NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 24th November 2020

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, 24th NOVEMBER 2020, 1.30pm – 4.25pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	1.30pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 29th September 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	1.40pm	Verbal
2.2	Chief Executive's Report	Chief Executive	1.50pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.05pm	3
2.4	Quality Dashboard (Q2)	Medical and Quality Director	2.15pm	4
3. Items for decision / approval				
3.2	Quality Accounts 2019/20	Associate Director of Quality & Governance	2.25pm	5
4. Items for discussion				
4.1	Freedom to Speak Up Report	Freedom to Speak Up Guardian	2.35pm	6
5. Items for noting				
5.1	DET Annual Complaints Report	Director of Education and Training	2.45pm	7
5.2	Board Assurance Framework (BAF)	Chief Executive	2.55pm	8
5.3	Operational Risk Register (Q2)	Associate Director of Quality & Governance	3.05pm	9
5.4	Guardian of Safer Working (Q2) Report	Medical and Quality Director	3.15pm	10
5.5	Serious Incidents Report (Q2)	Medical and Quality Director	3.25pm	11
5.6	NHS People Plan Report	Director of Human Resources and Corporate Governance	3.35pm	12 late
5.7	Race Equality Strategy	Director of Human Resources and Corporate Governance	3.45pm	13 late
5.8	EU Exit	Deputy Chief Executive / Director of Finance	3.50pm	14

		Presenter	Timing	Paper No
6. Board Committee Reports				
6.1	Education and Training Committee	Committee Chair	4.00pm	15
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	4.05pm	16
6.3	Integrated Governance Committee	Committee Chair	4.10pm	17 late
6.4	Audit Committee	Committee Chair	4.15pm	18
7. Any other matters				
7.1	Any other business	All	4.25pm	
8. Date of Next Meeting				
	26th January 2021, 2.00pm – 4.00pm – Online / The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			

Board of Directors Meeting Minutes (Part 1)
29th September 2020, 3.00pm – 4.30pm, via Zoom

Present:			
Paul Burstow Chair	Paul Jenkins Chief Executive	David Holt Senior Independent Director	Deborah Colson Non-Executive Director
Helen Farrow Non-Executive Director	Dinesh Bhugra Non-Executive Director	David Levenson Non-Executive Director	Terry Noys Deputy Chief Executive / Finance Director
Craig de Sousa Director of Human Resources and Corporate Governance	Sally Hodges Clinical Chief Operating Officer	Dinesh Sinha Medical and Quality Director	Rachel Surtees Director of Strategy
Chris Caldwell Director of Nursing	Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Ailsa Swarbrick Director of Gender Services	Tim Kent Divisional Director AFS
Rachel James Divisional Director CYAF			
Attendees:			
Fiona Fernandes Business Manager Corporate Governance	Jessica Anglin D'Christian Governor		
Apologies:			
None received			

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

1. Administrative matters

1.1 Welcome and apologies

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

1.2 Declarations of interest

1.2.1 No declarations of interest were declared.

1.3 Minutes of the previous meeting

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

1.4 Matters arising and action points

1.4.1 All the actions were noted as completed.

2. Operational items

2.1 Chair and non-executives' reports

2.1.1 Prof Burstow noted that he attended the NHS Confederation, NHS Reset event where one of the key focusses was on Inequalities during the pandemic. He emphasised that addressing inequalities must be at the forefront of the reset process not only for the Trust but across the system.

2.1.2 Prof Bhugra noted that he attended a Trust Scientific meeting that had taken place earlier in the month and had over 2,000 people attended. Prof Bhugra noted his thanks and congratulations to Dr Stern, Dr Stubley and Dr Yakeley for their talks and lectures.

2.1.3 Mr Levenson noted that he attended the virtual centenary celebrations, he noted that it was wonderful on all levels. Mr Levenson noted that the filming of the events should be made widely accessible for external audiences.

2.1.4 The board of directors noted the report.

2.2 Chief executive's report

2.2.1 Mr Jenkins presented the report and highlighted:

Centenary

- Although the Trust's plans for the Centenary celebrations had to be changed in light of the pandemic, on 25th September a series of online events were held to celebrate the work of the Trust and included a focus on historical highlights, a video tour of current services, an event on patient involvement and a celebratory event in the evening. The first event on Friday evening had nearly 300 staff and other stakeholders in attendance.

- Commencing 30th September there were plans of a festival of online events to mark the Centenary. He add that it would include content which would have been part of the face to face conference that was originally planned. The first event would involve an evening with poet and writer Lemn Sissay.

- On behalf of the Board, Mr Jenkins thanked all those who worked very hard in organising a very successful Centenary celebration.

Ms Surtees

- Ms Surtees would be leaving the Trust to take up a board level post at the London Borough of Haringey in October. He added that Ms Surtees had been an outstanding member of the Executive team and that she would be greatly missed.

Covid

- The Trust was responding to the recent increase in demand and changes in national regulations, and had done the following:
    - re-instated Emergency Preparedness, Resilience and Response (EPRR) Gold command;

- re-enforced guidance around Infection, Prevention and Control (IPC);
- proceeded with a programme of online delivery for educational activities for Term 1;
- reviewed arrangements for protecting staff wellbeing building on the work that has already been done on demographic risk assessment and taking into account staff vulnerabilities;
- participated in an ICS and London wide planning activity for the impact of a second rise in cases.

Honorary posts and equalities

- In the last month the Trust received some negative publicity around the advertisement of an honorary assistant psychology post in GIC. A lot of those who commented on this saw the role as inimical to equality of opportunity, especially in a profession where there are significant issues about the lack of diversity. In response the advertisement was withdrawn and the service were rethinking our approach on handling this.

- The incident was relevant to wider issues on equalities and there were things that as a Trust we need to consider and address. He added that the Trust was significantly dependant on honorary input and Mr de Sousa would undertake work to deal with the issues. He emphasised that the conclusions would also be relevant to the Strategic Review.

2.2.2 Regarding Covid, Dr Sinha noted that he had been closely following the trends and that he was concerned about the varying indicators. He emphasised that EPRR Gold would be meeting on a weekly basis with a specific focus on planning for a second wave. He further noted that localised decisions will be made about service delivery and where any exceptions were agreed to ICS, regional or national guidance would be reported directly to the board.

2.2.3 Mr Rock noted that student recruitment for 2020-21 academic year had progressed well overall. He added that 600 new year one enrolments had occurred, the position was similar to the previous academic year and term one activity would be delivered online.

2.2.4 Responding to Mr Kent, Dr Hodges noted that the Trust was involved in the modelling and that there were two levels as well as the use of CAMHS crisis hubs/beds. The recovery modelling has a five point plan and the national template had eight both for mental health and Covid. There is a flexibility that services can be used as needed. Dr Sinha added that it would be useful to triangulate the initiatives the government has and to come up with a strategy/plan which is sustainable during these times.

2.2.5 Prof Burstow thanked Ms Surtees and added that he was saddened as she was an invaluable member of the board with the ability to speak truth and to power.

2.2.6 The board of directors noted the report.

2.3 Finance and performance report

2.3.1 There was nothing to report in Part one.

3. Items for discussion

3.1 Workforce Race Equality Standard (WRES)

3.1.1 Ms Henderson was in attendance for this item.

3.1.2 Mr de Sousa presented the report and highlighted:

- The WRES was introduced in 2015 and that this year would be a good time to do a comprehensive lookback. Within this organisation there had been issues surrounding race diversity for many years.
- The data was submitted to NHS England/Improvement.
- Board diversity had improved over the years.
- The organisation is less white than it used to be but not at the higher levels.
- BAME staff were more likely to be appointed following shortlisting, but in reality this is in positions graded band 5 and below.
- Bullying and harassment remained an issue and the Trust needed to do more to identify ways that staff can confidently report this for it to be investigated and addressed.
- The data suggested BAME staff were more likely to enter into a disciplinary process in 2017 and 2018. He emphasised an comprehensive case review had been undertaken by himself, the chair of staff side and the race diversity champion which concluded the processes used were proportionate to the issues.
- Access to professional development for BAME staff had decreased this year.

3.1.3 Ms Henderson added that work was being undertaken however the key findings did not come as a surprise.

3.1.4 Mr Holt noted that the Trust appeared to be struggling to make progress but not through lack of aspiration.

3.1.5 Dr Hodges noted that there were some Band 4 and 5 clinical support posts in the organisation.

3.1.6 Ms Surtees noted that the report was not a positive read however it was helpful to see the figures of clinical versus corporate roles. She emphasised that the Board should carefully reflect on ‘why diversity matters’ and ‘what is the impact of this of deficit’.

3.1.7 Mr Kent noted that he had taken part in an advocacy network meeting regarding health inequalities and that the majority of those present were from the voluntary sector. He particularly noted that the main theme of the meeting was about the lack of trust in public services amongst underrepresented communities.

3.1.8 Dr James noted that they did try to recruit staff from the local populations, however the standard format for banding is guided by the Agenda for Change (AfC) bandings therefore making it a bit more difficult.

3.1.9 Dr Colson also conveyed her disappointment that this had not moved forward. There are external factors that we cannot influence, however there are things that the Trust could take forward. The bullying and harassment was not getting any

better. Perhaps getting in an external consultant to move this forward would be advisable.

3.1.10 The board of directors noted the report.

4. Items for decision

4.1 A Cultural Assessment and Action Approach Proposal

4.1.1 Mr de Sousa presented the report and highlighted:

- Dr Bowen-Wright had developed a proposal of how the Trust might address systemic cultural challenges, specifically through an externally commissioned review.
- The proposal was aimed at improving the experiences of BAME staff and the culture of the organisation to ultimately improve patient care.
- The proposal would form an important strand of the refresh of the race equality strategy.
- To make the change happen, a meeting took place in August between Dr Bowen-Wright, Mr Jenkins, Ms Henderson, Mr Sumpton and Mr de Sousa.
- A small steering group would be established to help shape the work and form a basis for ongoing oversight and ensuring delivery. The group would report into the executive management team and to the board via the equality, diversity and inclusion committee.
- To deliver this proposal, the Trust would need to conduct a full procurement activity.

4.1.2 Mr Levenson noted that to affect change recruitment was not the place to start. He added that this was not a task solely for the board and felt very strongly that there should be non-executive director representation on the steering group.

4.1.3 Ms Henderson noted that the board should consider, carefully, what the consequences ought to be for individuals demonstrating behaviours that were inconsistent with the expectations.

4.1.4 Mr Jenkins noted that the board would need to give a statement of leadership that is the matter is being taken forward.

4.1.5 The board noted its thanks to Dr Bowen-Wright.

4.1.6 The board of directors noted the report and unanimously agreed to the process and the procurement of the external consultant to undertake the cultural work.

5. Board Committee Reports

5.1 Equality, Diversity and Inclusion Committee

5.1.1 Mr de Sousa noted the committee met and undertook a focused discussion on:

- The Workforce Race Equality Standard (WRES) data
- The effectiveness of the committee and specifically how to give more focus on disability and health inequalities.
- A review of the activities that were undertaken for Pride month.

5.1.2 The board of directors noted the report.

6. Any other matters

6.1 Any other business

6.1.1 Dr Sinha noted that the Trust was trialling a new process regarding exemptions surrounding the use of face masks.

6.1.2 Prof Burstow noted his thanks, on behalf of the board of directors, to Ms Surtees for contribution to the organisation and wished her well for her new role at the London Borough of Haringey.

6.1.3 The board of directors noted this.

7. Date of next meeting

7.1 24th November 2020 at 1.30pm

7.1.1 The meeting closed at 4.25pm.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24th November 2020

Chief Executive's Report

Executive Summary

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

Recommendation to the Board

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

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Covid

1.1 The Trust has responded proactively to the worsening of Covid indicators in recent weeks.

1.2 Following the first wave and in preparation for the next phase, we completed divisional level planning and a number of further assessments, including team level, individual risk, IPC and estates planning. This included working through all relevant aspects of the recent IPC guidance, as applicable for a community setting for now and the future.

1.3 Various variables were taken into account including external factors like the reopening of schools, as some of our services work in such settings and we also run a school. We took the following steps at team level and completed service level SOPs:

- Assessment of need for F2F work
- Virtual consultation to check Covid symptoms
- Cohorting of patients into positive or suspect or shielded or negative for Covid19
- IPC procedures such as social distancing and/ or PPE depending on the cohort - keeping patient safe and staff Safety

1.4 In addition, we took the decision to stop all face to face teaching/ training events and continue limits of numbers of any clinical groups

1.5 The Trust EPRR Gold group is meeting weekly to take stock of the changing situation and modify information and communications to the Trust using a variety of methods including all staff briefings, communication email and daily digests (issued twice weekly). Any relevant information is also shared with the EMT and 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.

1.6 We have now entered the second wave of the ongoing pandemic and major incident level 4, which has been linked with high number of community infection rates and rising number of deaths. Along with the other leading indicators of the pandemic there have continued to be a number of outbreaks of infection in health settings, including within mental health and community providers.

1.7 The Trust has continued to monitor the latest practice expectations in the context of the Covid19 pandemic and the actions of other providers, for instance a Trust that is not allowing any clinical interventions without the use of masks.

1.8 The Trust has continued to use a mixed model of delivery for all services to provide face to face and remote interventions for service users based on assessment of need and risk.

1.9 DET continues to deliver all of its activities via remote methods.

1.10 The process of seeking exemptions has been reviewed and the expectation is that each exemption is an exception, which will be regularly reviewed and only permitted with all other aspects of IPC.

1.11 Several individual mask exemptions were agreed by operational leads and the DipC, in keeping with practice in various providers for patients with specific issues. We are currently trialling the use of transparent face masks in some of these clinical scenarios.

1.12 During the period of lockdown all clinical groups have been paused. This has resulted in some degree of disruption to the ongoing therapeutic work. However, a review of the balance of risks at EPRR was that it was not safe to continue face to face group based work at this time.

1.13 Gloucester House was granted an exemption based on being an educational setting within the Trust. It is operating in line with the expectations for school settings in Camden.

1.14 More recently, the school has again gone remote due to an outbreak in which two member of staff and a pupil have tested positive.

1.15 We are continuing work to support take up of flu vaccination by Trust staff. At present 351 staff have received a vaccine, of those:

1.15.1 45% of all staff have been vaccinated; and

1.15.2 46.79% of our patient facing workforce have been vaccinated.

1.16 We have plans to follow up, on a targeted, with those who have not been.

1.17 Under the direction of the ICS we are beginning to plan for providing access to a Covid vaccine when it becomes available.

2. Quality Improvement

2.1 At a recent QI project board there was an update about the progress of Quality Improvement in the Trust and the following highlights:

- Dynamic project register with a number of ongoing projects across clinical divisions and DeT
- Significant infrastructure improvements and supports for QI
- Trust wide QI projects for Remote working
- First Trust led level 1 QI Training for staff, which will be a regular feature
- QI Coach training for several staff

2.2 The Trust project for remote working has continued in the past few months. There was a Trust wide event on the 13/10, which had a series of presentations from the various teams representing all the 3 clinical divisions and the DET. This event was well received due to its demonstration of positive themes from various projects including:

- Use of QI methodology and data

- Continuing engagement and empowerment of groups of staff and involvement of patient voices in managing change
- Teams involved across the Trust including clinical and educational services
- Projects presented a combination of qualitative and quantitative data following project methodology
- Enthusiasm for co- creation of interventions
- Examples of changes that have had positive impact for care and education

3. GIDS Judicial Review

3.1 As the Board is aware the Judicial Review relating to the issue of the ability of young people in GIDS being able to consent to treatment was heard. We still await the judgement.

4. Centenary Festival

4.1 As the Board is aware, we took the decision, given the pandemic, to cancel our planned Centenary Conference on 24th September. In its place we have organised an online Festival - *100 years of the Tavistock and Portman*. The Festival includes an online festival of events, website, Trust Scientific Programme, Group Relations Conferences, Arts Group events and research of the Trust's history. The Festival celebrates our history and explores contemporary issues in relation to identity, relationships and society. It is considering how we continue to draw on our heritage to provide valuable responses to contemporary and future problems.

4.2 So far, over 2,000 people have joined these events since our launch event with poet and playwright Lemn Sissay at the end of September. As well as existing audiences including students, alumni and members, these events are engaging with a new generation of people interested in the work of the Tavistock and Portman. There will be another four events before Christmas including on neurodiversity, infant observation and decolonising therapy. In December, we will be announcing a series of 10-12 events from January through to March. The participation breakdown of our recent events is set out **Annex A**.

4.3 Aligning with our strategic objectives and following Black Lives Matter, this project includes a clear focus on equalities, inclusion and diversity one and is engaging with a new generation of clinicians. We are inviting BAME clinicians to participate as speakers and chairpersons. We are also explicitly advising speakers and chairpersons to consider race, gender, sexuality, and socio-economic diversity in the subject matter of their talks, as well as call upon a diversity of voices during the Q&A.

Paul Jenkins
Chief Executive
16th November 2020

Annex A – Attendance at *100 years of the Tavistock and Portman* Festival Events

Talk	**Speakers**	**Attendees**
Who do we think we are?	Lemn Sissay, Dexter Benjamin, Sheena Webb and Karen Izod, Chair: Paul Jenkins	470
Relevance of the Tavistock model of consulting in the context of a crisis	Ajit Menon, Gwen Hanrahan and Vega Roberts, Chair: Francesca Cardona	200
The Tavistock and Portman: A history of ideas	Sebastian Kraemer, Sarah Helps, Glenn Gossling, Chair: Roina Daniel	272
Childhood and parenting – Psychoanalytic perspectives	Margaret Rustin and Andrew Balfour, Chair: Sarina Campbell	760
Tavistock Policy Seminar: Whiteness – A problem for our time	Helen Morgan, Chair: Andrew Cooper and Helen Shaw	764

Report to	Date
BOARD	24 November 2020

Trust Finances

Executive Summary

This paper seeks to bring the Board up to date with the state of the Trust's finances

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

TRUST FINANCES

1. PURPOSE

1.1 This paper seeks to bring the Board up to date with the state of the Trust's finances.

1.2 Appendix A (which forms part of this note) provides an overall summary.

2 OVERVIEW / SUMMARY

2.1 The Trust has submitted a return to NCL ICS / NHSE/I showing a second half / full year deficit of £2.3m. (The second half and full year deficit figures are the same as for the first half NHSE/I ensured that the Trust achieved break-even.

2.2 If Top-Up payments and COVID-19 income and costs are ignored, for the full year the Trust is forecasting an underlying deficit of £5.3m

2. YEAR TO DATE – SIX MONTHS ENDED 30 SEPTEMBER 2020

2.1 For the first half of the financial year the Trust achieved a net break-even position.

2.2 This is after the inclusion of top-up payments of £3.2m and COVID-19 related costs of £0.8m, meaning an underlying deficit of £2.4m.

2.3 Compared with the original Budget, the Trust had lower levels of income and higher levels of non-staff costs.

2.4 Lower income reflects shortfalls in short courses / Tavistock Consulting in DET; deferment of research projects; and shortfall in Camden CAMHS (off-set by lower staffing costs).

2.5 Non staff costs are high reflecting IT and Relocation costs which have been expensed rather than capitalised – as a result of the capital expenditure cap imposed via the NCL ICS.

3 SECOND HALF / FULL YEAR FORECAST

3.1 Appendix A shows an overview of the forecast for the full year.

3.2 The Trust has made a forecast for H2 / full year to the NCL ICS of a net deficit of £2.3m.

3.3 The key assumptions underpinning the forecast are set out below.

Clinical Income

3.4 During H1, the Trust received monthly 'block' payments totalling £2.29m per month, equal to £13.8m for the full six months and equivalent to £27.6m for the year. For H2 we are assuming £2.33m per month, giving a total for the full year of £27.8m.

3.5 This block payment covers the Trusts key clinical services notably those commissioned by Camden CCG / NCL ICS and Specialised Commissioning (Gender and Portman Clinic).

3.6 Other clinical income (£6.5m for the full year) comes from other CCG / local authorities.

3.7 For the full year, clinical income is forecast to be £34.3m, versus an original Budget of £38.4m, the shortfall of £4.2m representing income not achieved from new business developments.

Education And Training Income

3.8 For the full year the forecast assumes income of £17.1m versus an original Budget of £18.7m, the shortfall of £1.6m representing assumed lost income from short and long courses and from Tavistock Consulting.

Top Up Payments / COVID-19

3.9 Top up payments have ceased for the second half.

3.10 The Trust has received an allocation of £681k to cover second half Covid-19 related costs (including costs of covering staff absences and travel).

Second Half Movements v H1

3.11 Income is forecast to be within 1% of H1 (ignoring Top-Up Payments).

3.12 Staff costs are forecast to be 3% higher, reflecting unfilled vacancies being filled.

3.13 Non-staff costs are forecast 7% higher (than H1) reflecting, mainly, visiting lecturer spend.

Key Uncertainties

3.14 There are a number of material uncertainties within the forecast, notably the accrual for annual leave and the provision for legal costs.

3.15 It is likely that these will both need to be significantly increased, which would impact negatively on the current forecast.

3.16 The forecast also assumes £450k of 'efficiencies'. These have yet to be identified.

3 ACTION TO IMPROVE THE UNDERLYING POSITION

3.1 As previously advised to the Board, a Strategic Review of the Trust's activities is currently taking place.

3.2 A key outcome of the review – though not the only one – is identification of actions to move the Trust back into a break-even position.

APPENDIX A

FIRST HALF ACTUALS AND SECOND HALF / FULL YEAR FORECAST 2020/21

	YTD Act £'000	YTD Bud £'000	Var £'000	H2 F'Cast £'000	H2 Bud £'000	Var £'000	FY F'Cast £'000	FY Bud £'000	Var £'000	Change H2 v H1 £'000	
Income	29,492	28,038	1,454	27,478	30,852	(3,374)	56,970	58,890	(1,920)	**150**	**1%**
Staff costs	(21,774)	(22,078)	304	(22,460)	(22,582)	122	(44,234)	(44,660)	426	**(686)**	**3%**
Non staff costs	(6,666)	(6,065)	(601)	(6,207)	(6,058)	(149)	(12,873)	(12,123)	(750)	**459**	**(7)%**
Interest receivable	2	27	(25)	0	27	(27)	2	54	(52)	(2)	
Interest payable	(17)	(16)	(1)	(51)	(16)	(35)	(68)	(32)	(36)	(34)	
Depreciation	(714)	(810)	96	(714)	(810)	96	(1,428)	(1,620)	192	0	
PDC	(324)	(354)	30	(324)	(354)	30	(648)	(708)	60	0	
Net surplus / (deficit)	**(1)**	**(1,258)**	**1,257**	**(2,278)**	**1,059**	**(3,337)**	**(2,279)**	**(199)**	**(2,080)**	**(2,277)**	

Underlying deficit			
- Forecast deficit	**(1)**	**(2,278)**	**(2,279)**
- Add back top up payments	**(3,285)**	**(440)**	**(3,725)**
- Take off COVID costs	**842**	**(148)**	**694**
- Underlying deficit	**(2,444)**	**(2,866)**	**(5,310)**

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: November 2020

Report to	Date
Board of Directors	24 November 2020

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q2 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 was a sharp increase in referrals between Q1 and Q2 of 721
- Compliance with targets for first appointment and treatment appointment were mixed. CYAF continued to see 90% of patients for first appointment within the contracted waiting time, including, for the first time since Q1 2018/19, the Adolescent service. Compliance with referral to treatment appointments increased across Camden Camhs and Other Camhs but decreased in Adolescent services, more particularly those under 18 years of age.
- TAP saw an increase in waiting times for first appointment dropping from 21% in Q1 to 7% in Q2 but have recently recruited to 2 vacant posts which will increase capacity. Adult Complex Needs waits from referral to treatment decreased from 50% to 30%. The service has increased the number of staff who can take on new assessment cases, and allocated two trainees (0.8WTE) to the Trauma Unit to help improve compliance.
- Among our outcome measures, CORE improvement rates have been under review with data collection now including all patients discharged in period with a minimum of two completed CORE forms. In Q2 30/44 discharged patients showed improvement (68% up from 65%).
- HR information shows a further reduction in staff sickness from 0.61% in August to 0.34% in September. Mandatory training was on hold for Q1 but has begun to increase in Q2. Staff appraisals, also on hold for Q1 are to be completed by the end of November 2020.
- The applications cycle for long courses in DET opens annually in November. Student registrations closed in October and data shows the number of applications remain buoyant, despite the pandemic. Short course activity is showing an increase in the average number of students per activity from last year. All delivery has successfully moved online.

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

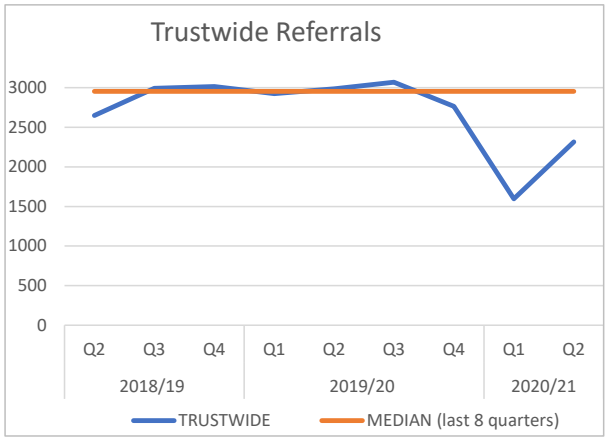
- Trust patient contacts decreased by a further 42 to 5567 for Q1, with small increases in Other CAMHS, Adolescents, GIC, Adult Complex Needs, City and Hackney and FCAMHS.
- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthy.
- Among our outcome measures Time 1 and Time 2 Goal Based Measure completion rates have continued to decrease. Both remain under target. Work is being done to improve GBM Carenotes reminders and data completion.
- MHSDS collection rates are from July 2020 and show an ongoing small decrease in two areas where we have been showing consistently poor data – ethnicity and accommodation status (adults). However, it should be noted that Adolescent and Portman services have seen sustained increases in 'accommodation status' data collection. Compliance with the Ex-British Armed Forces indicator continues to improve with 56%.
- Q2 saw an increase in complaints compared to Q1, from 15 complaints to 40. The increase was primarily in the Gender Services but CYAF also saw an increase from 3 in Q1 to 11 in Q2. The 'pause' in the complaints process due to the coronavirus was for the Q1 period. This led to a backlog in investigations and responses which is being addressed.
- Overall Trust DNA compliance decreased marginally in Q2 moving from 8% in Q1 to 9%. The areas of greatest challenge this quarter, and over target, have been Adolescent, TAP, Family Assessment Service (FAS) and GIC services.
- The number of followers across all Trust social media platforms continues to increase quarter-on-quarter, including on Instagram. The quarter was spent promoting our centenary with the top tweet gaining 9.271 impressions, 31 likes and 16 retweets. The % of positive print media articles increased from 48% in Q1 to 53% in Q2 with a lower proportion of GIDS related coverage.

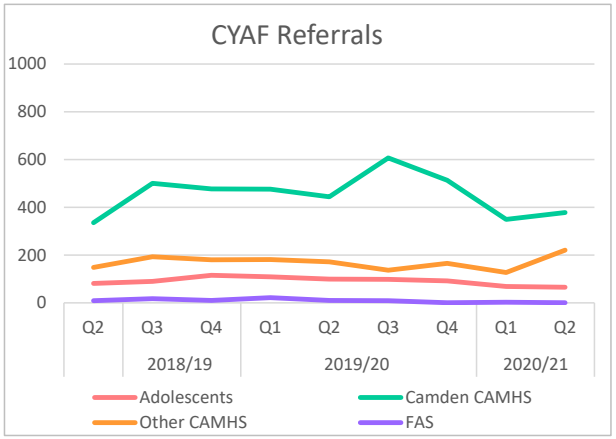
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.

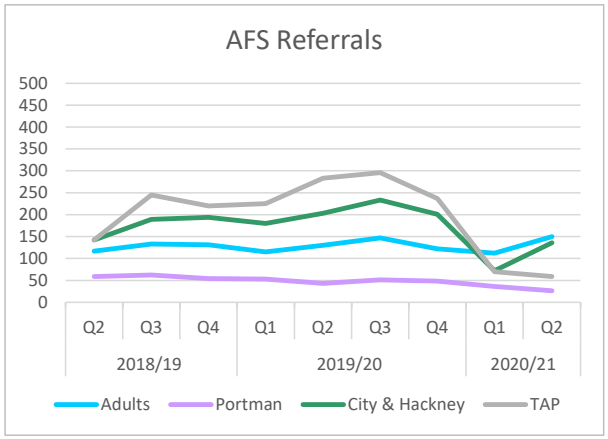
Trust strategic objectives supported by this paper
Finance and Governance

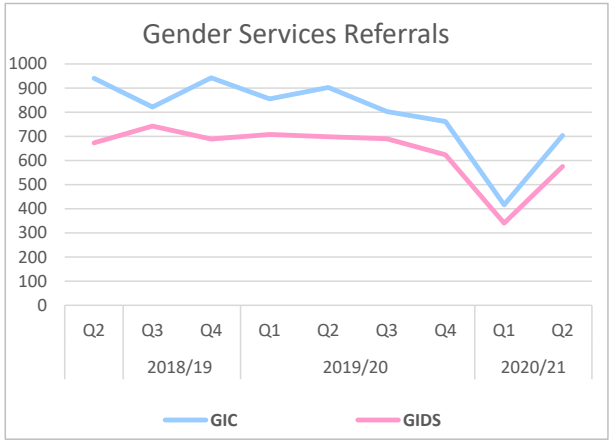
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q2 20/21: Trust Reach – Access









Data source: Q2 data as recorded on 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.

Number of Referrals Received:

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

Trust-wide we saw drop in referral numbers in Q1, in Q2 those number have increased but still under previous averages. In Q2 the trust received 2317 which is 620 lower than the average number of referrals over the last financial year.

Adolescents: in Q2 received 66 referrals, 3 fewer than Q1 - the average of referrals received during last financial year was 100 per quarter

Camden CAMHS: in Q2 received 379, 29 more than in Q1. The average of referrals during last financial year was 510 per quarter.

Other CAMHS: in Q2 received 221 referrals, 93 more than in Q1. The average of referrals during last financial year was 166 per quarter.

Family Assessment Service: the number of referrals decreased in Q2, with 1 referral. The average of referrals during last financial year was 10 per quarter.

Adults Complex needs: in Q2 received 150, 38 more than in Q1. The average number of referrals received during last financial year was 128.

Portman: in Q2 received 26, 10 fewer than in Q1. The quarterly average last financial year was 49.

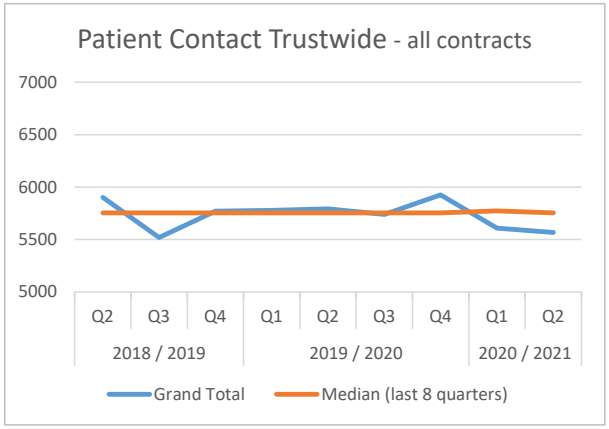
C&H PCPCS: in Q2 received 136, 64 more than in Q1. The quarterly average last financial year was 204.

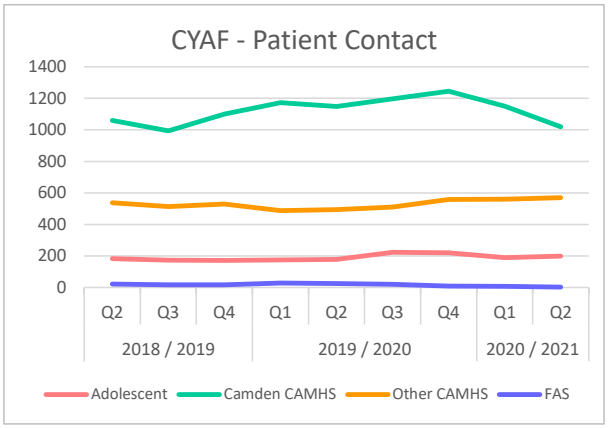
Team Around the Practice: in Q2 received 59, 11 fewer than in Q1. The quarterly average last financial year was 260.

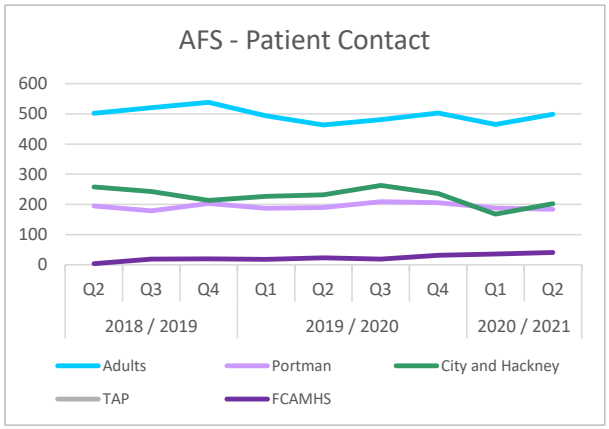
GIDS: in Q2 received 575, 235 more than in Q1. The quarterly average last financial year was 680.

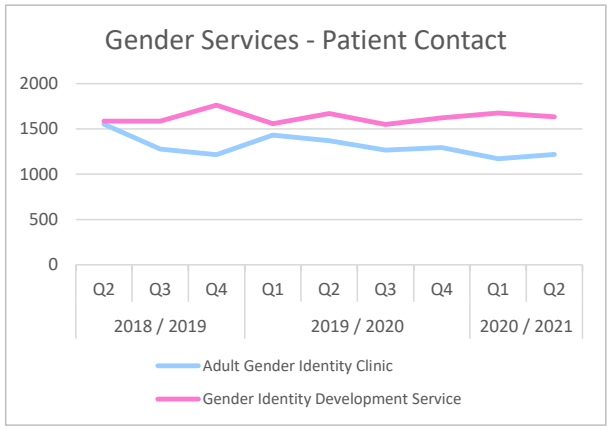
GIC: in Q2 received 704, 288 more than in Q1. The quarterly average last financial year was 830.

Q2 20/21: Trust Reach – Access









Data source: Q2 data as recorded on 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.

Individual patients in contact with our services

We include all individual patients in all contracts who have had contact with our service, excluding EIS and Mosaic. They are reported only once per quarter. Data includes telephone and zoom contacts. As a result of the pandemic the majority of consultations in Q2 continue to be undertaken through the use of zoom.

Trust-wide, we saw a slight decrease in the individual number of patients seen in Q2. In Q1 the trust saw 5609 individual patients, and 5567 in Q2, which is 202 lower than the average number of contacts over the last financial year.

Adolescents: in Q2 saw 199 individual patients, 10 more than in Q1. The average during last financial year was 199, so very similar performance.

Camden CAMHS: in Q2 saw 1019 patients, 131 fewer than Q1. The average of number of patient contacts during last financial year was 1191 per quarter.

Other CAMHS: in Q2 had contact with 570 patients, 9 more than in Q1. The average of number of contacts during last financial year was 513 per quarter.

Family Assessment Service: : experienced a decrease in contacts, in Q1 they saw 7 patients and in Q2 they saw 3 patients. The average of number of contacts during last financial year was 20 per quarter.

Adults Complex Needs: in Q2 saw 498 patients, an increase on Q1 data when 465 patients were seen. The average of number of patient contacts during last financial year was 480 per quarter.

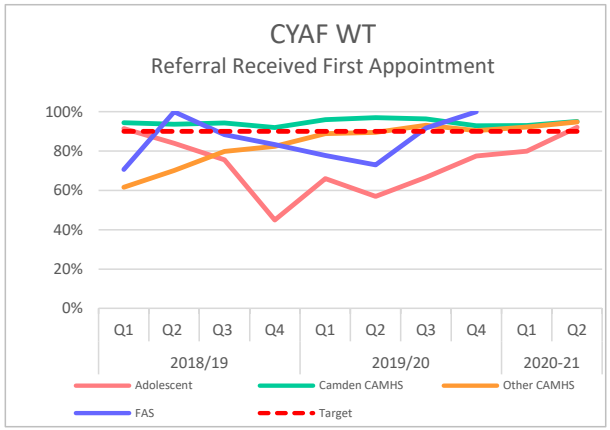
Portman: in Q2 had contact with 184 patients, slightly lower than in Q2 when they saw 188. The average of number of patient contact during last financial year was 198 per quarter.

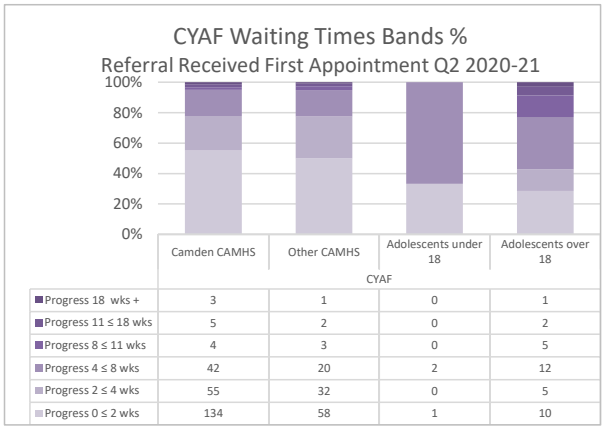
C&H PCPCS: in Q2 made contact with 202 patients, an increase from Q1 when they saw 168. The average number of patient contact during last financial year was 239 per quarter.

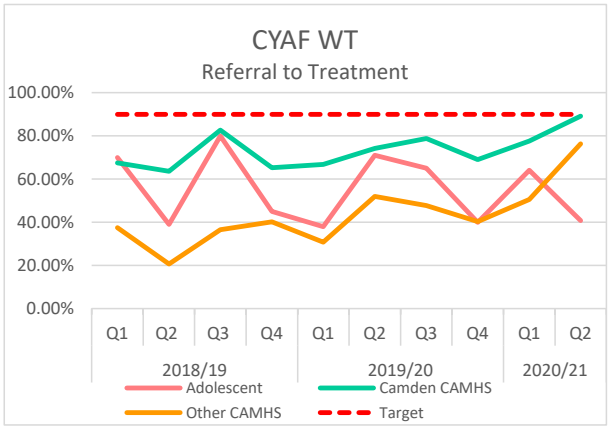
GIDS: in Q2 contacted 1634 patients, a slight decrease on Q1 when saw 1675. The average last financial year was 1599 per quarter.

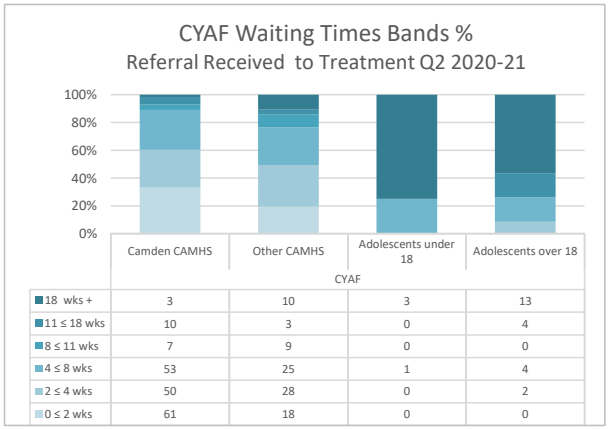
GIC: in Q2 contacted 1217 patients, an increase from Q1 when they saw 1170 The average of number of contacts during last financial year was 1240

Q2 20/21: Quality Responsive – Access









Data source: Q2 data as recorded on 08/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data

CYAF Waiting Times:

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

Referral to 1st appointment: In Q2 CYAF saw 95% of patients within the contractual waiting times. This is slight a improvement compared to 92% in Q1.
Referral to Treatment: In Q2 CYAF saw 81% of patients within the contractual waiting times. This is an improvement compared to 70% in Q1.

