These issues are of serious concern in the local area at present, as well as nationally, and affect many young people seen in the Trust. This event was an opportunity to hear about some of these cases, to share the learning and to think together about how we can best support young people in these situations. This was an opportunity to discuss challenges in clinical practice and participants benefitted from being in a multi-disciplinary forum to maximise learning.

Infection Prevention and Control (IPC) – delivered on 15th October 2020
Infection Prevention and Control (IPC) occupies a unique position in the field of patient safety and quality since it is relevant to healthcare staff and patients at every single health care encounter. The current Covid-19 pandemic underscores this reality, as we recognise that strict infection prevention and control practice in our workplaces is essential in order to stop the development or further spread of infection. This learning lessons event was an opportunity to learn from other organisations who had experienced outbreaks, hear from Trust staff members about the impact of IPC on clinical practice and who have been engaged in IPC work. It was also a forum to consider the ways we are likely to work in the foreseeable future and learn lessons.

Adult Safeguarding – delivered on 3rd November 2020
This was an opportunity to discuss key issues in adult safeguarding practice linked to case presentations.

Suicide Prevention – delivered on 2nd December 2020
This event discussed recent evidence and guidance on suicide prevention including around Covid-19. The presentation drew particularly on the resources available from University of Manchester, National Confidential Inquiry into Suicide and Safety in Mental Health.

All relevant services continue to feed into the work around the action plans identified in the 2018 CQC inspection, and these action plans are regularly monitored by the Executive Management Team.

Identified learning via the Incident Panel
During 2020-21 the following are learning lessons that were identified from the incidents reviewed during the year at the incident panel:

October 2020 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 2020 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 2020 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.

February 2021 Incident Panel
- Ensuring adequate time to check through detailed communication. Consider ways in which existing systems might compliment work and reduce opportunities for administrative errors, e.g., by utilising carenotes letter auto populate
- GIDS service: information about accessing support in an emergency is now included in automatic out of office hours email replies.

March 2021 Incident Panel
- Clarify escalation routes for agreement to local capacity management decisions, so risk across the service can be assessed, monitored and addressed. Need to progress GIDS Transformation Programme actions, particularly in relation to staff recruitment and retention and capacity management.

Thematic Case Review
Dr Caroline McKenna completed the thematic review in relation to gang violence in early 2021 and this has been submitted to the Camden commissioners, Commissioning Support Unit and the Trust Board. Two of our previously investigated incidents, which were included in this thematic review, will now have an action plan developed, based on the findings from this thematic review.

There are no areas of concern around the clinical incidents identified and managed during 2020-21.

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

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 14 January 2021

Key items to note

The committee met and had good attendance at this last meeting. Since the last meeting of the committee, Craig de Sousa, director of HR and corporate governance has gone on secondment to the national covid vaccination programme. The committee welcomed Sheila Cunliffe, interim director of HR.

As part of the agenda the following items are highlights for the board of directors:

EDI champions

Each CYAF team now has a nominated EDI champion, including GIDs. Their role is to highlight EDI issues within their team.

Disability and long-term health conditions staff network

Karen Merchant and Irene Henderson have a plan in place to launch the Trust's new disability and long-term health conditions staff network around mid-February 2021.

QI projects

AFS has an active QI project looking at intake and diversity in terms of the service given. Tim Kent noted that Professor Frank Keating from Royal Holloway has been invited to talk to AFS staff about black men and mental health.

DET update

In response to Black Lives Matter, DET ran 2 thinking space events for students, which were well attended. A programme of thinking space events has also been put in place for 2021.

Race equality network

The race equality network and race equality network allies group are going well. Main point of discussion was covid-19 vaccinations.

Actions required of the Board of Directors

None

Report from	Prof Dinesh Bhugra, Committee Chair
Report author	Karen Merchant, interim Head of HR Business Services
Date of next meeting	29 April 2021

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	18 May 2021

Equality, Diversity and Inclusion Annual Report

Executive Summary

This report summarises the actions taken by the EDI committee throughout 2020. It also summarises patient-related data in relation to equality, diversity and inclusion.

This report fulfils the Trust's statutory requirements under the Equality Act 2010 (Specific Duties) Regulations 2011.

This report relates to the activities spanning the period January 2020 – December 2020.

Recommendation to the Board

Members of the board of directors are asked to note this report.

Trust strategic objectives supported by this paper

People and Services

Author	Responsible Executive Director
Interim Head of HR Business Services	Director of HR

Equality, Diversity and Inclusion
Annual Report

1. Introduction

This report summarises the actions taken by the EDI committee throughout 2020. It also summarises patient-related data in relation to equality, diversity and inclusion.

This report fulfils the Trust's statutory requirements under the Equality Act 2010 (Specific Duties) Regulations 2011.

This report relates to the activities spanning the period January 2020 – December 2020.

2. The work of the equality, diversity and inclusion (EDI) committee

The Trust has an established EDI committee which has continued to exist throughout 2020 and is chaired by Professor Dinesh Bhugra. The committee reports its activities to the board of directors.

Throughout the year, the committee has continued to meet and there have been four formal meetings of the committee.

3. Committee changes in year

In the last year we saw a number of changes to the committee in terms of how it manages its business and the membership. The following summarises the changes to date:

- In January 2020, the committee approved the revised terms of reference, with the addition of a council of governor member.

- In November 2020, Glenn Gossling joined the committee as the communications representative.

- In November 2020, Craig de Sousa went on secondment to the national covid vaccination programme. Ian Tegerdine is attending the committee as interim director of HR.

- The committee continues to invite individuals with specialist areas of expertise to attend (in 2020, this included Dan Sumpton, who was freedom to speak up guardian at the time and Rhia Gohel, physical health specialist practitioner).

- In November 2020, the committee agreed to extend its meetings to 2 hours per meeting.

4. Review of effectiveness

The committee continues to run effectively and reports its activities to the board of directors. This link keeps the board sighted on the work being undertaken by the committee and maintains oversight of progress on its plans and challenges that are emerging.

In September 2020, a standard reporting template was introduced so that the various sub-groups could report their activities in a consistent format. In November 2020, the committee meetings were extended to 2 hours to allow sufficient time for discussions.

Attendance at each committee meeting has been good with the committee being quorate at each of its meetings.

