The Tavistock and Portman
NHS Foundation Trust

100 YEARS
1920 to 2020

Quality accounts

2020-21

Contents

Part 1: Statement on quality from the Chief Executive 3

Part 2: Priorities for improvement and statements of assurance from the board 5

2.1 Progress against priorities from 2020/21 6
2.2 Our quality priorities for 2021/22 9
2.3 Statements of assurance from the Board 12
A review of our services 12
Participation in clinical audits and national confidential enquiries 12
Participation in clinical research 13
Goals agreed with commissioners for 2020/21 14
Regulatory compliance – Care Quality Commission (CQC) 14
Data security and quality 15
Reporting against core indicators 21

Part 3: Review of quality performance 23

Quality of care overview: performance against selected indicators 23
Quality Improvement (QI) 23
Patient safety 24
Patient Experience 27
Clinical Effectiveness 30
Reported raising of concerns: Whistleblowing 38
Staff Rota Information 38

Part 4: Annexes 39

Statements from North Central London (NCL) Clinical Commissioning Group (CCG), Camden Healthwatch, Health Scrutiny Committee and Governors and response from Trust. 39
Statement from North Central London (NCL) CCG 39
Camden Local Authority Health and Adult Social Care Scrutiny Committee 40
Healthwatch Camden 41
Statement from our Governors 41
Statement of directors' responsibilities for the quality report 42
Independent auditor's report to the council of governors of The Tavistock & Portman NHS Foundation Trust on the quality report 43
Appendix – Glossary of Key Data Items 44

nderstand their behaviour.

expected. Childbirth can leave you feeling exhausted and anxious, as well as shocked by the sudden changes in your life as a result of becoming a mother.

- Instead of being in control of your life, you may feel taken over by the constant demands of a

Understanding Childhood

supporting teenagers

helping parents and professionals to understand the early teenage years

Parents usually develop some confidence in their capacity to see their young children through problems. Everyone knows how important it is for parents to be involved with their children in the early years and at primary school, so it's not difficult to get to know your children's friends and share anxieties with other

Understanding Childhood

a series of leaflets written

experienced child

psychotherapists to give

into children's feelings

Part 1: Statement on quality from the Chief Executive

It is my pleasure to introduce the 2020/21 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 means 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 deliver a high-quality service for our patients.

Across the organisation more than 22,000 patient contacts were made in the past year. This was slightly below the 23.000 seen the previous year but has been a significant achievement given the impact of the Covid-19 pandemic. This past year has been a challenging time for patients and staff alike and the Covid-19 pandemic has forced us to think differently about how we could continue to best meet the needs of our patients, ensuring both the safety of staff and service users alike. In March 2020 services very quickly moved to provide services remotely.

At the same time a quality improvement project was set up early in the year to monitor and improve service user and staff experience of remote working via Zoom or telephone. Thirteen projects were undertaken across the organisation and the data and analysis positively impacted on remote working by improving the experience of interventions and demonstrating the best way to deliver certain interventions within pathways of care. The ongoing delivery of excellent care has been a credit to all our staff.

During the year we have strengthened our governance and risk processes, reviewing and updating the integrated governance committee and subcommittee structures to improve quality assurance functions and implemented a new electronic risk management system. We have also developed our inter-trust learning events which, due to the virtual environment have been better attended, enabling participants from across the world to attend, and building on the Trust's strengths as a listening and learning organisation.

There have also been additional challenges during the year for the Trust's Gender Identity Development Service (GIDS). The CQC undertook a focused inspection of the service in October 2020 and the report, published in January 2021, rated the service 'inadequate', driven by 'inadequate' ratings for the responsive and well led CQC domains. The service was rated "good" for the caring domain with patients and families the CQC talked to giving positive feedback about the understanding, compassion and kindness of staff.

The biggest concern raised by the CQC in their report related to waiting times and we accept the serious nature of issues around these and the distress that delays in treatment cause patients. Other areas of criticism included the need for improvements in record keeping, and action to support the service around culture and leadership. The Trust Board fully acknowledges the need for improvement and has established a transformation programme with strengthened governance arrangements to address this.

We have submitted a plan to the CQC on actions we can take to reduce waiting times and address other concerns. The CQC report recognises that demand has increased beyond the capacity of the service and we are in discussion with NHS England, our commissioner, about how we manage our referral criteria. We are also working closely with the Independent Review led by Dr Hilary Cass, former President of the Royal College of Paediatrics and Child Health which is looking at the wider care pathway for young people with issues about gender identity.