Adolescent services
Referral to 1st appointment – in Q2 the whole service line saw 92% of patients within contractual waiting times, an improvement on the 80% in Q1.
- Adolescents under 18 - 100%
- Adolescents over 18 - 91%

Referral to Treatment– – in Q2 the whole service line saw 41% of patients within contractual hours, compliance decrease compared to 64% in Q1.
- Adolescents under 18 - 25%
- Adolescents over 18 - 43%

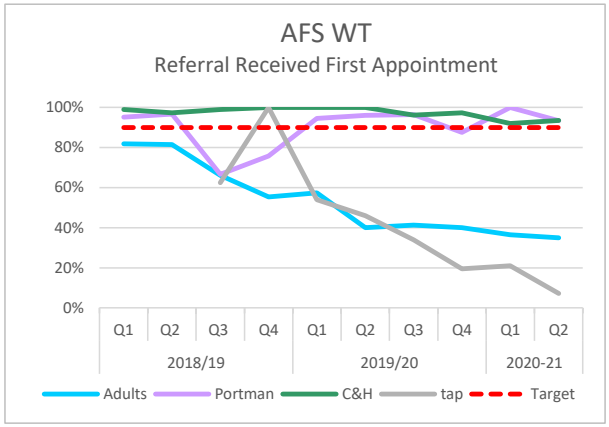
Camden CAMHS
Referral to 1st appointment – has consistently done well since 2017/18. The compliance rate in Q2 was 95%, a slight increase from 93% rate in Q1.
Referral to Treatment– in Q2 89% of the patients had an appointment within 8 weeks, an improvement in compliance compared to 78% in Q1.

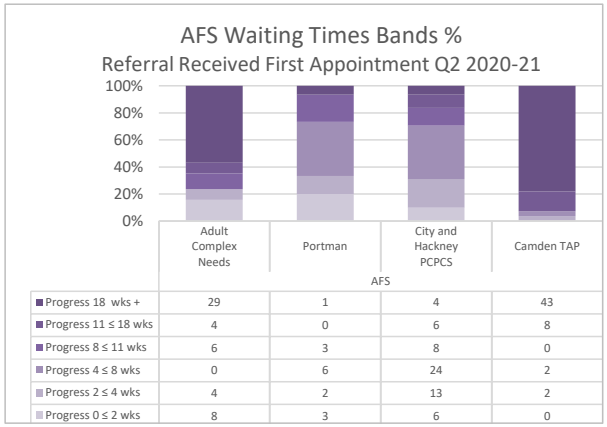
Other CAMHS
Referral to 1st appointment – has meet the target during last 4 quarters. In Q2 they achieved 95%. In Q1 rate was 92%.
Referral to Treatment– in Q2 we noticed a significant improvement reaching a 76% compliance rate, compared to 51% in Q1.

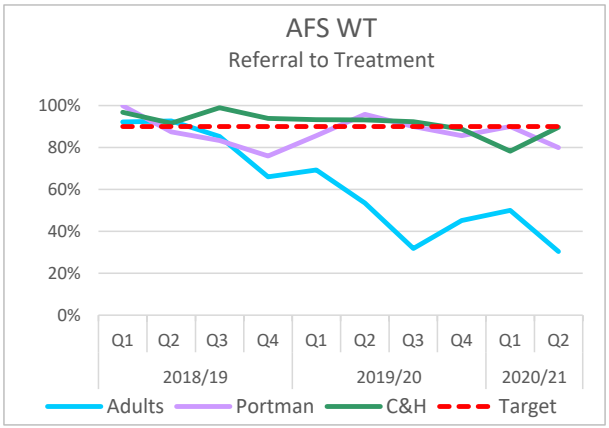
Family Assessment Service (FAS) is separate from the CCG and Mental Health Service contracts and the usual waiting time targets don't apply.

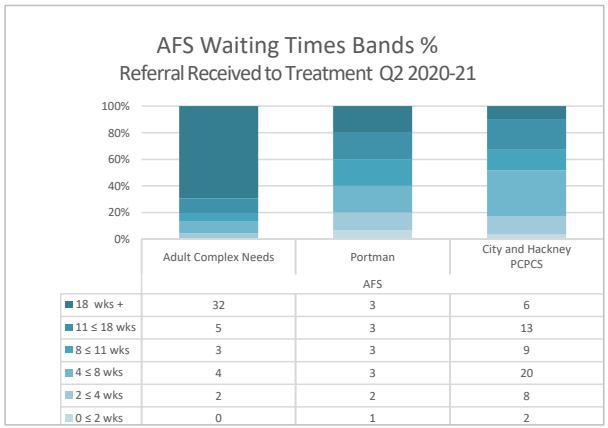
For further comments from service leads please see the commentary part of the report Page 21

Q2 20/21: 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 Q2 AFS saw 51% of patients within the contractual waiting times. In Q1 this compliance was to 48%.
Referral to Treatment : In Q2 AFS saw 66%. of patients within the contractual waiting times. In Q1 this compliance was to 65%.

Adult Complex Needs
Referral to 1st appointment –in Q2 they had 35% compliance, a slight decrease on Q1, when 37% compliance was achieved.
Referral to Treatment– in Q2 they had 30% compliance, a significant decrease on Q1, when they had 50% compliance.

Portman
Referral to 1st appointment – in Q2 they had 93% compliance, a slight decrease on Q1, when they achieved 100% compliance.
Referral to Treatment– in Q2 they had 80% compliance, a decrease on Q1, when they had 90% compliance.

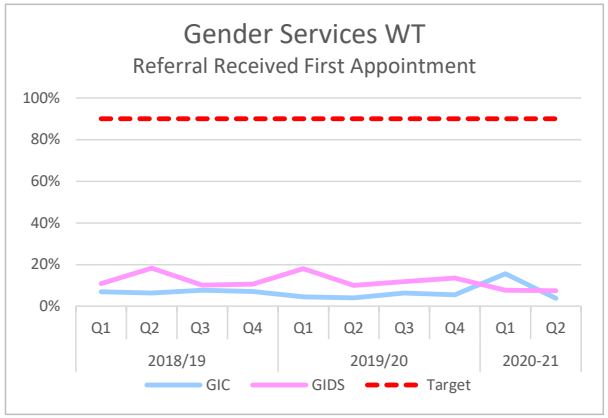
C&H PCPCS
Referral to 1st appointment – in Q2 they had 93% compliance, a slight increase on Q1, when they had 92% compliance.
Referral to Treatment– in Q2 they had 90% compliance, an increase on Q1, when they had 78% compliance. The target was met this quarter.

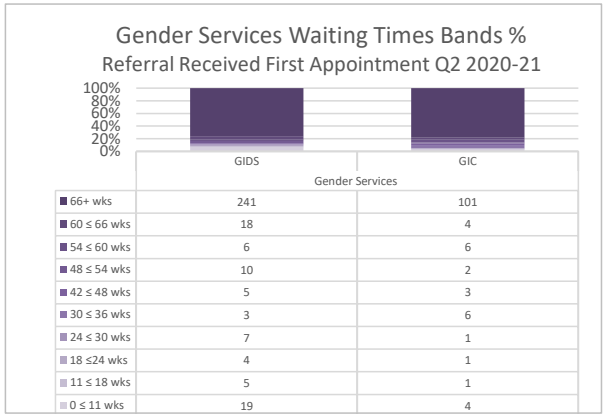
Team Around the Practice:
Referral to 1st appointment – in Q2 the percentage of patients seen on time decreased significantly to 7%, in Q1 compliance was 21%.
Referral to Treatment– this service does not report on second appointments as their system (EMIS) is not able to provide the data.

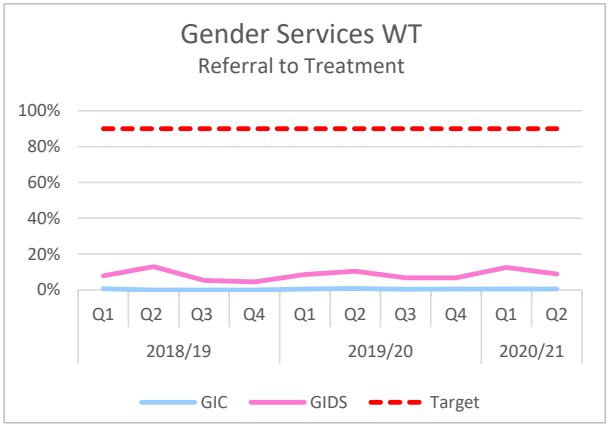
For further comments from service leads please see the commentary part of the report Page 22

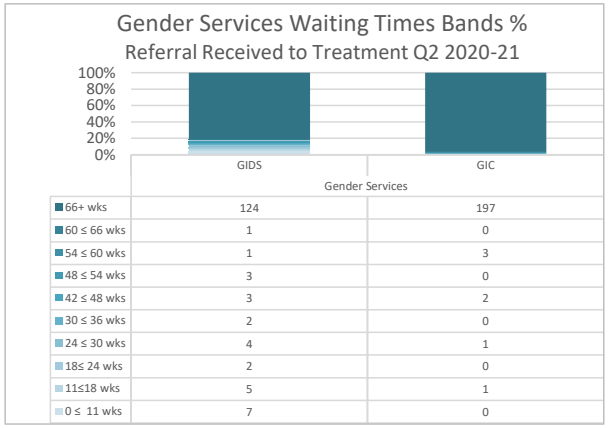
Data source: Q2 data as recorded on 08/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data.

Q2 20/21: Quality Responsive – Access









Data source: Q2 data as recorded on 08/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data.

Gender Services Waiting Times:

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

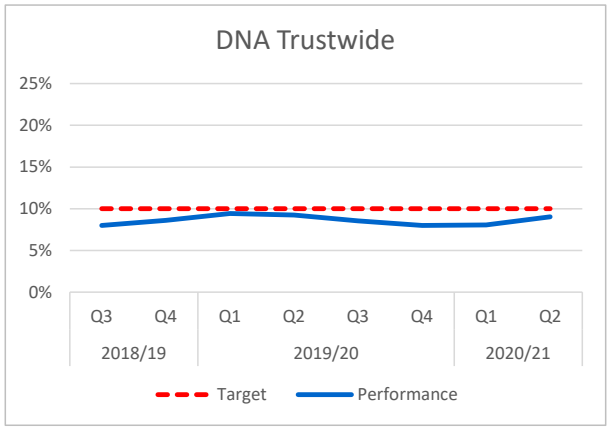
Referral to 1st appointment: Gender Services Directorate saw in Q2 6% of patients within the contractual waiting times. This is a decreased rate compared to 10% in Q1.
Referral to Treatment : Gender Services Directorate saw in Q2 4% of patients within the contractual waiting times. This is a slightly lower rate compared to 6% in Q2.

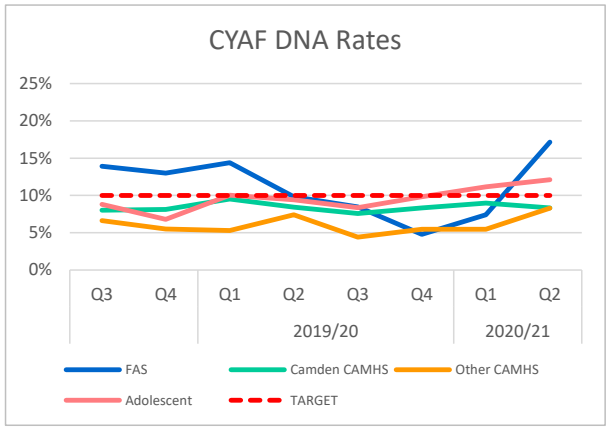
GIDS: as a measure of awareness the GIDS website shares information about the WT issue; the current waiting time is advised on the website to young people and referrers and explains that they currently see young people who were referred 22-26 months ago.
Referral to 1st appointment – in Q2 had 7% compliance, a decrease on 8% in Q1.
Referral to Treatment – in Q2 had 9% compliance, a decrease on 13% in Q1.

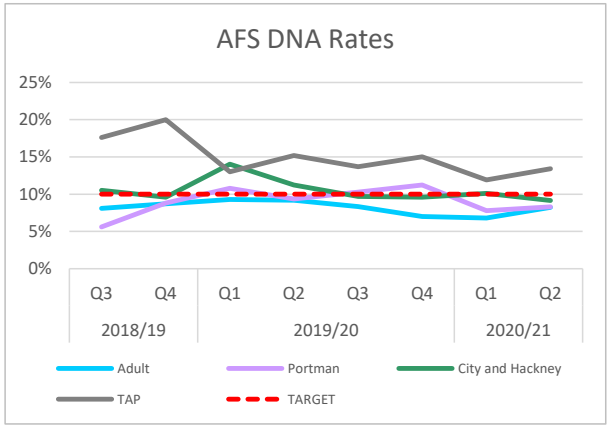
GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.
Referral to 1st appointment – in Q2 had 4% compliance, a decrease on 16% in Q1.
Referral to Treatment– in Q2 had 0.5% compliance, a slight increase on 0% in Q1.

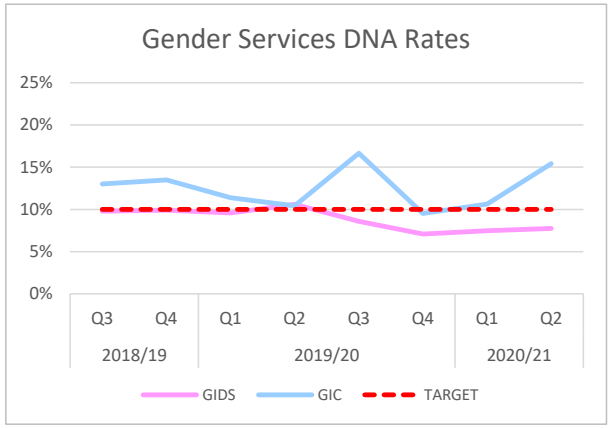
For further comments from service leads please see the commentary part of the report Page 23

Q2 2020/21: Quality Effective – Access









Data source: Q2 data as recorded on 01/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

Did Not Attend (DNA)

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

Trust-wide, we continue to maintain a good DNA rate. In Q2 our compliance rate was 9.03%, slightly higher than in Q1 when 8.08% of patients DNAed.

Adolescents: in Q2 had 152 DNAs and 1104 attended appointments, with a DNA rate of 12.10% – the rate has been increasing since Q4 2019/20 and is now above the target. The DNA average during last financial year was 9.4%.

Camden CAMHS: in Q2 had an 8.33% DNA rate (471 DNAs with 5182 attended appointments), in Q1 the rate was 8.98%. Target has been met for the last 2 years. The DNA average during last financial year was 8.5%.

Other CAMHS: in Q2 had a DNA rate of 8.27% (268 DNAs and 2972 attended appointments), an increase on Q1 5.45%. The average during last financial year was 5.6%.

Family Assessment Service: in Q2 had a DNA rate of 17.14% (6 DNAs and 29 attended appointments), a significant increase on Q1 7.41%. The average during last financial year was 9.4%.

Adults Complex Needs: in Q2 had a DNA rate of 8.23% (251 DNAs and 2800 attended appointments), a slight increase on Q1 6.79%. The average during last financial year was 8.5%.

Portman: in Q2 had a DNA rate of 8.29% (119 DNAs and 1316 attended appointments), a slight increase on Q1 7.79%. The average during last financial year was 10.4%.

C&H PCPS: in Q2 had DNA rate of 9.14% (72 DNAs and 716 attended appointments), a decrease on Q1 10.09%. The average during last financial year was 11.1%.

Team Around the Practice: saw an increase in DNAs in Q2, resulting in a 13.40% DNA rate compared to a 11.90% rate in Q4.

GIC: in Q2 287 patients DNAed and 3914 attended appointments. This signifies an increase, as in Q2 the DNA rate was 15.42% and in Q1 was 10.63%

GIDS: in Q2 there were 329 DNAs out of 4031 attended appointments, achieving a rate of 7.75%, slightly higher than in Q1, when it was 7.46%,

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

Q2 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 was published with a three-month delay – The most recent published DQMI is for March 2020, we understand this wont be published for the foreseeable future.

- We were pleased to report we have achieved the 95% target, with a compliance rate of 95.60% in March 2020.

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 rates, the reports are discussed at the Quality Assurance Group (QAG) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved. The Quality Assurance Group (QAG) has been defining and implementing operational changes in all service lines to accommodate the requirements. We have accomplished an incremental increase in collection rates of Primary reason for Referral, and the Ex-British armed forces indicator.

	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
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%
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%
Valid Date of Birth	95%	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%
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%
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%
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%
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%
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%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%	99%	99.00%	99.00%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%	46%	48.00%	56.00%

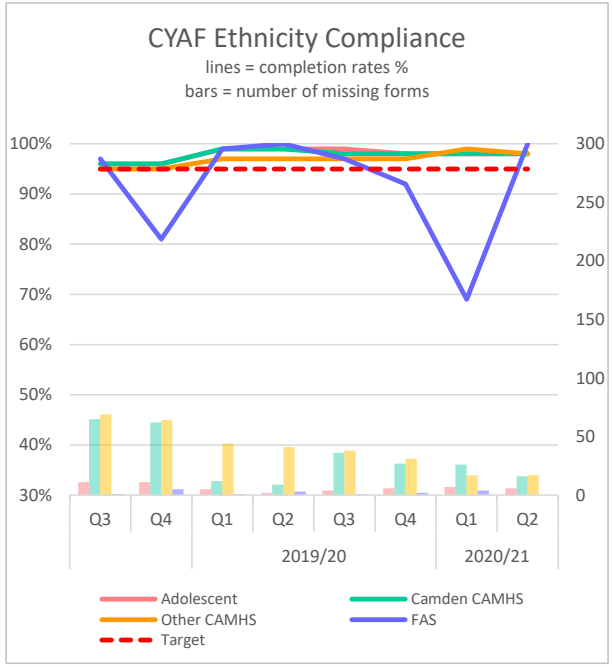
Data source: Data warehouse, informatics team 01/10/2020

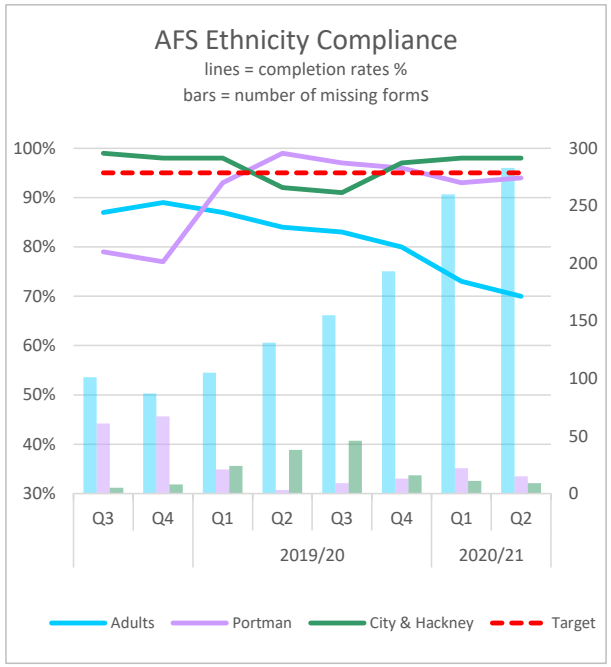
Q2 2020/21: Single Oversight Framework – Access

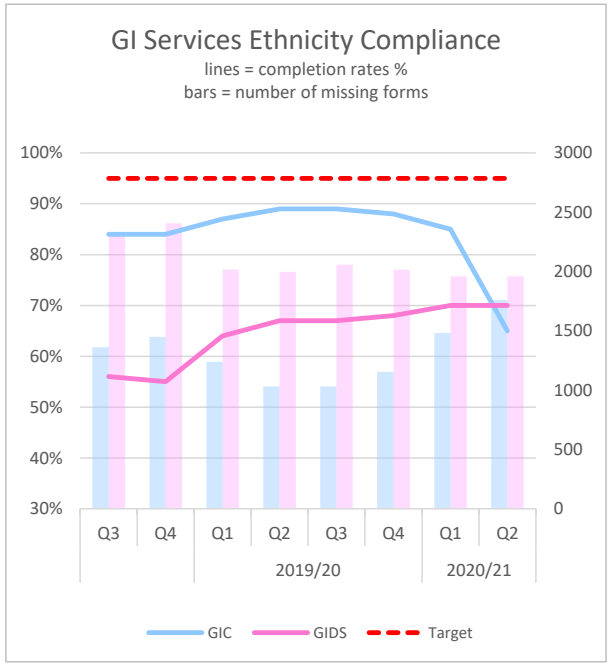
Ethnicity Rates

Ethnicity completion rates has been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%, in April last year. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. A significant aspect in not reaching the target is the large number of patients open to teams who have not been seen.

In order to better understand the impact on the overall ethnicity rate we have incorporated bars on the graphs representing the number of patients with missing ethnicity on each service line.
The Quality Assurance Team (QAT) continue to work with teams in the Quality Assurance Group (QAG), raising awareness of the situation in order to improve this data further. The QAT along with the QAG has developed a new report is called 'Basic Contact Details and Demographic Print-out ' - it allows teams to validate with patients the current information held in CareNotes and to collect missing pieces of information in our system. This process would work best on the services who have a reception as administrators can ask patients to review the form. Unfortunately test have not been possible due to Covid-19.

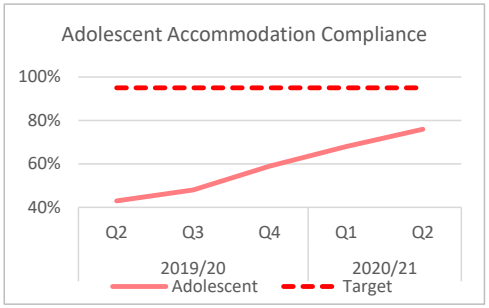


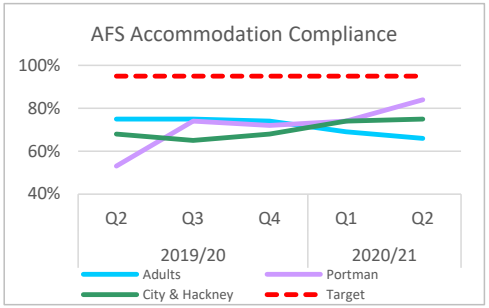


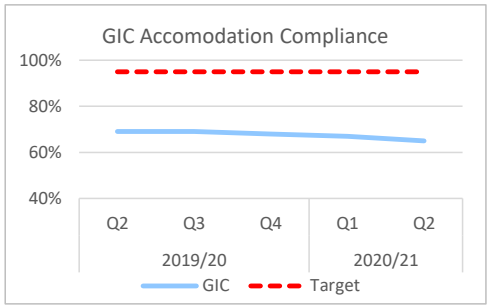


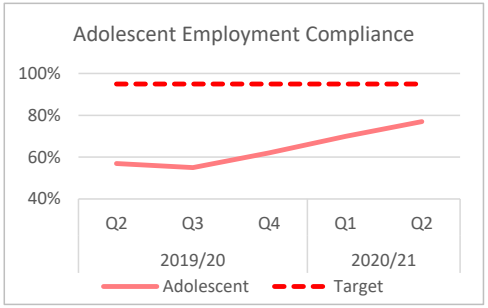
Data source: Q2 data as recorded on 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

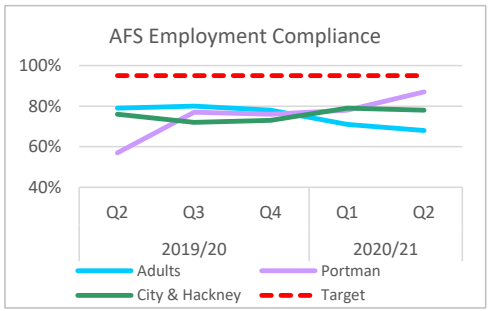
Q2 2020/21: Single Oversight Framework – Access

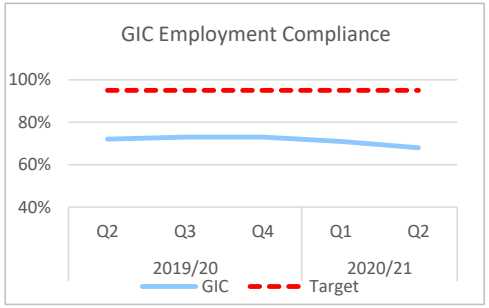


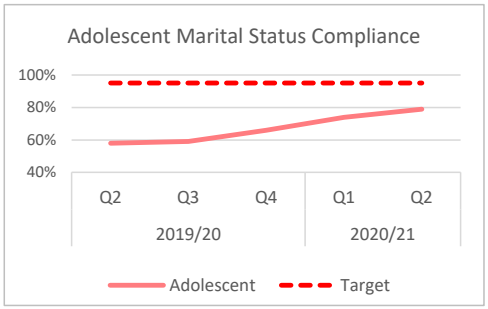


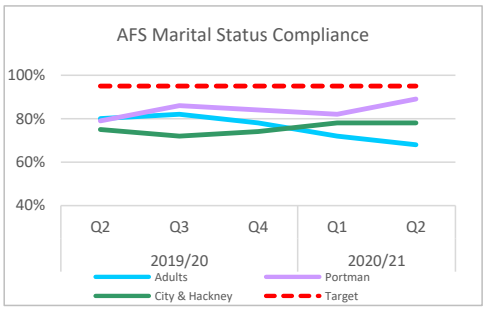


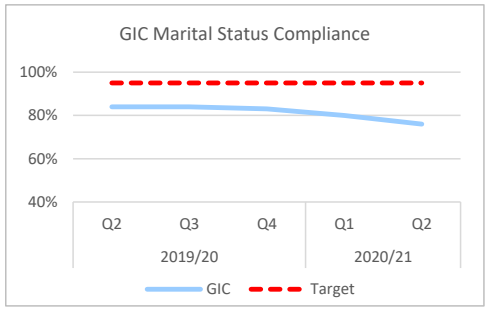












Accommodation, Employment and Marital Status Rates

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

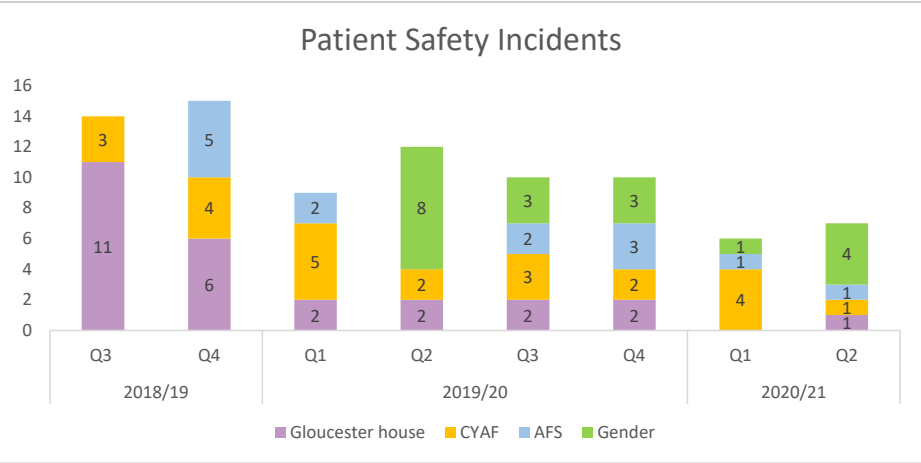
Please note the remarkable and sustained improvement of Adolescents over 18 Services data collection. It is also worth noting that Portman and C&H have improved over the last two/three quarters.

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

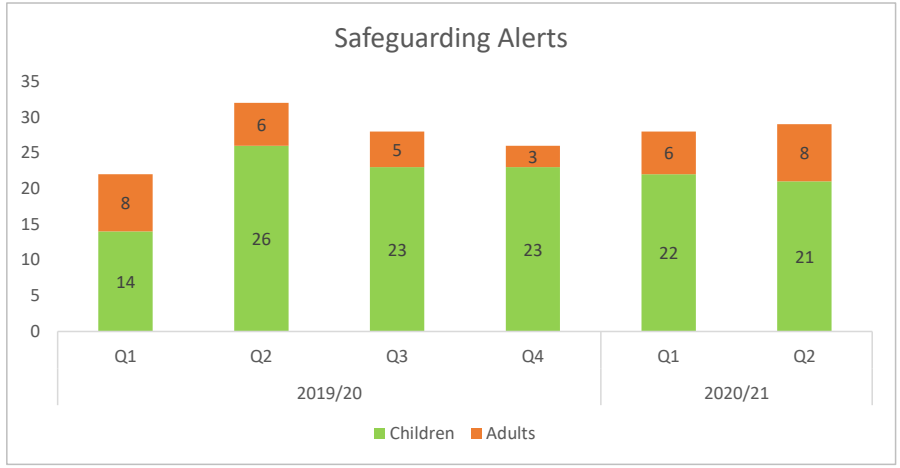
Over the last few months the QA team has been working with informatics and admin leads in developing a new report/tool to improve their data quality in basic patient details. This new report is called 'Basic Contact Details and Demographic Print-out' and it allows teams to validate the current information held in CareNotes and to collect missing pieces of information in our system. Unfortunately due to lockdown we have not been able to test this new tool as it requires patient contact.

Data source: Q2 data as recorded on 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

Q2 2020/21: Quality Safety – Care



There have been seven NRLS reportable incidents this quarter, one was clinical and six were IG. These went to the incident panel and were discussed. The clinical incident was an attempted suicide of a patient in residential care who are investigating this. The six IG incidents all related to data that was disclosed in error. Five involved a single patient and one involved 21 patient names being sent to the parent of a patient. All names were known to the parent. The IG checklist has been recirculated and the processes reviewed within that service. Our usual numbers come from the school, but this has not been the case in Q2 with no physical school attendance in July , summer holidays and a huge reduction in the classes returning to school in September and October.



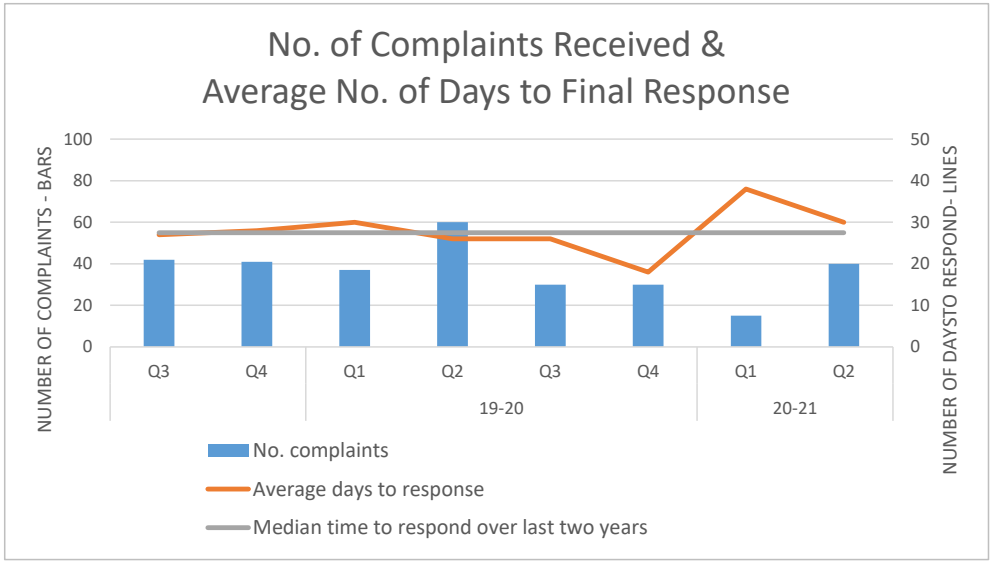
Some cases have more than one type of concern and were counted as one for accurate reporting

Data & commentary source: Clinical Governance 09/10/2020

Incidents Reported by Risk Level – Trust wide	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2
1-4	117	82	101	65	65	60	37	34
5-8	38	23	28	27	28	30	11	19
9-12	3	9	3	11	12	18	3	3
15+	1	1	0	2	0	1	1	2
Total	159	115	132	105	106	109	52	58

Data & commentary source: Health & Safety Department 15/10/2020

Q2 2020/21: Quality Responsive – Care



Directorate	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2
Adult and Forensic Services (A&F)	5	4	4	5	2	4	0	1
Children, Young Adult and Families (CYAF)	36	36	32	0	4	4	3	11
Gender Services	-	-	-	55	24	21	12	25
Corporate	1	2	1	0	0	1	0	3
Total	42	42	37	60	30	30	15	40

During Q2 a total of 40 complaints have been received, this is an increase from last quarter. Complaints investigations have now re-started following the pause imposed during the first part of the coronavirus pandemic, however there is a backlog of complaints to be dealt with leading to further delays in responding to complainants. Of the complaints that have been responded to from Q2 8 were not upheld and 6 were either upheld or partially upheld.

See Slide 31 for further KPI complaints information

Total PALS enquiries Q2		
Quarter	Total	Main enquires:
2020/21 Q2	**239**	• Communications
2020/21 Q1	216	
2019/20 Q4	178	• Access to Treatment or Drugs
2019/20 Q3	212	

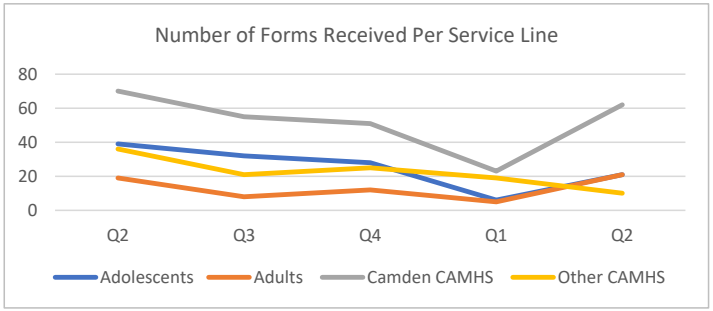
Data & commentary source: Complaints Department 09/10/2020

Q2 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%**										
Q6 from ESQ "The information I received about the Trust before I first attended was helpful."	Quarterly	75%	35	33	**94%**	73	78	**94%**										
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%**										
Q12 from ESQ "Options for my care were discussed with me"	Quarterly	n/a	28	28	**100%**	49	55	**89%**										
Q13 from ESQ 'Involved in important decisions about my care'	Quarterly	n/a	26	26	**100%**	48	53	**91%**										
Q15 from ESQ "Overall, the help I have received here is good"	Quarterly	92%	42	42	**100%**	106	106	**100%**										

ESQ Rates

Traditionally the responses and feedback from our patients are very positive and we are very pleased with the comments and scores received, however we feel that the number of forms returned could be higher. The trust is piloting a new shorter form which aims to improve the collection rates. 'ESQ Implementation' is one of our current year Trust Quality Priorities and the schedule is progressing well and feedback is positive. It is worth noting that the current trialled forms are anonymised and not included on the above report as they cannot be input into CareNotes. Current information also does not allow link to a specific contract. Further developments are being considered to support reporting requirements



Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team 07/10/2020

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

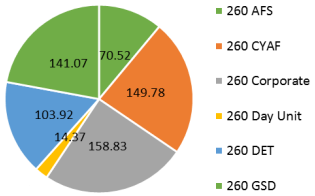
Q2 2020/21: Quality Well-Led

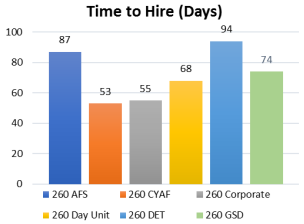
Workforce Headcount

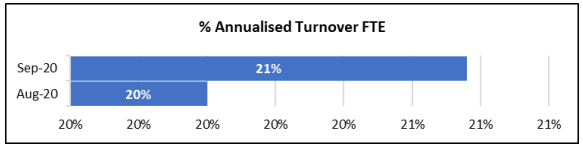
788 Total Headcount

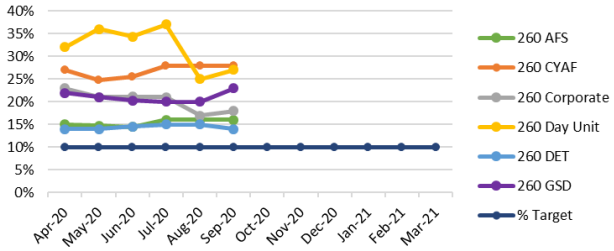
588 Female

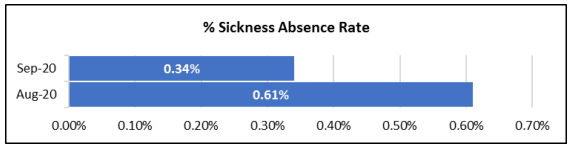
200 Male

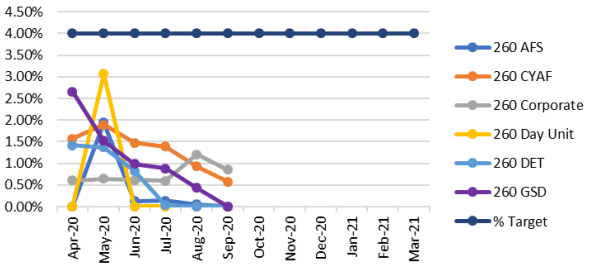


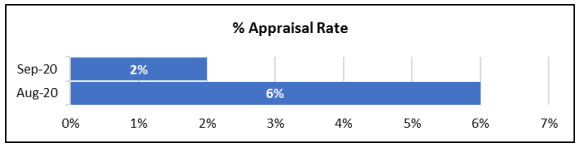


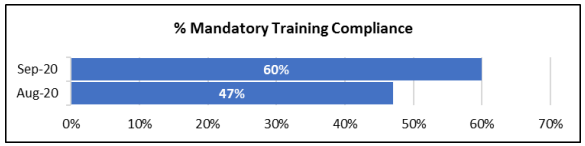


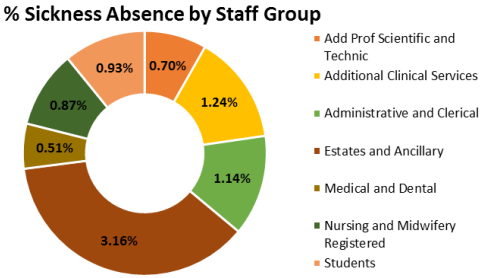


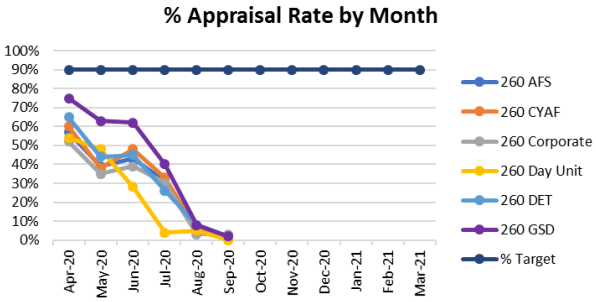


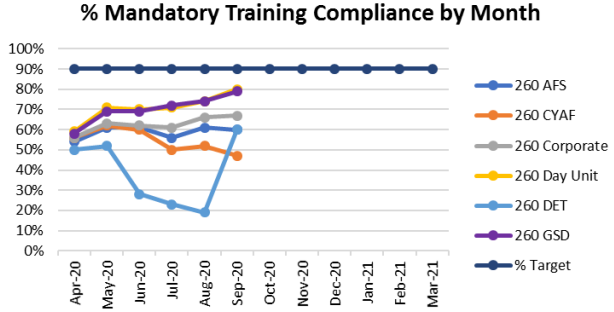












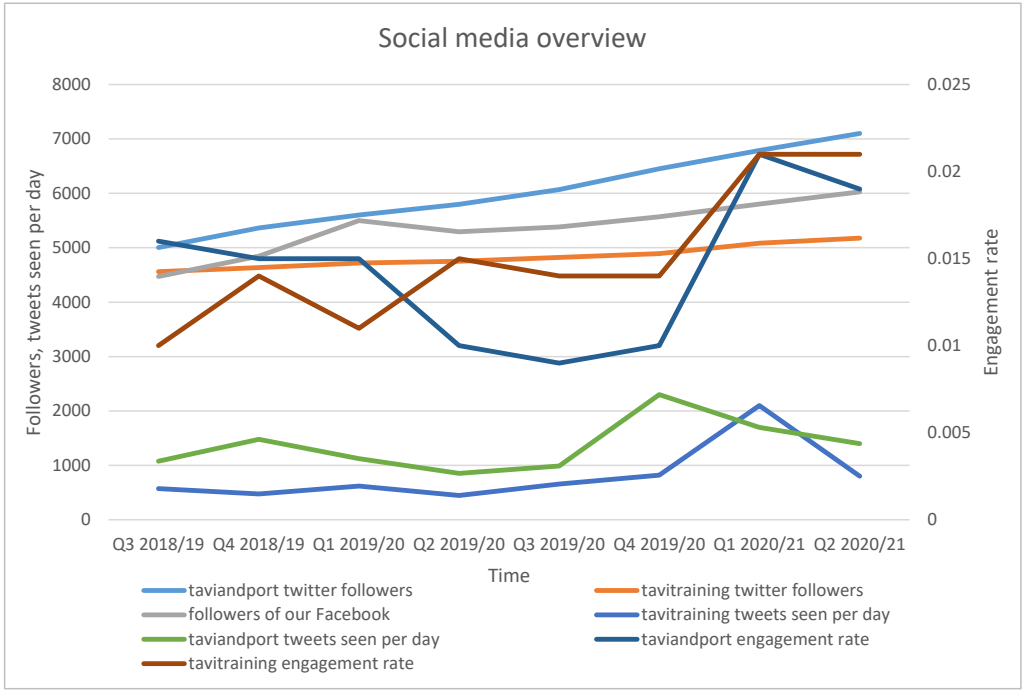
See Slide 33 for further KPI HR information

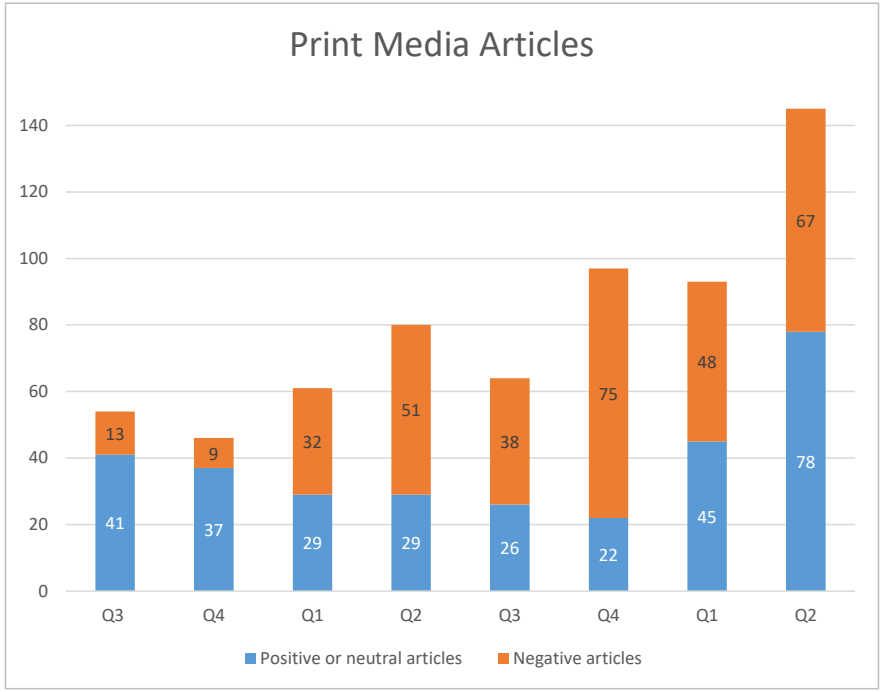
Staff survey reporting was additionally suspended in Q2 2020/2021 due to Covid-19. A light touch appraisal process has started in September 2020 – appraisal process was previously suspended due to Covid-19. A mandatory training update was run in September 2020 to help increase statutory and mandatory training compliance.