5. Notable events

In the last year, there have been a number of notable events which the committee has overseen, these include:

- Twenty-five EDI champions nominated across CYAF.
- A successful equalities training session at Gloucester House in relation to the young people within the service.
- Creation of the disabled student network.
- In support of LGBTQI+ awareness month in February 2020, an evening event and art exhibition took place.
- Launch of the NHS rainbow badge scheme.
- Successful bid to the Tavistock Clinic Foundation covid appeal for under-represented group grants – a grant of £4,000 was received for each group (disability, race and LGBTQI+).
- LGBTQI+ group organised a virtual Pride event, due to covid-19 restrictions.
- In response to the BLM, DET put on thinking space events, which generated extremely positive feedback.

- WDES and WRES submissions were made (there was no gender pay reporting in 2020 due to covid-19).

6. Forward plans

For the coming year, the committee will continue to support the board in developing and implementing the Trust's comprehensive EDI strategy. This will enable the Trust to articulate its vision of equality and a number of steps which will ultimately improve the experience of service users, staff and students. This will include support in developing the Trust as an anti-racist organisation and the committee will input as requested into the race equality strategy monitoring group.

The committee will ensure that the equality, diversity and inclusion actions set out in the NHS People Plan will be incorporated into its work.

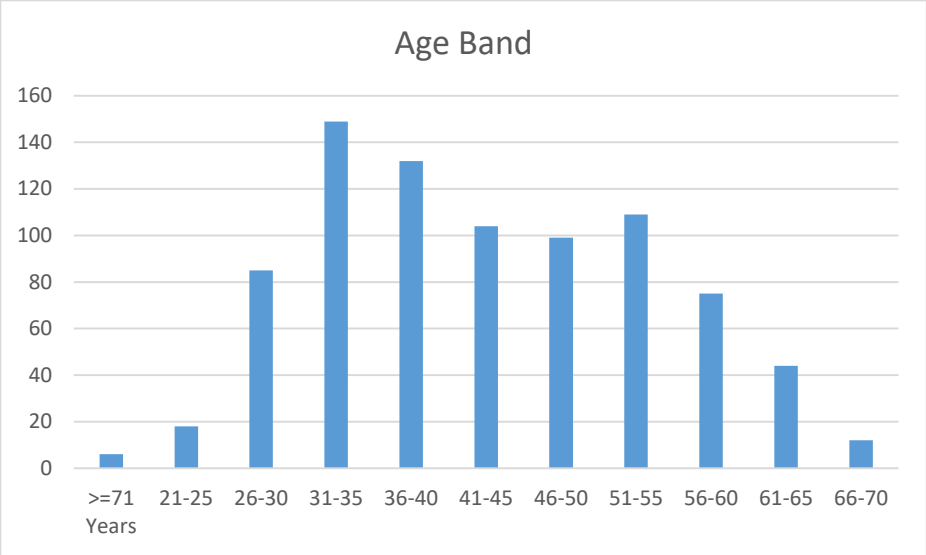
The committee will support the introduction of a disability and long-term health condition staff network and will also consider whether any other staff networks should be established.

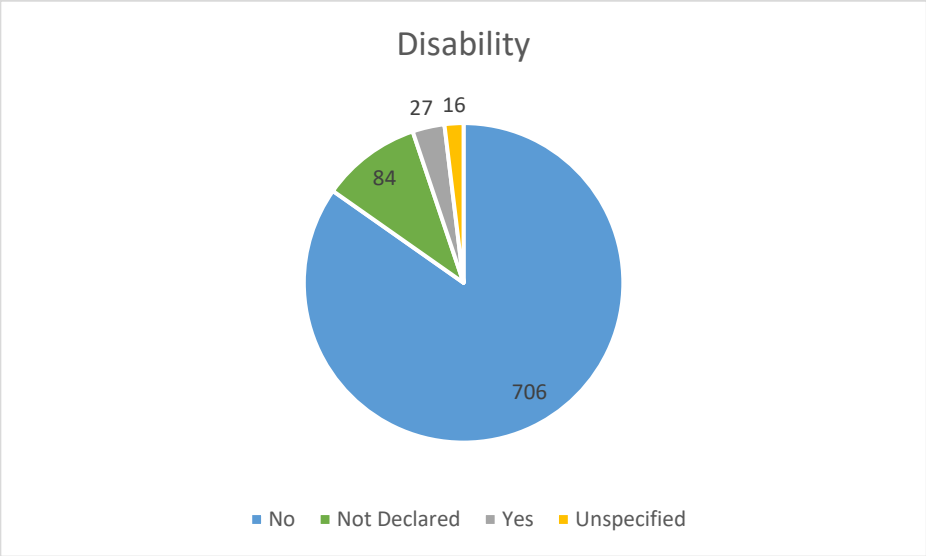
7. Conclusions and recommendations

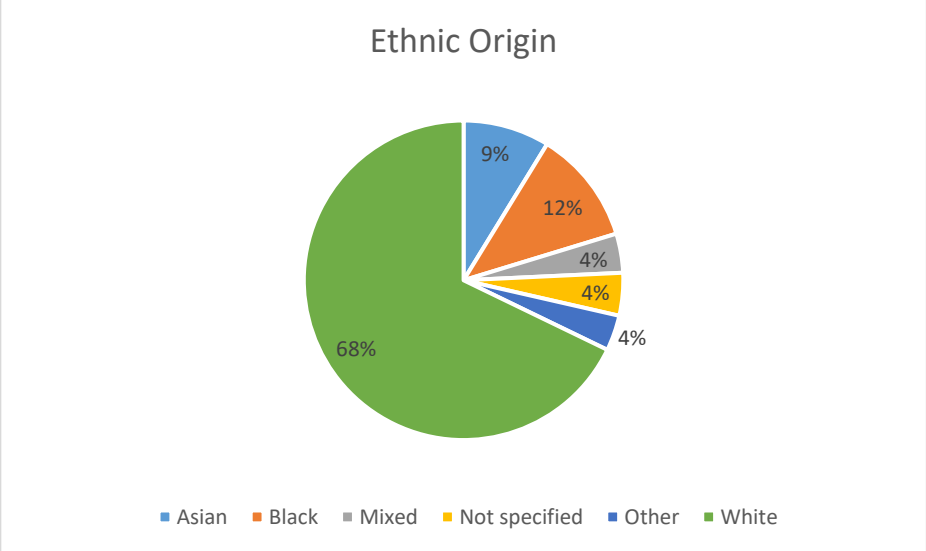
The board of directors is asked to note the contents of this report and provide its endorsement of the forward plans set out in this paper.