Our initial communications to patients and families over the findings included an open letter and video message where we acknowledged criticisms, particularly in relation to waiting times, and set out our commitment to make improvements while building on the caring quality of clinical work which is clearly appreciated by patients and families. Management arrangements and clinical and operational capacity to deliver change have been strengthened to support the work.

Internationally, the murder of George Floyd by police in the USA which ignited the Black Lives Matter (BLM) movement across the globe also highlighted the need to tackle our own internal struggles with racism and difference as an organisation. The Trust Race Equality Network and an Allies Forum are committed to ensuring we have a refreshed race equality strategy that is fit for purpose and Trust-wide discussions on racial injustices

have shown staff's commitment to being involved in real, positive and lasting change in our organisation. Additionally, the Trust has recognised that it would benefit from external support in this journey and have commissioned an independent company with expertise in race equality matters, to support us. The Trust is committed to looking at staff experience and developing services to meet the needs of the communities we serve.

In 2020-21 we had four quality priorities across the Trust which included:

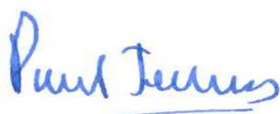
- focusing on enhancing patient safety and communications by standardising the use of Alerts on our electronic patient records;
- reviewing and updating our experience of service (ESQ) patient questionnaires with service users, to improve completion rates and provide richer qualitative data;
- improving waiting times across the Trust and
- embedding the meaningful use of patient completed outcome measures

The first two priorities were fully completed. Waiting times continue to be longer than we would wish particularly in our adult and as previously covered, our children's gender services where there are high referral rates. This will be an ongoing priority for 2021/22. The priority on outcome measures has focused this year on the quality of outcome reporting to support clinical decision making and will also continue for 2021/22.

Finally, the Trust has reviewed its strategic objectives and is undergoing a strategic review across the organisation, in order to best meet the challenges of a developing integrated care system. This is being developed to improve the provision and delivery of services across healthcare providers.

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.

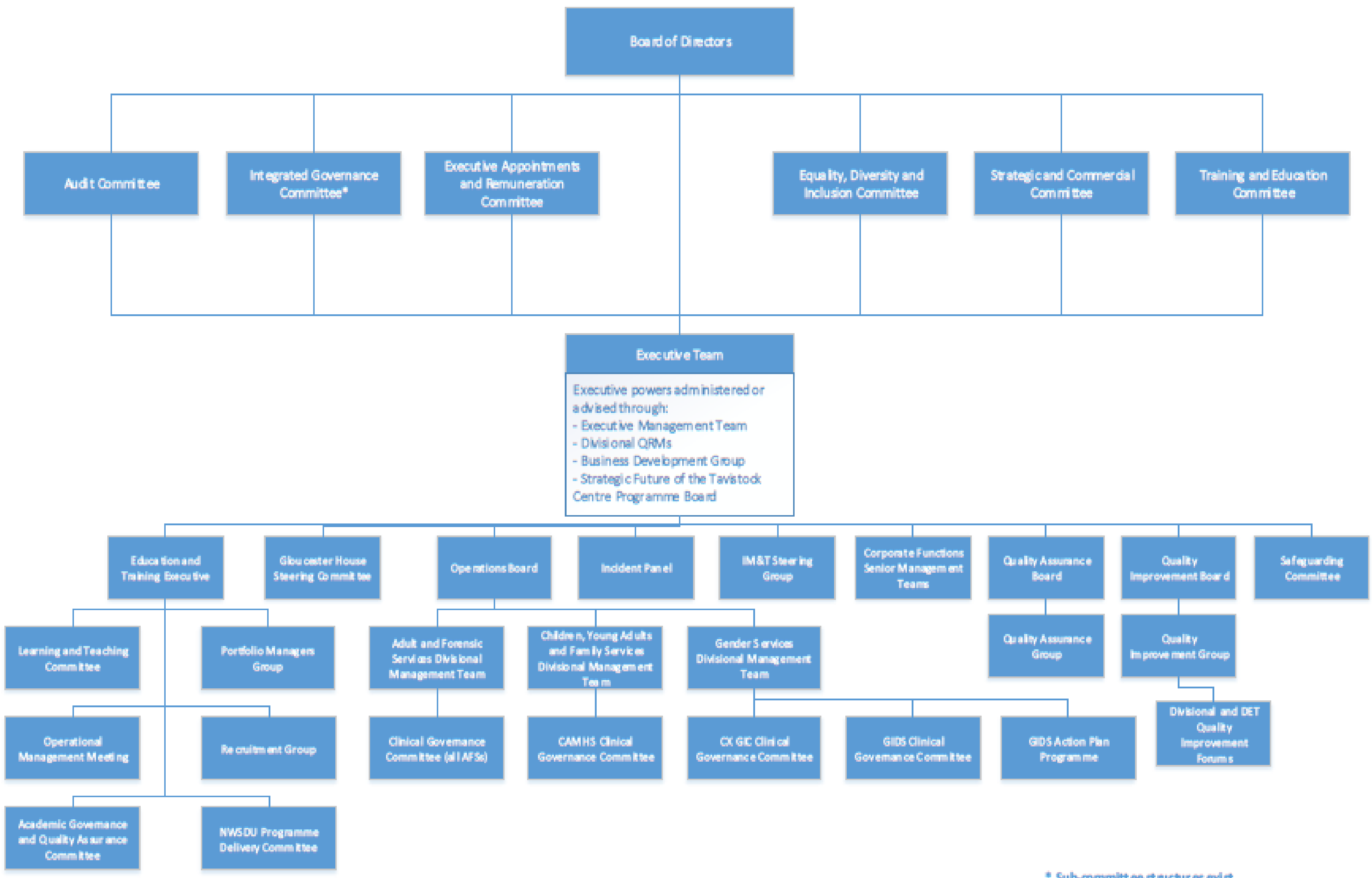
I confirm that I have read this Quality Report which has been prepared on my behalf. I have ensured that, whenever possible, the Report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge, within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