Data source: Human resources 13/10/20

13

Q2 2020/21: Media – Care





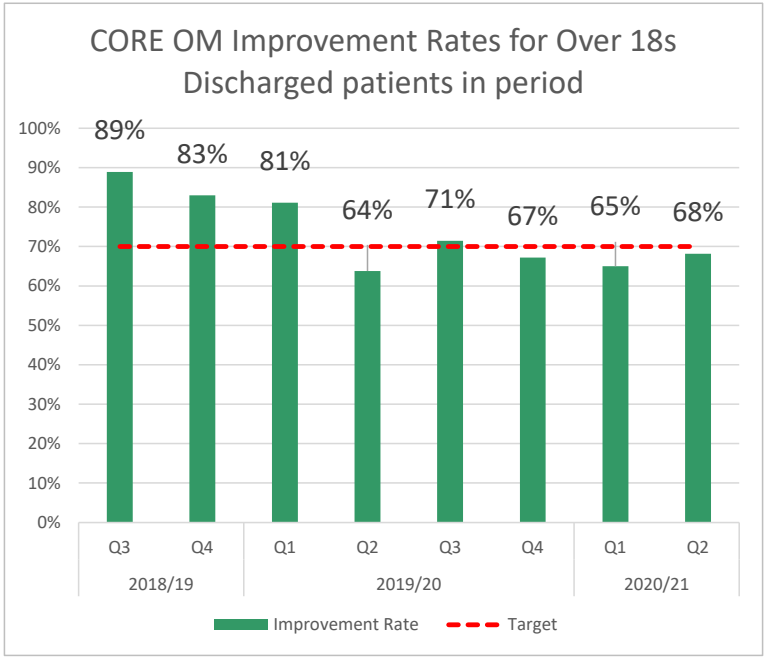
The number of followers across all platforms continues to increase quarter-on-quarter, including on Instagram, where we now have over 500 followers.
We spent the quarter promoting our centenary. Top tweet (9,271 impressions, 31 likes, 16 retweets.

This is a higher volume of overall coverage compared to Q1, and a lower proportion of GIDS related coverage, with a slight increase in sentiment: 53% positive or coverage, compared to 48% positive in Q1.

Data & commentary source: Communications Department 14/10/2020

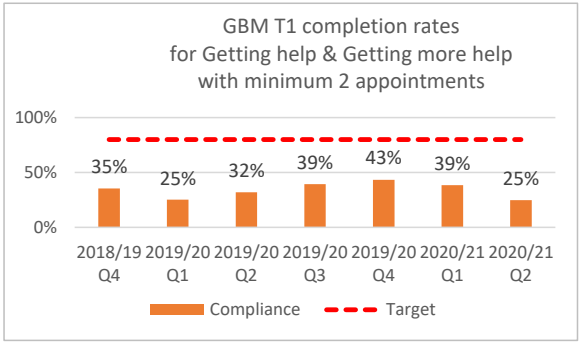
Q2 2020/21: Quality Effective – Outcome Measures

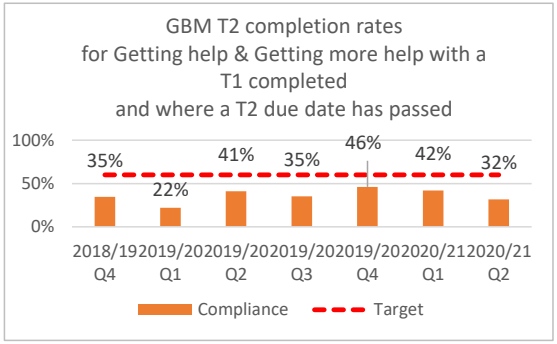
A F S and Adolescents over 18

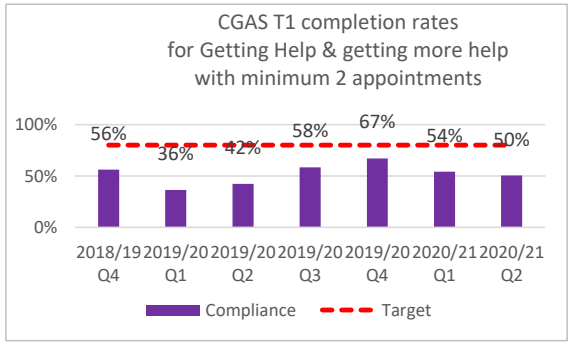


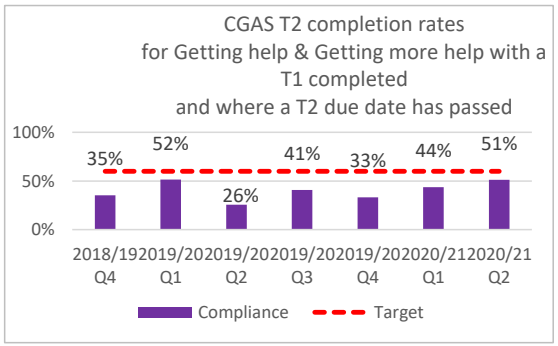
The way of reporting CORE OM improvement rates has been under review over the last few months. Previously we assessed only patients who had a CORE OM at Pre-Assessment and at End of Treatment stage, the number of cases within these parameters were very low and not representative of the Trust service. We are now including all patients discharged in period with a minimum of two completed CORE OM forms. In Q2 out of 44 patients discharged, 30 of them showed improvement, We are reviewing the form collection process as we are aiming to improve the return rates trust wide.

C Y A F









The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: GBM T1 has decreased again in Q2, 25% of the patients with a due T1 were completed. GBM T2 has also decreased with 32% completed. We believe the drop on the completion rates is related to Covid-19. The QA team has been working with CYAF on improving GBM Carenotes reminders and data completion. In Q2, a new reminder system for Adolescents was implemented. If the test is successful we will apply those changes to other teams and assess improvement on compliance rates.
-CGAS rates: CGAS T1 decreased in Q2, with 50% completion rates. CGAS T2 has increased 7% achieving 51% in Q4.

See Slide 35 for further GBM and CGAS information

Data source: Q2 data as recorded on 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data for CORE OM has been re-run and for GBM and CGAS as reported in relevant earlier reports.

Q2 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Long Course Applications Summary by Portfolio

* Showing recruitment details up until 8th October for each year for **London based and Alternate Centers only**.

	2020/21 Entry			2019/20 Entry			2018/19 Entry		
Portfolio	**Applications**	**Offers Made**	**Offers Accepted**	**Applications**	**Offers Made**	**Offers Accepted**	**Applications**	**Offers Made**	**Offers Accepted**
Psychoanalytic Applied	**359 ↑**	**260↑**	**199 ↑**	**316**	**230**	**173**	**332**	**241**	**180**
Psychoanalytic Clinical	**253 ↑**	**159 ↑**	**123 ↑**	**213**	**121**	**107**	**200**	**114**	**98**
Psychological Therapies	**140 ↓**	**94 ↓**	**82 ↓**	**150**	**112**	**86**	**158**	**108**	**89**
Social Care, Management and Leadership	**68 ↓**	**63 ↓**	**51 ↓**	**92**	**73**	**59**	**65**	**51**	**50**
Systemic	**263 ↑**	**195 ↑**	**146 ↑**	**230**	**153**	**134**	**232**	**155**	**123**
Total	**1083 ↑**	**771 ↑**	**601 **↑**	**1001**	**689**	**559**	**987**	**669**	**540**

* Showing recruitment details up until 08 Oct for each year for London based and Alternate Centers only.

**The figures above show application and offers accepted information for courses applied for via SITS and there are three courses that are not applied to in this way. M45 (Social care portfolio), M23 (Social care portfolio) and M35 (Systemic portfolio) have all generated 15, 34 and 21 offer holders respectively in the 2020/21 cycle.

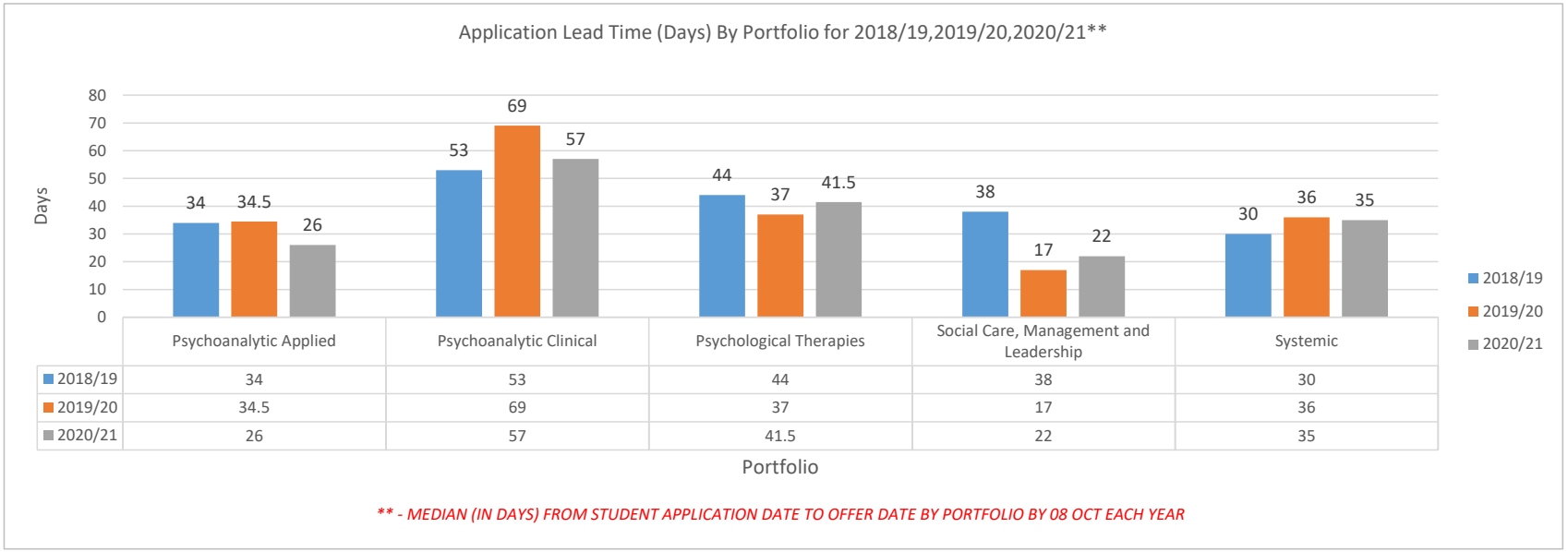
The applications cycle for long courses opens annually in November. Student registration opened in July and is due to close in October, at which point the student recruitment cycle for 2020/21 is completed.

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

Data & commentary source: DET Department 13/10/2020

Q2 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Long Course Application Decision Lead Time by Portfolio



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

Some courses within the Psychoanalytic clinical portfolio require two interviews and this can cause striking delays between applications and offer but the applicants are informed of this at every stage. The M6 (Systemic portfolio) and D10 (Social care, management and leadership) courses require group interviews so applicants who apply early can appear to be waiting a long time until the group interview is scheduled and carried out.

Data & commentary source: DET Department 13/10/2020

Q2 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Short Course Activity and Financial KPIs

Q2 Activity	2020-21		2019-20		2018-19	
	No. activities	No. students	No. activities	No. students	No. activities	No. students
Portfolio CPD	30	588	38	561	44	1023
Bespoke	12	159	33	749	10	161
International	1	0	3	104	7	84
HEE funded activity	9	158	6	270	0	0
Total Q2	**52**	**905**	**80**	**1684**	**61**	**1268**
Full Year (forecast for 20-21**)	175	1959	160	3161	153	2193

Q2 Financials	2020-21			2019-20			2018-19		
	Income	Costs*	Contribution %*	Income	Costs*	Contribution %*	Income	Costs*	Contribution %*
Portfolio CPD	£195,957	£57,148	71%	£204,210	£88,067	57%	£317,405	£141,188	56%
Bespoke	£65,872	£39,600	40%	£196,882	£116,256	41%	£87,536	£58,190	34%
International	£56,585	£0	100%	£38,622	£20,379	47%	£82,558	£38,884	53%
HEE funded activity	£92,509	£51,428	44%	£138,869	£99,962	28%	£0	£0	0%
Total Q2	**£410,923**	**£148,176**	**64%**	**£578,583**	**£324,664**	**44%**	**£487,499**	**£238,262**	**51%**
Full Year (forecast for 20-21**)	£979,491	£401,146	59%	£1,156,859	£639,824	45%	£1,047,018	£480,423	54%

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

** Full year forecast for 20-21FY as at 30 September - figures will be subject to change as courses continue through the year and new commissions come in

The CEDU KPI's are based on training activities that start within the reported timeframe (Q2). CEDU activities take place throughout the year and so the number of courses, student numbers, income and costs will continue to change throughout the full financial year and will be reported here accordingly on a quarterly basis and compared to the same period in recent years.

Portfolio CPD represents the range of external courses that are run for external, paying individuals to book onto. This has remained relatively stable in this period. Whilst the number of activities has reduced slightly, we are showing an increase in the average number of students per activity to 20, up from 14 last year. All delivery has been successfully moved online and in Q3 we will be looking in more depth at the impact this has had on the geographic spread of our students.

Data & commentary source: DET Department 13/10/2020

Quarterly Quality Report Commentary Q1 2020/21

Introduction

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

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

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

The following metrics are summarised below:

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

Waiting Times - feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q2	Objective / plan for next Quarter
Adolescent /AYAS	AYAS has been piloting an pre assessment intervention to ensure that we see newly referred patients within the waiting times from referral to first appointment. This enabled us to start assessing our patients needs and offering appropriately targeted support and intervention whilst they wait for their psychotherapy assessment. The current data indicates that this intervention has been successful	To continue to implement the pre assessment intervention and assess its impact in terms of patient experience and clinician feedback.
Camden CAMHS	In the Camden Service line 80% of clients have received their first appointment within 4 weeks and 95% within 8 weeks. Regarding second appointment (proxy for treatment) 59% have had 2 appointments within 8 weeks and 89% within 8 weeks.	A backlog of referrals had built up which needed information gathering regarding to work out what the best form of help would be. At one point in September there was a 28 day wait for information gathering. This has been addressed through setting targets for dealing with information gathering and the wait time is falling significantly. Tracking systems are being improved and a more system to monitor internal waits for treatment, which will be more meaningful that the 2nd appt proxy.
Other CAMHS	We are again pleased that we have maintained the waiting time target for 1st appointments. Second appointment waiting times are likely to have been impacted in this service line due to a pause in the ASD diagnostics during lockdown and has now recommenced	We are again pleased that we have maintained the waiting time target for 1st appointments. Second appointment waiting times are likely to have been impacted in this service line due to a pause in the ASD diagnostics during lockdown and has now recommenced

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

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q2	Objective / plan for next Quarter
Adult Complex Needs	Complex Needs Service put on hold the initial appointment for new patients for 2 months since the lockdown took place since the end of March. We resumed the offer for them from late May first by experienced members of staff as remote assessment was an unfamiliar area of our work. It was crucial to assess how it could work by experienced members of staff to secure the safety and wellbeing of patients. Also we have experienced the increase number of referrals to Trauma Unit and therefore we have not been able to catch up with this change for the staff resources.	Complex Needs Service has allowed less experienced members of staff, trainees, to take on new assessment cases as it has proven that remote assessment is helpful enough to asses each patient with clear limitation. We have allocated two trainees equivalent to 0.8 WTE to Trauma Unit in order to increase their resources.
Portman	All patients seen for assessment during the last quarter were seen within the expected 11 week timeline bar one. This is well within the required limit. We have moved to providing online (Zoom) assessments and once this was piloted and established, after which staff were able to offer assessment consultations relatively quickly.	We will continue to monitor this data, and continue to hold the second assessment consultation with the required limit where possible. We will also address any particular issues in this area as and when they arise. Patient satisfaction with the assessment process tends to be positive.
City and Hackney PCPCS	PCPCS are satisfied with our Q2 waiting time figures. The majority patients were seen for a 1st appointment within the 18 week target. 4 patients waited longer than 18 weeks and all these patients have now been seen for therapy. The national lockdown meant that all our Primary Care sites in Hackney were closed to face-to-face appointments. While effects of lockdown remain ongoing, we have made significant adaptations to our service, offering the vast majority of appointments remotely (via video or phone), so it is rewarding to see that most patients were seen within a safe and appropriate timeframe. 2nd appointment waiting times were also affected by the lockdown, with many appointments having to be postponed while we moved, safely and securely, to remote working. Although PCPCS did not meet its 'Referral to Treatment' target again this quarter, the reports shows an improvement from Q1.	Seeing patients within an appropriate timescale, particularly within a Primary Care setting, can reduce risk, result in better patient experience, mean less mental pressure on staff, and encourage GPs to make mental health referrals as they can expect their patients to be seen by our service in a safe and timely manner. Since July, referrals to the service have increased to an amount in line with previous years, showing our vital place within mental health provision in Hackney. PCPCS are currently able make patients a substantial assessment and treatment offer, through phone and video appointments. We will continue to offer these as standard, as well as limited face-to-face appointments when clinically indicated and when a safe, suitable location can be found.
TAP	We recognise the increasing wait for first contact at TAP, which can be understood in terms of the significant funding cuts to the service from 1 April 2020. We have lost clinical staff, both as a direct result of the financial cuts and subsequently as two of the remaining staff decided to leave the service. The reduced staffing has inevitably impacted on our capacity and finite numbers seen. Recently, one of factors affecting this further may be the decision to change the assessment/treatment ratio to favour treatment in an attempt to use our resource to reduce treatment waiting times. We note the complexity of Primary Care patient referrals including the fact that some are referred for psychological help with primary physical issues which can lead to some ambivalence and at times reluctance.	We have recently recruited successfully to the 2 recently vacated posts at TAP and expect to see some increase in capacity in the months ahead.

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

Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q2	Objective / plan for next Quarter
GIC	The wait times for first appointments is an ongoing problem for all of Gender Services. We are working on service developments to think about how to make a patient's wait more active and less stagnated. As well, we are considering the types of patients waiting and is there a possibility of service development for specific sections of patients who need less support.	More conversation and development of active waiting as well as service developments will continue and hopefully some pilot project will be ready by Q4. Continue to work on Quality initiatives for more active waiting. This will be on ongoing project that will continue to evolve and develop.
GIDS	The total number of new patients we commenced clinical work with in Q2 is 318, which is slightly lower than Q1.	We are currently conducting a QI project into the parity of waiting times in GIDS. This looks at potential reasons why some patients experience a different (shorter or longer) waiting time than others.

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

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q2	Objective / plan for next Quarter
Adolescent /AYAS	The AYAS DNA rate has increased since the start of the COVID pandemic. This is due in part to our population dispersing more than other patients within the trust as many of our patients are students. In addition to how the therapy appointments are currently being offered remotely.	We are addressing the increase in the DNA rate on an individual basis and will assess the need for a change in approach once the patients with the highest DNA rates are addressed.
Camden CAMHS	Camden Service Line has consistently achieved low DNA rates, below the 10% target.	The Camden Service line has a range of systems in place to keep DNA to a minimum that will continue to be implemented
Other CAMHS	Our DNA rate has now remained below target for two years. We are pleased that we have been able to maintain this and continue to monitor it. Recent increase in part due to the FAS service having a smaller number of families in the service (due to coming to imminent contract end) and the mandated rather than voluntary referral to the service.	Maintain low DNA rate into the next year and scrutinise any increase.

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

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q2	Objective / plan for next Quarter
Adult Complex Needs	We think it is a great achievement that Complex Needs sustain the target of DNA rate under the difficult time of lockdown as it is difficult to sustain communication.	I think this data demonstrates how we work with patients in a involving and communicative way. We shall continue to sustain this level of work.
Portman	The initial trend of the rise in DNA appointments seen in Q4 (2019/20) dropped significantly prior to the onset of the pandemic, and has only risen slightly since then. Our experience has been that patients have been motivated to attend their appointments by telephone or online as their sense of isolation has increased. We have felt that maintaining sessions has prevented many patients from breaking down due to the strain of the lockdown.	To continue as planned.
City and Hackney PCPS	PCPCS are pleased our DNA rate has again met the target set for the Trust, dropping below 10% in Q2. This quarter continued what has been a challenging time for the service, but PCPCS has adapted. The vast majority of our patients are now receiving their therapy remotely (via video or phone). The lower DNA rate indicates patients are appreciative of PCPCS continuing to offer treatments during this time. 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 in the majority of cases not been feasible.	We hope to maintain a similarly low rate going into the next quarter, and continue to use the means available to us to sustain patient engagement in their treatment. The service has adapted well to provide therapies remotely, and the response from patients has been positive. We will continue to keep the possibility for face to face work under review and to inform our patients of any changes that may affect the service over the next quarter. We encourage all members of the team, clinical and administrative, to communicate clearly and in an open and straightforward manner when in contact with patients. We believe this creates mutual respect and trust, positively impacting outcomes and engagement.
TAP	Looking at the graph, the trend for DNA rates has been decreasing overtime. Non outcomed appointments on Emis don't automatically default to DNA. The definition of DNA has been clarified with the service in order to improve data quality. It is not clear why there seems to be an increase in the last quarter without looking more closely at the data. In Tap we are planning a small qualitative QI project looking at reasons for DNAs.	It is possible that the lockdown in Q1 has led to an increase in DNA rates. This is based on comments made by clinicians that fewer patients missed appointments during lockdown, possibly due to more flexibility or greater awareness of need.

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

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q2	Objective / plan for next Quarter
GIC	Some patients have reported that IT issues including connectivity and lack of a safe space to communicate has impacted on the DNA rate. We have continued to contact every patient before their appointment to confirm their attendance. When they DNA, we contact them again confirm they knew they DNAed an appointment.	There will be a review of DNAs in Q3 and Q4 to try to identify why the rate has increased again after the work that was done in Q4 last year.
GIDS	DNAs of 7.7% we feel are relatively high for the service. This may be due to new factors such as technical issues on the day, or equally due to caution about travelling where patients are face to face.	We will look into ensuring communication lines and options for patients to let us know if they are likely to experience difficulties are available.

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 2 Narrative Updates**	**RAG Rating**
Complete audit of Carenotes Alerts within each of the clinical directorates (AFS, CYAF and Gender) to clarify current use of Alerts	An audit has been completed in AFS and identified the main uses of alerts in that directorate are congruent with usage in CYAF. An audit has not been completed in Gender as there are limits on their capacity at present and anecdotal evidence from the General Manager suggests it is likely that their use of alerts is similar to CYAF and AFS. The main themes were communication and risk and safeguarding concerns.	Ongoing
Agree parameters for when Carenotes Alerts should be used across the Trust	The QI project in North Camden was unable to progress due to staff sickness. Therefore, the CYAF and AFS General Manager has drafted guidance on the use and review of Carenotes alerts, and this will be shared with managers and teams across all directorates in Q3 with a view to roll-out by end of November 2020. This will include systems for reviewing alerts and auditing compliance. An audit will then be conducted in Q4 across all 3 directorates.	Ongoing
Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review	See above. In addition, this will be discussed in the DD monthly meeting with General Managers, as per the statement in Q1.	Ongoing
Implement guidance and re-audit across the directorates to assess adherence to the new guidance.		n/a

3.2 **Quality Priority 2**

Quality Priority	2 - Experience of Service Questionnaire (ESQ) implementation	Quality Priority
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Evaluate and review Q4 testing and test in 2 Adult and Forensic Services teams, reviewing and adjusting the form following these tests	Feedback has been compiled. AFS Director has been provided with data to discuss at relevant team meetings as of 7/10/2020	Ongoing
Identify and assess methods of streamlining collection of the information and obtain a consensus for delivery across the Trust	To be reviewed with overall methods of collection for data Trustwide in current climate.	Ongoing
Evaluate effectiveness of the new form for increasing ESQ return rates and improving qualitative feedback	No forms have been collected during Q2 as no tests were active.	Ongoing
Work with teams to increase use of the ESQ data to improve and develop services	Ongoing – AFS director has data from services and will be taking this forward with local teams.	n/a

3.3 **Quality Priority 3**

Quality Priority	3. Improve Waiting Times Across the Trust	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice	Unfortunately progress on this has been delayed due to other pressing priorities. Discussion on this is scheduled for the second half of October, and we will also press ahead with staff and patient surveys during Q3.	On hold
Survey staff and patients to understand their experience of being on or working in services with long waiting lists, and their thoughts about how to manage these (Q3)	Dependent on the above.	On hold
Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 & Q4)	Dependent on the above.	On hold

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback	Each directorate and service line has reviewed its use and application of OM in internal governance and service meetings. We have learnt that directorates and in some case teams have different cultures and standards which reflect a heterogeneous use and application of PROMs. The purpose of this Quality priority is to develop a more consistent culture going forward such that clinicians, patients and administrative / operational colleagues are clear and agreed about what to expect (in terms of Oms) when and why and that the emerging data is used routinely to inform service quality and development.	Ongoing
Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications	The Quality Assurance Team is undertaking the following workstreams in relation to OM's: ➢ CareNotes interface- we are reviewing that the relevant fields are made mandatory, that the descriptions are intuitive for the end user encouraging accuracy and consistency. ➢ CareNotes Assist panel logic- we are revising that the logic meets the clinical needs and expectations. ➢ Completion Date in the CORE form. Quality Assurance Team have led on a project to make OM Completion Date field mandatory, and in the field description on CareNotes to describe it as: 'Completed Date, when form completed or form received by Trust'. Where the form is returned without completion date we will use date of return by email or post." ➢ Date sent would be when physically passed to the patient, emailed or posted.	Ongoing
To develop a robust and standardised system of user friendly reminders and follow up on missing OM through the EPR and team level reporting	**CYAF Update:** The CORC (CAMHS Outcomes Research Consortium) survey has now completed and we have received our results, this has provided us with a lot of feedback and insight into staff perceptions of OM, it function, value and application. CYAF management will be reviewing the data in October and using findings to decide what actions need to be taken over the next quarter. **AFS Update:** We are currently running a 68% improvement rate on CORE OM at discharge across AFS (also including adolescents over 18) As stated elsewhere returns are generally down across the trust during lockdown due to a variety of factors. Qualtrics Update – on 13th October the Executive Management Group will hear a brief paper on the potential benefits of using Qualtrics across services (currently used in GIDS) to gather patient level data electronically. It is not a panacea but, if approved will save paper, time and be more in line with contemporary forms of communication in outcome monitoring. Adult Complex Needs – considering Core 10 as an option, it is briefer than Core 32 and our hypothesis is that patients and staff may find it less burdensome to complete. To update on outcomes next Qtr. Data Quality & Complex Needs have met to consider CORE form preferences i.e. Which forms will appear on the Care notes Assist Panel at which points, and subsequently when those forms should flag up as being due for completion. TBC for next QTR Primary Care Update- we have found a way to incorporate all four 'expected' CORE forms for PCPCS into their logic and have clear guidelines set out by PCPCS as to when the forms should appear on the Care notes Assist Panel and when they should be considered due. TAP – continue their QI projects into Black and Minority Ethnic patient access to clinical service and Outcome monitoring.	Ongoing

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures	**Gender Services Update-** GIDs as with all our services has seen a reduction in returns during lockdown. As such the main reason why we had these issues was actually to do with email addresses. We require an email address for the young person and the Caregiver to send out these questionnaires and, in compliance with GDPR we only send these once we have verified email addresses. Our biggest issue has been getting these emails verified in the first instance (or even getting email addresses) – this is potentially likely to be a Trust-wide issue unless there is a process that is agreed in order to acquire this information for OM use. Technical aspects in Qualtrics remote data collection - depending on the email sent to these could be going to junk mail/being parked as spam if they include 'clickbait' type text . The Adults Gender Identity Clinic As previously reported, remote work has disrupted the previously high return rates for ESQ (paper based) as the Gender Identity Clinic and attempts are being made to recruit alternative, digital methods to locate and embed this data. We will report on outcomes and return rates in the next Qtr. It is important to note that this clinic is not a mental health service and as such does not use routine OM in the form of Psychological testing used by CYAF and AFS, but does focus on. We are pleased to report and have been greatly impressed by the wide range of medical, occupational and speech related monitoring and testing that the clinic uses in its ambition to provide a caring and humane service that is not predicated on a psychiatric model of care.	Ongoing
To develop a robust and standardised system of user friendly reminders and follow up on missing OM through the EPR and team level reporting	AIMS for next Quarter: 1. My recommendation to teams and service leads has been to agenda items for team meeting discussion to engage clinicians and their operational and administrative colleagues in discussion about the factors that support and encourage completion but also to relate to this data as important clinical information as well as statistical information for measurement against CQUINS or externally mandated evaluation. 2. The 'reducing the burden' initiative of last year gives us food for thought for making the process of ending out and retrieving OM as manualised as possible using modern technology and saving paper. EMT will consider the potential of Qualtrics alongside other free and commercially available solutions. Technology will not provide a simple answer, it is more complex and relates to the Meta burden of lockdown as well as our services not being in physical proximity to our patients and service users. 3. We are pleased to report a high level of engagement from all services and real development in the consistency of governance and operational structures such that we look at Quality Priorities across the services and talk to each other rather than taking a more piecemeal approach. 4. Last but not least we will continue to explore the frame of co-production as well as consultation with service users who always add perceptive and a grounding sense of reality to any operational changes. Quality improvement methodology has helped here and engaged more services in their own mini evaluations of test and re-test new ideas and modifications so that we constantly reflect on developments and consider the best way forward.	Ongoing

Section Five: Trust Targets – KPI

Quality Key Performance Indicators										
Target See Slide 11 for complaints graphical representation	Monitoring	Target %	% Progress 20/21				RAG Progress 19/20			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Complaints* - % Response to Complaints A - 90% of complaints acknowledged within 3 working days.	Quarterly	>90%	93% 1/15	87.5% 35/40						
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						
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	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 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						
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						
ii) Number of complaints reported to CQC	Quarterly	n/a	none	none						
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	none	none						
iv) Number of re-opened complaints.	Quarterly	n/a	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%						
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q4	n/a								
Clinical Audit A - Provide CCGs with copy of Trust wide audit programme in Q2.	Q2	n/a		See attached clinical audit paper Document						
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	Q2 & Q4			See attached clinical audit paper Microsoft Word Document						
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Q4									
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	Q2 & Q4	n/a		See attached clinical audit paper Microsoft Word Document						

Section Five: Trust Targets – KPI

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target See Slide 13 on HR for graphical representation	Monitoring	Target%	% Progress Q1 20/21				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Appraisal/ Personal Development Plan Quality and Development of staff: Target 90% of staff to have a PDP.	Quarterly	90%	47%	45%						
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%		0.50%						
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%						
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%						
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 Q2 20/21	RAG Progress			
					Q1	Q2	Q3	Q4
CAMHS Transformation Targets	80% initial completed care plans	Q1-Q4	80%	During Q2 20/21 29 assessment summaries were completed, out of those 15 initial care plans were created/shared giving a **compliance of 52%** (55% in Q1 19/20) *We note that there has not been an improvement in the completion rates since Q1. In Q2 we initiated dashboard reporting, which provided team level information on care plan compliance an outstanding assessment forms. In doing this we have identified that compliance varies widely across the teams in CYAF, and that care plans are often completed, but not in a timely way which affects the data. We have approached those team managers achieving higher rates of compliance to understand what is contributing to their success, with a view to share the learning across the directorate.*				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	During Q2 there were 231 Assessment Summaries completed. Of those, there were 106 Review Care Plans created/shared – giving a **increased compliance rate of 46%** (45% in Q4). The percentage of those care plans completed with in 6 months of the initial Assessment Summary was 8% in Q2 (20% in Q11 20/21) *Data collection for review care plans is highly complex as the reports do not flag when a review is due. We have focussed our efforts on initial care plans, and will take the learning from initial care plan completion to promote increased completion rates for review care plans.*				
	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 Q2 there were 77 responses from CAMHS patients to the ESQ question 7 ('I feel that the people who have seen me are working together to help me'). Of these 77 responses, 64 patients answered 'certainly true' and 11 answered 'partly true' **giving a compliance rate of 97%** *We are pleased to have achieved this target, but recognise that completion rates of outcome tools across the directorate have reduced through remote working. We are in the process of exploring using Qualtrics to improve our return rates.*				

Data source: 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Team

Section Five: Trust Targets – KPI – London Contracts

Target	Detail of indicator	End of Year Target %	% Progress Q2 20/21 See Slide 15 for OM graphical representation	RAG Progress Q1	Q2	Q3	Q4
CYAF Outcome Monitoring **GBM** - Goal Based Measure **CGAS** - Children's Global Assessment Scale Reported Quarterly	**GBM** Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**26 out of 105 due GBM T1's completed during Q2 - 25% compliance (39% in Q1)** *Unfortunately GBM T1 completion has dropped from 39% to 25%. This is despite admin systems being in place and regular reminders from staff. This could be linked to the Covid outbreak where work is often focused on coping rather than moving towards goals, but this is only a hypothesis.*				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**52 out of 103 due CGAS T1's completed during Q2 - 50% compliance (54% in Q1)** *Completion rates have dropped slightly from 54% to 50%. This is a clinician measure so should be easy to complete. The view of the usefulness of this measure varies between different staff which may affect compliance, but it is hard to find a rational for this drop, which has taken place while reminders are being given to staff regularly.*				
	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%	**25 out of 79 due GBM T2's completed during Q2 - 32% compliance (42% in Q1)** *GBM Time 2 has dropped from 42% to 32%. The rates were higher in Q4 last year and at this quarter last year was at 41%. This is despite admin systems being in place and regular reminders from staff. This could be linked to the Covid outbreak where work is often focused on coping rather than moving towards goals, but this is only a hypothesis.*				
	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%	**22 out of 43 due CGAS T2's completed during Q2 - 51% compliance (44% in Q1)** *CGAS time 2 has increased from 33% (Q4) to 44% (Q1) to 51% (Q2) which is a positive trend.*				

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Data source: 07/10/2020 SRRS (Internal Reporting System) Reported by the Quality Team

Report to	Date
Board	24 November 2020

Quality Accounts 2019-20 Report

Executive Summary

The purpose of this report is to provide information about the quality of services offered by the Trust. The report is published annually by the Trust and made available to the public. This year owing to the covid-19 pandemic the timescales were amended with NHS England /NHSI recommending publication to NHS Choices by 15th December 2020.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

Analysis and narrative is provided within the report in respect to Key Performance Indicators and CQUINs. Furthermore, the report presents Trust Quality Priorities to be measured in the year 2020/21. No External Auditor statement is required this year as a result of the pandemic. Positive statements have been received and included in the report from our Commissioners, Camden Local Authority and Healthwatch and Trust Governors in respect of the report.