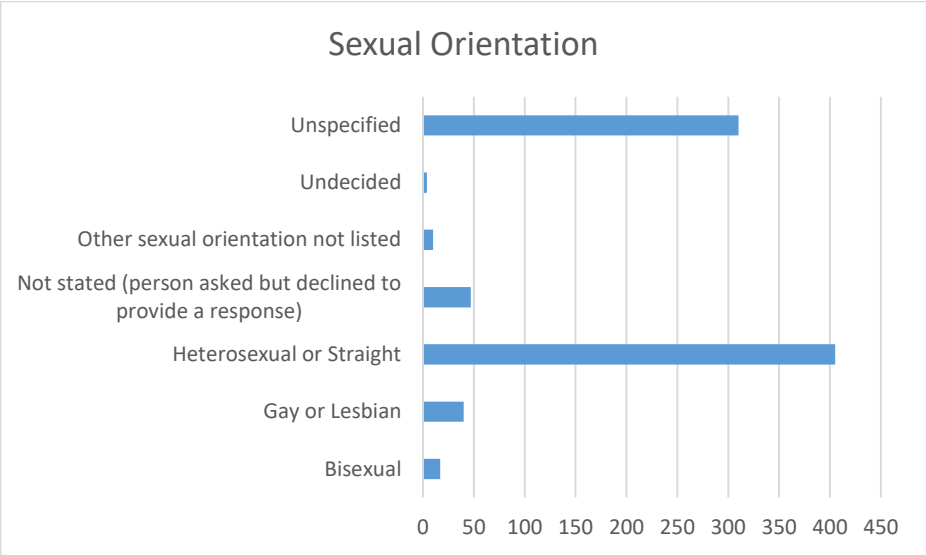
Karen Merchant
Interim Head of HR Business Services

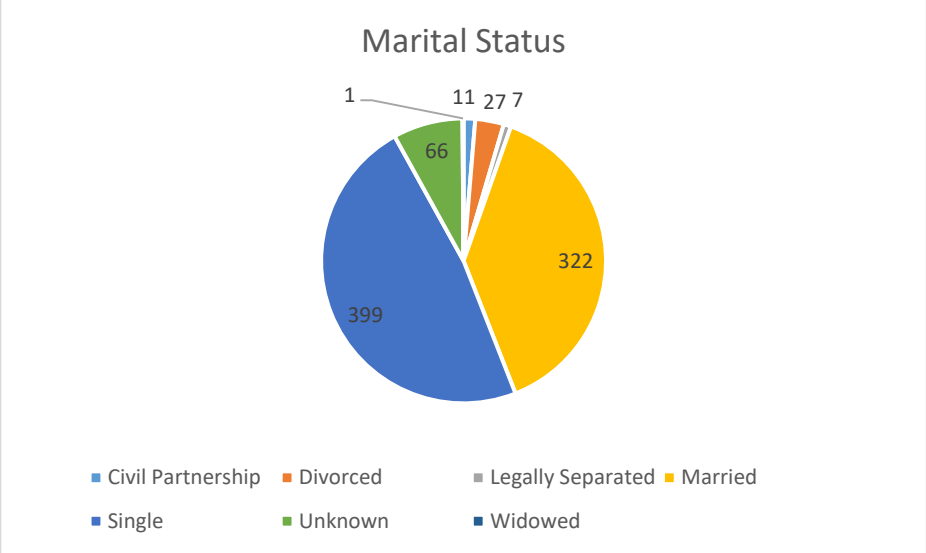
Appendix A – Equality Monitoring Data – Workforce

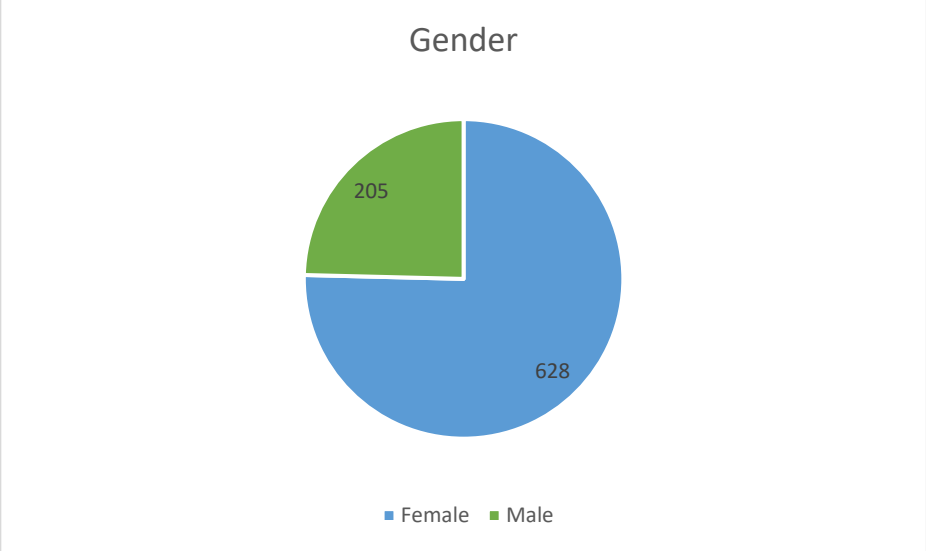







Sexual Orientation
Unspecified
Undecided
Other sexual orientation not listed
Not stated (person asked but declined to provide a response)
Heterosexual or Straight
Gay or Lesbian
Bisexual
0
50
100
150
200
250
300
350
400
450


Marital Status
1
11
27
7
66
322
399
Civil Partnership
Divorced
Legally Separated
Married
Single
Unknown
Widowed