Paul Jenkins 9 June 2021

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 2020/21, along with statements of assurance from our Board of Directors.

2.1 Progress against priorities from 2020/21

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?
Standardise the use of Carenotes Alerts to enhance patient safety and communication	➢ **Complete audit of Carenotes Alerts within each of the clinical directorates (AFS, Gender and CYAF) to clarify current use of Alerts**	***We achieved this*** • Audits were undertaken in two of the three clinical directorates during 2020/21 – AFS and CYAF. • Feedback sought from Gender Directorate service leads, who confirmed usage in line with AFS and CYAF directorates. • The main themes identified were around communication, risk and safeguarding concerns.
	➢ **Agree parameters for when Alerts should be used across the Trust**	***We partially achieved this*** • During 2020/21 guidance was drafted on the use of Carenotes Alerts. • This included systems for reviewing alerts and auditing compliance. • This guidance was shared with service leads in Q3 and is now in the process of being rolled out across services, with some minor tweaks needed for the Portman service
	➢ **Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review**	***We achieved this*** • Starting in Q2, the weekly Divisional Directors meeting included General Managers once a month to ensure consistency across the Trust and to monitor progress on the Quality Priorities across the directorates. •
	➢ **Implement guidance and re-audit across the directorates to assess adherence to the new guidance**	***We partially achieved this*** • AFS and CYAF directorates started working on clearing out all old and inappropriate alerts. With the exception of the Portman, AFS have now completed this work and a recent re-audit showed good compliance. • This same work in CYAF has been slightly delayed owing to staff sickness but is underway and expected to be completed in early May 2021. • The timescales for Gender services undertaking this same work is due to be discussed at the next Directors meeting, as they have a number of competing priorities at present.

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	➢ **Evaluate and review Q4 testing and test in 2 Adult and Forensic Services teams, reviewing and adjusting the form following these tests**	***We achieved this*** • Additional trial of new ESQ form carried out within Adult Complex Needs service. • Further feedback obtained from additional testing. • Feedback compiled and shared with relevant groups and at associated meetings.
	➢ **Identify and assess methods of streamlining collection of the information and obtain a consensus for delivery across the Trust**	***We achieved this*** • The PPI team shared thematic analysis of data collection with clinical team leads through the test process. • Trust looking into using Qualtrix to help streamline and automate ESQ feedback pathways.
	➢ **Evaluate effectiveness of the new form for increasing ESQ return rates and improving qualitative feedback**	***We achieved this*** • Higher response and completion rates in all tests and feedback from teams suggest that using a shorter questionnaire seems to encourage service users/clinician engagement in completing the ESQ. • An increase in the number of completed open-ended questions allowed respondents across all tested services to provide richer, more in-depth comments about their experiences.
	➢ **Work with teams to increase use of the ESQ data to improve and develop services**	***We achieved this*** • The PPI team worked within clinical services to ensure that meaningful ESQ data is being shared in team meetings. • Due to covid there were limited resources for development of the use of data – however the PPI team have compiled data collected, explored themes and fed back to the teams who were able to participate. This information has been shared by the PPI director at EMT.