This report was reviewed by the Integrated Governance Committee on 16th September and by the Audit Committee on 15th October who requested confirmation about the 'dropout rate' in the waiting time quality priority, and some further explanation for the reduction in patient improvement for the Goal Base Measure outcome measure to 22% compared with 57% in 2018/19. The first amendment is in Part 2 and the second in Part 3.

Recommendation to the Board

Board is asked to approve the report

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
AD Quality & Governance	Medical and Quality Director

The Tavistock and Portman
NHS Foundation Trust

YEARS

1920 to 2020

Quality accounts 2019-20

The Tavistock and Portman NHS Foundation Trust

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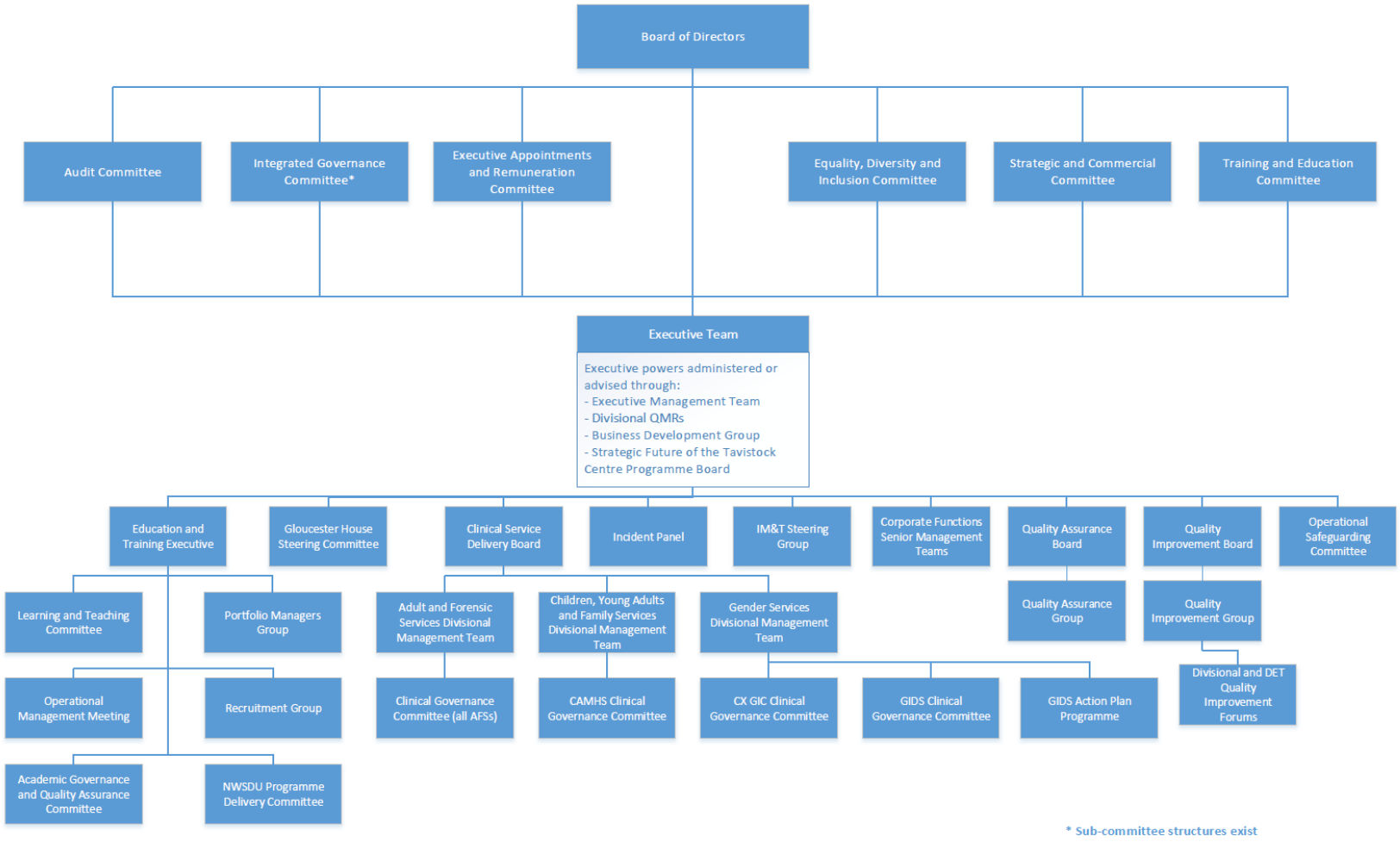
Flows of Assurance Map



Part 1: Statement on quality from the Chief Executive

It is my pleasure to introduce the 2019/20 Quality Report. This includes information required by Foundation Trusts and also reporting requirements for quality accounts which all NHS healthcare providers are required to publish each year.

This Report is an important way for the Trust to communicate its commitment to delivering quality services and to show what improvements we have made in the services we deliver to local communities and stakeholders. The Board of Directors is ultimately responsible for ensuring that we continue to raise the bar on all our quality initiatives.

Our patients tell us that knowing that they will receive good treatment is the most important quality priority and we are pleased that most of our patients continue to rate the help they receive at the Trust as 'good'. To continue to improve our services it is vital that we understand, in detail, how well we are providing services, and where we can improve. This report sets out the ways in which we strive to provide that assurance to our patients, carers, commissioners and other stakeholders.

We provide specialist out-patient mental health services locally and in many different community settings for patients of all ages. We also have a national remit for providing gender specific services for children and adults. In addition, in Camden we provide integrated mental health and social care service for children and families, have a specific expertise in providing assessment and therapy for complex cases including forensic cases. We aim to make a difference to the lives of those who use our services by seeking excellence in all areas of mental health

The COVID-19 pandemic has challenged us to think differently about how we can continue to best meet the needs of our patients, ensuring both the safety of staff and service users alike. As a result, at the time of this report, most of the services we provide are now fully, or nearly fully being provided virtually. We are embarking on a review of the impact such changes are having on patients and staff to inform ongoing service provision. The ongoing delivery of excellent care is a credit to our staff, both clinical and on the administration support side.

Delivering quality care requires good leadership, a knowledge of organisational goals and strategies and a commitment to achieving quality outcomes. Our 2018 CQC inspection confirmed we had a clear strategy that was well understood across the organisation. However, it was identified that the monitoring of service line quality and performance was not sufficiently robust and there were variations between directorate governance meetings. This meant that that teams might not have access to adequate learning from incidents, complaints or other methods of assurance such as clinical audits.

We have continued to provide teams and the Trust Board with detailed information about performance but we have also fully reviewed our governance processes and the performance information we provide. As a result we established a new divisional structure to manage our Children, Young Adult and Family, Adult and Forensic and Gender Services (see glossary) and appointed an executive director with overall responsibility for all clinical services. Supporting governance structures were strengthened to oversee clinical operational matters, and individual divisional quarterly quality review meetings were established. The oversight of clinical data is undertaken by a newly established quality assurance board and ongoing monthly reviews of operational data have enabled us to make significant improvements in the quality of data. Presenting information more clearly over a longer time period has helped support our decision making.

Our recently updated Clinical Quality Strategy underpins the governance changes we have made. Staff have been involved in further developing our quality improvement (QI) approach and

the Director of Quality and the Quality Improvement Group provide leadership which supports and encourages teams and clinicians to use QI methodologies to identify improvement needs and address challenges and issues, linking practice, innovation and research. Quality Improvement at the Trust is focused on improving patient outcomes and experience, system performance and professional development. Active QI forums led by our QI leads are increasing staff skills and together with a new QI board alongside the QI Group are helping support an active culture of QI activity across the organisation.

In 2019-20 we had six quality priorities focusing on improving the identification and management of high risk patients, providing effective sleep management information and improving the experience of patients in their waiting time experience, the planning of their care or feedback of their progress (outcomes) during treatment. Whilst not fully implementing them, progress has been made in all. QI methodology has been used to focus on our waiting time and patient outcome quality priorities.

Although our patients continue to rate our services 'good' we know that we still have work to do, particularly around improving waiting times in some of our services. Referral numbers in our Gender Identity Development Service (GIDS) for children and Gender Identity Clinic (GIC) service for adults remain high leading to longer waiting times than we would wish.

Across all clinical services we have been working at reducing the numbers of patients who do not attend appointments by sending text reminders and are seeing rates reduce. Pre appointment information and support continues to be provided. We continue to work closely with those who commission these services and to explore ways in which we can bring about further improvements. Our team by team waiting times report continues to keep the Board and clinical teams alert to these issues.

In March 2019 the Trust published an action plan for GIDS. This followed a review of the service undertaken by the Trust's Medical Director. The review did not find any immediate issues in relation to patient safety or failings in the overall approach taken by the service in responding to the needs of the young people and families who access its support. However, it did make some recommendations for improvements in the operation and transparency of the service. At the time of this report most actions have been completed.

Trustwide we continue to have relatively small numbers of incidents including those which are serious, but are committed to learning lessons where possible. Learning events were established during the year to share learning information with staff and these have been well attended. The Board receives reports in its public meetings on all serious incidents involving death. In addition we have a good record on safeguarding with strong leadership from the Medical Director.

The 2019 annual staff survey recognises our staff are committed to providing excellent quality of care and continue to recommend the Trust as a place to work or receive treatment and the Trust provides a safe environment to work in. However, we know that there are areas we need to continue to work on. Despite actively working with staff from BAME (see glossary) backgrounds over the past year the survey shows that our staff experience around fairness in promotion and development remains a concern, particularly when we look at the divergent experience between White and BAME staff. We also still have some work to do to address long hours of working and note that workplace stress has been increasing. Work to address these issues will continue to be a priority and reviewed by the Board.

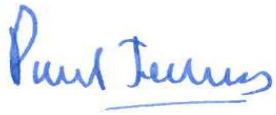
Over the last year the work of our Freedom to Speak up Guardian has continued to be well received in the Trust. The role is much appreciated and supports a culture of openness through providing an additional avenue for staff to raise concerns.

You will find more details in the next section and throughout the Report about our progress towards our priority areas as well as information relating to our wider quality programme. Some

of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible. We have also included a diagram at the end of my statement to help make sense of the operational and assurance structures we hold within the Trust.

However, if there are any aspects on which you would like more information and explanation, please contact Marion Shipman (Associate Director Quality and Governance) at mshipman@tavi-port.nhs.uk, who will be delighted to help you.

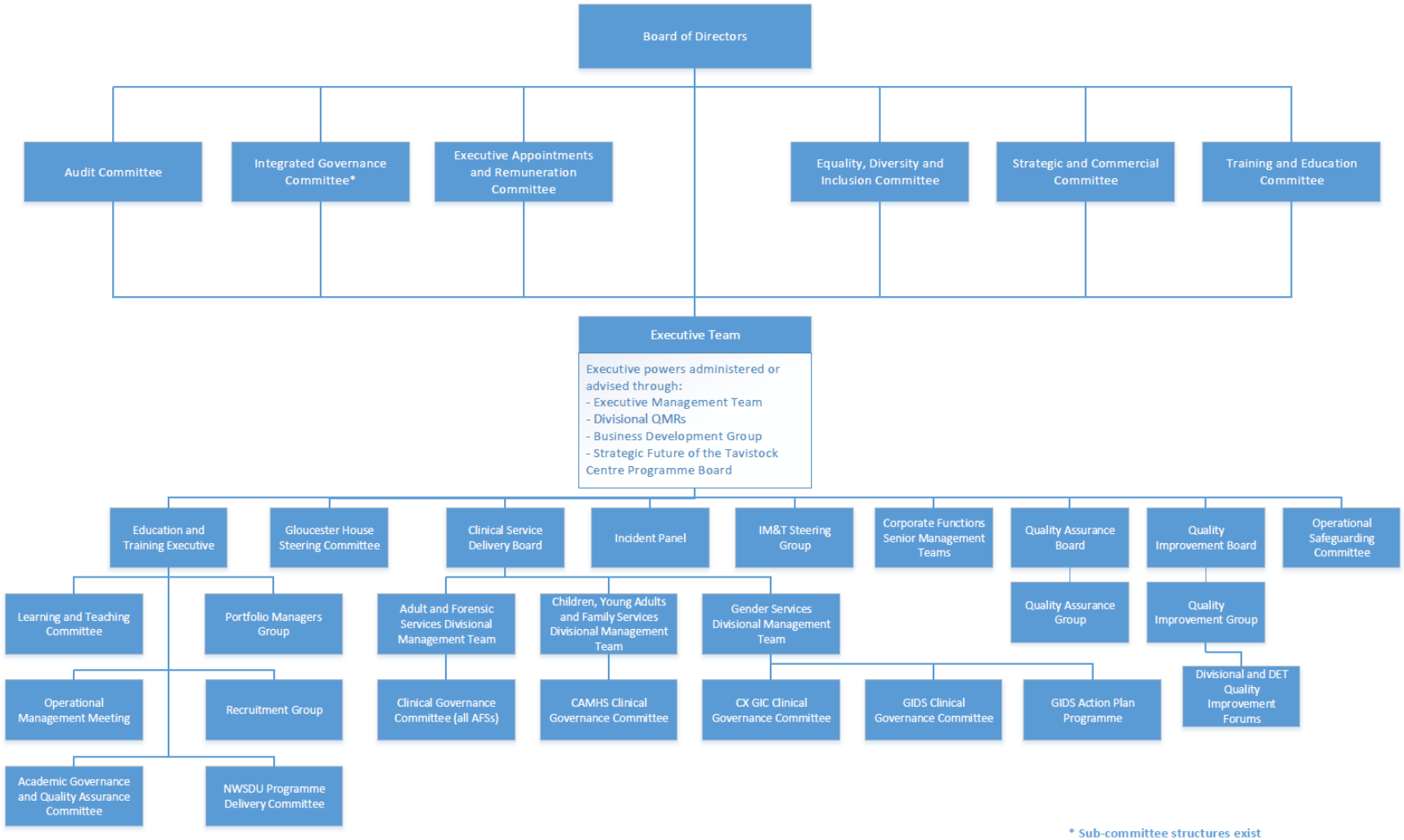
I confirm that I have read this Quality Report which has been prepared on my behalf. I have ensured that, whenever possible, the Report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge, within the data constraints outlined, the information contained in this Report is accurate.



Paul Jenkins 24 November 2020

Chief Executive

Flows of Assurance Map



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

In this section the Trust updates on progress of delivering our priorities for improvement for 2019/20, along with statements of assurance from our Board of Directors.

2.1 Progress against priorities from 2019/20

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

Patient safety

Our quality priority	What success will look like	How did we do?
Improve the identification and management of high-risk patients	➢ **Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust**	***We partially achieved this*** • Risk assessment material available for clinicians to access on staff training system • Quarterly interactive assessment skills workshops open to all clinicians • Risk assessment and risk management also considered where appropriate at the monthly incident panels and at the Trust wide Learning Lessons Forums • Discussions around risk concerns take place in team meetings and in individual and peer supervisions • Care plans sent to GPs/referrers include information about risk assessments and risk management where indicated • Going forwards the Trust patient safety lead will review training requirements of clinical staff in the area of risk assessment and update training materials and/or procedures if indicated.
	➢ **Ensure all CYAF crisis plans have been regularly reviewed and updated. The frequency will need to be decided on a case by case basis but minimally once every 3 months**	***We achieved this*** • Case notes audits undertaken within three clinical teams within CYAF • Standard of completion of crisis plans good overall – will be reviewed regularly • This work will continue during 2020/21 and will be included in yearly audit programme
	➢ **Continue to audit recording of clinical risk assessments and actions taken**	***We achieved this*** • Audits of clinical risk undertaken during 2019/20 • Case notes audits undertaken, and results triangulated and reported at Clinical Governance meetings (see Glossary) • Cycle of audits and reviews ongoing, will be included in yearly audit programme for 2020/21

Patient Experience

Our quality priority	What success will look like	How did we do?
Standardise our Experience of Service Questionnaire feedback forms in line with patient and staff feedback and test more streamlined ways of collecting information	➢ **Further consultation with Quality Advisory Group before completing and testing new forms**	***We achieved this*** • Group including three patient representatives agreed design, layout, key questions and scoring system for new forms • Case notes audits undertaken, and results triangulated and reported at Clinical Governance meetings. • Cycle of audits and reviews ongoing, will be included in yearly audit programme for 2020/21
	➢ **Test streamlined forms in one service initially and review and evaluate effectiveness**	***We achieved this*** • Use of new ESQ form piloted in clinical team during Q2 • Data and qualitative feedback from patients and clinicians gathered • Trial in this initial team extended into Q3 to maximise the amount of forms & feedback collected • Analysis of data indicates an increased number of patients/parents completing ESQ forms as well as an increased amount of qualitative feedback being obtained • Positive clinician feedback also obtained
	➢ **Test streamlined forms in second service, building on the evaluation of first service**	***We achieved this*** • New ESQ form trialled in second clinical service during Q3 and Q4
	➢ **Evaluate and review second test and adjust with a view to rollout across the directorates**	***We partially achieved this*** • Evaluation of feedback from second phase of trial will take place during 2020/21 due to limited opportunities to obtain feedback during Q4 as a result of the COVID-19 pandemic

Clinical Effectiveness

Our quality priorities	What success will look like	How did we do?
Provide effective sleep management information and support to patients and carers of those with sleep disorders	➢ **Establish an adolescent only group for patients experiencing sleep difficulties *(those aged 14-18)***	***We achieved this*** • Two small adolescent groups successfully ran over the course of the year
	➢ **Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input**	***We partially achieved this*** • Sleep hygiene guidance has been developed; however, feedback has not been fully collated due to restrictions around group meetings as a result of the COVID-19 pandemic. Meetings will be held, and feedback obtained as soon as it is possible. The guide will be published in 2020.
	➢ **Develop and disseminate information for clinicians on sleep in adolescence**	***We partially achieved this*** • Sleep hygiene guidance has been developed and is currently awaiting upload to the Trust's

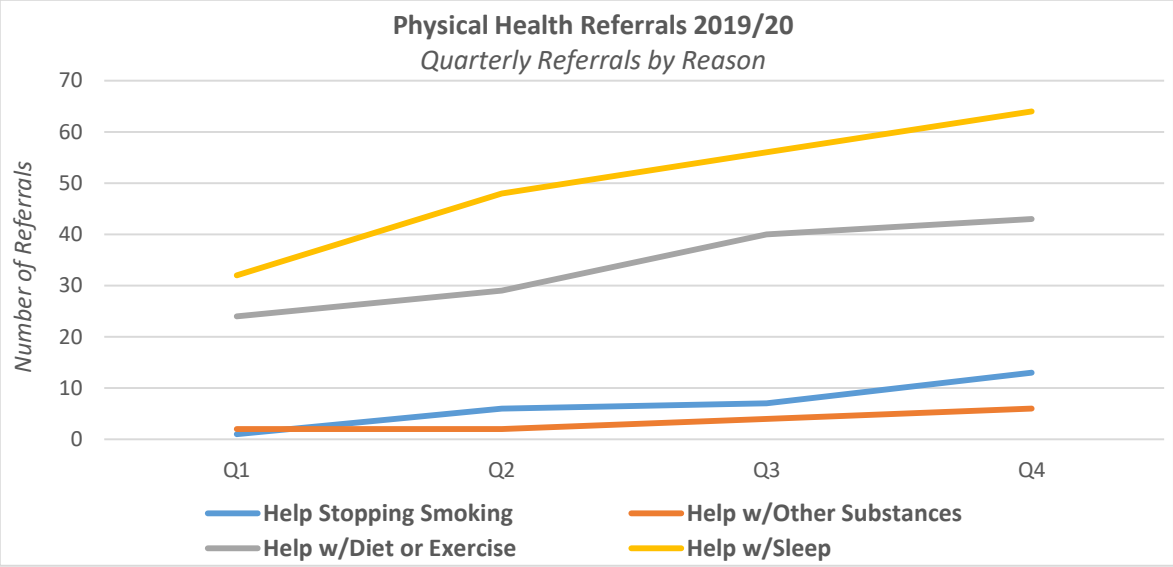
Our quality priorities	What success will look like	How did we do?
		intranet to allow wider access. This will take place in 2020.
	➢ **Share sleep information more widely with other external agencies**	***We partially achieved this*** • Sleep hygiene guidance has been developed and will shared more widely during the 2020/21 financial year.

Improving the physical health of patients

This programme of work is led by the Physical Health Specialist Practitioner (PHSP), a health psychologist, supported by two consultants. It is widely recognised that people with mental health conditions are likely to die on average 10-25 years younger than the general population within the United Kingdom. This is not because of the mental health condition itself but is largely down to preventable healthcare behaviours within this population, such as an increased level of smoking, alcohol and substance misuse, poor diet and poor sleep.

In order to holistically improve the health and wellbeing of the population we serve we conducted work around a sleep programme as a quality priority for 2019-20.

Since the inception of the programme, work has been undertaken to improve the use of the physical health form across the Trust for all patients 13 years and above, with referrals to the PHSP for an appropriate assessment, and if required, one to one or group treatment, or, if appropriate, onward referrals into existing community services. The Living Well Service provides evidence-based treatment for smoking, drinking, substance use, healthy weight, and sleep. A training programme for Trust staff is regularly delivered to staff within training days.



Our quality priorities	What success will look like	How did we do?
Improve waiting time experience from end of assessment to first treatment sessions in the generic Adult Complex Needs service	➢ **Reduce the number and percentage of patients dropping out between the end of assessment and first treatment episode**	***N/A*** • The drop-out rate was assessed at the beginning of year and found to be much lower than expected at 28%. A decision was therefore made to focus the work of this Quality Priority on the experience of service users awaiting a first treatment appointment. An audit of all discharged patients over the year confirmed a dropout rate of 26% which equated to seven patients.
	➢ **Obtain feedback from service users on their experience of the gap period**	***We achieved this*** • Feedback has been obtained from patients who started therapy between April – December 2019. Phone calls were made to 25 patients to request qualitative feedback, with six patients agreeing to take part • Qualitative feedback obtained from the six willing participants on both length of wait and communications during their waiting time
	➢ **Review reasons for drop out and patient experience to improve the service for both patients and staff**	***We achieved this*** • Based on feedback received, the Adult Complex Needs service will implement a trial of a two-phase treatment plan for newly assessed patients to help 'bridge the gap' between the end of the assessment and the start of regular therapy • In the first phase, an intermittent set of treatment appointments will be offered for the patient to be seen every 4-6 weeks. • In the second phase, the patient will commence regular, ongoing therapy

Our quality priorities	What success will look like	How did we do?
Embed meaningful use of outcome measures in CYAF services	➢ **80% of children and young people with Thrive (see Glossary) categories, 'getting help' and 'getting more help' have a Time 1 goal recorded for the Goal Based measure (GBM) and Children's Global Assessment Scale (CGAS)**	***We partially achieved this*** • We are pleased that the GBM T1 completion rate has increased consistently over the year. Completion rates have almost doubled since the start of the year, but at years' end were still below the target of 80%. • For GBMs, Clinicians have commented on the challenge of completing goals so early in an intervention. We are continuing to pursue a QI project to set some initial goals and then for these to be reviewed when it feels appropriate to do so. Consideration will be given once this is completed to how this learning can be shared across teams. • Completion rates for CGAS forms consistently increased over the year, however the final completion rate was still below the target of 80% • For CGAS, we will continue to investigate the reasons for improvement and seek to share good practice more widely to further motivate staff in the completion of outcome forms.

Our quality priorities	What success will look like	How did we do?
	➢ **Obtain service user feedback on the use of outcome measures to feedback on progress**	***We did not achieve this*** • A group was established during Q4 across Camden with a view to engaging service users re: sharing data and obtaining feedback, however initial meetings were cancelled as a result of COVID-19. We will reactivate this group and think about how we can facilitate running these groups remotely.
	➢ **60% of closed cases or cases open longer than six months with Thrive categories, 'getting help' and 'getting more help' have a paired Time 2 GBM and Time 2 CGAS measure**	***We did not achieve this*** • Although there was some improvement during the year, the improvement was not consistent and T2 completion rates for both CGAS and GBM remained below the 60% target. • In is unclear why the T2 improvements were mostly with GBM forms and CGAS saw relatively less improvement. We will undertake work in 2020/21 to look at why this may have been the case and to improve meaningful feedback to staff on how to improve completion rates
	➢ **Develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress and opportunities for review**	***We did not achieve this*** • A group was established during Q4 across Camden with a view to engaging service users re sharing data and obtaining feedback, however, initial meetings were cancelled as a result of COVID-19. We will reactivate this group and think about how we can facilitate running these groups remotely.

Clinical Effectiveness and Patient Experience

Our quality priorities	What success will look like	How did we do?
Improve patient and carer involvement in care planning in Adolescent and other CAMHS services	➢ **Improve quality of patient and / or carer involvement in the development of care plans.**	***We did not achieve this*** • We were unable to address this target this year due to challenges measuring 'quality of involvement' in a meaningful way. We will link this with the service user involvement needed for outcome measures to address this issue in 2020/21.
	➢ **Increase the quality of data recorded of care plans shared with patients and referrers**	***We partially achieve this*** • As above, it was difficult to identify a consistent method of reviewing the quality of care plans. An audit of completed care plans was undertaken to evaluate completeness and content against feedback from service users in previous focus groups and internal processes were developed to help add additional checks to ensure that completed care plans are being shared with patients and referrers where appropriate. Further work will be undertaken in 2020/21 to address this issue.

Our quality priorities	What success will look like	How did we do?
	➢ **Increase the percentage of care plans shared with patients and referrers**	***We partially achieved this*** • Work was undertaken over the year to increase the completion rates of both assessment summaries and care plans. • Additional work was undertaken within teams to ensure that relevant fields were completed and boxes checked on electronic forms to ensure care plans intended for sharing were being reliably flagged up to admin staff. This led to a steady increase in care plans being shared during Q's 1 – 3. For the final month of Q4 a number of staff were unwell or unable to access a device as a result of COVID-19 which resulted in a slight decrease in the rate of care plan sharing in Q4. Further work will be undertaken in 2020/21 to meet this target.

2.2 Our quality priorities for 2020/21

The priorities for 2020/21 which are set out in this Report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, patient experience and clinical effectiveness. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

Patient Safety		
Priority 1	Standardising Use of Carenotes Alerts	**New Priority**
Priority 2	Experience of Service Questionnaire (ESQ) implementation	**Builds on a Quality Priority from last year**
Priority 3	Improve Waiting Times across the Trust	**New Priority**
Priority 4	Embed Meaningful Use of Outcome Measures across the Trust	**Builds on a Quality Priority from last year**

How we chose our priorities and our targets for success

In looking forward and setting our quality priority goals for 2020/21 we were keen to include issues which would make a real difference to the quality of care our patients receive. We undertook a wide consultation with a range of stakeholders, both internally with staff, our Quality Advisory Group and governors, and externally, including Camden Clinical Commissioning Group (CCG, see Glossary). We have chosen those priorities which reflect the main messages from these consultations including building on two earlier quality priorities namely, rolling out the updated ESQ across the Trust and further work developing the meaningful use of outcome measures. Two new priorities focus on areas that directly impact on patient experience; the first focuses on improving communications to both patients and professionals, and the second on improving waiting times.

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Board and our commissioners.

Patient Safety

Priority 1: Standardise the use of Carenotes Alerts to enhance patient safety and communication

We have become aware that there are inconsistencies in the use of Alerts within our patient administration system (Carenotes) across individuals, teams and directorates. This quality priority seeks to develop standardised guidance to support an improvement in the quality of Carenotes Alerts across the Trust to improve patient safety through internal and external communications. This priority will agree a consistent standard that supports the implementation of the Health Information Exchange (HIE) and Accessible Information Standards (AIS). The AIS targets will include the sharing of information about people's information and communication needs with other teams, services, agencies and providers and taking steps to ensure that people receive information in the way they have requested, with the support they require.

Quality Priority 1: Standardise the use of Carenotes Alerts to enhance patient safety and communication
Targets for 2020/21 *New Priority*
1. Complete audit of Carenotes Alerts within each of the clinical directorates (AFS, Gender and CYAF) to clarify current use of Alerts
2. Agree parameters for when Alerts should be used across the Trust
3. Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review
4. Implement guidance and re-audit across the directorates to assess adherence to the new guidance

Priority 2: Experience of Service Questionnaire (ESQ) implementation

The PPI team is responsible for collating qualitative data from the ESQ and sharing this with team leads, as well as aiming to support teams where appropriate with implementing changes. The updated ESQ form was redesigned in 2019/20 following wide consultation and testing in two Children Young Adult and Family teams, to give more rich qualitative data by reducing the questions and allowing more free text space for service users to feedback. The results so far have been encouraging, one team has already adopted the new form. The aim for 2020/21 is to undertake further testing, collating the data for agreement by the Board, before implementing the form across the Trust, with the aim of increasing the ESQ return rates and use of the data in response to patient feedback, without losing what is unique to each service.

Quality Priority 2: Implement updated Experience of Service (ESQ) feedback forms across the Trust
Targets for 2020/21 ***Continuation of a Quality Priority from 2019/20***
1. Evaluate and review Q4 testing and test in 2 Adult and Forensic Services teams, reviewing and adjusting the form following these tests
2. Identify and assess methods of streamlining collection of the information and obtain a consensus for delivery across the Trust
3. Evaluate effectiveness of the new form for increasing ESQ return rates and improving qualitative feedback
4. Work with teams to increase use of the ESQ data to improve and develop services

Waiting times to a first appointment are an issue of concern across all our clinical divisions although not all services. Those with the most significant challenges are within the adult and children gender services but adolescent, primary care and adult complex needs services also have challenges Meeting waiting times to a second appointment are a concern across all services.

This has an impact on patient care, experience and safety; on staff wellbeing; on the Trust's contractual and financial position; and on its reputation. Through work on this quality priority we will seek to understand better the range and variation of waiting list length across the Trust; the ways waiting lists are managed and good practice which might be shared; and staff and patient experience of waiting for care. We will then bring interested parties together from across the Trust to consider and implement Quality Improvement (QI) approaches to reducing waiting times and to share learning from these.

Quality Priority 3: Improve Waiting Times across the Trust
Targets for 2020/21 *New Priority*
1. Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice.
2. 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).
3. Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 and Q4).

Clinical Effectiveness and Patient Experience

Priority 4: Embed Meaningful Use of Outcome Measures across the Trust

This quality priority has developed following a review of outcome measures across the Trust during 2019-20, feedback from patients and consultation with key operational staff. Outcome measures have a number of possible uses including the systematic evaluation of clinical progress, as a means of eliciting self-reported feedback on an individual's mental health state and providing data separately to clinical observations or opinion. We will be focusing on growing and developing a data-led culture that makes consistent use of appropriate outcomes and patient feedback. This will involve standardising the electronic patient record system (EPRS) processes behind our outcome measures (OMs), in order to improve the accuracy and validity of reports and their applications. Feedback on the value and meaningful qualities of outcome measures from staff and patients will be used to inform this work as part of a co-design process.

Quality Priority 4: Embed Meaningful Use of Outcome Measures across the Trust
Targets for 2020/21 *Development of a 2019/20 Quality Priority*
1. To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback.
2. Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications.
3. To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures.
4. To develop a robust and standardised system of user-friendly reminders and follow up on missing OM through the EPR and team level reporting

2.3 Statements of assurance from the Board

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

A review of our services

During the reporting period 2019/20 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 208 contracted services, across three Clinical Directorates, covering 117 clinical teams.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to it on the quality of care in these 208 contracted services.

The income generated by the relevant health services reviewed in 2019/20 represents approximately 59.4% (£36.7m) of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2019/20.

Participation in clinical audits and national confidential enquiries

National clinical audits and confidential inquiries

During 2019/20 there was one national clinical audit and one national confidential enquiry which covered relevant health services that the Tavistock and Portman NHS Foundation Trust provides. During that period the Tavistock and Portman NHS Foundation Trust participated in 100% of the national clinical audits and national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquiries that Tavistock and Portman NHSFT was eligible to participate in during 2019/20, and did participate in are as follows:

- National clinical audit on anxiety and depression (RC Psych)
- National confidential enquiry into suicide and safety in mental health

National clinical audit on anxiety and depression (NCAAD)

This was the only relevant national clinical audit that the Tavistock and Portman NHSFT participated in and for which data collection was completed during 2018/19. The report of this national clinical audit was published in January 2020 and is therefore included in returns for 2019/20. 100% of registered cases required by the terms of that audit were submitted. A separate local report was later generated for the Tavistock & Portman NHS Foundation Trust.

The NCAAD was a three-year quality improvement programme, established to improve the quality of NHS-funded care provided to service users with an anxiety and/or depressive disorder (England).

National key findings from the audit found that most adults who received psychological therapy rated their therapists highly and felt helped by the treatment they received, but access was poor with almost half of adults waiting over 18 weeks from referral to the start of treatment. Many service users also reported a lack of choice in key aspects of their therapy and outcome measures were not being routinely used to assess change. The principal recommendation was that all mental health trusts should have a trust-wide Psychological Therapies Management Committee.

The audit standards included: access and waiting times; appropriateness of therapy; service user involvement; outcome measurement and therapist supervision and training.

NCAAD Local Report:

The NCAAD team produced local reports which show Trust services results benchmarked against national findings.

The Tavistock and Portman NHSFT submitted 30 cases (the required number), 27 therapist surveys and 7 service user surveys. The latter figure was lower than had been hoped and means that comparisons with national data is difficult to apply locally. Data collection was co-ordinated by the central NCAAD team not by the Trust.

The Tavistock & Portman NHS Foundation Trust has discussed findings at relevant Trust departmental clinical governance meetings in order to improve the quality of healthcare provided. The Trust specialises in the use of psychological therapies across many of our services such as Adult Complex Needs and Adolescent and Young Adult services and brings together psychoanalytic, psychodynamic and systemic theory and practice and other psychological approaches. For this reason, a separate Psychological Therapies Management Committee is not required.

Many of the audit standard information highlighted above is provided to our Trust Board in quarterly quality reports to provide assurances in respect of services. In addition, we introduced new divisional structures during 2019/20 including establishing divisional quality review meetings where issues highlighted above are discussed.

National Confidential Inquiry into Suicide and Safety in Mental Health

There had been a plan to present the key findings from the National Confidential Inquiry into Suicide and Safety in Mental Health – Annual Report 2019 (published in December 2019) at a Trust wide learning lessons event but this has been deferred due to the current COVID-19 pandemic. On request the Trust completes returns to the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) at the University of Manchester.

Local clinical audits

There were 13 local clinical audits undertaken during 2019/20 with two reports outstanding and four audits still in progress. The reports of seven local clinical audits were reviewed by the provider in 2019/20 and the Tavistock & Portman NHS FT intends to take the following actions to improve the quality of healthcare provided:

1. Trust wide case notes audit and several service level and team level case notes audits took place during 2019/20. The audits focused on completion of risk assessment and risk management sections of EPR, crisis plans and care plans, completion of GP letters, timeliness of entry of notes, matching clinical entry with patient diary, completion of physical health forms. Actions taken - findings discussed at Clinical Governance Meetings and Team Meetings and local action plans in place if required. Similar case notes audits will be undertaken during 2020/21.
2. Safeguarding audits - regular audits of safeguarding supervision in relation to children and young people subject to Child in Need and Child Protection Plans and audits of completion of safeguarding sections of the Electronic Patient Record. Any issues identified are raised with team managers and individuals and are discussed at Safeguarding Committee Meetings, Clinical Governance Meetings and with individual clinicians. Findings are reported quarterly to the Trust's Integrated Governance Committee (see Glossary).
3. Prescribing audits. Undertaken in Q2. Monitoring adherence to Prescribing and Administration of Medication Procedure. No significant areas of concern highlighted. Re-audit was due to be completed in Q4 but due to COVID-19 pandemic this audit is still ongoing. It will be completed during Q1 2020/21.
4. Consent audits: to gather evidence to inform team leads on the completeness of patient documentation in respect of consent to treatment and to provide information to promote

improvements in this area of care. A new consent protocol is being developed (April 2020) due to the move to telehealth consultations during the COVID-19 pandemic.

5. Gender Identity Clinic audit programme: The Trust Gender Services (Adult and Children) have a programme of clinical audit that aligns with the Trust wide programme, for example case notes audits and safeguarding audits but is also specific to the work of those services. Actions are discussed at service level.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the Tavistock and Portman NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 163 across 5 studies.

Study	Principal Investigator	Number
Longitudinal Outcomes of Gender Identity in Children (LOGiC)	Eilis Kennedy	154
Video Interactive Positive Parenting-Foster Care (VIPP-FC)	Eilis Kennedy	4
Should health services be adapted to meet the needs of autistic people with gender dysphoria?	Una Masic	3
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Louis Appleby	1
Scoping review psychological interventions wellbeing in young people		1
		163

The Trust is hosting two large scale NIHR funded programmes of research focused on children, young people and their families:

- NIHR PGfAR Personalised Assessment and Intervention Packages for Children with Conduct Problems in Child Mental Health Services (PPC). 01.01.2016-31.12.2021 https://tavistockandportman.nhs.uk/research-and-innovation/our-research/research-projects/personalised-programmes-children-ppc/
- NIHR HS&DR Longitudinal Outcomes of Gender Identity in Children (LOGiC). 01.02.2019-31.01.2023 https://logicstudy.uk

In addition the Trust is collaborating on a number of research studies focused on a range of different areas including forensic mental health (Mentalisation for Offending Adult Males led by Prof. Peter Fonagy, UCL), children in foster care (the Nurturing Change study led by Prof. Pasco Fearon, UCL) and a data linkage study evaluating the real world implementation of the Family Nurse Partnership led by Dr Katie Harron at the UCL Institute of Child Health.

Goals agreed with commissioners for 2019/20

The use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the Tavistock and Portman NHS Foundation Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Tavistock and Portman NHS Foundation Trust and any person or body with whom the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

Further details of the agreed goals for 2019/20 are available electronically at https://tavistockandportman.nhs.uk/about-us/cquin/. At the time of reporting CQUINS have not been agreed for the following 12-month period owing to the COVID-19 pandemic.

The total possible financial value for the 2019/20 CQUIN was £300,358. The Tavistock and Portman NHS Foundation Trust has received this performance payment in full.

The CQUINs the Trust participated in for 2019/20 are as follows:

CQUIN Title	CQUIN description
Anxiety Disorders and RCADS Outcome Measuring	The Revised Children's Anxiety and Depression Scale (RCADS) and the RCADS - Parent Version (RCADS-P) are questionnaires that measure the reported frequency of various symptoms of anxiety and low mood. This local CQUIN target was to put into place the systems and processes to enable the data to be collected across CAMHS services, build new reports to enable use of the 'current view' form of patient record to be monitored and paired scores to be reported.
Increasing flu vaccination uptake amongst frontline staff	National CQUIN measuring increase in uptake of flu vaccinations amongst frontline healthcare workers.
MHSDS DQMI – Maturity Index	The aim of this national CQUIN was to improve the quality and breadth of data submitted to the Mental Health Services Dataset (MHSDS). The MHSDS Data Quality Maturity Index (DQMI) score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS. The target score was 90 – 95%.
Mental Health Data Interventions	This national CQUIN measured the referrals with at least one SNOMED CT procedure code recorded between the referral start date and the end of the reporting period. Completion rates were provided by NHS Digital for Trustwide data based on MHSDS submissions with a target of 70%.
Telemedicine / virtual patient sessions	Telemedicine is a methodology used by the NHS to support accessibility of services whenever there are geographical barriers to patients. The Gender Identity Development Service (GIDS) is a highly specialist national service and hence accessibility is a key issue for those patients who may have to travel long distances or do not have the means to do so. The target for this local CQUIN was to initially test and enable remote participation in professional meetings involving GIDS clinicians and to then to use this development to offer greater flexibility across the GIDS service to enhance patient experience.