Gender
205
628
Female
Male

Appendix B – Equality Monitoring Data – Clinical Services

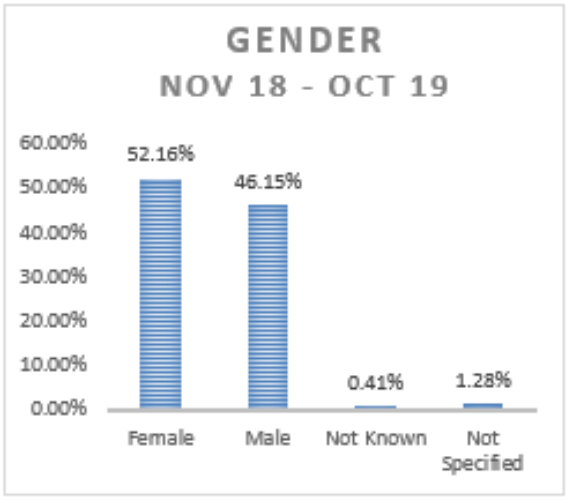
Introduction

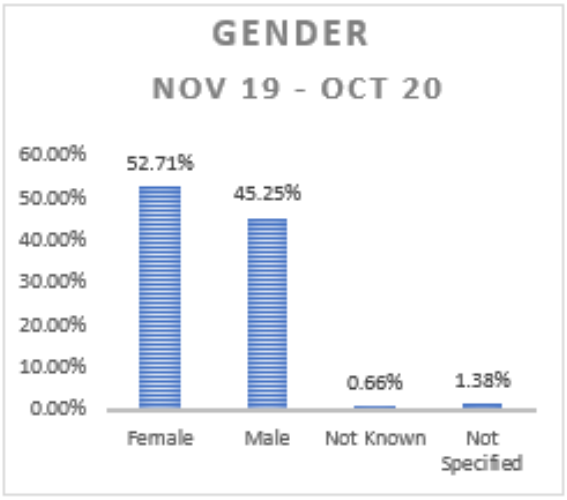
We collect data in line with our Equalities Annual Plan, and in a way that complies with NHS guidance and publication timescales. We have run the data for November 2019 to October 2020 and we are also showing this data alongside last year's report data (November 2018 to October 2019) for comparison.

The Mental Health Services Data Set (MHSDS) requires for us to have 95% completeness within patient demographics. The demographics analysed in this report relate closely to those of the MHSDS, but specifically covers the 9 protected characteristics of equality. This report shows equality data for patients with open non-rejected referrals in the period that have been seen, at any time. From November 18 to October 19 we had 16,185 cases within these parameters and from November 19 to October 20 we had 16,899.

Gender

The ratio of female service users has been higher than the male ratio for the last three yearly reports. When we compare the female and male representation from November 17 to October 2019 the female ratio was 6.54% higher, from November 2018 to October 2019 was 6.01% higher and in this last period of November 2019 to October 2020 it is 7.46% higher.

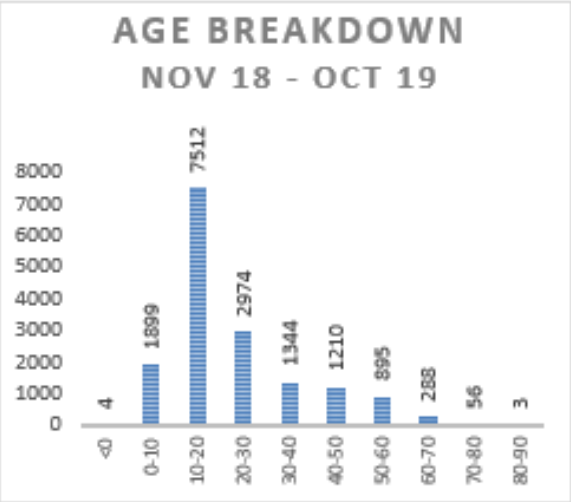


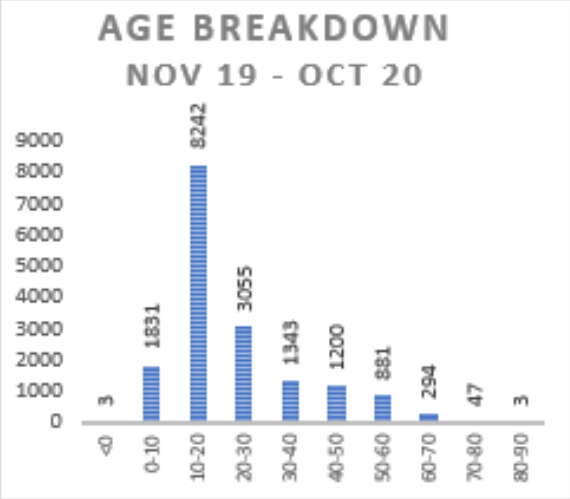


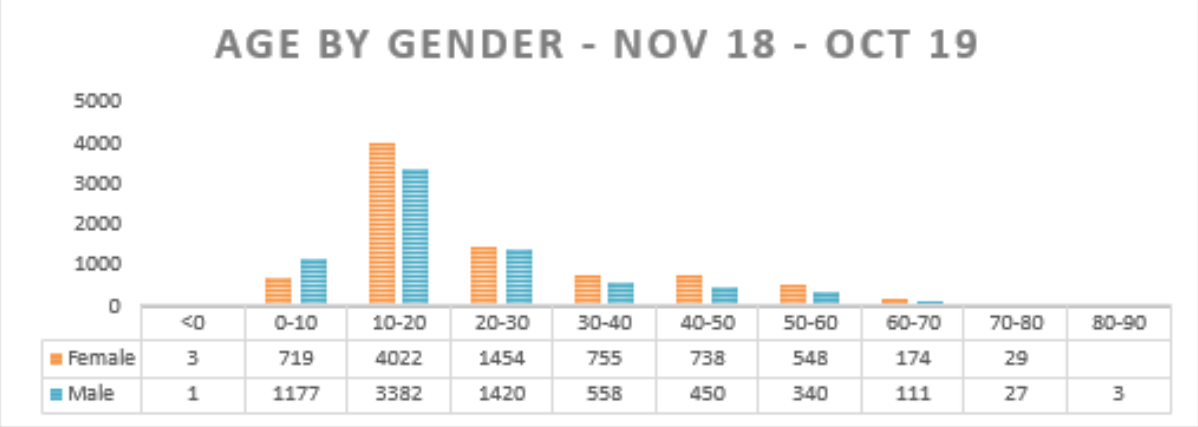
Both the ratio of 'not known' or 'non specified' has increased slightly. The variations are minimal: for not known was 0.25% and for not specified was 0.1%.