Clinical Effectiveness and Patient Experience

Our quality priority	What success will look like	How did we do?
Improve Waiting Times Across the Trust	➢ **Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice**	***We did not achieve this*** • We have now rolled this Quality Priority forward to 2021/22 to reflect work which has started on waitlist management in Gender Services.
	➢ **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)**	***We did not achieve this*** • We have now rolled this Quality Priority forward to 2021/22 to reflect work which has started on waitlist management in Gender Services.
	➢ **Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 and Q4)**	***We did not achieve this*** • We have now rolled this Quality Priority forward to 2021/22 to reflect work which has started on waitlist management in Gender Services.

Clinical Effectiveness and Patient Experience

Our quality priority	What success will look like	How did we do?
Embed Meaningful Use of Outcome Measures across the Trust	➢ **To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback**	***We partially achieved this*** • A great deal of work has been undertaken during 2020/21 to understand and make improvement plans for the use of outcome data and patient feedback. • At Q4 we have a more sophisticated and integrated understanding of the co-dependencies between the data gathering software (Qualtrics or other), the EPRS (Carenotes) and what software or human resource we need to convert raw data into meaningful statistics with clinical and organisational application.
	➢ **Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications**	***We partially achieved this*** • The CYAF & AFS General Manager has set up an OM logic group to systematically work through the Carenotes logic with colleagues from data quality. • The trust continues to trial Qualtrics (a data gathering software solution) and we will roll out using it to collect CORE OM in Adult complex needs at the end of Q4. This will be kept under review and if successful ESQ and Patient Demographic Information for a wider range of services can be included.
	➢ **To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures**	***We partially achieved this*** • Results of the quality Improvement project on use of Qualtrics to collect OM has been fed back to the Adult Complex Needs service as part of our plan to create a feedback loop between governance initiatives, staff doing front line clinical work and informatics/data quality. • The aim of such QI projects has been to generate a better understanding of the value and applications of patient data and create stronger interest in its value. • There is also thought to adapt the suite of OMs to the population served, e.g., the Adult Trauma service has started a QI project on using measures specific to PTSD (such as the impact of Events Scale and others).
	➢ **To develop a robust and standardised system of user-friendly reminders and follow up on missing OM through the EPR and team level reporting**	***We achieved this*** • Informatics have produced a new report which allows local admin teams to quickly run reports to identify which outcomes measures are due for patients, and so the hope is that the introduction and use of this report will result in an increase in forms being completed. • New logic has been added to the Carenotes system that adjusts the way that certain 'due' forms are flagged up, to make it clearer to teams which is the most recent due form that requires completing.

2.2 Our quality priorities for 2021/22

The priorities for 2021/22 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.

Clinical Effectiveness		
Priority 1	Embed a revised job planning process within clinical services	*New Priority*
Patient Experience		
Priority 2	Improve the collection of race and equality data	*New Priority*
Clinical Effectiveness / Patient Safety		
Priority 3	Improve waiting times across the Trust	*Builds on a Quality Priority from last year*
Clinical Effectiveness		
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

Priority topics for 2021/22 were developed following discussions with a number of service users, non-executive directors, staff, management and commissioners. In addition we considered current Trust Quality Priorities, service challenges, key performance issues and quality data reviewed and presented to Board over the past year. As a result we chose four priorities which reflect the main messages from these consultations.

Clinical Effectiveness

Priority 1: Embed a revised job planning process within clinical services

Our ambition in this priority is to embed the revised job planning process effectively with the aim to improve productivity and therefore access to patients.

Quality Priority 1: Embed job planning process within clinical services
Targets for 2021/22 *New priority*
1. Clarify parameters for job planning across the directorates (AFS, CYAF and Gender) and the processes for updating job plans when situations change.
2. Ensure all clinical staff across the trust have an initial job plan and review these at a divisional level to identify areas that reduce clinical capacity, e.g., supervision, team meetings.
3. Agree principles across the Trust on the identified areas to ensure staff have sufficient capacity for clinical work as expected for their banding and role.
4. Implement the agreed principles and review job plans accordingly.
5. Agree standard timescales and mechanism for reviewing job plans and monitoring capacity on an ongoing basis.

Patient Experience

Priority 2: Improve the collection of race and equality data

The target of this priority is to improve both the collection of ethnicity data and ensure that it is used in a meaningful way for example, ensuring we represent the populations we serve in an equitable manner.