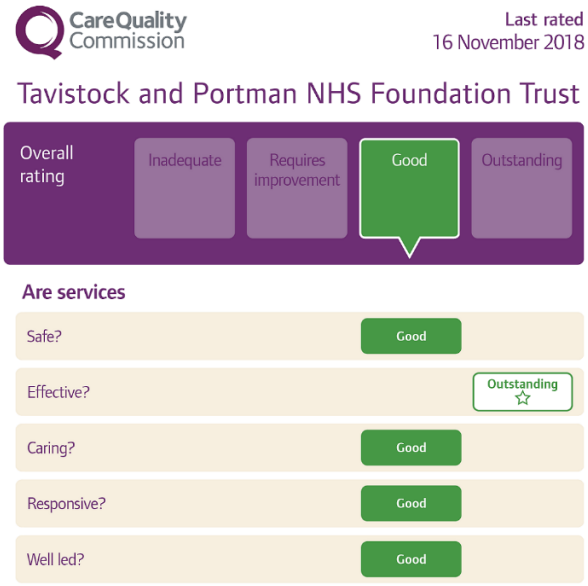
Regulatory compliance – Care Quality Commission (CQC)

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Care Quality Commission has not taken enforcement action against the Tavistock and Portman NHS Foundation Trust during 2019/20.

The Tavistock and Portman NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2019/20.

In August and September 2018 the Trust underwent a routine and well-led inspection by the Care Quality Commission, with a rating of 'outstanding' for the 'Effective' domain, and 'good' for all other domains and an overall rating of 'good'. The full report is available on the CQC website, www.cqc.org.uk. The Trust assessment of domain compliance is below.



Two large clinical services were selected for inspection: The adult Gender Identity Clinic (GIC) and specialist community mental health services for children and young people. The GIC service was taken on by the Trust in April 2017 and came with a number of improvements required by the CQC following a partial inspection in 2016. The CQC found that for the GIC service the trust had implemented improvements to previous recommendations made from the last inspection, reducing waiting times, reducing delays in sending letters, reducing delays in responding to complaints and embedding service user involvement.

Both the adult GIC and the specialist community services were assessed as 'outstanding' for the 'Effective' CQC line of enquiry, 'Requires Improvement' for the 'Responsive' line of enquiry in the GIC service and 'Good' for all other lines of enquiry.

The CQC commended the Trust in a significant number of areas:

- Our strong values and ethos, based on strong clinical traditions made relevant for the current day.
- High calibre Board, appropriately skilled, open and determined to make necessary changes to provide high quality care. The Trust has a clear and well-understood strategy and a linked clinical quality strategy.
- Our strong academic and research links mean that patients have access to innovative treatments. Clinical innovation influenced the evidence base and clinical practice around

mental health and well-being, one example being the CAMHS THRIVE model developed with other providers.
- High staff engagement, developed through improvements in communication, appraisals and access to leadership development opportunities.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Feedback from patients showed high levels of satisfaction with care and treatment. The Trust has many examples of working with people who use services. Our patient and public involvement strategy is supported by PPI co-ordinators who facilitate a range of activities in the trust and with community colleagues and other stakeholders.
- The Trust is outward looking and an active participant in the North Central London sustainability and transformation partnership, with executive members of the Trust's leadership team taking leadership roles.
- Staff worked closely with other organisations supporting people so they received co-ordinated care.

The CQC also outlined areas where the Trust should improve. The majority of these matched issues the Trust had identified prior to inspection and work was already in hand to address them. These issues included:

- Monitoring of quality and performance in service lines and further aligning and integrating cross trust governance systems;
- Undertaking more work to address issues raised by BAME staff. Whilst it was acknowledged that the Trust was working to implement a range of measures to improve career progression and address discrimination for black, Asian and minority ethnic (BAME) staff, some BAME staff felt that the measures had not yet positively affected their experience of working for the Trust;
- Responding to complaints in a timely manner. Responses to complaints were of high quality and showed empathy and willingness to apologise where necessary but significant delays had occurred in responding to Gender Services complaints;
- Improve health and safety issues. Work was already in hand to improve health and safety, including fire safety but needed to be completed and ongoing safety closely monitored;
- Working on addressing long waits in the adult GIC services, although it was acknowledged that the Trust had worked with Commissioners to try to increase funding.

The Trust has delivered a comprehensive action plan to address these issues and an additional number of issues specific to clinical services inspected. Work is ongoing in respect of BAME issues which were again highlighted in the 2019 national staff survey, and in respect of waiting times, which is a Trust quality priority for 2020/21.

Data security and quality

The Tavistock and Portman NHS Foundation Trust did not submit records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a consultant-led, nor an in-patient service.

Owing to the management of the COVID-19 pandemic no data security and protection assessment report score is available at the time of reporting. The Data Security & Protection toolkit national submission deadline has been extended until September 2020. Progress has been made on updating data security and protection policies and procedures.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20.

Data Quality Maturity Index (DQMI)

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

Tavistock and Portman NHS FT	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
DQMI – Data Quality Maturity Index	91%	94.1%	94.4%	TBC

The importance of having high quality data on which to base decisions, whether clinical, managerial, or financial, is recognised by the Trust. An ongoing focus on having robust systems, processes, data definitions and systems of validation helps assure us of our data quality. The Tavistock and Portman NHS Foundation Trust will be taking the following actions outlined below, to continue to improve data quality.

Continuing and developing internal and interrelated processes to support high levels of data quality including:

Trust Developments - Infrastructure and Results

The Trust has undertaken significant work over the last 12 months to improve data validation and completeness. This has included how we collect and use information from our service users, in order to support their communication and information requirements. We have made changes in the Carenotes and updated protocols and data collection tools. This has been part of meeting the requirements of Accessible Information Standards legislation and the focus on this will continue.

The Trust participated in two CQUINs which directly related to data, updating our patient administration system to refine the recording of data requirements and updating and revising national procedure codes to make them relevant to our services.

In addition we have been working on improving communication of care plans with referrers. This issue was identified in our last CQC inspection. The Trust developed a project to improve both the completion rates of assessment summaries and care plans and develop new reports to better meet team needs and match the process in place. The Trust is starting to see improvements in the completion rates of initial care plans and the quality of those is being monitoring closely through clinical audits.

Finally, across our services we use a variety of mental health outcome measures in order to measure the effect on a person's mental health as a result of health care intervention. One of our main measures is the Goal Base Measure (GBM), used primarily in our children's services. The higher the completion rates, the better understanding we have of our service users and services. We identified that our completion rates were not very good and have worked over the past year to improve these through improvements to our data collection system, making it more user-friendly, flexible and intuitive. At the same time we have also noticed a reduction in the improvement rate score which may be as a result of discrepancies in how we record the GBM data. We will be working on these issues over the next 12 months through a Quality Improvement project.

Overall Oversight

- Further development of the Quality Assurance Board. This group was established during the year, is chaired by the Medical Director and is made up of clinical, performance and operational management representatives. It meets quarterly and is responsible for

providing overarching governance of data quality including review and sign off for the Trust Board quarterly quality report;

Quality assurance work

- Continuation of an established monthly Quality Assurance Group which reports to the Quality Assurance Board. This group meets to analyse and critique data from the patient administration system, with clinical governance and administration leads. The number of clinicians who attend this Group was expanded in 2019/20;
- Ongoing work by a service level data project group to support improvements in the Gender Identity Development Service (GIDS);
- The validation of data and checks on the completeness and accuracy of data as outlined in the Trust's Clinical Data Quality Management Procedure;
- The use of standard operating procedures (SOPs) for data collection, validation and reporting to support the quality of data by the Quality Assurance Team and services;
- Review of key performance target reports at clinical governance meetings on a monthly basis;

Training and Education

- Mandatory training on our electronic patient administration system (Carenotes) and outcome monitoring has been a success and continues. This is essential to ensure good quality data is entered to enable robust reporting;
- Ongoing support of services by the Quality Assurance Team to deliver improvements in relation to CQUINs, KPIs, locally-agreed targets and where data quality issues are identified. This includes the provision of monthly team reports on missing data in order to improve data completeness for reporting purposes.

Patient safety incidents resulting in severe harm or death

The number and rate of patient safety incidents (PSIs) reported within the Trust during 2019/20 are below. The Trust does not report enough patient safety incidents to be included in the national reporting and learning system reports for comparative statistics.

During the period 1 April 2019 – 31 March 2020 we submitted 37 patient safety incidents to the National Reporting and Learning System (NRLS). Of these 11 resulted in severe harm or death which accounted for 30%. Five patient deaths were due to medical conditions or causes not linked to Trust care and six were suspected suicide. Of the 37 patient safety incidents reported to NRLS 26 (70%) resulted in no harm.

	2015/16	2016/17	2017/18	2018/19	2019/20
Total reported incidents	401	449	401	511	469
Patient Safety Incidents	34	114	82	40	37

Source: Quality Portal (QP), PSIs reported 1 April 2019 to 31 March 2020

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

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

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

The Trust is committed to an open culture focused on learning and improving safety for patients and staff. Over the past year the Trust has taken the following actions to improve clinical knowledge of self-harm and suicide and so the quality of its services by:

- Ensuring risk assessment training material is available for clinicians to access on the staff training system. Reviewed and updated in Q4 2019/20.
- Providing quarterly interactive clinical risk assessment workshops. This is face to face teaching and learning from clinical cases.
- Consideration of risk concerns i.e. risks to self, risk to others and risk from other discussions about individual cases in team meetings and in individual and peer supervisions.
- Focusing on ensuring care plans copied to GPs/referrers include information about risk assessment and risk management where indicated.
- Providing suicide prevention learning lessons event yearly.
- Undertaking annual case note audits of risk assessments.
- Team based case notes audit including documentation of risk.

Learning from deaths

During 2019/20, twenty one Tavistock and Portman patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Number of deaths which occurred in each quarter for 2019/20:

Number of deaths which occurred in each quarter for 2019/20:	
Quarter 1	6
Quarter 2	4
Quarter 3	6
Quarter 4	5

Trust definitions and guidance for reports relating to those who have died differ from the Quality Accounts guidance. Concise reports are completed for unexpected or untimely deaths, mortality reports are completed where death is likely to have been due to natural causes and serious

incident investigations, use Root Cause Analysis (RCA) methodology. For the purposes of this report, concise reports and serious incident investigations have been defined as: 'investigations' and mortality reports as 'case record reviews'.

By 31 March 2020 3 case record reviews (mortality reviews) and 12 investigations have been carried out in relation to 21 of the deaths above. In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

The number of deaths in each quarter for which a case record review or an investigation was carried out was:	
Quarter 1	1 investigation (concise) completed 3 investigations (full RCA) completed 2 case record reviews (mortality reviews) completed
Quarter 2	2 investigations (concise) completed and 1 awaited 1 case record review (mortality review) completed
Quarter 3	5 investigations (concise) completed 1 concise investigation awaited (inquest outcome is awaited)
Quarter 4	1 investigation (concise) completed 1 care record review (mortality review) completed 2 case record reviews (mortality reviews) awaited. 1 former patient death was not investigated as the patient was discharged several years ago.

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

Nine deaths were reported on the national Strategic Executive Information System (STEIS) (see Glossary) during 2019/20 which included eight suspected suicides. Six were de-escalated after initial review as not meeting national serious incident definition requirements or where the lead organisation was not this Trust.

All deaths of patients on the waiting list and/or where death was thought to be due to medical causes have been reviewed. All unexpected patient deaths at the Trust are investigated under the Trust's Procedure for the Investigation of Serious Incidents and an investigation team is appointed by the Medical Director.

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

Summary of what we have learnt from case record reviews and investigations conducted in relation to deaths identified above

Key learning from deaths include:

- Importance of risk assessment skills and knowledge updates for clinicians;
- The meaning and understanding of Duty of Candour;
- Use of the Mental Health Act;
- Recognition of physical co-morbidities in our patient group;
- The importance of peer discussion in complex cases;

- Sharing learning not just at learning lessons events but wherever the opportunity arises for example at team meetings, individual or peer supervision;
- Support for staff in the event of a patient death;
- Supporting family members after a death;
- Keeping in mind the possibility of suicide clustering;
- Increasing staff awareness about bereavement resources that are available after someone may have died by suicide.

Actions taken in the reporting period

An incident panel is convened monthly, chaired by the Medical Director. All deaths are discussed, and any reports reviewed.

A 'learning lessons' event is convened quarterly for Trust staff. Themes and best practice points from recent learning lessons events include the following:

- Risk assessment documentation;
- Use of crisis plans;
- Documenting multidisciplinary team discussion of complex cases;
- Documenting supervision discussions;
- Suicide prevention;
- Physical health monitoring;
- Follow up of action plans in relation to each investigated death;
- Supporting and involving families and carers;
- The role of the Coroner;
- Giving evidence at an inquest;
- Supporting staff after a patient suicide.

Investigation and review processes

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

Concise investigation reports

These are requested following the unexplained/ untimely death of a patient. The report includes details of the most recent risk assessment, any safeguarding concerns, details of the incident if known and of any relevant prior and circumstances. The clinician must give an account of actions taken, any support offered to the family and to staff. Duty of Candour is applied where appropriate. Initial learning from the incident is documented in order to prompt the team/service line to consider in more detail. It is anticipated that the learning will be augmented through further discussion at the monthly Incident Panel meeting and at any subsequent learning lessons forum. An action plan is completed and reviewed.

Mortality reviews

These are brief reports requested when death of patient is likely to be due to natural causes. These reports include basic details about what was known about the patient and seek an opinion from the clinician on preventability and/or predictability.

Serious incident investigations

The overarching questions addressed in a serious incident investigation are the following:

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

- What lessons, if any, have the clinical staff taken from the incident?

A core group of clinicians and other senior staff members recently attended a skills update training in RCA methodology.

Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to the trust by NHS Digital. In respect of patient safety incidents, the Trust does not report enough incidents to be included in the national report for comparison but provides information over time. (See details on page 23). The Trust is exempt from the National Patient Experience Survey for community mental health services but undertakes a similar internal survey which is reported below.

Patient experience

In 2019/20, 97% of patients rated help they had received from the Trust as 'good'.

Indicator	Q1	Q2	Q3	Q4
Patient rating of help received as good during 2019/20	**98%**	**98%**	**97%**	**96%**

Please note, the logic surrounding the calculation of the percentages changed in 2017/18 to improve data quality.
* Yearly averages: 2019-20 = 97%; 2018/19 = 98%; 2017/18= 99%; 2016/17 = 93%; 2015/16 = 94%; 2014/15 = 92%
Numerator = 'certainly true' + 'partly true' Denominator = certainly true' + 'partly true' + 'not true'.
Source: Quality Team, Data received and calculated: 04/05/2020

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

The ESQ was reviewed during 2019/20 to improve patient response rates and feedback. This shortened version of our ESQ form was developed with patients and is part of a quality improvement project which continues as a Trust Quality Priority for 2020/21. (See details on page 8).

The Patient and Public Involvement (PPI) team are working closely with existing and ex patients on models of co-design and co-delivery of projects. This model of co–design represents a high standard of meaningful and effective involvement.

Other projects co-designed and delivered with service users include: interview panel training, our quarterly trust wide forum; the primary care psychotherapy service adult photography group; the Trust art board; the adult complex needs forum; a PPI training programme for the Department of Education and Training. The Gender Identity Clinic (GIC) waiting list patient orientation day is now co-presented with an ex patient and we have collaboration from young consultants on the update of the GIC website to provide the most up to date gender information.

Service user representatives are members of local focus groups, forums and committees to feedback and influence service development and delivery, e.g. new our trust wide service user forum is co-chaired with an ex service user of our Team Around the Practice (TAP) primary care mental health service (see Glossary). This group includes representation from service users and carers across clinical services and the primary care Hackney secret garden group. Both GIC and GIDS also run independent stakeholder groups.

Examples of changes made as a result of feedback received from ESQ, forms, forums and surveys include:

- Changes in process in the TAP primary care team following the recommendation of the TAP advisory group, including informing patients of changes to service formation following commissioning restructure.
- The Gender Identity Clinic (GIC) steering group advised on their bid for the service, on the design of the website and requested a 'crisis' button to be added for patients in extreme distress. An ex-patient delivered a session on the Induction day for new patients to the service.
- The Gender Identity Development Service (GIDS) holds regular stakeholder groups and are working with the National Institute for Health Research on a longitudinal study (LOGIC) tracking outcomes of children and young people referred to GIDS, current and future patients are meaningfully involved in this research.
- Signage around the Trust has been reviewed following service user feedback.
- Camden therapeutic photography exhibition suggested by service users to be shown in an accessible location to raise awareness of mental health as well as showcase the artwork.
- Praise for clinician's ability to listen was evident in all feedback.
- In Child Young Adult and Family (CYAF) services ESQ feedback was positive about treatment and young people feeling listened to.
- GIC service user feedback informed the formation of their steering group.
- CYAF Team Manager conducted a short survey involving young people, parents and carers regarding the colour of furniture in the CYAF waiting room; 48 (roughly) comments were left behind with the most popular colour being cobalt blue.
- The CYAF services are working with young people to redesign their Cams Den website page. As part of this the CYAF and PPI team conducted a short review with school councillors from Primrose Hill Primary School regarding the content of the website. Overall students liked it and its information. They would like a link of the website to go in all letters addressed to parents and guardians before visiting any team in the Trust and a letter to be addressed to them also.
- South Camden Open Minded Team conducted a survey about the waiting area; young people from their involvement group suggested a "Welcome" Board with 5-6 most common spoken languages in the area. These include Farsi, Arabic, Somali, Urdu.

Single Oversight Framework Indicators

The Trust has a range of NHS Improvement (NHSI) targets on which we report throughout the year and which form part of the Single Oversight Framework (SOF), used by NHSI to detect possible governance issues and identify potential support needs.

Such information, including Mental Health Services Data Set (MHSDS), and operational performance information is presented quarterly to the Board alongside formal complaints, staff Friends and Family Test (FFT) findings and actions and patient safety incidents.

MHSDS Single Oversight Framework Indicators	Target (%)	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)
Valid NHS number	95%	99.00	98.99	98.95	99.01
Valid Postcode	95%	99.70	100	100	99.71
Valid Date of Birth	95%	100	100	100	100
Valid Organisation code of Commissioner	95%	99.20	99.21	99.15	99.21
Valid Organisation code GP Practice	95%	98.90	98.88	98.78	98.46
Valid Gender	95%	99.40	99.44	99.47	99.41
Ethnicity	85%	80.60	81.88	78.76	77.79
Employment Status (for adults)	85%	59.30	59.79	57.94	56.67
Accommodation status (for adults)	85%	58.30	58.78	56.90	55.64
Primary Reason for Referral	-	Not reported	96%	98%	99%
Ex-British Armed Forces Indicator	-	Not reported	27%	41%	46%

MHSDS Data is published monthly. Quarterly data is represented by April, July, October and January figures.

Ethnicity completion rates have been one of the most challenging owing to the number of service users awaiting first appointment. Employment and accommodation status compliance only relates to service users over 18 years of age. A new report has been developed to allow teams to validate this information on the patient record system and to work on collecting missing information.

Part 3: Review of quality performance

Quality of care overview: performance against selected indicators

This section contains information on the quality of services provided by the Tavistock and Portman NHS Foundation Trust during 2019/20, describing the Trust's progress against indicators selected by the Trust Board in consultation with service users.

This includes an overview of the quality of care offered by the Trust based on our performance in 2019/20 on a number of quality indicators selected by the Board in consultation with internal and external stakeholders. At least three indicators for each of the three quality domains of patient safety, clinical effectiveness and patient experience are included. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other trusts. Indicators include those reported in the past three years.

The Trust Board, the Integrated Governance Committee, along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2019/20. Monitoring has also been undertaken through our divisional quality review monitoring, operational clinical governance and quality improvement processes.

Quality Improvement (QI)

The Trust's first clinical quality strategy covered the period 2017-19. Since then there have been many continuing improvements and growth in delivering quality improvement (QI) across the Trust. Over the past year we have further developed QI support structures and capability to enable staff to become actively involved in this approach and for it to become part of everyday work. Actions have included:

- developing leadership and support structures through the appointment of QI leads supported by an Associate Director for Clinical Governance and QI in each of our clinical divisions;
- supporting staff to become actively involved in the clinical division QI forums;
- developing the capability of our staff to develop QI skills through training and coaching;
- relaunching QI internal communications with clear and consistent messages about QI;
- ensuring QI information resources were of good quality to support use and uptake by staff;
- establishing a QI Board for clear strategic oversight.

With an ever-changing health and social care landscape this approach has been helping us to develop high quality clinical services which are tailored to our patient needs.

Quality Improvement (QI) at the Trust is focused on improving patient outcomes, system performance and professional development. At the heart of our approach is our strong commitment to improving patient experience and outcomes, and our belief that quality improvement is about both relationships and the effective use of proven methodology. We therefore seek to engage with, and respect the views of, staff and patients, as well as using well evidenced and structured tools and methods.

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

The QI objectives for 2019/20 were to:

- Increase staff engagement in QI;
- Evidence change and demonstrate measurable improvement;
- Increase patient engagement in QI projects.

Progress has been made in all areas including:

- delivering Board level QI training to increase understanding and engagement;
- changing the way we present patient data so that it is presented over time. This has helped us to better identify trends, understand where there are areas requiring improvement and recognise when this has occurred. Such data is now used at various quality assurance meetings, and informs Board discussions and decisions. This is seen in the presentation of outcome measures, did not attend rates (DNAs) and waiting times data in the following pages;
- using QI across the Trust to explore how to continue to work over the COVID-19 pandemic.

All the objectives are carried forward and the strategy into 2021 looks at building further on the work to date.

Patient safety

Patient Safety Incidents (PSIs)

This information is included on p.23 of this document.

Safeguarding

	2015/16	2016/17	2017/18	2018/19	2019/20
Child Safeguarding Alerts	71	111	239	377	86
Adult Safeguarding Alerts	7	6	6	9	22

Source: Clinical Governance Report

The child safeguarding alert figures from 2016/17 to 2018/19 are the result of cumulative electronic data, which falsely inflated annual outcomes. The data report for 2019/20 was amended providing accurate (non-cumulative) in-year alert numbers.

The 2019/20 alerts reflect numbers from all of the Trust's Divisional structures and is indicative of Trust clinicians and practitioners maintaining fundamental, safeguarding practice; to recognise and report harm.

The Trust's Safeguarding Children agenda, in brief, relates to safeguarding supervision – the provision of consultation and advice from Safeguarding Leads, working with partnership agencies and staff training to support the delivery of keeping patients and service users safe.

The increase in recording adult safeguarding concerns is to do with improvements to the Adult Safeguarding Over 18's form (which has improved the recording of concerns), the delivery of Level 3 safeguarding adults training (which has received very good feedback from all those who attended) and the hard work undertaken by both Patient Safety Officer and Adult Safeguarding Lead to raise awareness on the importance of recording concerns.

Training 2019/20

Description	2018/19 Overall Figures	Apr – Jun Quarter 1	July – Sept Quarter 2	Oct – Dec Quarter 3	Jan – Mar Quarter 4	2019/20 Overall Figures
Core Subject Mandatory Training Compliance	94%	94%	72%	82%	85%	85%
Local Induction Checklists Completed	98%	100%	98%	100%	97%	97%

Source: Electronic Staff Record, 11-5-2020

Every member of staff employed by the Trust is required to be compliant with a range of mandatory and statutory training requirements. In 2019/20 the Trust signed up to adopting a consistent approach with partner organisations across north central London surrounding the requirements and curriculum for each topic area. In addition, the organisation now accepts training delivered at other NHS organisations.

Compliance throughout the year has been lower than expected and reflects a range of new subject areas introduced into the requirements that were not previously delivered by the Trust.

Disclosure and Barring Service (DBS) compliance 2019/20

Description	2018/19 Overall figures	Apr – Jun Quarter 1	July – Sept Quarter 2	Oct – Dec Quarter 3	Jan – Mar Quarter 4	2019/20 Overall Figures
DBS Compliance Checks Completed	98%	99%	99%	99%	99%	99%

Source: Electronic Staff Record, 11/05/2020

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

The Trust maintained a high level of compliance to the required standards. To ensure visibility staff that are on maternity leave or a prolonged absence are included in the denominator for this metric which accounts for the 1% who do not currently have an up to date check in place.

The Trust's recruitment and selection procedure requires that all staff that conduct Regulated Activity should undergo a disclosure check before commencing with the organisation. In addition to this, the Trust also ensures that all staff are rechecked every three years. The indicator measures compliance against this policy.

Patient Experience

Formal complaints received

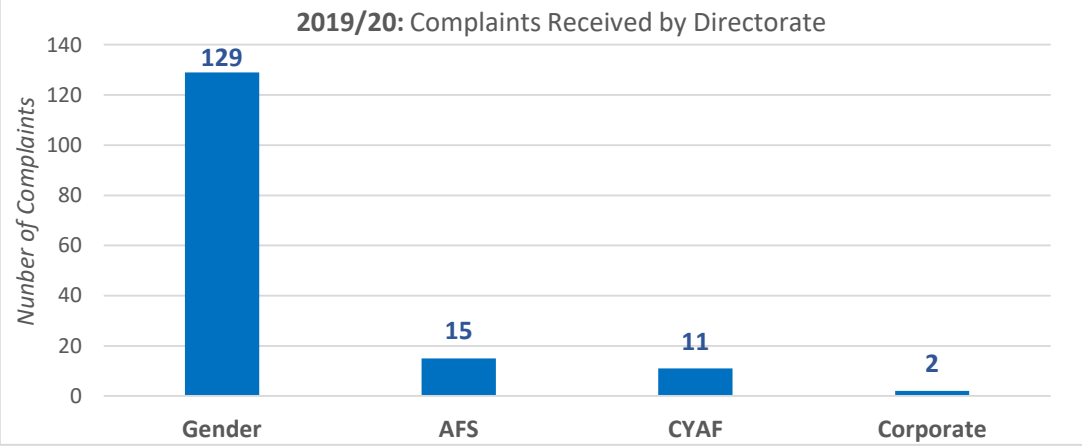
	2015/16	2016/17	2017/18	2018/19	2019/20
Formal Complaints received	27	39	154	158	157

Source: Quality Portal 15/04/2020

A formal complaint is defined as any written complaint received from a patient or a representative of the patient. A verbal complaint may be treated as a formal complaint if the complainant wishes their concerns to be treated formally. The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. Following a rise in complaints from 2016/17 to 2017/2018 (due to the Trust's acquisition of the Charing Cross Gender Identity Clinic) complaints have remained at

approximately the same level. For 2019/20 we received 157 complaints of which 113 related to the Gender Identity Clinic. The service receiving the next largest number of complaints was the Gender Identity Development Service for those under 18 years of age, which received 16 complaints. It should be noted that the 32 Information Governance complaints relate to a single incident where a group email was sent to patients using the 'to' button and not the 'bcc' button.

Complaint Category	No. of Complaints
Access to Treatment or Drugs	21
Admissions Discharges	1
Appointments	2
Clinical	27
Commissioning	1
Communications	27
Information Governance	32
Information Technology	1
Prescribing	1
Trust Administration	9
Values & Behaviours	10
Waiting Times	25



Source: Quality Portal 15/04/2020

Due to the current COVID-19 crisis all complainants, who have not yet been responded to, have been written to with the information that there will be a delay in responding to their complaint as staff are focusing on assisting with the current crisis.

Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. In Quarter 2 one complaint was being looked into by the Health Service Ombudsman. Information was provided, but no further information has been received on this complaint. Information has been requested by the Ombudsman on two further complaints (one is Q3 and one in Q4), but again nothing further has been received on these. With the current COVID-19 crisis we have been advised by the Ombudsman that no new cases are being opened at present and there is likely to be a delay in progressing existing cases.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our

services for service users, to ensure that improvements to our services are made we have instigated a more robust system of actions plans following upheld complaints. Action plans following complaints are reported to the Patient Safety and Clinical Risk meeting.

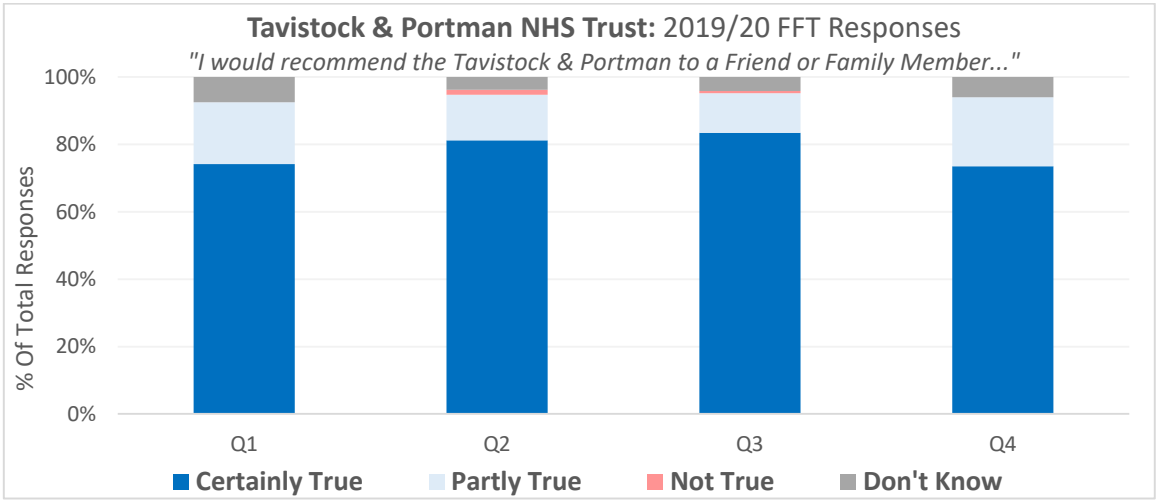
During 2019/20 we have given presentations to staff both at Staff Induction Days and INSET days to ensure that staff are aware of the complaints procedure and how to advise patients who wish to make a complaint. In addition, the Complaints Manager has attended Team Meetings within both CYAF and AFS to talk to staff about the complaints process. We have also ensured that information on how to raise a complaint is in all patient waiting areas and on the website.

Experience of survey questionnaire: friends and family test

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

	2015/16	2016/17	2017/18	2018/19	2019/20
% of Patients who would recommend the Tavistock and Portman to a Friend or Family Member if they required similar treatment	94%	93%	98%	97%	94%

Breakdown of 2019/20 Responses



Source: Quality Team, Data received and calculated: 01/04/2020

The Trust received a reliably positive response to the FFT questions over the course of 2019/20, with 94.3% of patients answering 'Certainly True' or 'Partly True' to the FFT prompt and only 3 negative responses returned over the course of the year.

As a trust we have noted that our ESQ feedback from patients accessing treatment has been high in satisfaction rates. We have made an investment to look deeper into feedback by redesigning our ESQ to be able to further analyse qualitative feedback in order to improve services. In quarter 1 20/21 the redesigned ESQ will be its third test stage with the final redesign to be agreed at board level over the year.

Patient satisfaction

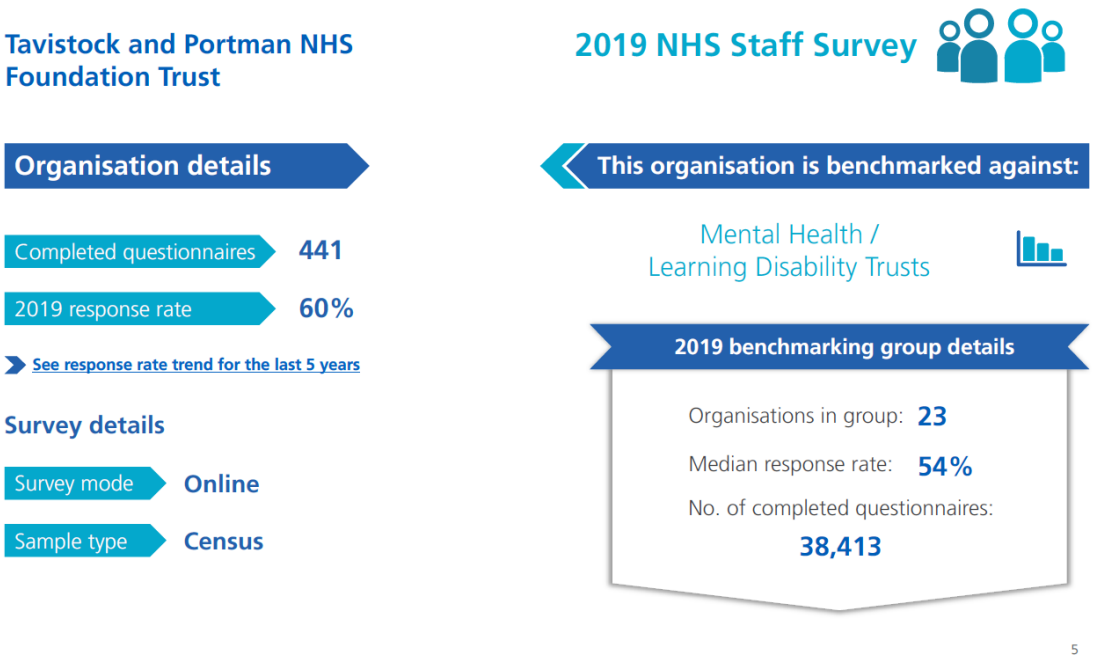
This information is included under reporting against core indicators covered on page 27.

Clinical Effectiveness

National Staff Survey 2019 – quality of care provision

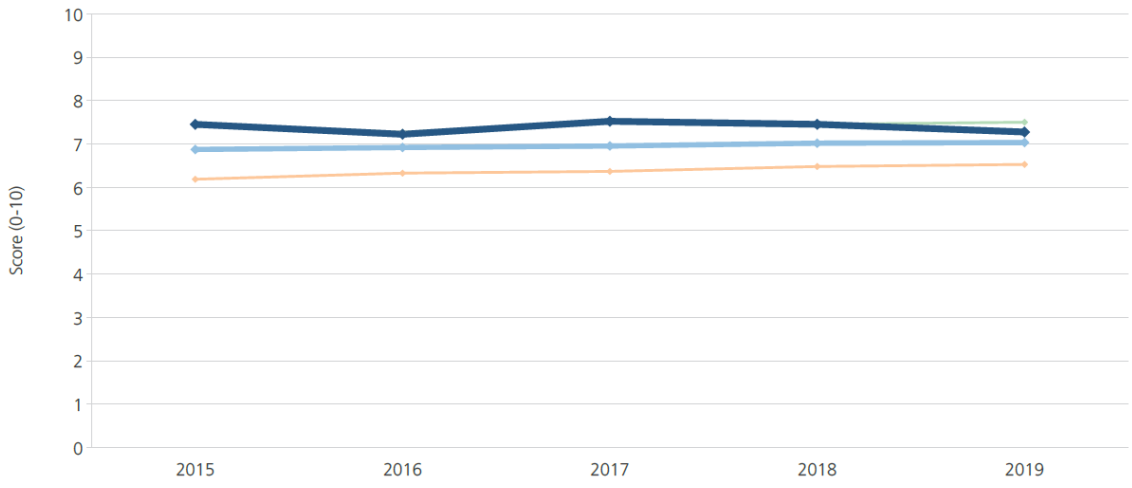
The NHS Staff Survey takes place each year between September and December. In 2019 the Trust offered all staff who were employed on or before 01 September 2019 the opportunity to respond to the survey.

60% of eligible staff responded to the survey which is the same level as participation as the previous year and is above average for mental health and learning disability trusts.

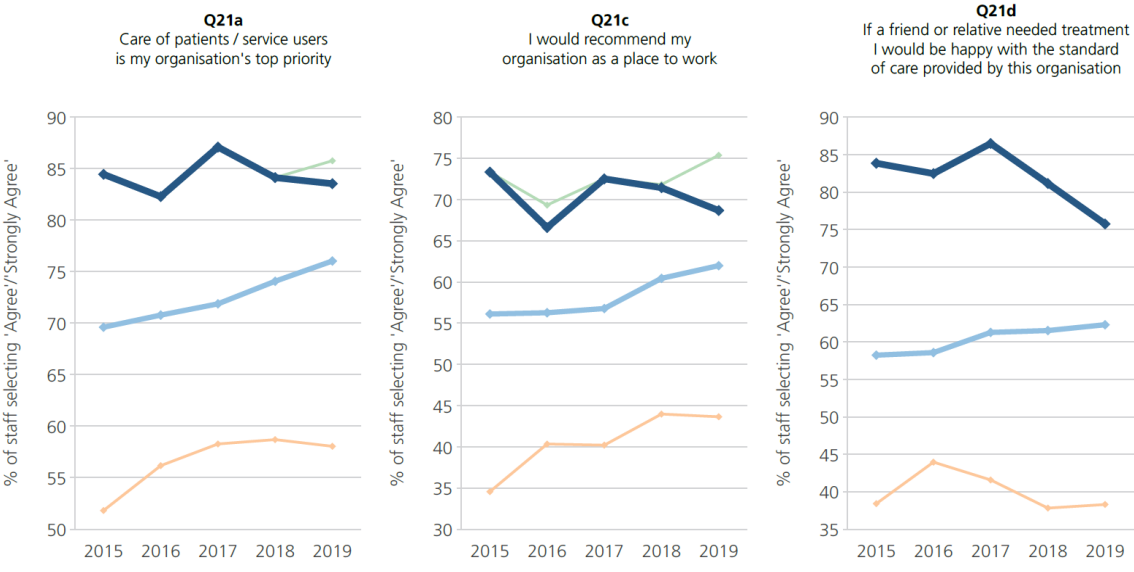


Overall staff engagement

The graph below highlights Trust performance with staff engagement overall. The Trust performed well alongside the average score of 7.0 although there was a slight dip in the 2018 score.



	2015	2016	2017	2018	2019
Best	7.5	7.3	7.5	7.5	7.5
Your org	7.5	7.2	7.5	7.5	7.3
Average	6.9	6.9	7.0	7.0	7.0
Worst	6.2	6.3	6.4	6.5	6.5
Responses	255	321	349	384	439



	2015	2016	2017	2018	2019
Best	84.5%	82.3%	87.1%	84.1%	85.8%
Your org	84.5%	82.3%	87.1%	84.1%	83.5%
Average	69.6%	70.8%	71.9%	74.1%	76.0%
Worst	51.8%	56.2%	58.3%	58.7%	58.0%

	2015	2016	2017	2018	2019
Best	73.3%	69.3%	72.5%	71.8%	75.4%
Your org	73.3%	66.6%	72.5%	71.4%	68.7%
Average	56.1%	56.3%	56.8%	60.4%	62.0%
Worst	34.6%	40.3%	40.2%	44.0%	43.6%

	2015	2016	2017	2018	2019
Best	83.8%	82.5%	86.5%	81.1%	75.7%
Your org	83.8%	82.5%	86.5%	81.1%	75.7%
Average	58.2%	58.6%	61.3%	61.5%	62.3%
Worst	38.4%	44.0%	41.6%	37.8%	38.3%

Key findings

It is really pleasing to report that engagement across the organisation remains high and that for another year running the Trust ranks the best performing mental health and learning disability trust in two of the eleven theme areas, these are:

- Bullying and harassment; and Safety.