Age

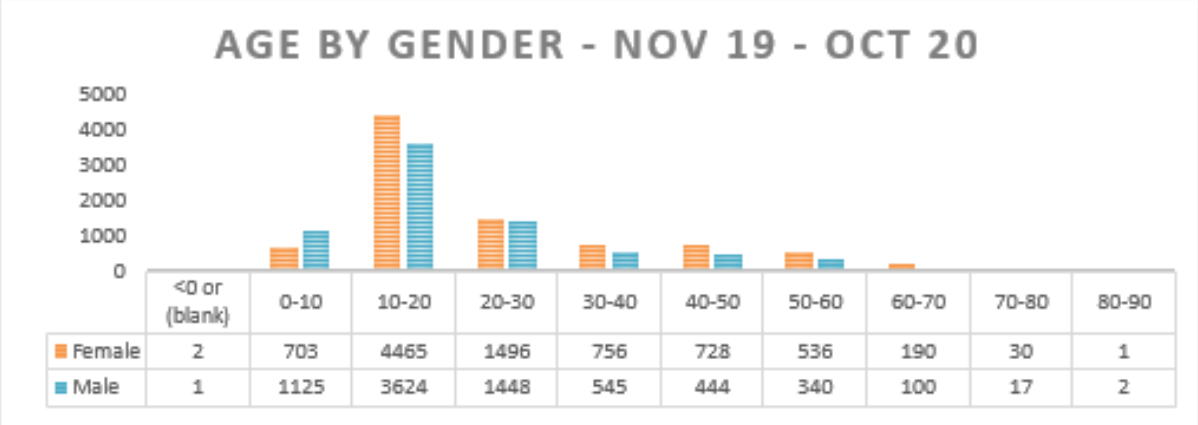
Below we have an age breakdown and a further breakdown by age and gender. The distribution of gender in the age bands is very similar over the two analysed periods. On the other hand, the number of open cases had been reduced by 1,257 cases. This would suggest a higher proportion of discharged cases in the last 12 months.







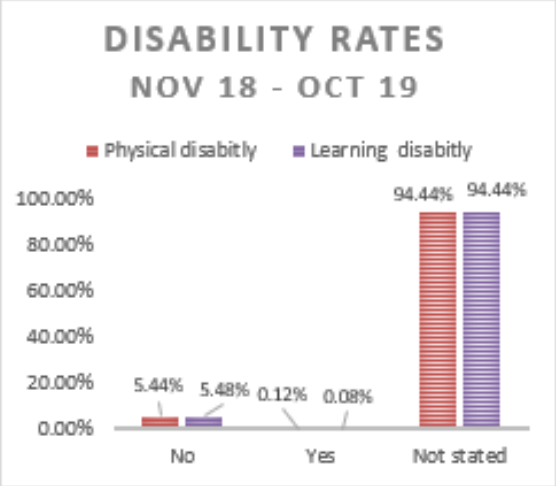
	<0	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90
Female	3	719	4022	1454	755	738	548	174	29	
Male	1	1177	3382	1420	558	450	340	111	27	3

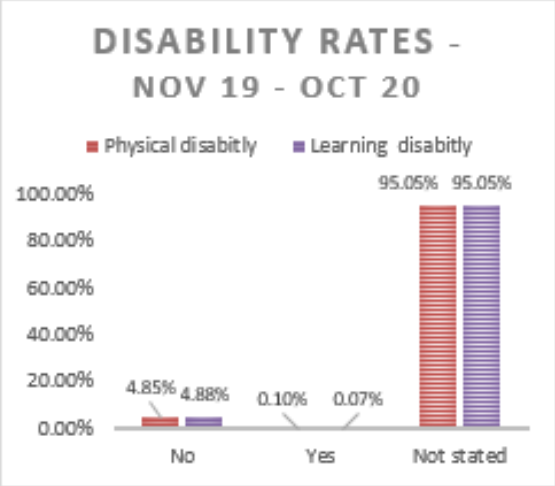


	<0 or (blank)	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90
Female	2	703	4465	1496	756	728	536	190	30	1
Male	1	1125	3624	1448	545	444	340	100	17	2

Disability

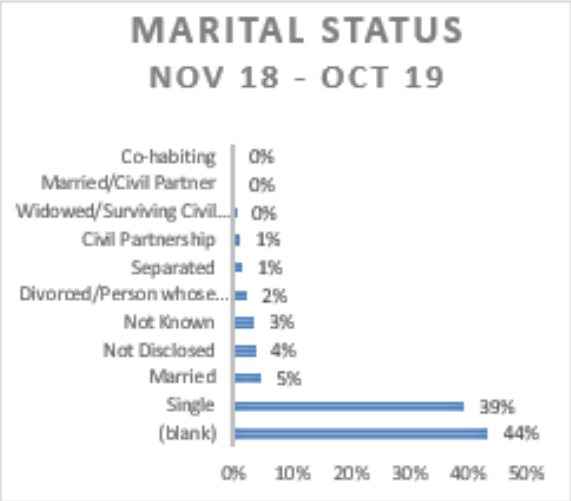
Information on learning and physical disabilities was only stated in our database system in under 5% of the cases. Improving the identification and recording of this data is important to ensure we are providing high quality services for all our patients, including those with learning and physical disabilities. The Trust believes the reason for the low recordings is that the disability form is an independent process from recording the main part of the referral data. So the disability form is often only opened for those cases where information is provided on the patient information forms.

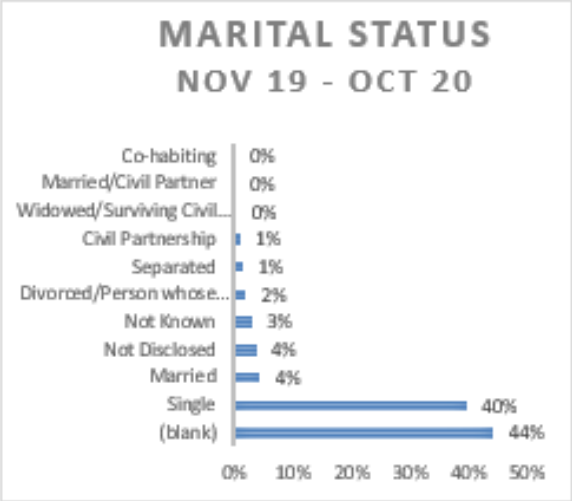




Marital status and civil partnership

The data below depicts recorded marital status. There has been little change in recording this data with the number of "blank" responses having remained at the same percentage: 44%.





The Trust has revised the GP referral and patient information forms used by all service lines to support an increase in the collection rates of demographic information. In order to support services to better record equalities data, the Trust has developed a tool to validate personal information with patients. At the time of this report the tool is being tested in one of our directorates. Due to the small scale of the test and the impact of covid-19 on the numbers of patients who are seen face to face, where the forms are collected, we do not expect to see significant improvements by next report, but to learn if this method is successful and if it should be implemented in other teams.

Religion/Beliefs

Religion is not currently asked of every patient in the Trust. However, the Trust has increased the recordings substantially over the last 3 years.

Currently we have records for 97 types of beliefs/religions; below are listed the top 20 options most used and the percentage they represent. The twenty most recorded options for the last two years have remained the same.

November 18 to October 19

(blank)	50.11%
Atheist	11.96%
None	11.20%
Christian	6.60%
Unknown	3.16%
Muslim	2.64%
Church of England	2.32%
Agnostic	2.00%
Declines to Disclose	1.56%
Roman Catholic	1.14%
Jewish	1.04%
Own Belief System	1.01%
Buddhist	0.61%
Pagan	0.58%
Anglican	0.40%
Other Religions	0.37%
Catholic Apostolic Church	0.30%
Free Thinker	0.25%
Spiritualist	0.23%
Hindu	0.19%

November 19 to October 20

(blank)	51.15%
Atheist	12.50%
None	11.01%
Christian	6.10%
Unknown	2.62%
Church of England	2.31%
Agnostic	2.13%
Muslim	2.08%
Declines to Disclose	1.63%
Roman Catholic	1.17%
Own Belief System	1.02%
Jewish	0.91%
Pagan	0.69%
Buddhist	0.61%
Other Religions	0.42%
Anglican	0.38%
Catholic Apostolic Church	0.31%
Free Thinker	0.24%
Spiritualist	0.23%
Hindu	0.19%

Looking at the period November 2019 to October 2020 the highest to types of believes are 'atheist' or 'no religion or belief'. Both remain the most chosen options over the last two years.

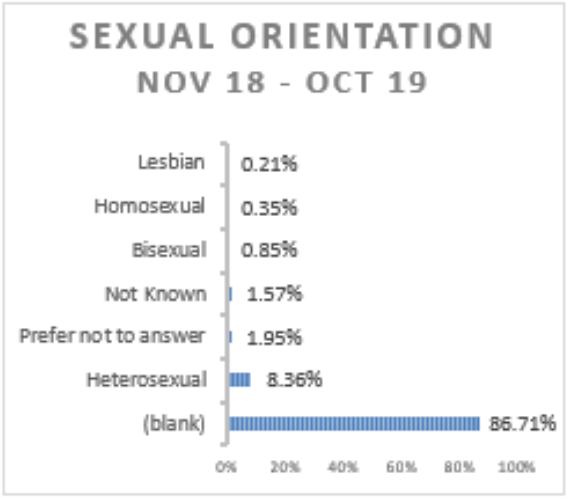
In the current reporting period, the percentage of 'unknown' has dropped from 3.16% to 2.62%. Unfortunately, the number of 'blanks' has increased slightly, potentially related to covid-19.

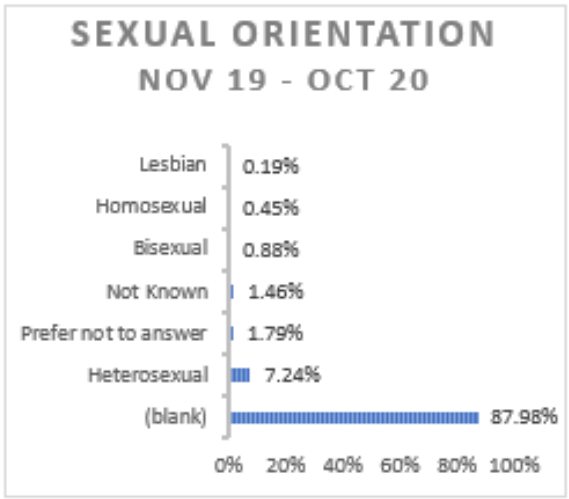
Pregnancy and maternity

We do not collect this data as it is not relevant to service delivery.

Sexual Orientation

We currently collect sexual orientation for those using our services. For some patients in certain services this may be quite an intrusive question, however, there is a 'prefer not to answer' option for those who do not wish to disclose on the equalities monitoring form. The Trust has been raising awareness of this option and patient information forms for most services include this information.

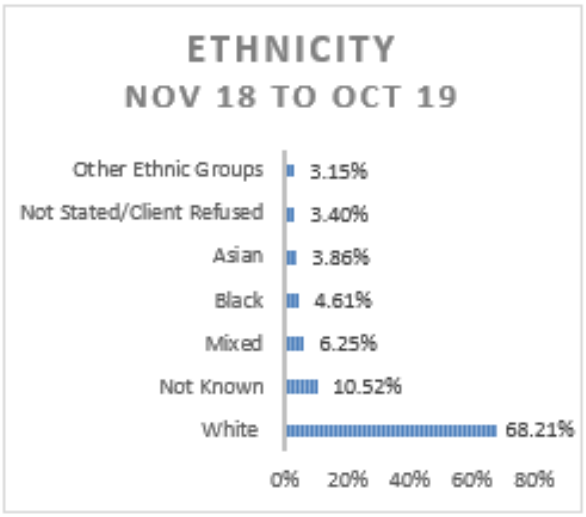


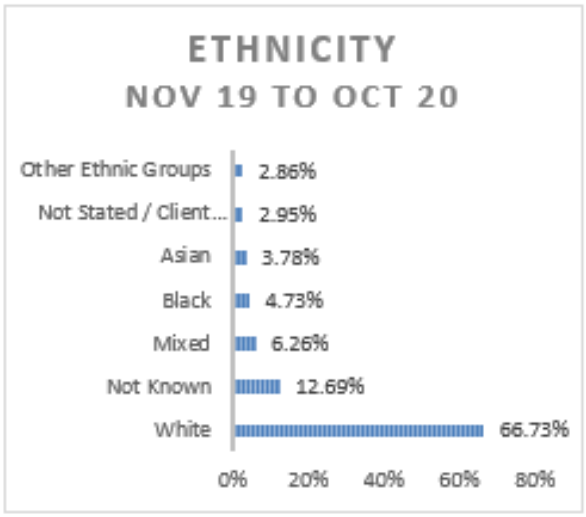


The percentage of cases not including information on sexual orientation has increased.