When reading the results carefully it is noticeable that staff would recommend the organisation as a place to receive care and that staff feel able to make improvements in their areas of work.

Staff engagement also remains above average when compared to Trusts in our peer group.

The survey does, however, share that there are a number of areas where there are issues, some which were similar to last year. These include:

- That a high number of staff are feeling unwell, stressed and coming to work when they are poorly.
- There is also a strong feeling that people who are responsible for managing teams should focus on their staff's wellbeing.
- The experience of BAME staff, in terms of fairness in career progression and development, has declined quite significantly in the last year.
- That whilst appraisals happen across the organisation, they are not used effectively as a means of having ongoing conversations about career development and progression.
- Confidence in feeling safe when raising concerns and reporting incidents has declined.
- Staff recommending the organisation as a place to work has also reduced.

These messages have been shared with a number of senior managers across the organisation and conversations have started to understand the underlying issues behind them.

Outcome monitoring data

Goal Based Measure (GBM) outcome data for child and adolescent mental health service (CAMHS)

	2015/16	2016/17	2017/18	2018/19	2019/20
% of qualifying Camden CAMHS patients who completed 'Time 1' and 'Time 2' Goal Based Measure (GBM) forms	59%	48%	56%	49%	50%
% of the above patients who reported an improvement in their GBM scores from Time 1 to Time 2	83%	80%	77%	57%	22%

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 9-4-19

For our Camden Child and Adolescent Mental Health Services (CAMHS), we use the Goal-Based Measure (GBM) to enable us to know what the service user wants to achieve (their goal or aim) and to focus on what is important to them. This helps us to make adjustments to the way we work with the individual.

Time 1 refers to the pre-assessment stage, where the patient is given the GBM to complete with their clinician. This is when they are seen within the first two appointments and decide what they would like to achieve. The patient is asked to complete this form again with their clinician after three months or, if earlier, at the end of therapy/treatment (known as Time 2). This information is scored to indicate whether the patient has 'improved', 'not improved' or there has been 'no change' in the achievement of their goals.

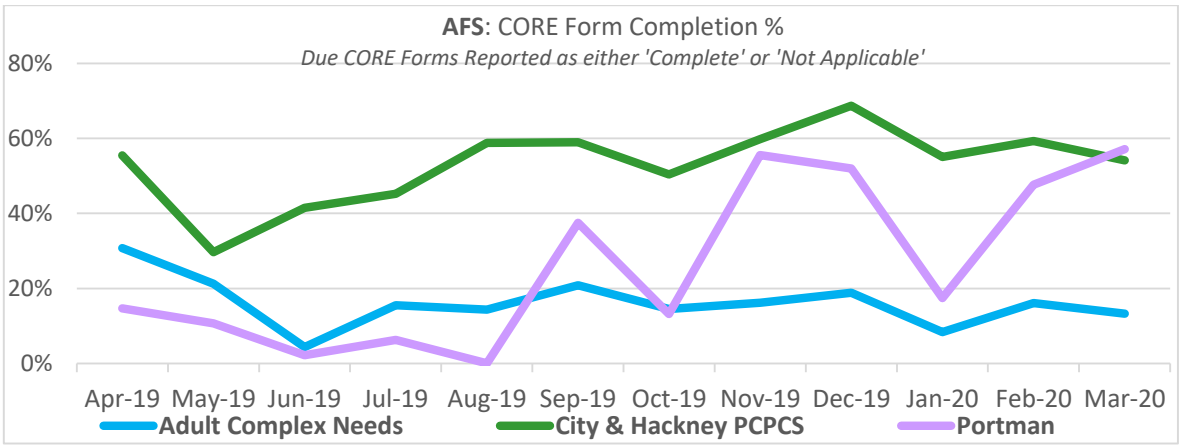
The GBM improvement scores reduced significantly in 2019/20 owing to changes in data collection over the period. During the year there was a review to improve GBM collection rates and service user goal information reducing the period between Time 1 and Time 2 to a few weeks, rather than months. This reduced the time available for improvements to take place, with the unintended consequence of negatively impacting on the improvement scores. During 2020/21 the trust will be re-assessing how to measure GBM improvement rates in a meaningful way.

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

The outcome measure used across all adult services is the CORE. This is designed to provide a routine outcome measuring system for psychological therapies covering four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm. The following table

shows the completion rates for this measure, broken down by the service line. Further work will be undertaken during 2020/21 to improve the quality of this data and enable us to use this data for benchmarking purposes, for providing information on how our improvement rate for adult patients compares with other organisations and services.

	2019/20 CORE form completion			
	Total CORE Forms Due	Total Forms Recorded as Complete or N/A	Total Forms Recorded as Outstanding	2019/20 Completion %
Adult Complex Needs	1915	321	1594	**16.8%**
City & Hackney PCPCS	1317	700	617	**53.2%**
Portman	390	100	290	**25.6%**



There have been logistical and technical issues as a result of the COVID-19 pandemic that have made it more difficult for clinicians to complete CORE forms during March 2020 and which we expect plays a role in two of the three AFS services completion rates dipping at year-end.

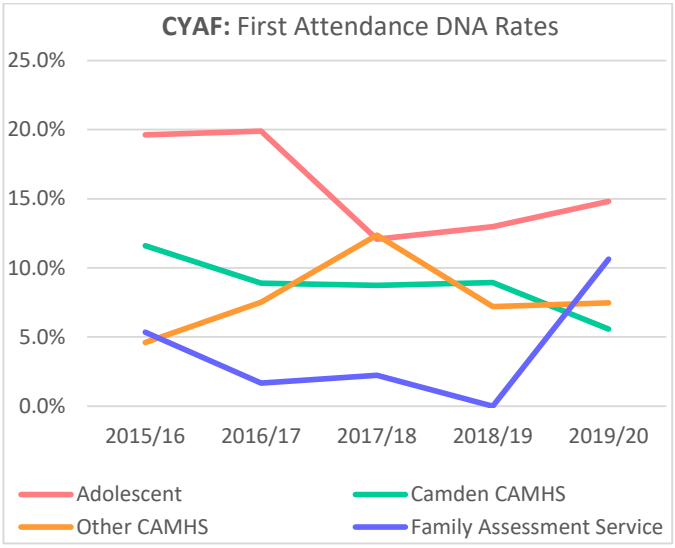
We started a project in May 2020 looking at both the technical (electronic patient record system logic) and operational factors (timing of staff giving out monitoring forms) that could make our outcome monitoring data more useful for patients and clinicians alike and emphasise the value to our clinical teams. Our aim is to increase the use and awareness of data in line with the trusts' Quality priority on Outcome Monitoring for 2020/21 and to develop a culture of data led services.

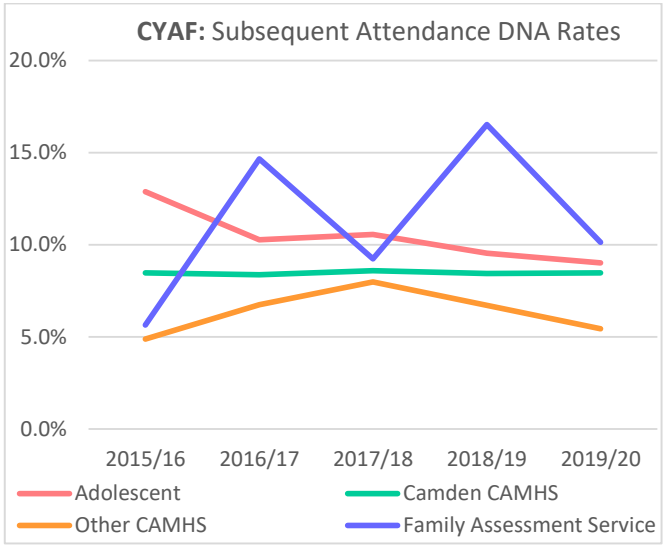
Did not attend (DNA) rates

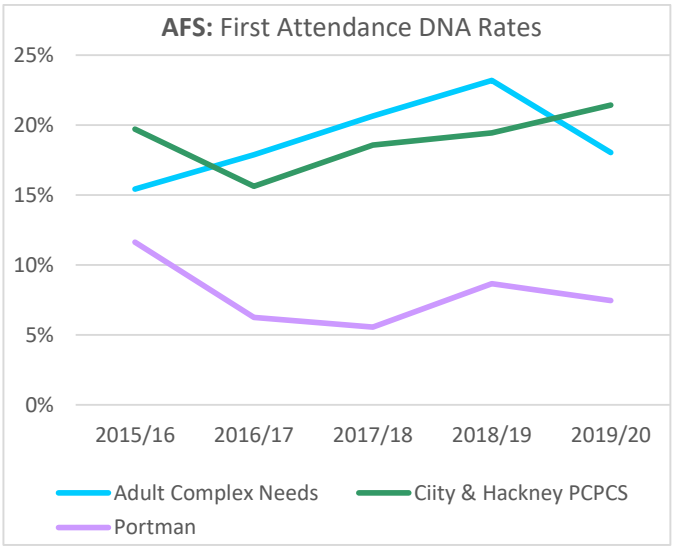
The National target for DNA rates is below 10% which has continued to be met for the Trust for 2019/20. The outcome of all patient appointments is monitored to improve the engagement of patients, and where possible to minimise wasted NHS time. The Trust continues to offer choice concerning the times and location of appointments; emailing patients and sending them text reminders for their appointment, or phoning patients ahead of appointments as required. The Trust continues to work with clinical & administrative teams, support services and Quality Improvement groups to identify methods of reducing DNAs.

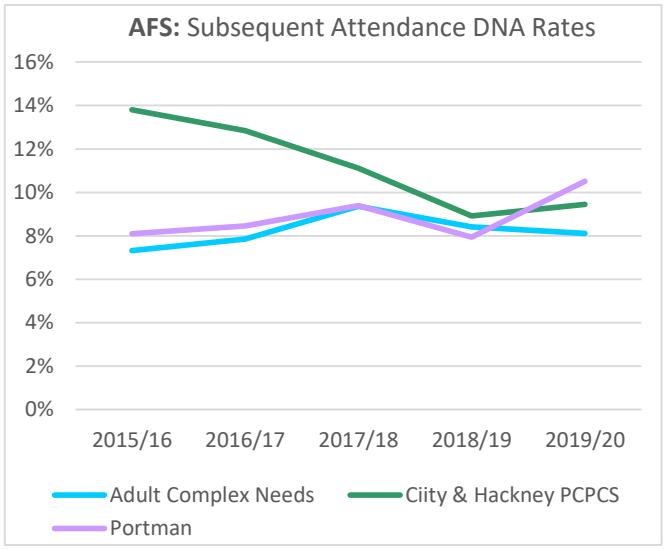
	2015/16	2016/17	2017/18	2018/19	2019/20
Trust-wide Total					
First Attendance DNA %	11.8%	11.3%	12.1%	12.2%	10.4%
Subsequent Appointments DNA %	8.6%	9.0%	9.7%	8.8%	8.8%
Adolescent and Young Adult					
First Attendance DNA %	19.6%	19.9%	12.1%	13.0%	14.8%
Subsequent Appointments DNA %	12.9%	10.3%	10.6%	9.5%	9.0%
Adult Complex Needs					
First Attendance DNA %	15.4%	17.9%	20.7%	23.2%	18.0%
Subsequent Appointments DNA %	7.3%	7.9%	9.4%	8.4%	8.1%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)					
First Attendance DNA %	11.6%	8.9%	8.7%	8.9%	5.6%
Subsequent Appointments DNA %	8.5%	8.4%	8.6%	8.4%	8.5%
Other CAMHS					
First Attendance DNA %	4.6%	7.5%	12.4%	7.2%	7.5%
Subsequent Appointments DNA %	4.9%	6.7%	8.0%	6.7%	5.4%
City & Hackney Primary Care Psychological Service					
First Attendance DNA %	19.7%	15.6%	18.6%	19.5%	21.4%
Subsequent Appointments DNA %	13.8%	12.8%	11.1%	8.9%	9.5%
Portman					
First Attendance DNA %	11.6%	6.3%	5.6%	8.7%	7.4%
Subsequent Appointments DNA %	8.1%	8.5%	9.4%	7.9%	10.5%
GIDS					
First Attendance DNA %	10.7%	12.8%	11.5%	13.4%	12.5%
Subsequent Appointments DNA %	8.8%	8.7%	10.2%	9.8%	10.2%
GIC					
First Attendance DNA %	4.1%	10.0%	12.3%	11.5%	8.2%
Subsequent Appointments DNA %	11.3%	14.4%	14.7%	12.6%	12.8%
Family Assessment Service					
First Attendance DNA %	5.4%	1.7%	2.2%	0.0%	10.6%
Subsequent Appointments DNA %	5.6%	14.7%	9.2%	16.5%	10.1%

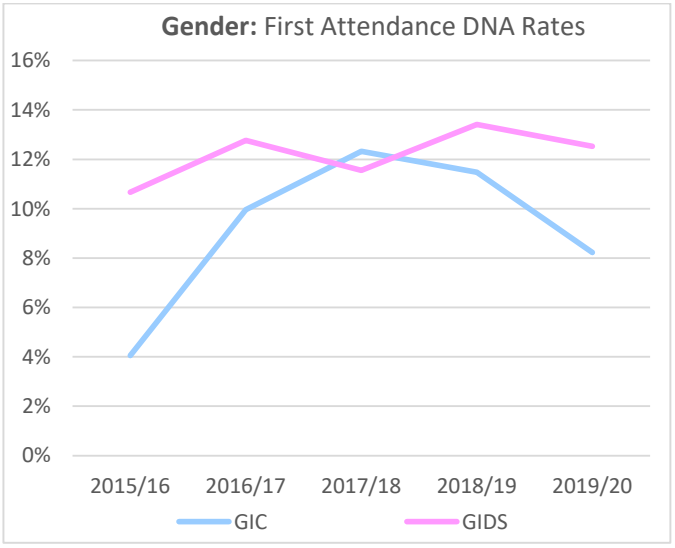
Despite an increase in the number of 1st appointments taking place across the Trust over the reporting period there has been a decrease in DNA's for first appointment by 1.9%. There was a slight decrease in the number of subsequent appointments from 2018/19 with the Trust-wide DNA rate remaining consistent at 8.8%.

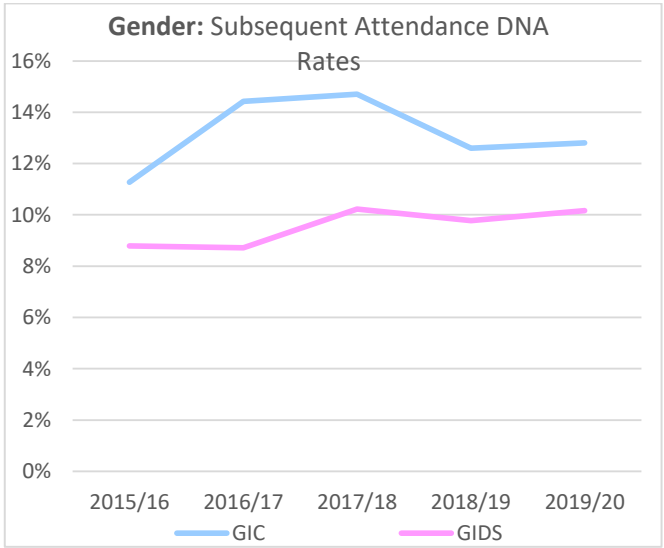












Definitions used for DNA's for percentages are as follows:
1st DNA(%) = Total 1st DNA / (Total First Attended + Total 1st DNA appointments)
Subsequent DNA (%) = Total sub DNA / (Total subsequent attended + Total subsequent DNA appointments)

Total DNA(%) = Total DNA / (Total Attended + Total DNA appointments

Waiting Times

Compliance with Waiting Time Targets for 1st Appointments

Five out of the Trust's nine clinical service areas increased compliance with our waiting time targets and saw a reduction in the number of patients waiting for a first appointment compared with 2018/19 financial year. The biggest challenges continue to be in our gender services, owing to the number of referrals. The Adults Complex Needs service undertook a Quality Priority project over the 2019/20 financial year that focused on improving the experience for patients who were on the waiting list for treatment. The team has received a good amount of qualitative feedback that has been used to formulate plans for improving the waiting time experience during the 2020/21 financial year. Additional funding has also supported new staff appointments to address increasing referrals over the past five years.

Waiting time compliance (percentages) is shared with service leads on a monthly basis along with specific data on waiting time breaches. This has helped clinical leads remain engaged with waiting time performance and lead to an increased understanding of internal factors that have resulted in us not seeing service users within agreed waiting time targets.

		2017/18	2018/19	2019/20
Service	**WT Target for 1st Appts**	**% Patients Seen for 1st Appt within Target**	**% Patients Seen for 1st Appt within Target**	**% Patients Seen for 1st Appt within Target**
Adult Complex Needs	*< 11 Weeks*	88.1%	73.7%	44.2%
City & Hackney	*< 18 Weeks*	99.1%	98.6%	98.3%
Portman	*< 11 Weeks*	99.0%	85.4%	94.3%
Adolescent *(Under 18's)*	*< 8 Weeks*	74.2%	50.0%	50.0%
Adolescent *(Over 18's)*	*< 11 Weeks*	87.0%	82.1%	73.0%
Adolescent Total		84.4%	79.8%	70.2%
Camden CAMHS	*< 8 Weeks*	96.6%	94.1%	95.7%
Other CAMHS	*< 8 Weeks*	76.1%	72.4%	77.9%
GIC	*< 18 Weeks*	4.9%	6.1%	4.9%
GIDS	*< 18 Weeks*	21.3%	12.4%	12.7%

Source CareNotes.16/04/2020

Notes on Waiting Time & Waiting List Calculations

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

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

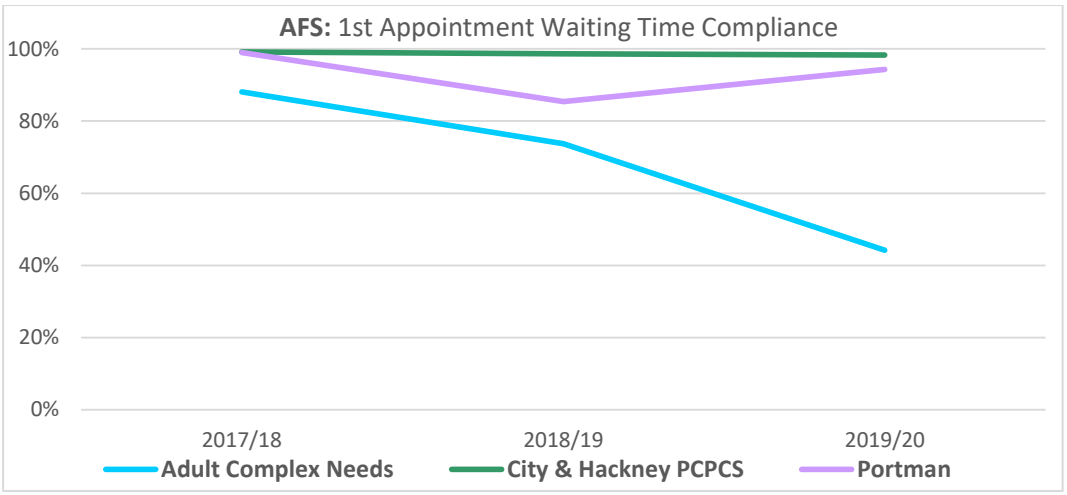
The numerator for the quarterly calculations is the sum of:

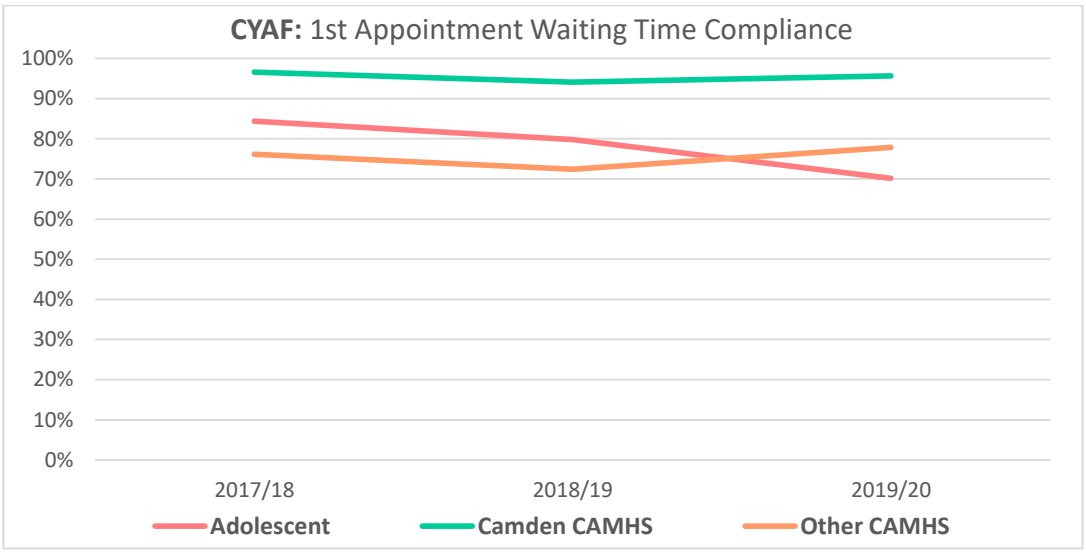
- Number (n) of referred patients who had attended a first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received;

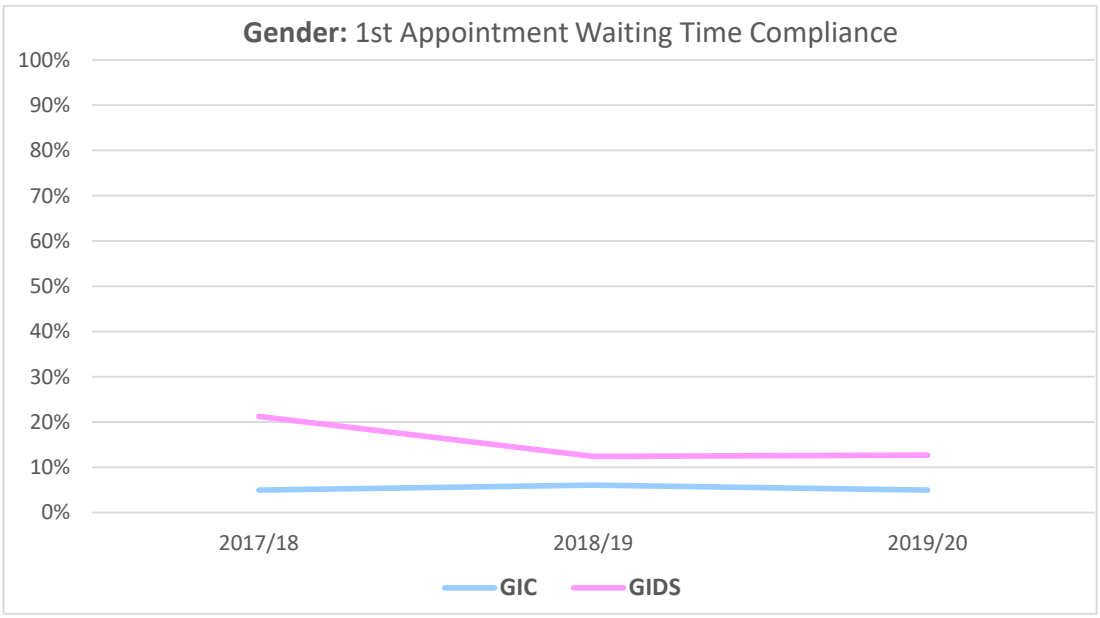
The denominator for the quarterly calculations of the indicator is the sum of:

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

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







Reported raising of concerns: whistleblowing

The Trust takes the issue of staff being able to raise concerns by speaking up, or 'whistleblowing', very seriously and appointed a Freedom to Speak Up Guardian (FTSUG) in October 2015. This was in line with the Francis Review recommendations. (See Glossary)

The Trust conducted a thorough review of its processes and systems for raising concerns in May 2019. It also reviewed and updated the freedom to speak up: raising concerns and whistleblowing procedure in December 2019 and following the National Guardian's Office guidance on good practice allocated ring fenced time for the role of FTSUG (3¾ hours).

Regular communications have gone to staff to make them aware of our FTSUG and of their role and contact details. Throughout the year, meetings have been held with groups of staff to raise awareness and there are regular presentations at mandatory training update days and updates sent out via the communications team.

In January 2020, Dan Sumpton took over as the Trust FTSUG from Gill Rusbridger who had undertaken the role for 5 years. Dan undertook the National Guardian's Office information training and attended the Regional Integration and Development Event in March 2020.

The Trust scored as one of the highest in the FTSUG Index Report 2019 published by the National Guardian's Office. This Index is based on a review of 4 questions in the NHS Annual Staff Survey for 2018 which related to speaking up and patient care / safety. These questions cover whether staff felt secure in raising concerns, know how to raise concerns, feel the Trust encourages staff to report of errors, near misses and incidents and whether staffs feels the Trust treats staff fairly when reporting errors, near misses and incidents. This is really positive news and an indicator of the great work Gill Rusbridger did in her FTSUG role and the emphasis that the Trust places on the importance of promoting a culture where people feel able to speak up about any concerns they may have.

From a review of the NHS Annual Staff Survey results for 2019 in relation to the same questions that influence the FTSUG index, there was a general decline in how positively staff responded to questions with a varying degree of percentage change and impact. The raising concerns review conducted in May 2019 set out a number of actions to address this trend, they included shorter term process changes through to longer term cultural programmes of work. The Trust will need to review the staff survey results and consider what actions to take regarding this matter.

There were two whistleblowing complaints raised in the reporting period, both were investigated thoroughly.

During the 2019/20 period, 28 staff members approached and spoke with the FTSUG. 19 of the 28 staff raising concerns spoke about not feeling listened to by managers and senior people in the Trust, with elements of bullying and harassment also noted. 14 of the 28 staff raising concerns spoke about their concerns about patient safety and quality of care. It has proved possible for certain of these concerns to be discussed more openly and for some of them to be resolved, but others have needed more ongoing follow up with both staff and senior managers.

The Trust is committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question. Staff need to feel empowered to speak up in whatever way they feel comfortable with, even if this is anonymously or through staff other than the Freedom to Speak Up Guardian. This needs a flexible approach as the pressures on staff working in different areas of the Trust fluctuate and change and it is not always easy to anticipate and respond to perceived difficulties effectively. However, the Trust has a responsibility and is committed to learning from issues that are raised and working together with staff and managers to improve communication.

The FTSUG is in regular contact with the National Guardian's Office and support systems in place such as the national whistleblowing helpline. The FTSUG is also a member of the London and East of England Regional Group for FTSUG. The National Guardian's Office is now well established and arranges regular conferences and training events. The FTSUG also meets regularly with other staff in the Trust who holds responsibility for staff wellbeing, such as the staff side representatives, the HR and corporate governance director and a linked non-executive; alongside consulting with the Chief Executive, service directors and managers when issues are raised.

Over the coming year of 2020/21 the FTSUG will continue to keep the profile of the role in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness in which staff are encouraged to speak up about patient safety and care, knowing that their concerns will be welcomed, taken seriously and responded to quickly and appropriately. Over the coming few months the FTSUG will meet with the Chief Executive and HR Director to present a plan for promoting a culture of speaking up in the Trust, the role of the FTSUG and how to improve access to the FTSUG for staff.

Bolstering staffing

On the basis that the Trust had over-performed on the adult trauma unit service contract for 5 years, was under-funded and had long waiting lists for this service our commissioners provided an increase in funding during 2019/20 to enable an increase in staffing for this service.

Staff Rota Information

The Trust appointed a Guardian of Safe Working Hours to coincide with the implementation of the new junior doctors' contract. Earlier in the financial year there were two vacancies on our rotation allocation from Health Education England (HEE). Following extensive work from our training programme director and working collaboratively with the London regional team at HEE the Trust has reached the financial year end with no vacancies within our training allocations.

Part 4: Annexes

Statements from North Central London (NCL) Clinical Commissioning Group (CCG), Camden Healthwatch, Health Scrutiny Committee and Governors and response from Trust.

Statement from North Central London (NCL) CCG

Until 31 March 2020 Camden Clinical Commissioning Group (CCG) was the lead commissioner responsible for the commissioning of health services provided by the Tavistock and Portman NHS Foundation Trust, for Camden's population and surrounding boroughs. On 1 April 2020, the five CCGs across North Central London (including Camden CCG) merged and NCL CCG was established. This quality assurance statement is written by NCL CCG and continues to reflect the views of its predecessor organisation.

We have worked closely with the Tavistock & Portman NHS Foundation Trust to ensure we have the right level of assurance regarding commissioned services, obtained mainly via regular Clinical Quality Review Group (CQRG) meetings. The CCG welcomes the opportunity to provide this statement on the Trust's Quality Account.

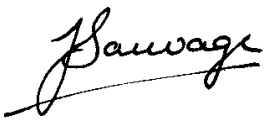
We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in June 2020). The document received complies with the required content as set out by the Department of Health or where the information is not yet available a place holder had been inserted.

The Care Quality Commission rated the Trust as 'Good', following their inspection in 2018. The Trust developed an action plan to improve areas highlighted by the inspection. This included, the updating of their Clinical Quality Strategy and strengthening their governance structures to support Quality Improvement (QI) projects. Commissioners are pleased to note that the Trust are continuing their work on improving service user experience. Views and feedback received from service users, are key to shaping and improving the quality of services delivered by the Trust. This has been illustrated through the work undertaken by the Trust and service users to co-design the Experience of Service Questionnaire during 2019/20.

Waiting times for initial appointments are an area of concern for the Trust and commissioners, as this has a direct impact on quality and patient experience. We welcome the QI work proposed by the Trust to understand the range and variation of waiting list lengths across the Trust, which seeks to streamline their management, leading to a positive impact on patient care, experience and safety.

The Trust have an established programme in place to implement a range of measures to improve Black, Asian, Minority Ethnic (BAME) staff experience, opportunities for career progression and address discrimination. We encourage the Trusts commitment to building a culture of openness and responsiveness to ensure staff feel empowered to speak up, which will positively influence the quality of clinical services received by service users.

Overall, this is a positive Quality Account and we welcome the vision described and agree on the priority areas.



Frances O'Callaghan — Accountable Officer, NCL CCG

Dr Josephine Sauvage — Clinical Chair, NCL CCG

Trust Response

The Trust welcomes comments on the Quality Report by NCL CCG and note that these reflect the views of our lead commissioner for 2019/20 Camden CCG.

We are pleased that the work undertaken to improve areas highlighted by the Care Quality Commissioner inspection in 2018 and in particular the updating of our Clinical Quality Strategy and strengthening of our governance structures to support Quality Improvement (QI) work across the Trust has been recognised.

Also, during the year, we have continued to seek the views and feedback from our service users and have welcomed joint working with groups to co-design our Experience of Service Questionnaire (ESQ). We look forward to further developments in the coming year.

We share our commissioner concerns around waiting times for initial appointments, recognising the impact that long waits have on quality and patient experience, and have identified the improvement of waiting times as a Trust quality priority for 2020/21.

The Trust has an established programme in place to improve Black, Asian, Minority Ethnic (BAME) staff experience, opportunities for career progression and address discrimination. We are aware that more work is required and the Trust is committed to working with our BAME colleagues and staff across the Trust to improve the culture of openness, racial awareness and responsiveness across the organisation. We know that when all staff are empowered to speak up and to reach their potential, that this positively influences the quality of clinical services experienced by our service users.

We look forward to continuing to work collaboratively with our commissioner colleagues on quality issues and the implementation of our quality priorities during the coming year.

Joint Statement by Camden Healthwatch and Camden Local Authority Health Scrutiny Committee

Healthwatch Camden thanks the Trust for the opportunity to comment on your Quality Accounts. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS along with the additional pressures created by the Covid-19 crisis means that we do not have the human resources to consider Quality Accounts in the detail that they deserve.

Although we are not making a formal comment on the Quality Accounts, we would like to welcome the emphasis placed on improving the use of patient experience data to improve and develop services and the decision to seek more rich qualitative data by reducing the questions and allowing more free text space for service users to feedback in the Experience of Service (ESQ) feedback forms.

Anna Wright	James Fox
Policy and Insight Lead	Senior Policy and Project Officer
Healthwatch Camden	Camden Local Authority

Trust Response

Thank you very much for your feedback which we will include within our final Quality Accounts. Given the increased complexity in the local NHS and pressures created by the COVID-19 crisis we are extremely grateful to you for taking the time to consider the report.

We welcome your support for the work we have prioritised this year around the use of patient experience data to improve and develop our services and look forward to continuing our relationship with Camden Healthwatch in these endeavours.

Statement from our Governors

As a Council of Governors, we are fortunate in having had opportunities, both in formal Council meetings and individually through attendance at various of the Trust's key Committees, to understand and, where appropriate, interrogate the Trust's Quality strategy. Throughout the year we have been able to observe the real and ongoing commitment across the Trust to deliver quality care. We welcome these Annual Quality Accounts as evidence of that commitment and the progress that the Trust has made, and also for their honesty about the work that remains to be done.

Trust Response

The Trust welcomes the feedback from the Governors to the draft Quality Accounts and appreciates the ongoing commitment to support Trust staff to ensure the delivery of excellent quality services.

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2010/20.

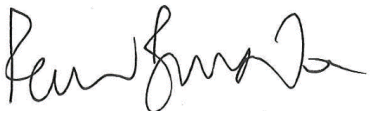
The content of the Quality Report is not inconsistent with internal and external sources of information including:

- board minutes and papers for the period 1 April 2019 to 31 March 2020
- papers relating to quality reported to the board over the period 1 April 2019 to 31 March 2020
- feedback from commissioners dated 28 July 2020
- feedback from governors dates dated 14 August 2020
- feedback from local Healthwatch organisations dated 14 July 2020
- feedback from Health Scrutiny Committee dated 17 August 2020
- the trust's complaints data published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 28 July 2020
- the 2019 national staff survey 18 February 2020
- CQC inspection report dated 16 November 2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board



Rt Hon Prof Paul Burstow

Trust chair

24 November 2020

Paul Jenkins

Chief executive

24 November 2020

Independent auditor's report to the council of governors of The Tavistock & Portman NHS Foundation Trust on the quality report

Owing to the national Covid-19 pandemic it has been confirmed nationally that an Independent auditor's report is not required for the 2019-20 Quality Accounts.

Appendix – Glossary of Key Data Items

AFS – Adult and Forensic Services.

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

CAMHS – Child and Adolescent Mental Health Services

CCG (Clinical Commissioning Group) – CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31 March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

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

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

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

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

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

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

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

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

CGAS – Children's Global Assessment Scale

CYAF – Children, Young Adults and Families services.

CORE – Clinical Outcomes in Routine Evaluation

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

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

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

Data Security and Protection Toolkit (replacing the Information Governance Toolkit) – It is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardians' 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. It also draws together legal rules and central guidance included in the various Acts (GDPR, DPA18) and presents them in one place as a set of data security and protection assertions.

Francis Report – The Francis Inquiry report was published on 6 February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report makes 290 recommendations, including: openness, transparency and candour throughout the health care system (including a statutory duty of candour), fundamental standards for health care providers and improved support for compassionate caring and committed care and stronger health care leadership.

The appointment of Freedom to Speak Up Guardians across the NHS was in line with the recommendations.

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

Goal-Based Measure – These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc. to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

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

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

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

Information Governance Assessment Report – The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorized access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

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

Integrated Governance Committee (IGC) – the IGC is a standing committee of the Trust's Board of Directors. It was established to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

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

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

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

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

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

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

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

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

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

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

NHS Improvement (NHSI) – NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. The organisation works with the Department of Health and Social Care.

NHS Resolution (formally the NHS Litigation Authority (NHSLA)) – The NHSLA changed its name to NHS Resolution in April 2017 but is still legally the 'NHSLA'. It is a not-for-profit part of the NHS. They manage negligence and other claims against the NHS in England on behalf of member organisations. They help resolve disputes fairly; share learning about risks and standards in the NHS and help improve safety for patients and staff. They are also responsible for advising the NHS on human rights case law and handling equal pay claims.

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

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

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

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

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

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

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

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

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

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

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

Rapid Transfer Incidents – When a patient becomes acutely unwell they should be rapidly transferred from the Trust to a suitable healthcare setting for assessment and treatment; this will usually be by a local Accident and Emergency department.

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

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

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

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

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

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

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

Team Around the Practice (TAP) – a primary care mental health service working with adults to manage their mental health needs and is delivered in general practice settings in Camden. The

service is specifically designed for people whose mental health difficulties are long-standing and recurrent and/or may not have benefitted from previous help. TAP primarily provides psychotherapeutic clinical interventions, consultations and support to people who are too complex, risky or treatment resistant for IAPT services. The service is now part of a Primary Care Mental Health Network and works in partnership with Camden and Islington Foundation Trust and Hillside Clubhouse for employment support. The service has strong links to colleagues in the local IAPT and personality disorder services and meet regularly with colleagues from crisis services and the rest of the Camden Primary Care Mental Health Service.

TEL – Technology Enhanced Learning

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

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

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

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

Trust-wide Induction – This is a Trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear that they are required to attend this induction as part of their employment by the Trust.

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

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

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

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24 November 2020

Report from the Trust's Freedom to Speak up Guardian

Executive Summary

This report is an update from the Trust's Freedom To Speak Up Guardian (FTSUG) since the last report presented in May 2019 and focuses on the work he has been involved in since taking over the role in January 2020.

The first part is an overview of the service, the context of the last 1 year period and the contacts that the FTSUG has had since the last report.

The second part focuses on key interactions with other parts of the Trust.

The third part raises areas of concern and considerations for development for the Board to consider and discuss.

Recommendation the [Board / Committee]

The Board is asked to approve this report.

Trust strategic objectives supported by this paper

People: supporting and developing our staff now and in the future.

Author	Responsible Executive Director
Dan Sumpton	Paul Jenkins

SERVICE LINE REPORT – TRUST WIDE

1. OVERVIEW OF THE SERVICE

1.1 The 2015 Francis Review recommended that all NHS Trusts should appoint Freedom to Speak up Guardians as an additional, confidential person available for staff to turn to if they wanted to raise concerns about anything that gets in the way of providing high-quality effective care, or that affects their working life. The current Freedom to Speak Up Guardian (FTSUG) has ring fenced time of 1 paid session per week (3 ¾ hours) at 8C equivalent.

1.2 The Trust appointed me to this role in January 2020 replacing Gill Rusbridger who had been in role since it began. The FTSUG is available to meet with all staff in the Trust, whatever their role and wherever they are based. Meetings can be held both in person, via zoom and over the phone, and/or in a location that feels safe to the person wishing to speak.

1.3 Since earlier this year and in response to the Covid-19 situation, where the majority of staff have been working remotely or combining remote working with some on site working, contacts with staff raising concerns have generally happened by zoom or telephone. I think this has been a successful approach and has allowed contact with people in a timely manner.

1.4 I will be leaving the Trust on 4th December 2020 and a new FTSUG will be in post prior to my leaving. I am moving on to a new full time FTSUG role but will support the new FTSUG during my time remaining the Trust and would be happy to offer support to them whilst they find their feet with the role once I have left.