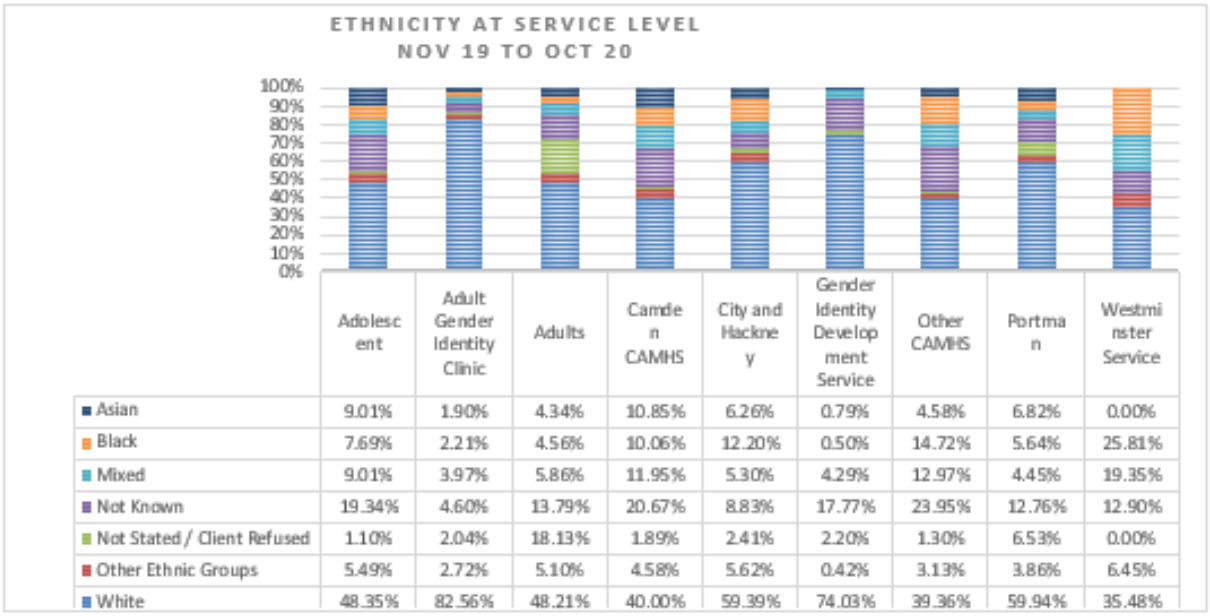
Ethnicity

Ethnicity collection rates have remained very similar when comparing November 2018 to October 2019 and November 2019 to October 2020. However, the 'not-stated/client refused' ratio has decreased slightly.



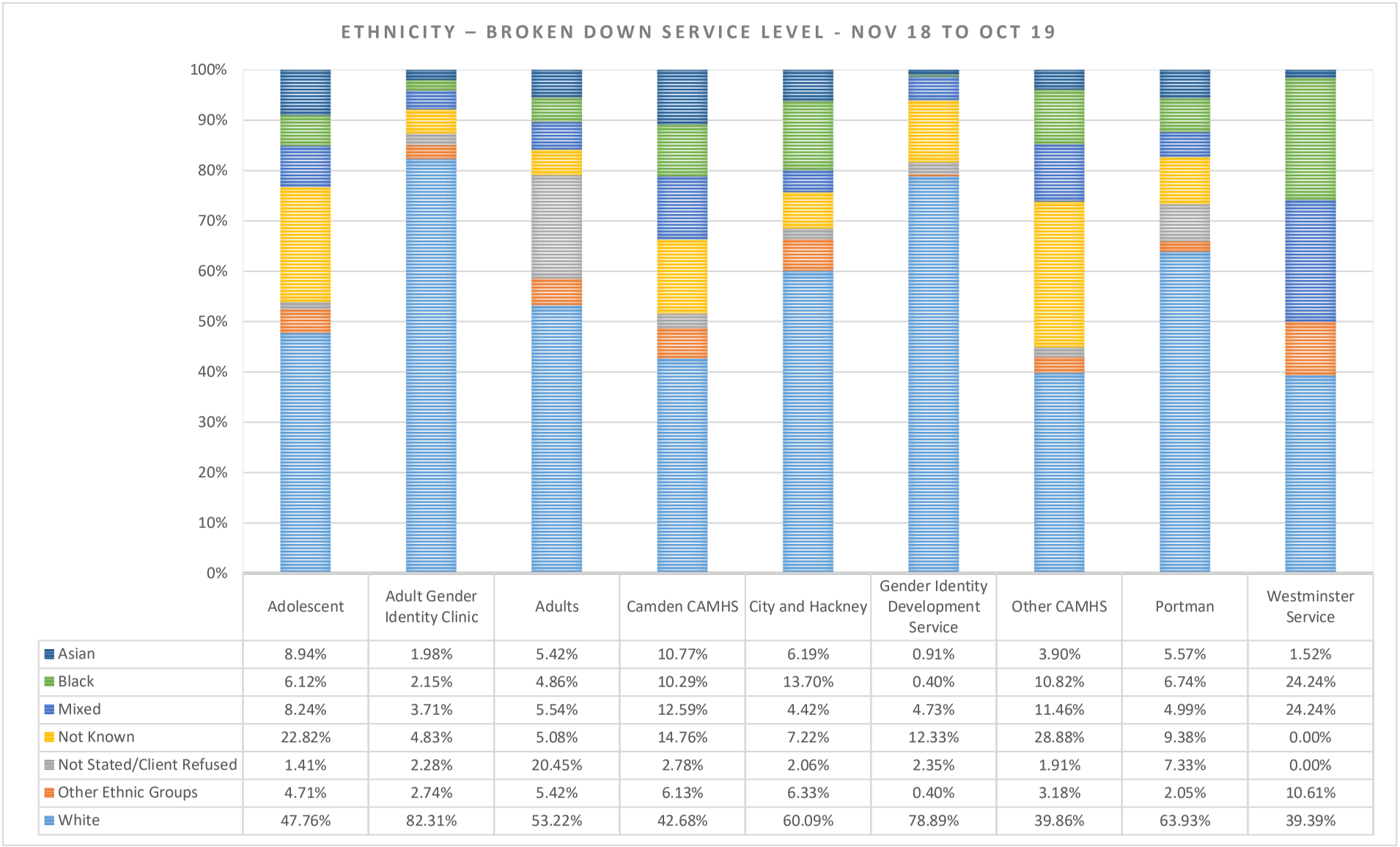


Below is ethnicity breakdown per service line, which should help our understanding of who is accessing our services by ethnicity distribution. Please note that both the Gender Identity Clinic (GIC) and Gender Identity Development Service (GIDS) have a much higher ratio of white ethnicities and a smaller proportion of Asian backgrounds. The Westminster service which works very closely with families, often providing court reports, has the highest representation of patients with mixed and black backgrounds.



	Adolescent	Adult Gender Identity Clinic	Adults	Camden CAMHS	City and Hackney	Gender Identity Development Service	Other CAMHS	Portman	Westminster Service
Asian	9.01%	1.90%	4.34%	10.85%	6.26%	0.79%	4.58%	6.82%	0.00%
Black	7.69%	2.21%	4.56%	10.06%	12.20%	0.50%	14.72%	5.64%	25.81%
Mixed	9.01%	3.97%	5.86%	11.95%	5.30%	4.29%	12.97%	4.45%	19.35%
Not Known	19.34%	4.60%	13.79%	20.67%	8.83%	17.77%	23.95%	12.76%	12.90%
Not Stated / Client Refused	1.10%	2.04%	18.13%	1.89%	2.41%	2.20%	1.30%	6.53%	0.00%
Other Ethnic Groups	5.49%	2.72%	5.10%	4.58%	5.62%	0.42%	3.13%	3.86%	6.45%
White	48.35%	82.56%	48.21%	40.00%	59.39%	74.03%	39.36%	59.94%	35.48%

Percentage of ethnicity – broken down by year and service level



	Adolescent	Adult Gender Identity Clinic	Adults	Camden CAMHS	City and Hackney	Gender Identity Development Service	Other CAMHS	Portman	Westminster Service
Asian	8.94%	1.98%	5.42%	10.77%	6.19%	0.91%	3.90%	5.57%	1.52%
Black	6.12%	2.15%	4.86%	10.29%	13.70%	0.40%	10.82%	6.74%	24.24%
Mixed	8.24%	3.71%	5.54%	12.59%	4.42%	4.73%	11.46%	4.99%	24.24%
Not Known	22.82%	4.83%	5.08%	14.76%	7.22%	12.33%	28.88%	9.38%	0.00%
Not Stated/Client Refused	1.41%	2.28%	20.45%	2.78%	2.06%	2.35%	1.91%	7.33%	0.00%
Other Ethnic Groups	4.71%	2.74%	5.42%	6.13%	6.33%	0.40%	3.18%	2.05%	10.61%
White	47.76%	82.31%	53.22%	42.68%	60.09%	78.89%	39.86%	63.93%	39.39%

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AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 18TH MAY 2021, 2.00pm – 4.15pm, 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
2.3	Minutes of the meeting held on 30th March 2021	Chair		1
2.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	3
2.4	VfM Self-assessment	Deputy Chief Executive / Director of Finance	2.40pm	4
3 Items for discussion				
3.1	Board Assurance Framework (BAF)	Chief Executive	2.50pm	5
3.2	GIDS Transformation Programme	Divisional Director Gender Services	3.00pm	6 - late
3.3	Quality Accounts 2020/21	Associate Director Quality and Governance Quality Directorate	3.10pm	7
3.4	Guardian of Safer Working Report	Medical and Quality Director	3.20pm	8
3.5	Quality Dashboard (Q4)	Medical and Quality Director	3.30pm	9
3.6	Clinical Thematic Case Review	Medical and Quality Director	3.40pm	10
4 Items to note				
4.1	Serious Incidents Annual Report	Medical & Quality Director	3.50pm	11
5 Board Committee Reports				
5.1	Training and Education Committee	Committee Chair	4.00pm	12
5.2	Audit Committee	Committee Chair	4.05pm	Verbal
5.3	Equality, Diversity & Inclusion Committee and Annual Report	Committee Chair	4.10pm	13

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6 Any other matters				
6.1	Any other business	All		
8 Date of Next Meeting				
	27th July 2021, 2.00pm – 4.00pm – Online meeting			

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	18 May 2021

GIDS Transformation Programme: Update

Executive Summary

This report summarises GIDS Transformation Programme progress, following the Judicial Review and CQC focused inspection. It covers:

- Progress
- Forthcoming activity
- Key risks and issues

Recommendation to the Board

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

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Divisional Director, Gender Services	Chief Executive

GIDS Transformation Programme: Update

1. Introduction

1.1 This paper provides an update on the Gender Identity Development Service (GIDS) transformation programme.

2. Progress

2.1 The Transformation Programme encompasses projects to develop a new endocrine pathway to respond to the judicial review; waiting list management; clinical governance, safety and practice; organisational design and development, including staff engagement; and data. There is also a refreshed Patient and Public Involvement (PPI) Stakeholder Group, which meets monthly to ensure that patient involvement is integrated into the Transformation Programme.

2.2 Oversight is via the GIDS Oversight Committee, which meets fortnightly and is chaired by the Trust Chief Executive; and the GIDS Interim Management Board (IMB), which meets weekly. The IMB has oversight of GIDS service delivery, the GIDS Transformation Programme, and CQC Action Plan reporting. All the Project Boards within the programme meet regularly as they develop and implement their plans. About one third of GIDS staff are contributing directly to this work.

2.3 All staff in GIDS continue to work extremely hard to maintain day to day delivery of clinical services, alongside the transformation programme.

2.4 Work is progressing against the actions agreed in the CQC Action Plan and the CQC Waitlist Action Plan, and we continue with monthly reporting to CQC against these. In addition, we have now completed initial piloting of the Multi-Disciplinary Clinical Reviews (MDCRs) of endocrine treatment decisions, involving 24 young people. The MDCRs have been established following the judicial review and NHSE service specification amendment of December 2020.

2.5 Forthcoming activity includes:

- Scoping and development of a GIDS Workforce strategy, focused on both short term and long-term capacity needs.

- Evaluating the initial pilots of MDCRs, prior to the roll out of these to all young people who need them.
- Piloting a proposed new, structured initial assessment for GIDS patients.
- Continued monthly PPI Stakeholder Group with young people and parents.
- Continued development of communications, engagement and PPI strategies, focused on ensuring we communicate and engage well with GIDS staff and also with young people and families.
- Continued development and implementation of actions in the CQC Action plan and the Wait List Action plan, and monthly reporting against these.
- Continued management of all Transformation Programme project briefs, risks and timelines, ensuring they are aligned and interdependencies are being managed.
- Identifying key data, KPIs and reporting requirements across the Programme.

3. Key risks

3.1 Key risks relate to the waiting list; and staff morale, retention and capacity to deliver against an extremely challenging work programme. These are reported as risks on the Trust's Operational Risk Register.

4. Conclusion

4.1 The Board are asked to consider and note this update.

Ailsa Swarbrick
Divisional Director of Gender Services
14 May 2021