1.5 Since being in post a similar amount of staff have contacted me to discuss concerns as with the previous FTSUG. Only one concern was raised anonymously with me via the Union Rep/Staff side Chair. Since the last report in May 2019 and from the data available to me

we have recorded 40 cases of contacts with the FTSUG. This dates from start of Quarter 2 of 2019/20 to end of Quarter 2 of 2020/21and full records of mine and the previous FTSUG data can be seen on the National Guardian's office website.

1.6 Since being in post, the themes of concerns being raised have been around patient care/safety, bullying/harrassment/behaviour and staff safety/care or a combination of the above. In Quarter 4 of 2019/20 there were 5 issues related to patient care/safety, 2 of bullying/harrassment and 1 of staff safety. This was also the initial period of Coronavirus, and we saw the impact of this in concerns being raised generally around patient and staff safety, prior to clearer protocols and risk management plans being in place.

1.7 In Quarter 1 of 2020/21 people raised 7 cases regarding concerns around staff safety/care, generally in relation to covid-19 and also in relation to Race Equality and racism in the Trust. This became a more raised concern to the killing of George Floyd, during a greater acknowledgement and recognition of the racism that people from different ethnically in response diverse communities experience, the structural racism within society and the Trust's response to racism in society and the Trust. There were 2 concerns raised in relation to patient care and safety and 1 related to bullying/harrassment/behaviour.

1.8 In Quarter 2 of 2020/21 the large majority of cases were related to concerns about bullying/harrassment and staff care/safety. A lot of these involved concerns about racism and discrimination more generally in the Trust. There was one case that led to a formal whistleblowing procedure and an external investigation.

1.9 At the time of writing this report there had been 3 cases raised with me as the FTSUG in Quarter 3 of 2020/21 and all of them related to bullying and harrassment or concerns about conduct.

1.10 To my knowledge, there has been one formal whistleblowing complaint that has been raised as part of my role as FTSUG and

there is a current investigation in progress. From discussions with the HR Director, I understand there were 3 formal whistleblowing complaints in the last year, 2 of which I have not been involved with.

2. KEY INTERACTIONS WITH OTHER PARTS OF THE TRUST

2.1 As well as meeting with staff, I arrange regular meetings with other senior staff in the Trust who are available to hear about staff concerns. On the whole I have had a very positive experience when approaching people about staff concerns and in my view Speaking Up is seen as an important issue for Senior Management. I have always found people to be responsive and wanting to resolve any concerns that are being raised.

2.2 I keep in touch with Paul Jenkins, CEO and with Craig de Sousa, Director of HR and Corporate Governance. I have had regular meetings with Helen Farrow, Non-Executive Director as the FTSUG link on the Board. I have found all of them to be supportive and responsive to concerns being raised.

2.3 I meet with Angela Haselton from Staff side and with Irene Henderson in her role as Race Diversity Champion. We have worked closely in regard to concerns being raised either through me or directly with them and I think this has been an important way of supporting staff and the Trust in dealing with concerns being raised.

2.4 I have also had meetings with the Medical Director, Clinical Chief Operating Officer, Directors and Service Managers on a regular basis. I have attended a number of all staff meetings and have attended the Race Equality Network meeting and some team meetings in order to discuss and promote the role of FTSUG.

2.5 The Trust reviewed and revised the Freedom to Speak Up; Raising Concerns and Whistleblowing Procedure in Dec 2019. Alongside this, they also provided a Raising Concerns chart and a short guide

for Raising Concerns and Speaking Up which are both available on the intranet. I think these 3 documents have helped provide more information to staff.

2.6 In early 2020 I updated the intranet site to provide helpful and easy to understand information regarding Speaking Up and how to do it. We also placed a Speak Up button on the front page of the intranet which takes people directly to the page. We set up a separate Speak UP email address for people to use so there is a consistent contact available when the Guardian isn't around or changes. However, this has generally not been used as much as expected and people still prefer to use the personal Trust email address. An article about the role appeared in the Trust's *In Mind* magazine when I was first appointment. As part of Freedom to Speak up Month I sent out a number of emails to staff talking about the role and giving a few examples and comments from people who had accessed me as FTSUG.

2.7 I have made links with other FTSUG's and the National Guardian. The National Guardian's office is well established and has become a very helpful and active channel for meeting and linking with other local and national FTSUG's. It provides helpful information which I have used regularly. I have also been able to have contact with staff there for advice and to access resources. I am a member of the London FTSUG network and have attended all of the meetings that have been available in person and on zoom.

2.8 I am currently part of the Race Equality Strategy Group in my role as FTSUG. This steering group is taking a lead on the external review of the Trust with regarding to Racial Inequality and trying to move towards being an Anti-Racist Organisation.

3. AREAS OF CONCERN FOR FURTHER DISCUSSION & DEVELOPMENTS

3.1 The Trust scored as one of the highest ranked in the FTSUG index report for 2019 which is based on 4 questions in the NHS Annual

staff survey (2018). In the 2020 index report which covers the 2019 staff survey report, The Trust had the largest decline out of all Trusts, a change of -4.1% compared to the previous year going from 81.6% to 77.5%. The highest score for a Trust in the index was 86.6% and the lowest was 68.5%. The following 4 questions make up the FTSUG index report and are taken from the 2019 staff survey report to which 60.3% of staff responded.

3.2 For Q17a "My Organisation treats staff who are involved in an error, near miss or incident fairly", the Trust scored 64.8% which was a decrease of 6.7% from the previous year but above the average for all Trusts (57%). The Trust ranked as the best in this question.

3.3 For Q17b "My organisation encourages to report errors, near misses or incidents", the Trust scored 86% which was a decrease of 1.6% from the previous year and below the average for all Trusts of 88.2%.

3.4 For Q18a "If you were concerned about unsafe clinical practice, would you know how to report it ?", the Trust scored 89.5% which was a decrease of 7% on the previous year and well below the average for all Trusts of 95.7%. The Trust ranked as the worst in this question.

3.5 For Q18b "I would feel secure about raising concerns about unsafe clinical practice", the Trust scored 69.9% which was a decrease of 1.6% from the previous year and below the average for all Trusts of 88.2%.

3.6 The above can also be thought about in the context of my recent attendance at the Race Equality Network (previously BAME Network). What stood out from that meeting from some of those who spoke was that whilst we may have a number of spaces and ways of Speaking Up, some people in the Trust don't believe they will be listened to or the information acted upon. I have heard a theme of people having a lack of trust that their concerns will be dealt with appropriately. In my view, this makes Speaking Up a

redundant process for some working in the Trust. This is something we need to take extremely seriously and try and resolve.

3.7 Whilst I don't have an answer to this problem I think it will be important for the Board, SLT, FTSUG and others involved to think about this further and continue to try and develop ways of breaking down these barriers to Speaking Up, especially for staff who we know face greater barriers to Speaking Up (e.g. staff from different ethnically diverse communities).

3.8 The Trust is currently going through the process of reviewing the Race Equality Strategy and bringing in an external person to review the Trust's culture surrounding race equality, diversity and inclusion. I think it is a brave and important step to take as long as it is done properly. We clearly have a long way to go and from the contact I have had with individuals and groups from different ethnically diverse communities, there is a real sense that things may not change or that their experiences will not be taken seriously.

3.9 There is a continuing perception that some staff are immune or untouchable when concerns are raised about them. This may be due to their seniority, because of their status or because there has been a history of issues being ignored. I know from my interactions with the SLT that these concerns are being heard and attempts are being made to deal with this perception/reality. This is something that needs continued and further attention and which was brought up in the last FTSUG report.

3.10 I have formed the opinion over the 11 months that I have been in post that there are still certain teams, services and parts of the Trust that I have not accessed or who may not think about contacting the FTSUG. Given the limited time the FTSUG has in role, it would be important to work with other parts of the Trust such as Communications to consider how best to reach out to as many staff as possible.

3.11 I think the Trust should consider a mandatory training related specifically to Speaking Up. I think having this as a stand-alone but short training on a regular basis may provide staff with ongoing knowledge of how to raise concerns and show how important creating a culture of speaking up is for all those working in the Trust. I think there should be a specific training for line and middle managers on the importance of listening and supporting the staff they manage to speak up. There is a helpful resource on training available from the National Guardians Office.

3.12 If I was to stay in this post, I would propose a regular meeting where those involved in hearing and responding to Speaking Up and Whistleblowing concerns can come together to share information together and identify themes from a range of sources in order to affect change and break down barriers to raising concerns in a meaningful and evidence based way.

4. ADDITIONAL CONSIDERATIONS FOR A NEW FTSUG

4.1 By the time this report is being read there will be a new FTSUG in role. I made a recommendation that the role go from 1 session per week (3 ¾ hours) at 8C grade to 2 sessions per week (7 ½ hours) at 8C grade which was accepted by the CEO and Trust. I think this shows the commitment the Trust has in the FTSUG role in the Trust. I also made the recommendation that any payment should be salaried and therefore pensionable. It is currently paid as a separate allowance. I am of the view that this may have put some people off applying given the negative impact this would have on their future income. I would recommend a review of this.

4.2 I think the SLT in the Trust has put an emphasis on the importance off the FTSUG role. However, I think there is still an emphasis on the FTSUG being the main person to promote and discuss the importance of Speaking Up in the Trust. I think it would be helpful for the Board, SLT and FTSUG to consider a plan for how to keep

Speaking Up at the forefront of the Trust's agenda and to promote the important Trust values of valuing staff wellbeing and embracing diversity in connection to Speaking Up. I think it is a powerful message when Leaders in the Trust promote the importance of open and honest dialogue for all staff on an ongoing basis.

I would like to take the opportunity to thank Paul Jenkins and other Leaders in the Trust for the support I have received whilst being in role for the past 11 months.

Dan Sumpton,
Trust Freedom to Speak up Guardian,
November 2020.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24th November 2020

DET Annual Student Complaints Report

Executive Summary

The purpose of this report is to provide a summary of the complaints received by the Directorate of Education and Training (DET) over the academic year 2019-20 and to outline the work undertaken to improve processes and implement learning from complaints.

DET have recently published a new Student Complaints Procedure, and will be working over the coming months to embed the new procedure with training for staff on how to handle complaints, and how to investigate complaints. The report sets out the reason for the changes, building on earlier improvements implemented in 2018-19.

There is also clearer, more transparent information to be provided to students on the Trust website on where to seek guidance and support in relation to making students complaints.

In the academic year 2019-20, DET received 9 formal and 3 informal complaints, as compared to 7 formal and 1 informal in 2018/19.

There have been 2 complaint reviews by the Chief Executive. One complaint was escalated to the Office of the Independent Adjudicator, who concluded that the complainant's complaint was Not Justified.

The Board of Directors is asked to confirm that it is adequate assurance that complaints have been managed in line with requirements.

Recommendation to the [Board / Council]

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

Trust strategic objectives supported by this paper

Student/User Experience

Author	Responsible Executive Director
Isabelle Bratt Strategic Projects Lead & Operations Coordinator	Brian Rock Director of Education & Training/ Dean of Postgraduate Studies

DET Annual Student Complaints Report

1. Introduction

1.1. This report provides a summary of complaints received by the Directorate of Education and Training ("DET") over the last academic year (2019-20) and outlines the work undertaken to improve processes and implement learning from complaints.

2. Complaints Received

2.1. In academic year 2019-20, DET received nine formal complaints and three informal complaints. This was compared to seven formal and one informal complaint(s) in academic year 2018-19.

2.2. Of the four informal complaints, none were escalated to a formal complaint, as they were all resolved at the informal stage.

2.3. Of the nine formal complaints received, one was not formally investigated as it was submitted out of time, and related to events pre-2017. The Operations Director and a Portfolio Manager met with the complainant to discuss her situation, but it was decided that there were no new material issues that would warrant a further full investigation being carried out.

2.4. Of the eight formal complaints which were investigated, two proceeded to a complaint review by the Chief Executive. The Chief Executive upheld the decisions of the Complaint Investigator in both cases, stating that the complaint was reasonably handled and the conclusions were correct.

2.5. One of these complaints were received by the Office of the Independent Adjudicator (OIA), and was subsequently investigated. The OIA concluded that the complainant's complaint was Not Justified. See Section 6 below for further detail.

2.6. There was one complaint which had been on-going since around 2014, due to the complexity of the issues involving an Associate Centre (with some independence from the Trust) and one of our accrediting professional bodies. Following negotiations between the Trust, the University of East London, and

Human Development Scotland with regards to a resolution. This complaint was finally settled in September 2019.

2.7. Over the last academic year, there have been a variety of areas which have been raised. One theme which has occurred in more than one complaint is around confidentiality and GDPR. This may reflect students increasing awareness of this area.

2.8. Another area which arose in more than one complaint was around TREC processes (Trust Research Ethics). DET have undertaken to review the processes to ensure that there is clear guidance for students, and that their progress through the TREC procedure is not unduly delayed.

2.9. Of note, only two complaints were received which related to the impact of the current Covid-19 pandemic. One was in relation to online delivery, and a student not wishing to continue their studies online in term 3. The other related to a delay in TREC processes due to the availability of assessors during the initial lockdown.

3. Time to Respond to Complaints

3.1. Of the informal complaints received, all were responded to within the timescales set out within the procedure.

3.2. Of the formal complaints investigated, four were responded to within the timescales set out within the procedure.

3.3. Four complaints were responded to outside of the timescales set out in the procedure. This was for a variety of reasons including staff sickness, and availability of staff to attend meetings with investigators. Delays ranged from 2 days to one week. All complainants were kept informed of progress and reasons for the delay. In two cases, the complainants had provided further information which needed to be investigated.

4. Topics of Complaints

4.1. The table below outlines the topics of complaints received by DET:

Informal
Data collection
Access to the University of Essex library
Equalities, Diversity and Inclusion

Formal
Confirmation of room booking
Delays in the processing of a student DBS
Breach of confidentiality
Access to prayer room and discrimination and unfair treatment in teaching session
Staff misconduct and receiving email in error about progression
Delays in TREC process
Breach of confidentiality, and incorrect advice from supervisor, and unfair marking
Student did not want to continue learning online, and had connectivity issues

Data Source: DET Complaints Log

5. Complaint Reponses

5.1. The table below outlines our responses to both formal and informal complaints in the academic year 2019-20 as compared to 2018-29.

Complaint Outcome	No. of Complaints 2018/19	No of Complaints 2019/20
Upheld in full	3	1
Upheld in part	1	6
Not upheld	4	4
Rejected*	1	1
Ongoing	0	1
Total	8	13

Data Source: DET Complaints Log

* Rejected at the initial assessment stage and therefore not investigated

6. Complaint Received by the OIA

6.1. In Academic Year 2019-20, the Office of the Independent Adjudicator received one complaint from a student of the Trust. This is the first Trust complaint which the OIA has investigated.

6.2. The original complaint was investigated by the Associate Dean, Learning and Teaching, and was then reviewed by the Chief Executive. The Trust partly upheld the complaint, which related to a student's experience of accessing the prayer room, as it found that there was inadequate information available to students. However, the Trust did not uphold a complaint of discrimination and unfair teaching as there was no evidence to support this.

6.3. The OIA reviewed our decision, and concluded that the student's complaint to them was Not Justified. In doing so, the OIA considered whether the Trust applied its procedures correctly and whether any decision made by the Trust was reasonable in all the circumstances.

6.4. The OIA was satisfied that it was reasonable for the Trust to Partly Uphold the complaint about access to the prayer room, but reject a complaint regarding discrimination and unfair teaching, given the evidence available to the complaint investigator.

7. Improvement Measures

7.1. The Directorate of Education & Training is constantly working to ensure that its complaints processes are clear to both students and investigators.

7.2. Taking into consideration feedback from both students and staff involved in complaints, the Student Complaints Procedure has been updated and came into force at the start of the new academic year (2020-21). The new procedure aims to provide clarity around timelines for the submission of complaints, and includes new forms for submitting a formal complaint, and for requesting a complaint review by the Chief Executive.

7.3. Alongside this, the information on the Trust website for students who are looking for guidance on how to make a complaint and who to contact has been updated. The Complaints Liaison Officer will be considering where else

information is published for students in relation to making a complaint, and whether this also needs to be updated.

7.4. Guidance and training for staff who may receive student complaints, and also staff who are asked to investigate student complaints is being prepared, with the aim of delivering CPD to all staff within DET.

7.5. A further update to the procedure is being drafted, in order for us to be able to identify and monitor where a complaint may raise issues of inequality, discrimination, bullying, harassment, or any other form of unfair treatment or victimisation.

7.6. The log of student complaints has been updated and refined to include logging of expressions of dissatisfaction that do not escalate to either informal or formal complaints so that DET can better monitor trends and improvements. This will be reported on in future.

7.7. The outcomes and learning from complaints are currently communicated to Portfolio Managers and Course Leads directly involved in complaints, and is now a regular item of the Portfolio Managers Group agenda to enable discussion and learning.

7.8. The Directorate of Education & Training has developed a new DET Staff Digest for this academic year. The newsletter will include a section on Learning from Student Feedback to allow us to disseminate learning from complaints to a wider spectrum of DET staff.

7.9. We are also considering more focused dissemination and learning through the Learning & Teaching Committee and Academic Governance & Quality Assurance Committee, to ensure action plans are progressed and any improvements made to our communications and processes with students.

7.10. Finally, the outcome of a formal complaint from August 2018 was a 23 point action plan around Students with Disabilities. This included improving the information available to students about declaring a disability and the support available to students. For Academic Year 2020-21, a new Students with Disabilities Procedure has been published, with clear processes and Standard Operating Procedures for staff to follow. A Disabled Students Support Fund

has been created to provide additional financial support to students with disabilities who may not be able to access the Disabled Students Allowance.

8. OIA Annual Statement for 2019

8.1. As a member of the Office of the Independent Adjudicator, the Trust is required to provide annual reporting on the number of complaints received, the number of Completion of Procedure letters issued and the categories of complaints received.

8.2. The OIA publishes information about all members' records in handling complaints and appeals for the preceding calendar year. This is so that:

8.2.1. More information is available to the public about higher education complaints;

8.2.2. Students can have greater confidence in complaints handling processes;

8.2.3. Providers can look at their own record alongside that of similar providers; and

8.2.4. The OIA can be open about their own processes.

8.3. The Annual Statement for the Trust for 2019 is attached at Appendix 1 and can also be viewed online at http://www.oiahe.org.uk/news-and-publications/annual-statements.aspx

8.4. The Annual Statement for 2019 provides a breakdown of categories of complaints against all providers. 48% of complaints against all providers closed by the OIA in 2019 were in relation to Academic Status. 29% of complaints related to Service Issues (Contract).

9. Conclusions and Recommendations

9.1. Members of the Board of Directors are asked to note and discuss this report.

Isabelle Bratt
Strategic Projects Lead & Operations Coordinator
Complaints Liaison Officer
16th November 2020

Appendix A

office of the independent adjudicator

'for students in higher education'

Tavistock and Portman NHS Foundation Trust Annual Statement for 2019

This is the Annual Statement for Tavistock and Portman NHS Foundation Trust for the calendar year ended 31 December 2019. It shows the record of Tavistock and Portman NHS Foundation Trust in handling complaints and appeals in that year.

Tavistock and Portman NHS Foundation Trust was categorised as a delivery partner for the purposes of the OIA core subscription for 2019. The OIA does not collect student number data for its delivery partner members and does not hold contextual information about the size and nature of each delivery partner member's provision. Therefore, the OIA does not calculate median data for its delivery partner members.

Completion of Procedures (COP) Letters issued

A student who has a COP Letter may not necessarily be unhappy with the outcome. Our Guidance on COP Letters says that providers should issue a COP Letter when they have upheld a complaint (or appeal), if the student asks for one. So it is difficult to compare "like with like".

Number of Completion of Procedures Letters issued	
Dated 2019	3

Annual complaints to the OIA

Complaints received by the OIA		
Year	about Tavistock and Portman NHS Foundation Trust	about all providers
2019	0	2371

Complaints closed by the OIA		
Year	about Tavistock and Portman NHS Foundation Trust	about all providers
2019	0	2185

 Complaints received at the OIA: Includes Not Eligible complaints.

 Complaints closed by the OIA: Some of the complaints might have been received in the previous year.

Complaints received at the OIA with Completion of Procedures (COP) Letter dated 2018

The table below shows the number of complaints about Tavistock and Portman NHS Foundation Trust we have received with a COP Letter dated 2018. We include this information in this Annual Statement because the 12-month deadline for bringing a complaint to us has now expired for students with COP Letters from 2018.

Complaints received at the OIA with a COP Letter dated	
2018	0

Relevant data for 2019 will be provided in the Annual Statement for the year ended 31 December 2020.

 Mean average proportion: We use the mean average for the OIA Band as a comparator, which is consistent with the way that we have previously calculated the ratio of "Completion of Procedures Letters to OIA complaints" for the OIA as a whole.

Complaints closed by outcome in 2019

The OIA did not close any complaints about Tavistock and Portman NHS Foundation Trust in 2019.

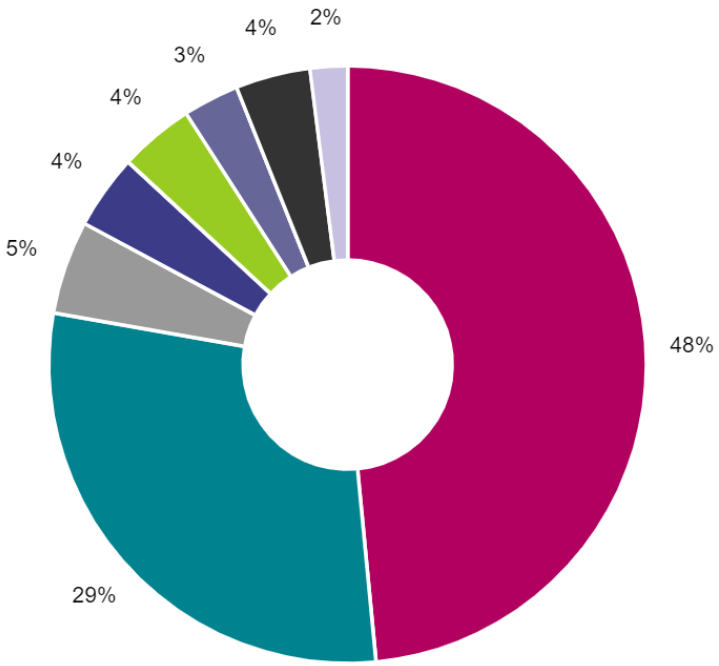
Complaints closed by complaint category in 2019

The OIA did not close any complaints about Tavistock and Portman NHS Foundation Trust in 2019.

Chart 1 breaks down the total number of complaints that we closed in 2019 (about all providers) by category of complaint.

Click on an individual chart colour below to display its complaint category.

Chart 1
All complaints closed by the OIA in 2019



Complaint categories
(Click on a category below for further information)

- Academic Appeal
- Financial
- Equality law / Human rights
- Not Categorised
- Fitness to practise
- Service Issues
- Disciplinary matters (academic)
- Disciplinary matters (non-academic)
- Welfare / Non-course service issues

Engagement with the OIA in 2019

This section includes general information about all providers' engagement with us in 2019. Where relevant, we include specific information about the individual provider as well.

Settlement of complaints made to the OIA

In 2019 we continued to look for opportunities to resolve complaints as early as possible. 10% of all the complaints we closed in 2019 were resolved by settlement.

Response times to our information requests

A key time frame for our review of a complaint is the time it takes for the provider to respond to our initial request for information that we need to review a case. In 2019, the average number of days providers took to respond to our request for this information was 28 days. In 2019, 7 providers took an average of less than 20 days. This is hugely helpful to us. However, 56 providers took on average more than 30 days to respond.

If a provider does not provide information we request during the course of our review, or does not provide it within the time limits set, the Independent Adjudicator may report it to the Board, and may publicise it in our Annual Report.

Compliance with OIA Recommendations

Where we decide that a complaint is Justified or Partly Justified we will usually make Recommendations to the provider. We expect providers to comply with our Recommendations fully and promptly. We monitor compliance carefully and the Independent Adjudicator must report a provider's non-compliance to the OIA's Board and publish it in our Annual Report.

Providers complied promptly with 94% of "student-centred" Recommendations with due dates in 2019. On average, providers took 20 days to comply with "student-centred" Recommendations with a due date in 2019.

Outreach events

In 2019, we ran a wide-ranging outreach programme including seminars, webinars, workshops and visits by OIA staff to individual providers. We hope that these events proved useful and informative for our member providers.

"student-centred" Recommendations These are recommendations which affect the individual student, such as a Recommendation for a rehearing or the payment of compensation. The OIA also makes "good practice Recommendations", such as a Recommendation to change or review procedures.

Complaint Categories

Academic Appeal

Complaints about academic matters such as assessments, progression and grades (including mitigating circumstances claims).

Service Issues

Complaints about the course or teaching provision, facilities and supervision.

Financial

Complaints about finance and funding: e.g. fees and fee status, bursaries and scholarships.

Disciplinary matters (academic)

Complaints relating to academic misconduct including plagiarism, cheating, collusion and examination offences.

Equality law / Human rights

Complaints where the student claims there has been discrimination, including harassment, and where they claim their Human Rights have been breached.

Disciplinary matters (non-academic)

Complaints relating to disciplinary proceedings for non-academic offences.

Welfare / Non-course service issues

Complaints about issues that are not directly related to the student's course, for example complaints about support services and accommodation issues.

Fitness to practise

Complaints relating to a person's suitability to practise the profession for which they are training or studying.

Report to	Date
Board of Directors	24 November 2020

Board Assurance Framework

Executive Summary

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

There are two risks rated 16 and five rated 12. No 'current risk' scores changed. The likelihood for the target risk score for Risk 10b increased 3 'could occur'. See page 3 for summary detail. Updates are highlighted as usual in red.

The new electronic risk register module has been piloted in DET and IM&T and all IM&T risks have been fully migrated. The annual BAF and Risk Management Culture Internal Audit Report was published 29th October 2020 with an audit assessment of 'reasonable assurance'.

The BAF was reviewed by the Executive Management Team for risks 15+ in September and October and all strategic risks on 17 November 2020.

The Trust Risk Appetite statement and assessment is agreed annually by Board. It was last confirmed July 2019. The Risk Appetite was reviewed by the Executive Management Team on 20 October and 17 November where the Risk Appetite statement was confirmed. Covid-19 has had significant impact on Trust operational priorities and practice which may not be consistent with the current Risk Appetite priorities. The question of whether having a 'Significant' risk appetite on delivery of Growth and Development was still appropriate in the current climate, or a 'High' risk appetite for delivery of risks under the People aim were considered. It was agreed the Risk Appetite assessment section required further detailed discussion before changes were made.

Recommendation to the Board

The Board are asked to discuss the board assurance framework and approve the Risk Appetite statement and assessment.

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

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

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

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

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

1.5 The new electronic risk management system was piloted in DET and IM&T services for Operational Risks only. Full planned implementation of the system will commence from late November with anticipated full use of the system from end March 2021.

2. APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

3. RISK SUMMARY [risk descriptions are shortened]

3.1 There have been no new strategic risks added this quarter.

3.2 There are two risks rated 16

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

3.4 There are five risks rated 12 as follows:

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

3.5 The Medical & Quality Director has been added alongside the CCOO as joint 'owner' of Risk 7: data systems and processes. Following the departure of the Director of Strategy the CEO has taken over ownership for Risk 10b.

3.6 No risks reduced in November 2020

4. RISK APPETITE

4.1 Risk Appetite Statement:

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

Agreed Board, July 2019

Overarching risk appetite descriptions

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

Risk Appetite assessment against Strategic Aims

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

5. CONCLUSION

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

November 2020 BAF HEAT MAP

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

July 2020 BAF HEAT MAP

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

Board Assurance Framework 2019/20 – Summary –

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**July 2020**	**Nov 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
1	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.	DoHRCG	People	1		8 (2x4)	8 (2x4)	8 (2x4)	12 (3x4)	12 (3x4)	**Green (1x4)**
2	The risk that the pandemic and pressures on leadership have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	CEO/ DoHRCG	People	2		12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	**Yellow (2x3)**
4	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	DoN	Services: Education	9		9 (3x3)	6 (2x3)	6 (2x3)	6 (2x3)	6 (2x3)	**Green (1x3)**

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**July 2020**	**Nov 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
5	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	DoF	People	4	15 (3x5)	15 (3x5)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	**Amber (2x5)**
6	The risk of insufficient staff capacity to keep activity within contracted levels across all services and manage all regulatory requirements because of a 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	CCOO	Services: Clinical	5		6 (3x2)	8 (4x2)	8 (4x2)	8 (4x2)	8 (4x2)	**Green (2x2)**

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**July 2020**	**Nov 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
7	The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	CCOO & MD	Services: Clinical	5		6 (3x2)	6 (3x2)	6 (3x2)	6 (3x2)	6 (3x2)	**Green (2x2)**
8	The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the ICS and the delivery of the Trust's wider objectives	CEO	Services: Clinical	6		12 (3x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	**Amber (3x3)**
9b	If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19.	CCOO	Services Clinical	7				12 (3x4)	12 (3x4)	12 (3x4	**Amber (3x3)**

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**July 2020**	**Nov 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
10b	The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.	CEO	Growth and Development	10		9 (3x3)	9 (3x3)	16 (4x4)	16 (4x4)	16 (4x4)	**Amber (3x4)**
11	The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision	DoET/ DeanPGS	Services: Education	8		12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	**Amber (3x3)**
12	If the Trust fails to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation and the quality of patient and student experience	MD	Finance and Governance	12		8 (2x4)	8 (2x4)	8 (2x4)	8 (2x4)	8 (2x4)	**Green (1x4)**

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

Strategic Aim: People

Corporate Objectives:

1. Increase the pace of progress in achieving equality of opportunity across the organisation including a particular focus on race equality and disability. **Director of HR and Corporate Governance**
2. Strengthen the engagement with the Trust's workforce addressing issues highlighted in the 2019 staff survey. **Chief Executive**
3. Develop an updated People Strategy for the Trust with a focus on future workforce needs and addressing staff welfare and morale. **Director of HR and Corporate Governance**
4. In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Clinic site. **Deputy Chief Executive**

<table>
<tr><td colspan="2">RISK 1): The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) with a negative impact on staff engagement and the quality of its services.</td></tr>
<tr><td><u>Risk Owner</u>: Craig de Sousa</td><td>Date reviewed: November 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 3 x Consequence 4 = 12 (risk score unchanged)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
Following a number of events in society there has been an increase in honest conversations about the experience of ethnic minority staff. The 2020 workforce race equality standard (WRES) has identified limited change in across the seven indicators.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
Implementation of the RES is monitored at the equality diversity and inclusion committee; Race diversity champion in post and race equality network well established: regular communication between the champion and the director of human resources and corporate governance;
NHS People Plan and People Promise launched July 2020.</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
WRES annual reported to the board of directors – October 2020 (+/–)
Workforce monthly dashboards developed (+ / –)
Staff survey 2019 (–)</td></tr>
</table>

London race strategy launched October 2020. New RES being developed with organisational consultation – commenced in November 2020.	November 2018 CQC report confirmed that staff remain concerned about the pace of progress (–)
Gaps in controls/influences: Understanding the significant impact of social factors and issues within our organisation that have impacted on staff sentiment and morale.	Action plans in response to gaps identified: *(with lead and target date)* Finalise the 2020 race equality strategy and seek ratification (DoHRCG November / December 2020). Co-create supporting year one action plan (DoHRCG January 2021). Race equality steering group established and seeking to commission a consultative review of culture – (Chief Executive Dec 2020) Action plan to accompany the new race equality strategy (DoHRCG – Jan 2021)

RISK 2): **If we are unable to maintain good staff morale and engagement there is a risk of negatively impacting on patient and student experience and the quality of services delivered**	
Risk Owner: Paul Jenkins/ Craig de Sousa	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12 (risk score unchanged)	TARGET risk rating 2 x 3 = 6
Rationale for current score: Recognition of negative impact of COVID-19 on staff morale and engagement with work	
Controls/Influences *(what are we currently doing about this risk?)*: Twice monthly all staff meetings held via Zoom Trust inter-professional meetings; Management development programme (cohort 1) launched. People management skills seminars launched. Appraisal round re-opened incorporating a wellbeing and career conversation. Currently in the surveying period for the 2020 NHS staff survey. Refresh of people strategy to reflect the requirements of the NHS People Plan; Demographic risk assessments	Assurances received *(independent reports on processes; when; conclusions)*: Staff survey (+/-) Staff feedback (formal and informal) (-) Quarterly Trust wide workforce dashboard (+ / -) Monthly divisional / directorate workforce dashboards (+ / -)
Gaps in controls/influences: Strengthen staff engagement More formal strategy for addressing staff morale and wellbeing Consequential impacts of the pandemic on motivation and morale.	Action plans in response to gaps identified: *(with lead and target date)* Staff wellbeing task and finish group - (DoHRCG - November 2021). Refresh of the flexible working procedure - (DoHRCG - November 2021) Tavistock and Portman aligned NHS People Plan (DoHRCG - January 2021) Launch of the second cohort of the management development programme - (DoHRCG - January 2021)

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

Strategic Aim: Services: Clinical

Corporate Objectives:

5. Develop and operationalise a strategic plan for high quality and financially sustainable clinical and educational services. **CCOO/DoE&T**
6. Contribute actively to the development of models of integrated care in Camden and across North Central London. **Chief Executive**
7. Complete implementation of the recommendations of the GIDS Review and any wider lessons from the Review for the Trust's services. **CCOO**

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

RISK 7): The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	
Risk Owner: CCOO and Medical/quality Director TBC	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 2 = 8 CURRENT risk rating: Likelihood 3 x Consequence 2 = 6 (risk score unchanged)	TARGET risk rating 2 x 2 = 4
Rationale for current score: Data reports from different sources e.g. team reports and contract still not consistent. Staff concerned that data does not reflect their experience. New IM&T structure and approach to process management appears to be having an impact, data becoming more reliable, but the strategic review process is highlighting new inconsistencies.	
Controls/Influences *(what are we currently doing about this risk?)*: Group overseeing data process set up	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of working group (+) Data strategy in place (+)
Gaps in controls/influences: Improvements required in relation operational data entry; and data analysis, operations delivery board will need to oversee some of this Strategic review information will help identify additional issues	Action plans in response to gaps identified: *(with lead and target date)* Work on data to continue (JR with data strategy fully implemented by ASAP) and Operations board Strategic review process to be complete by April 2021

RISK 8): The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the ICS and the delivery of the Trust's wider objectives	
Risk Owner: Paul Jenkins	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (risk score unchanged)	TARGET risk rating 3 x 3 = 9
Rationale for current score: Wider financial pressure across the STP with increased disruption owing to COVID-19. A significant amount of uncertainty remains.	
Controls/Influences *(what are we currently doing about this risk?)*: Work closely with partner provider organisations Support for NHS Provider Alliance Trust Strategic Review focusing on financial and operational sustainability	Assurances received *(independent reports on processes; when; conclusions)*: ICS action on managing financial pressures across the sector (+)
Gaps in controls/influences: Wider financial position across the ICS Changes in priorities in the ICS in the light of the pandemic Direction from ICS and NHS E/I on longer term action	Action plans in response to gaps identified: *(with lead and target date)* Continued engagement with sector (PJ/TN ongoing) Ongoing engagement on Provider Alliance (PJ/TN ongoing) Trust Strategic Review (PJ ongoing)

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

Strategic Aim: Services: Education

Corporate Objectives:

8. Increase the reach of the Trust's training and educational work including delivery of new long course programmes and initial rollout of the Trust's Digital Academy. **DoE&T/DPGS**
9. Further establish the Trust's external reputation as a voice on workforce development and wellbeing including the rollout of the ADD Wellbeing Programme and related initiatives. **Director of Nursing**

RISK 4): **The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England**	
Risk Owner: **Chris Caldwell**	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6 (risk score unchanged)	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE decreased from risk level 9 to 6 following: 1. Positive review of the Unit by HEE MH Delivery Board and recommendation to HEE national Board that the Unit element of the NTC is rolled continued and rolled into the NTC annually renewable contract. 2. Feedback from HEE London (contact managers) that they are recommending no change to the NTC contract for 2021/22 The NWSDU has maintained a profile and exposure in year through conferencing and the engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity. DET recruitment and CPPD profile has been positive and demonstrated measurable contribution to increased supply and upskilling of MH workforce. If HEE national Executive agree 'no change' position risk rating will be reduced to 1x3. At review date we have not received this confirmation via a legal amendment to the contractual arrangements	
Controls/Influences *(what are we currently doing about this risk?)*: NWSDU and NMHWDC Communications strategies and Plans in place NWSDU/ IJT /CC Objectives: Planned conference delivered to March 2020 IJT attendance at Pan ALB Health & Wellbeing Group	Assurances received *(independent reports on processes; when; conclusions)*: Coms Strategy and Plan documents in place (+) Conference evaluation and end of project report (+) Communications support proposal and contract (+)

CC profile in MH workforce and wider nursing agenda locally and nationally T&P presentation of work to HEE national MH Delivery Group meeting in Jan 2020 IJT Engagement in Pearson 'Learner MH & Wellbeing' HEE Workstream Exposure of Stress & Resilience work to Cavendish Square and 'Top Leaders' groups IJT presentation to HSJ workforce leaders' conference and subsequent HSJ follow up article. CC Profile in local STP/ICS External coms support to be extended to Nov 2021to ensure continued and increased exposure of the Units work Review of sign off and subsequent communication and engagement plans for the work of the Unit completed with HEE October 20	Report on the activity that was planned for NWSDU to deliver on presence at NHS Employers Health & Wellbeing conference, NHS Confed and PWP conference (+) Report of planned activity that is now completed – presence and conference presentation at NHS Expo Sept 19, Presence at NHS Providers Oct 19. (+) Completed work with Pearson Commission Group and Pan ALB H&WB group (+) Report of activity planned for conference season 2020 (+) Agreement and ongoing work for development of shared communications strategy with HEE Mental Health Programme Board (+)
Gaps in controls/influences: None identified	Action plans in response to gaps identified: *(with lead and target date)* Communications action plan in delivery (IJT Ongoing) Communications support extended to Nov 21 (IJT Nov 20)

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

Clear framework for delivery changes to programmes launched and being engaged with, including reviewing of lecture and seminar length. This is based on previous insights and proposals considered by two cycles of Task & Finish group co-chair by FD & DoET. Working group with internal and Essex representatives underway of scoping new long course development with agreed milestones including focus groups with students and employers. This is being scoped for AY21/22 due to impact of COVID-19.	International coordinator in role to support core team (April 2020) (+) Board sign-off on phase 2 of the DA (Sept 2019). (+) Branding guidelines agreed and soft launch of website on track (July 2020), key marketing role recruited to (July 2020) (+)
Gaps in controls/influences: International plan delivery is slowed by current COVID-19 situation, Focus diverted and capacity reduced in the foreseeable future on new developments.	Action plans in response to gaps identified: *(with lead and target date)* Reviewing current delivery plan for new modes of delivery including virtual international conference and other events. (DoE/DPGS & International Working Group, Sept 2020) Establishing Development Forum with Director of Strategy to engage across the organisations for new developments for educational delivery (DoE/DPGS & DoS~~, July~~ October 2020)

Strategic Aim: Growth and Development

Corporate Objectives:

10. Progress the Trust's longer-term priorities for new service development and meet the target for new growth in 2020/21. **DoS**
11. Develop as part of the Centenary Year, a strategic narrative for the role of the Trust's work and expertise in the 21st Century. **DoS**

RISK 10b): The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.	
Risk Owner: Paul Jenkins	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (risk score unchanged)	TARGET risk rating 3 x 4 = 12
Rationale for current score: The Trust has a strong record of good financial performance which has allowed it to maintain the quality and safety of our patient and education services. This has been achieved each year through a combination of modest cost improvement programmes; new income generation through the development of new courses and services; and annual contract activity uplifts. However whilst the organisation's overall financial position has been balanced, there is significant variation between services which has been exacerbated by a number of contract losses. In addition, costs have been incurred to support development and infrastructure work, and contribution from new business has been significantly affected by instability in the external commissioning environment. With the move towards the development of Integrated Care Systems, the impact of the pandemic, and the move towards 'digital first' it is anticipated that opportunities for growth will reduce and the pressure to reduce costs will increase. A significant amount of uncertainty remains.	
Controls/Influences *(what are we currently doing about this risk?)*: - Trust Strategic Review - Identification of refreshed business development priorities	Assurances received *(independent reports on processes; when; conclusions)*: - Programme Board for Strategic Review and regular review of business development priorities through Business Development Group

	- Governance oversight of Strategic Review through SCC
Gaps in controls/influences: - Uncertainty about size of business development opportunities - Scale and scope of opportunities in the Strategic Review for cost reduction or diversion	Action plans in response to gaps identified: *(with lead and target date)* - Strategic Review (PJ March 2021) - Business Development Plan (JS February 2021)

Strategic Aim: Finance and Governance

Corporate Objectives:

12. Meet the Trust's requirements with its national regulators. **MD**
13. Meet the Trust's budget and control total for 2020/21. **DepCEO**

RISK 12): If the Trust fails to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation	
Risk Owner: Medical Director	Date reviewed: November 2020
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8 (risk score unchanged)	TARGET risk rating 1 x 4 = 4
Rationale for current score: CQC targeted inspection due to be completed November in GIDs service.	
Controls/Influences *(what are we currently doing about this risk?)*: Completed well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps Continuing engagement with CQC Implementation of QAA review action plans and established plans from university partner institutional reviews (Essex and UEL) Annual student survey completed	Assurances received *(independent reports on processes; when; conclusions)*: Work streams reporting to the Board level Integrated Governance Committee to provide assurance of compliance with CQC requirements and raise issues of risk (+) Formal CQC report – 'good overall' and 'outstanding' for the Effective KLOE. Requires improvement in gender services for Responsiveness KLOE because of waiting times (+) Progress on CQC action plan monitored via EMT and IGC (+) Service Line self-assessments for CQC compliance (+/-) CQC Planning group monitoring implementation of actions (+) Service Manager and Board CQC seminars (+/-) Staff communications -'values' and messages about expected focussed inspection (+)

	Staff Governance Handbook updated and launched (+) Staff communications and 'values' cards available (+)
Gaps in controls/influences: Ongoing service line assessments of CQC compliance and action updates required in preparation for inspection NHSEI SA joining CQC inspection Significant media coverage of GIDS service which subject to planned focussed inspection	Action plans in response to gaps identified: CQC action plan (DS/CCOO November 2020)

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board	24 November 2020

Operational Risk Register

Executive Summary

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

1.2 There are currently 88 risks on the Operational Risk Register (ORR) which are open – 57 remain on the Excel ORR to be migrated across to the new system. These include DET risks which have not yet been fully migrated.

1.3 As a result of the pilot of the new electronic risk register system by IM&T and DET the planned implementation of the module will take place across the whole Trust starting in late November, so that the new system is fully operational by the end of March 2021. IM&T risks have been fully migrated and initial risk reports are now available.

1.4 The following report includes information on three risks:

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

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

1.6 The annual internal audit of Risk Management was completed in October with an internal audit opinion of 'reasonable assurance'. The findings from the risk culture questionnaire noted strong improvements in risk management compared to the review undertaken in 2019/20. The detailed findings identify two 'medium' and one 'low' management action relating to:

improving the maturity of risk management across the Trust, ORR updates and the EMT documentation of new operational risk approvals and discussions and an action plan has been agreed.

1.7 Operational Risk Register risks 15+ were reviewed by the Executive Management Team on Tuesday 17 November 2020.

Recommendation to the Board	
The Board are asked to note the Operational Risk updates and actions	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Associate Director of Quality and Governance	Deputy Chief Executive / Director of Finance

Reference	Date raised	Risk Owner	Scope of risk	Risk Category	Risk Summary	Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	Risk Description Detail: Event (what then is the possible resulting event?)	Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps	L	C	Current Risk	Action Plan (Ensure date and action owner are identified)	Actions update (updated along with the current risk position)	Operational Lead	Next Review	L	C	Target Risk
127	25/07/2019	Gender Divisional Director	GID Service, Communications staff, senior management	**Delivery**, financial, Quality of care, Safety, Reputation, Compliance	GIDS staffing	If internal and external scrutiny GIDS continue to escalate and involve Trust staff	Some staff may feel the work becomes too stressful, with an impact on morale, quality and staff retention	Resulting in a negative impact on service delivery and a further growth to waiting list.	5	4	20	Support from Director and Executive leads with the GIDS team and from Trust senior management through meetings, supervision and other fora; Consultation support service; Staff ~~satisfaction~~ survey review; Proactive communications taking forward recommendations of GIDS action plan and acknowledging impact of media.	Staff ~~satisfaction~~ survey; information from meetings with staff individually and in groups. (+/-) Strategy for supporting staff (+) Communications presentation at service awayday 16th August 2019, 15th October 2019 (+) Analysis of Exit Interviews (+/-) Monthly forum established to support London based 8A's in the service as a result of the 2019 staff survey results Communications presentation at service awayday March 2020 (+)	Further work to deliver GIDS action plan recommendations. Increased visibility of and contact with senior Trust staff. Further detailed analysis of Exit interviews,	4	4	16	Analysis of Exit interviews, Staff survey and other staff feedback (ongoing) HR engagement and individual GIDS staff interviews with HR (Feb 2021 PC) GIDs action plan to be co-designed with staff (Feb 2021 AS)	19 Nov 2020 update No change to score and ongoing actions with HR. Divisional Director currently reviewing analysis of initial information. Reviewed July 2020. No change to score or actions Leadership CPD for senior management team via Tavistock Consulting (+)	Kathleen Hughes	19/12/2020	3	3	9

128	25/07/2019	Gender Divisional Director	GID Service, Trust	**Safety,** delivery, financial, Quality of care, Reputation, Compliance	GIDS waiting times	If action is not taken to increase flow through the service waiting times will continue to increase.	The needs of young people and their families at a vulnerable time in their lives would not be met.	There may be an increased chance of a serious incident for a YP on the waiting list, and increased anxiety and stress for those patients waiting. Poorer quality service delivery if staff time is spent addressing urgent clinical and managerial issues arising rather than delivering well managed services and attending to longer term quality improvement and sustainability. Potential for loss of faith in the service by families waiting Burden on primary care increases.	4	4	16	Focus on recruitment; GIDS DNA and cancellation policy revised; caseload and activity monitoring and management strategy; waiting list project pilot; support for local services to manage concerns locally; quality improvement project for assessment clinics (Midlands) Monthly activity data reviews standing item on GIDS senior team agenda.	Demand and capacity modelling undertaken with NHS Improvement (Jan 2020) (+) Waiting list initiatives reviewed - informal report drafted. Continued monitoring of waiting list and other data (+/-) Monthly audit of activity data (+/-) Network model and enquiries line CPD for professionals	Data on impact of initiatives being taken and planned to address the issue.	4	4	16	Commencement of further data analysis work by service to understand referral trends, and initiation of relevant Quality Improvement work (Ongoing AS) Trust Quality Priority Waiting Times led by QI project - parity of wait times. (Admin Team-Onoging) Establishing Midlands Assessment clinic - QI project (Midlands Team - Ongoing)	19 Nov 2020 update No change to score September update No change to score. Divisional Director currently reviewing analysis of initial information. Reviewed July 2020. No change to score or actions Leadership CPD for senior management team via Tavi	Kathleen Hughes	19/12/2020	2	4	8

133	17/03/2020	CCOO; DET; GH	Trustwide	Delivery, Safety, Compliance/Regulation	Risk of disruption to service delivery, non compliance with contracts if COVID-19 pandemic not appropriately managed	If COVID-19 pandemic is not appropriately managed	There is a risk of increasing respiratory outbreaks affecting staff and patients who would be unable to work or attend appointments due to illness. There will be a need to self-isolate owing to the wider impact of COVID-19 and further issue will emerge from actions affecting schools, Universities, wider health and transport systems. Exposure to the virus through contact may also result in a minority of individuals having significant negative impact. Impact on provision of Trust services is already being experienced and could be severe, which will need ongoing mitigation	The result would be disruption to service delivery, non-compliance with contract requirements and possible serious health impacts. Community transmission may also result in unmitigated risks to safety of service users and staff	5	4	20	1.Local Business Continuity Plans 2. At peak of first wave EPRR Gold Command group Chair CEO, membership of key directors and WhatsApp group for 24/7, continued availability of EPRR group as needed 3.Revised BCP and Major Incident Plan 4.Trust Pandemic Influenza Plan and flu vaccination plans 5. Detailed planning for next phase including estates, IPC, team level planning and individual vulnerability assessment for staff 6. Engagement with regulators and ICS in response to pandemic 7. Flu vaccinations in progress 8. Second wave plans reviewed and agreed for clinical and education (all clinical groups paused/ new individual exemptions procedure established/ no groups in DET/ GH protocol agreed as exemption) along with comms	1.Local Business Continuity Plans 2. At peak of first wave EPRR Gold Command group Chair CEO, membership of key directors and WhatsApp group for 24/7, continued availability of EPRR group as needed 3. Director on call for any Alerts form NHSE 4.Recently revised BCP and Major Incident Plan 5.Trust Pandemic Influenza Plan 6. Trust EPRR Gold Command has restarted meeting once weekly to review situation and take required decisions from September	Unknown how long and to what degree Covid19 will be prevalent and endangering lives and service delivery. We are now in the midst of the second wave, which along with winter is likely to increase risks of both infection but also pressure on services from any absences due to testing/ contacts etc.	5	4	**20**	Follow PHE / NHS advice and ensure safety of vulnerable staff and patients and students - concerns about personal health and family. Ensure core staff group available to ensure delivery, mass communications (Ongoing)	3 Nov 2020 update No change to score	Dinesh Sinha	03/12/2020	2	2	4

Report to	Date
Trust Board	4th November 2020

Guardian of Safer Working Hours 2020 – 2021 Quarterly report

Executive Summary

This is my first report for the board in the role of the guardian.
Since then the number of exception reports has been 10 in total till 4th November
The trainees have attempted to spend some of the fines accrued but this has been complicated by the impact of the pandemic. There has been a delay in the payment of fines and this has been an ongoing issue even in the term of prior GOSH.

Recommendation to the Board of Directors

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Gurleen Bhatia , GOSWH	Dr Dinesh Sinha

Guardian of Safe working hours Q 2020 - 2021 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report from August 2020- November 2020 (Till 4th November only)

1.2. This is my first report in role.

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
August	4	o	2	2
September	4	1	2	1
October	1	0	1	0
Nov (till 4th Nov)	1	0	0	1

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

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 11
- However there are 2 vacancies on the on-call rota now
- There have been no formal requests for a work schedule review till date but this has been discussed

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. There are 2 vacancies on the on-call rota now and till Feb 2021, 21 locum shifts. The locum rate for the in house trainees has been increased.

2.5 Fines

Number of exception reports since August 2020 till 4 November 2020

August number of exception reports total 4, out of this 2 required no further action.

One of them was paid 3.5 hours plain time and the second one 2 hour's plain time

September- total number of exception reports were 4

One required no further action

One required TOIL and 2 hours plain time pay

One required 2.5 hours enhanced time pay

October- total number of exception reports one which required 4 hours of additional pay plain rate

November this is till 4 November only - one exception report requiring no further action

Fines accrued 2019 – 2020

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

3. Junior Doctors Forum (JDF)

Attended the junior doctor's forum on 21st July 2020. The previous guardian Dr Sheva Habel was also present.

Fine Disbursement:

2020 – 2021	£3986.235

4. Local Negotiating Committee (LNC)

I attended the LNC meeting and had discussed about the issues

1. Support to trainees (this has been set up by the medical director)

2. Late payment of fine money
3. Fine money not been spent on books or DBT training as of yet.
4. Locum rates of in house trainees (this has been since resolved).

5. Conclusions and Recommendations

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

5.2. Changes implemented during the pandemic have reverted back to a situation closer to “business as usual” from early July. The total number of exception reports compared to the start of the pandemic lockdown and now has decreased since August.

Gurleen Bhatia

Guardian of Safer Working Hours

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	

Serious Incidents – Quarterly Report – Q2 2020-21

Executive Summary

This quarterly serious incident summary report for the Board covers Q2 2020-21. There were no serious incidents or never events, either clinical or non-clinical, identified in Q2 so none of our reported incidents required a duty of candour.

Across all services there were 24 clinical incidents reported in Q2, which sadly included five patient deaths. At the time of writing four of the deaths are presumed to be natural causes and one a suspected suicide. Each of the patient deaths were reviewed via concise reports or mortality reviews at the monthly incident panels and although there were five patient deaths, we did not apply the duty of candour for the following reasons; four of the patients were in adult services and did not provide any contact details or consent to discuss their treatment with anyone else, and for the fifth death it was not considered to be clinically appropriate.

As previously noted in Q1, in December 2019 the Trust agreed with our commissioners to undertake a thematic case review of three of our previous serious incidents which were linked to gang related violence. This work was to involve many agencies working together to review these cases with a view to producing a combined report. However, this work has been heavily impacted by the Covid-19 pandemic and there are ongoing discussions with the commissioners to see how this can be addressed in the current climate.

Despite the on-going Covid-19 pandemic, the Trust has continued to provide regular lessons learned events, which is now done via online platforms and all relevant staff are invited and encouraged to attend. This online training provision has also enabled greater staff attendance at lesson learned events right across the Trust and may well become one of the preferred delivery methods of choice going forward.

The CQC inspection for 2020 is about to begin in mid-October and staff from across the Trust have continued to work hard to prepare for this inspection. All patient safety aspects of the 2018 CQC Inspection action plan continue to be regularly monitored by the Executive Management Team. All services feed into this process and there is continued progress on the actions identified to ensure patient safety.

Recommendation to the Board

The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper

Clinical Services

Author	Responsible Executive Director
Clinical Governance and Quality Manager	Medical Director

Report to	Date
BOARD	24 November 2020

EU EXIT

Executive Summary

With the UK exiting the European Community with effect from 1st January 2021, NHSE/I have again instituted EU Exit reporting.
Attached – for information – are some slides of a recent presentation given on this subject.
The key areas for the Trust to re-review are:

- Medicines – Dinesh Sinha (Medical Director)
- Staffing – Craig de Sousa (Director of HR)
- IT – Jon Rex (Director of IT)
- Estates and Facilities – Benita Mehra (Estates Consultant)

At the time that this report was written (13 November 2020), the Trust is not aware of any significant / critical EU Exit related issues.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

NHS Operational Response to EU Exit – End of Transition Period

Professor Keith Willett
Strategic Incident Director for COVID-19
Strategic Incident Director for EU Exit

4 November 2020

Changes in preparation for the End of Transition Period

NHS role to be focused on coordinating the best possible operational response for patients and the public.

- **Continuity of supply (DHSC lead)** – builds on learning to date; smarter procurement frameworks; alternative routes/ express freight; supplier engagement; tight schedule
- **Improved trader readiness** – but other factors may affect channel crossing and rerouting compliance; smaller stockpiles on UK soil
- **Winter pressures –** Covid impacts; compounded workforce issues; UEC demand; adverse weather; seasonal flu
- **Increased complexity for reciprocal and cost recovery –** challenge for providers to identify chargeable patients and recover costs
- **Staffing resilience –** challenges to reach staffing levels dedicated to EU Exit response – same people involved in Covid
- **Data** – ensuring safeguards are in place to ensure data can continue to flow between EU and UK
- **Ongoing review of government planning assumptions**

Coordinating the NHS response

- Operational model response principles – aligned to Covid and winter battle rhythms
- Escalation of issues
- Mobilisation
- Working with partners – Independent Sector; professional bodies, patient groups and charities; Devolved Administrations

Operational response principles

Single, unified response structure	• EU Exit issues will be managed through established incident response structures & battle rhythm in place for Covid-19 (local, regional and national level) • NHS organisations should have identified a named SRO for EU Exit • Winter operations as an aligned function
Escalation	• EU Exit issues requiring escalation should be escalated through current EPRR SPOC from trust/ system to regional ICC to national ICC • Existing ALB / BAU escalations to NHSBT; PHE; NSDR continue in parallel
Sit Rep	• Daily intelligence gathering from trust level • EU Exit sit rep is being reviewed, including alignment to Covid and winter sit reps
National Incident Coordination	• National ICC will include EU Exit SMEs (EU Exit cell) to support resolution of escalating issues (working with national cells) • Interface with DHSC Operational Response Centre • National incident coordination includes Commercial and Procurement Cell (CPC) and Shortage Response Groups (SRGs)
Commercial and Procurement Cell (National)	• Single Commercial and Procurement Cell across Covid and EU Exit • Working with NSDR, suppliers and clinicians to support NHS in responding to supplier disruption • Developing operational instructions e.g. to support change of supplier • Coordination of SME advice
EPRR and Shortage Response (National)	• Principle of subsidiarity and enhanced clinical advice to support this • Additional incident management capacity for escalating incidents • Access to serious shortage escalation protocols and national EPRR contingencies via ICC • National response for non-EU Exit EPRR incidents

High Level NHS Timeline

Sept 20 — **September:** Internal governance set up; understand and test DHSC/ Government planning assumptions and contingencies

Oct 20-Nov 20 — **October/ November:** Make ready the NHS system; ensure a resilient operational response infrastructure is in place

Late Nov 20 — **Late November:** Assurance of system preparedness

Dec 20 — **December:** Transition to incident response; daily sit rep; SRGs in place

Local actions

- Put in place and **test business continuity and EPRR plans**
- Ensure **EU Exit SRO and associated SME team** in place
- Make **Board aware** of issues
- **Communication plans / key messages to front-line colleagues**
- **Revisit operational guidance and current information** from each workstream to ensure plans are up-to-date
- Revisit assurance exercises and **address outstanding actions**
- Test and communicate **escalation routes**
- **Engage across system** and **'walk the floor'** to identify any further concerns, interdependencies and vulnerabilities around supply chain
- With partners **ensure integrated system-based approach** to plans
- **Consider differences** – implications of winter, assumptions about port access, vulnerable populations etc.
- Ensure **local risk assessments are up to date**

DHSC is pursuing a multi-layered approach to help minimise potential disruption to the supply of all medicines and medical products at the end of the transition period

The **'multi-layered' approach** consists of:

- **Alternative freight routes** away from potential disruption, includes HMG secured freight capacity for cat 1 goods (all medical products)
- **Trader readiness** – supporting all companies to be fully prepared for EU and UK customs checks
- **Buffer stocks** – asking suppliers to aim for target level of 6 weeks stock on UK soil
- **Regulatory flexibilities** so products continue to be placed on the UK market, including 2-year standstill on medicine regulations
- Enhanced shortage management via **National Supply Disruption Response (NSDR)** in DHSC, including end-to-end logistics solution as contingency.

Medicines

- **Prescribe and dispense as normal:** Clinicians and pharmacists should continue to prescribe and dispense as normal, and reassure patients that extra medication is not required and avoid issuing longer prescriptions.
- **Local stockpiling is not necessary**: It is not appropriate for anyone to stockpile locally. Organisational stockpiling risks putting pressure on medicines availability. Government has been engaging with medicine suppliers to support contingency planning.
- **Business as usual shortages management applies**: Reporting of any shortages should be conducted through usual routes, in line with published guidance on managing medicines supply and shortages. A national Medicines Shortage Response Group (MSRG) has been established to provide clear governance, communication and decision-making during the end of transition period.
- **Over-ordering will be investigated:** Incidences involving over-ordering of medicines will be investigated by the relevant Chief Pharmacist.
- **Ensure that your organisation is familiar with the latest information on supply disruption:** Ensure all appropriate staff are able to share the information contained in CAS alerts and other central communications with clinicians. Regional pharmacists will be supporting local planning to enable effective communication and escalation.
- **Provide patients with information:** A priority for the NHS will be to provide advice to patients about plans for continuity of supply, to provide confidence and assurance regarding medicine supply. We are developing briefing material and resources to support.

Medical Devices & Clinical Consumables (MDCC)

- **Multi-layered approach** to support continuity of supply for MDCC
- **Express Freight Service** in place and available for all workstreams
- Plan for **longer lead times for MDCC products 72 hours** – in the same way as for previous exit dates
- **DHSC assurance undertaken supplier-by-supplier**

Key LOCAL actions needed:

- **Review existing arrangements** regarding planning for longer lead-in times and communicate arrangements for this internally
- Continue to **manage any continuity of supply issues following business-as-usual routes**
- **Ensure all staff are aware of potential implications and that business continuity plans are in place**
- **Review the short lead time items to assess contingency and whether these items can be sourced via NHS Supply Chain**
- **No local stockpiling**

Non-Clinical Goods & Services (NCGS)

- Reviewed, **with a sample of trusts** across all regions, the list of suppliers to be nationally managed
- Supplier assurance with **nationally-managed suppliers,** across primary, secondary and social care **is underway**
- Additional suppliers identified through refreshed **analysis of supply chain data** and work has commenced on assurance and engagement
- Key categories such as **Food, Linen, Laundry and Lift Maintenance** are being reassessed with **key supplier business continuity plans reviews**
- We expect a **common sense approach to menu planning** will ensure continuous provision of nutritious and balanced meals
- NHS providing support to the frontline to resolve potential supply issues – a **Commercial and Procurement Cell (CPC)** extended from the current PPE service
- CPC to be operational for End of Transition Period **from 14th December 2020.**

Vaccines

- **Vaccines should not be stockpiled beyond business-as-usual levels.** Over-ordering will be investigated
- **Pharmacists and emergency planning staff should meet at a local level** to discuss and agree local contingency and collaboration agreements
- **Local cross-system medicines supply continuity plans should be developed and agreed at trust/ CCG board level** – including arrangements for collaboration to ensure shortages of locally-procured vaccines are dealt with promptly
- **There will be a Vaccines Shortage Response Group** for nationally and locally-procured vaccines, coordinated by PHE with NHS E&I and with membership from the Devolved Administrations.

Information for patients:

- ***The government, NHS and PHE have been working together to ensure vaccines will be available as needed after the UK leaves the EU***
- ***Vaccines brought in from the EU are covered by the Government's contingency plans; can be imported at short notice including air freight for products with a short shelf life***

NHS Blood and Transplant

- **Do not stockpile products from NHSBT.** NHSBT is aiming to supply as normal and is stockpiling medical devices and critical consumables from the EU
- **Continue to behave as normal around NHSBT products and services,** unless contacted by NHSBT to change
- **Group O Negative blood** is, as ever, a valuable resource and we thank hospital transfusion departments and users for their work in using this resource to its best effect. We ask that hospitals continue this good work.

Information for patients:

- ***Blood donors should continue to donate blood as normal.***

Clinical trials, research and clinical networks

- **Continue to recruit patients into clinical trials.** Recruitment should only be stopped where instructed from a trial sponsor or the organisation managing the trial
- Trusts, R&D departments and other providers involved in clinical trials should **be familiar with issued guidance and the series of DHSC technical notices**
- UK Chief Investigators, or organisations managing the clinical trial/ investigation, should **liaise with trial sponsors to understand their arrangements for ensuring supply of trial products**
- **NHS sponsors should understand their supply contingency arrangements and respond to DHSC's data requests**

Information for patients:

- ***Patients involved in clinical trials and other research should not be concerned about potential impacts of EU Exit.*** The NHS and the Government is working with organisations running clinical trials to ensure that research continues as normal in the coming months.

Section 2 – Other workstream updates

- Workforce
- Data
- Reciprocal healthcare/ cost recovery
- Adult social care
- Primary and community care

Workforce

- **Provide continued reassurance to EU staff; they are welcome** and make an important contribution to health and social care services across the UK.
- **The EU Settlement Scheme is open to all EU citizens, including NHS staff.** NHS staff from the EU already working here have access to the EU settlement scheme until June 2021. **Continue to promote the Settlement Scheme** to EU staff, and encourage staff to progress their application for 'settled' or 'pre-settled status'.
- There will be **no need for any change to existing employment contracts of EU staff** following the end of the transition period and EU staff do not need to reapply for their jobs.
- **Mutual recognition of profession qualifications (UK legislation recognising EU nationals qualifications)** will apply for at least two years post the end of the transition period. Please contact your relevant professional regulator for any registration queries.
- The UK's new skills-based immigration system will be introduced in 2021. The majority of healthcare roles are exempt from the restrictions imposed by the immigration bill.
- Working with partners across social care, **continue to assess the number of EU national staff and escalate concerns to regional teams** and ensure local contingencies are in place, feed these into Local Health Resilience Partnership and Local Resilience Fora.
- **Be aware that NHS England and Improvement encourages NHS organisations to allow staff to be 'passported' across different trusts**.

Data

Each NHS organisation is usually a data controller and therefore has its own legal obligation to meet the terms of the General Data Protection Regulations.

- **Data transfers:** identify your personal data flows from the EU/EEA and put in place alternative transfer mechanisms such as Standard Contractual Clauses (SCCs) to allow these flows to continue.
- **Data storage:** identify where your data is stored by EEA based processors, for example with cloud storage providers based in the EU, and engage with them to gain written assurances that data will continue to flow back to the UK.
- **Data audit:** conduct an audit of all your personal datasets, ensuring information is up to date and relevant meta-data is held, including geographical origin of the data and the legal basis for transfer.
- **Data protection:** ensure you are compliant with UK GDPR.
- **Implications of Schrems II case (transferring personal data internationally)**: currently NHSEI are advising that organisations continue to put in place appropriate mitigations e.g. SCCs and conduct a risk assessment following the recent ruling.

Information for patients:

- ***General Data Protection Regulations (GDPR) will still apply after the UK leaves the EU. Steps are being put in place by NHS organisations to ensure any patient data transfers are able to continue uninterrupted.***

Reciprocal healthcare and overseas visitors charging

- Staff should **be aware of the advice to provide** to patients.
- **Healthcare cover will change for EU citizens** who visit the UK after 31 December 2020 and whose country does not have a reciprocal healthcare agreement with the UK. Those visitors will be charged for accessing NHS healthcare, **unless it is a service that would be free of charge for everyone**, or they are exempt from charging.
- **Guidance** for the public, CCGs and providers on reciprocal arrangement and overseas charging will be updated once the Government has confirmed the new reciprocal arrangements with EU member states.
- The EU Directive will not be available from 1 January 2021 and, if no reciprocal healthcare agreement is made, S2s will not be available.
- The latest information about travelling abroad is available here: https://www.nhs.uk/using-the-nhs/healthcare-abroad/healthcare-when-travelling-abroad/travelling-in-the-european-economic-area-eea-and-switzerland/
- The overriding advice from UK Government is to take out insurance when travelling outside of the UK.
- DHSC, NHS England and NHS Improvement will provide updates and further information as the position develops.

Adult Social Care

Social care providers may be impacted by EU transition supply issues. Given the diverse nature of the sector, resilience to these and actions required will vary. DHSC is working closely with major suppliers. Local authorities will maintain local oversight.

Key actions

For you

- **Collaborate** - ensure that at all levels contingency plans are in place and shared on EU transition, winter and Covid. Reach out to Local Authorities, relevant provider partners and LRFs to share information about local level planning – collectively look at risks affecting care continuity and identify mitigations.

Providers

- As with NHS organisations, **do not stockpile medicines**.
- **Regularly review business continuity plans** to make sure they are up to date and work with local authorities to ensure these are aligned with local contingency plans, in particular those being developed by LRFs (see the Care Provider Alliance guidance).
- Plan for longer lead times of products imported from the EU and **be prepared to receive stock deliveries outside normal hours**.
- Inform staff and those receiving support who are EU citizens about the **EU Settlement Scheme** and help them apply if they need support.

Primary and community care

- **Understand the escalation route:** For primary care organisations any queries related to the end of the transition period should be raised with the organisation that commissions the service in the first instance. The commissioner can then escalate to regional incident co-ordination centres.
- **Prescribe and dispense as normal:** Doctors and pharmacists are encouraged to reassure patients that they do not need to order extra medication as this could contribute to or cause supply problems. Prescriptions covering longer durations than normally prescribed should be avoided. Prescription durations will be monitored and investigated where necessary.
- **Ensure you are familiar with the latest information on supply disruption:** Ensure CAS alerts and other communications are quickly and effectively shared with all team members who need this information.
- **Consider your supply chain:** Although national contingency measures are in place, it may be necessary to consider ordering business critical products earlier.
- **Encourage patients to take out travel insurance before travelling to the EU:** After the UK leaves the EU, European Health Insurance Card (EHIC) cards may not be valid.
- **Continue to register patients as normal:** Primary care services remain free to all, however there may be some changes around eligibility to receive NHS care which could be chargeable.
- **Encourage staff who are EU citizens to register with the EU Settlement Scheme.**

Further information

- As the UK/ EU negotiations continue, we will provide updates when there is any clarity on the actions for end of transition period in relation to the NHS.

- Key sources of further information:
  - All information will be shared via the incident coordination centre, out to the regional teams and then on to **EU Exit SROs** in the first instance.
  - **All information published by the DHSC** – and other parts of Government – on EU Exit can be **viewed on GOV.UK**.
  - **Information and guidance published by NHS England and NHS Improvement** will be available on our web pages shortly.
  - As part of the wider approach to **patient communications, patient-facing content** will continue to be published on the nhs.uk website under the appropriate section.
  - Similar webinars on actions to prepare for the EU exit End of Transition are being hosted with other stakeholders, independent sector, patient groups.

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 1st October 2020

Key items to note

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

Planning for Academic Year 2020-21

The committee noted the work that had gone into preparing for AY20-21, including delivering Welcome Week and inductions entirely online. Course teams, with Portfolio Managers, are continuing to explore how DET can be proactive in supporting students with clinical placements and observations. The committee noted the plan to continue to develop our work around innovation and sustainability of our course provision. This will be linked directly into appraisals, and the Trust Strategic Review.

EDI Roadmap

The committee noted that Portfolio Managers are undertaking a review of curricula as part of their equalities action plans, and that a series of EDI events are being planned for the academic year, including for students.

Registration with the Office for Students

The committee noted that our application to the Office for Students has not progressed due to the focus on existing providers during COVID-19 but active steps are being taken to engage with the regulator.

Online Platforms

The committee received a demonstration of our redesigned online learning platform, Moodle, which has been upgraded in time for AY20-21, and includes a new Student Community page, dashboard, and favourites function. The committee was also shown a preview of the Facebook Work Place pages which have been created for students to foster our learning community.

Digital Academy

The committee congratulated Barnaby Grainger, Associate Director of Delivery and Development, and his team, on the launch of the Digital Academy. The committee noted the need to strategically consider the Trust's digital learning offer more widely, and what the platform will be used for.

International Strategy

The committee noted with encouragement the developments of our partnership with the online platform WWYY in China. This has been a shift from in-person visits to delivering digital content. There is evidence to show this might become a sustainable development.

Annual Student Survey

The committee received a preliminary summary report, and noted that student satisfaction continued to be high, through the pandemic and the impact that had on AY2019-20. A fuller report will be received in due course.

HESA Reporting
The committee received an update on the process for the HESA return, which deals with student records for the previous academic year, and how lessons learned feed into this process. The committee noted very significant improvement in capability and timely delivery of data submissions.

Student Recruitment
The committee noted that year one enrolments have matched AY2019-20 recruitment figures.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	08 December 2020

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Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 12 November 2020

Key items to note

The committee met and had good attendance at its last meeting. The meeting time was extended to two hours to give more time and space to explore both routine standing matters and give good space to discuss Trust wide strategic priorities.

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

LGBTQI+ Work

On 20 November 2020 the Trust will be facilitating an organisation wide event for trans day of remembrance. This work has been heavily led by Dr Twist and the network.

Race equality toolkit for clinical services

A toolkit was endorsed by the committee to support clinical services to implement practical actions and approaches to improve diversity and inclusion in these areas. The toolkit reflects excellent work led by Ms Anglin d'Christian and thanks were noted for helping bring it to life.

The toolkit will be piloted in a number of clinical services before roll out in 2021.

Race equality story board

The committee noted and comments on the draft strategy storyboard. This will be consulted on trust wide.

Actions required of the Board of Directors

None

Report from	Prof Dinesh Bhugra, Committee Chair
Report author	Craig de Sousa, Director of Human Resources and Corporate Governance
Date of next meeting	14 January 2021

Report to	Date
Board of Directors	24 November 2020

Report on Audit Committee Meeting – 15 October 2020

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 15 October 2020.

Recommendation to the Board

The Board is asked to note the report and approve the Terms of Reference of the Committee

Trust strategic objectives supported by this paper

Finance and Governance

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

HIGHLIGHTS OF A MEETING OF THE AUDIT COMMITTEE HELD ON 15 OCTOBER 2020

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 15 June 2020.

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

2. CREDIT CARD FRAUD

2.1 The Trust has been the victim of a credit card fraud perpetuated by a former employee. Losses to the Trust from the fraud are estimated to be between £7k and £26k.

2.2 The Trust's Local Counter Fraud Service has been investigating the fraud and is submitting its findings to the Metropolitan Police with the hope that the latter will prosecute the ex-staff member.

3. REFURBISHMENT OF LEIF HOUSE / FINCHLEY ROAD

3.1 The Board was advised at its meeting in July about a significant overspend on the refurbishment of this property.

3.2 At its meeting, the Committee considered the report by RSM (internal audit) and the response by management.

3.3 The executive team expressed their considerable disappointment at the over spend.

3.4 The Committee then extensively quizzed RSM and interrogated the management regarding the failings in processes which had led to the over spend.

3.5 The Chief Executive of the Trust highlighted the central failing to be the lack of a proper business case, noting that the final spend was, in all likelihood, probably not unreasonable but that the lack of a business case meant that the work carried out was not properly scoped or valued at the start of the project.

3.6 The Finance Director of the Trust noted that whilst this instance was extremely embarrassing, the fundamental problem was the failure of a very senior manager within the Trust to act appropriately and that the failure in this instance did not reflect a deeper or wider failing in Trust controls and processes – as borne out by audits by internal and external audit both in the current and prior years.

3.7 The Committee noted its disappointment at such an over spend in the current financial climate.

3.8 There was a significant debate about how the Trust managed potential conflicts of interest (a matter raised by the RSM report), with the responses from management queried.

3.9 There was also a discussion around resources, it being noted that given its small size and financial challenges, the Trust was not in a position to staff its corporate functions as it might ideally like.

3.10 The Committee noted that there was no evidence of fraud, but it was agreed that some further work around this issue would be undertaken.

3.11 Finally, the Committee accepted the recommendations made by management, requesting that RSM / executive managers provide an update on progress at the March 2021 Committee meeting.

4. QUALITY ACCOUNTS ("QA")

4.1 The Committee reviewed the draft QA.

4.2 The Committee noted that it looked to the Integrated Governance Committee ("IGC") to carry out a more detailed review of the QA and to highlight any particular issues to the Committee.

4.3 In this regard, the Deputy Chair of the IGC (and a Committee member) stated that the IGC required a greater lead in time to carry out a more detailed review.

4.4 The Committee noted, however, that the contents of the QA were similar to the prior year – albeit slimmed down – and that senior managers and the Council of Governors, amongst others, had commented on the QA.

4.5 A query was raised around ethnicity completion rates which led to a discussion about the Trust's Workforce Race Equality Standard and to a broader debate around diversity and inclusion. The Committee noted that the Trust was about to undertake a piece of work (using external consultants) on diversity and inclusion and that the Trust's Strategy on Race Equality was also in the process of being revised.

4.6 The Committee determined that once these pieces of work had been concluded, it would undertake a 'deep dive' into this area.

5. INTEGRATED GOVERNANCE COMMITTEE / BOARD COMMITTEE REPORTING

5.1 As part of the review of the minutes of IGC meetings in May and September, it was noted that:

- Different sub-committtees of the IGC, used different approaches to their overall RAG ratings
- The Committee thought it would be helpful to be clear on the target RAG ratings

5.2 A number of committees did not use RAG ratings.

5.3 It occurred to the Committee, therefore, that it might be beneficial for there to be a broader Board discussion on this topic.

6. PERFORMANCE / REAPPOINTMENT OF THE EXTERNAL AUDITORS

6.1 The Committee considered the performance of the external auditors in their audit of the 2019/20 annual report and accounts. The performance of the auditors was considered to be reasonable, with no significant issues / concerns raised. Accordingly, the Committee will be recommending to the Council of Governors the reappointment of Mazars as auditors to the Trust.

7. AUDIT COMMITTEE EFFECTIVENESS

7.1 Assisted by RSM (the Trust's internal auditors), the Committee undertook a review of its effectiveness.

7.2 The results of this were positive, with only one amber and no red ratings.

7.3 The item scoring highest was that "Committee meetings are chaired effectively and with clarity of purpose and outcome".

7.4 The one amber item was that "Committee members contribute regularly across the range of issues discussed". 6 contributors out of 7 agreed / strongly agreed with the statement but one contributor disagreed.

8. TERMS OF REFERENCE ("ToR")

8.1 The Committee carried out its annual review of its ToR. These had been part of the overall review of governance carried out during 2019 by the Director of HR and Corporate Governance.

8.2 Other than reflecting changes in the name of one of the Trust's other Board committees the ToR were considered fit for purpose and the Board is asked to approve the updated Tor (which are appended to the report).

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AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 24th NOVEMBER 2020, 1.30pm – 4.25pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	1.30pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 29th September 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	1.40pm	Verbal
2.2	Chief Executive's Report	Chief Executive	1.50pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.05pm	3
2.4	Quality Dashboard (Q2)	Medical and Quality Director	2.15pm	4
3. Items for decision / approval				
3.2	Quality Accounts 2019/20	Associate Director of Quality & Governance	2.25pm	5
4. Items for discussion				
4.1	Freedom to Speak Up Report	Freedom to Speak Up Guardian	2.35pm	6
5. Items for noting				
5.1	DET Annual Complaints Report	Director of Education and Training	2.45pm	7
5.2	Board Assurance Framework (BAF)	Chief Executive	2.55pm	8
5.3	Operational Risk Register (Q2)	Associate Director of Quality & Governance	3.05pm	9
5.4	Guardian of Safer Working (Q2) Report	Medical and Quality Director	3.15pm	10
5.5	Serious Incidents Report (Q2)	Medical and Quality Director	3.25pm	11
5.6	NHS People Plan Report	Director of Human Resources and Corporate Governance	3.35pm	12 late
5.7	Race Equality Strategy	Director of Human Resources and Corporate Governance	3.45pm	13 late
5.8	EU Exit	Deputy Chief Executive / Director of Finance	3.50pm	14

		Presenter	Timing	Paper No
6. Board Committee Reports				
6.1	Education and Training Committee	Committee Chair	4.00pm	15
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	4.05pm	16
6.3	Integrated Governance Committee	Committee Chair	4.10pm	17 late
6.4	Audit Committee	Committee Chair	4.15pm	18
7. Any other matters				
7.1	Any other business	All	4.25pm	
8. Date of Next Meeting				
	26th January 2021, 2.00pm – 4.00pm – Online / The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			