Quality Priority 2: Improve the collection of race and equality data
Targets for 2021/22 *New priority*
1. Complete report of ethnicity data completion rates within each of the clinical divisions (AFS, CYAF and Gender) (Q1).
2. Provide a baseline of Experience of Service Questionnaire (ESQ) completion by ethnicity (Q1) and provide comparative data analysis during 2021/22
3. Clarify the current initial data collection methods and processes for updating based on changed situation. (Q2)
4. Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review. (Q3/4)
5. Implement guidance and report again across the directorates to monitor adherance and make adjustments where needed. (Q3/4)

Clinical Effectiveness and Patient Safety

Priority 3: Improve Waiting Times across the Trust

Waiting times to first and second appointments are a concern across many Trust clinical services. This has an impact on patient care, experience and safety; on staff well-being; on the Trust's contractual and financial position; and on its reputation. Through this quality priority we will seek to recommend and implement ways of improving waitlist management. The work will build on evidence of existing good practice. It will also be informed by work currently being undertaken to meet the GIDS CQC waitlist action plan and by analysis and recommendations by external experts currently supporting improvements in waitlist management in both the Trust's gender services. It will also support the implementation of recommendations from the Trust's strategic review.

Quality Priority 3: Improve waiting times across the Trust
Targets for 2021/22 *Development on 2020/21 priority*
1. Review waiting times across Trust services and identify range, variation and areas of good practice in waitlist management, based on Trust data (Q1).
2. Agree key areas of focus and hold workshops to develop plans and QI projects to address wait times, ensuring that work aligns with strategic review changes (Q2).
3. Implement, monitor and review these plans, based on agreed measures for waitlist reduction. (Q3 and Q4).

Clinical Effectiveness

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

Building on the developments in 2020/21 we will further develop the consistent use and analysis of Outcome Measurements across the Trust in parallel with the progression of semi-automated data collection software. Outcome measures have a number of possible uses including the systematic evaluation of clinical progress, as a means of eliciting self-reported feedback on an individual's mental health state and providing data separately to clinical observations or opinion. We will be focusing on improving the consistent collection of OM and having clearly defined mechanisms and accountability for all teams. Currently OM data is manually entered onto CareNotes which is labour intensive, may not be timely and risks data entry errors.

Quality Priority 4: Embed meaningful use of outcome measures across the Trust
Targets for 2021/22 *Development on 2020/21 priority*
1. To complete a pilot of an appropriate software solution for OM data email out and return that is compatible with Carenotes data. To reduce administrative time in manual data input.
2. To increase OM returns across all services by 25% above baseline by year end.
3. To pilot brief and STP wide OM feedback (e.g., dialog) OR for specific clinical services (e.g., Trauma) nationally benchmarked OM.

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 2020/21 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 2020/21 represents approximately (£41.4m) 63.3% of the total income (£65.4m) generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2020/21.

Participation in clinical audits and national confidential enquiries

National Clinical Audits and National Confidential Inquiries

During 2020/21 there was no National Clinical Audit directly relevant to health services that the Tavistock and Portman NHSFT provide.

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

Local clinical audits

There were 22 local clinical audits undertaken during 2020/21 with 1 report outstanding and 3 audits still in progress. The reports of 22 clinical audits were reviewed by the provider in 2020/21 and the Tavistock & Portman NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

1. RSM Audit of Clinical Audit
   During Q2, the internal auditors, RSM, looked in detail at the clinical audit process at the Tavistock & Portman NHS Foundation Trust. The auditors acknowledged that Covid-19 had impacted on the implementation of actions and sharing of lessons learnt from clinical audits undertaken. Improvements made to clinical audit processes, in particular the use of the Trust electronic audit template as standard and recording of audits and action plans on Trust Quality Portal. Virtual training on clinical audit methodology will continue to be provided and work is ongoing to integrate clinical audit and Quality Improvement projects.

2. Prescribing audit of controlled drugs
   The purpose of this audit was to review the controlled drugs prescribed at the Trust. This was re-audited in Q3. Amendments are to be made to the Prescribing procedure and a re-audit is scheduled for Q2 2021/22.

3. Case Note Audits

   Several service level and team level case notes audits took place during the year focusing particularly on completion of the risk and safeguarding sections of the Electronic Patient Record, completion of crisis plans, completion of care plans, timeliness of clinical entry onto EPR and timeliness of outcoming appointments. Findings were discussed at divisional Clinical Governance Meetings and Team Meetings. Local action plans are agreed when required. There is an ongoing programme of case notes audits which can be targeted depending on findings. Larger audit of case notes completed by clinicians in training will be undertaken to ensure standards for completion are maintained.

4. Demographics Audits reviewed the completeness of patient documentation in respect of demographics data. This data is published nationally. All services have reviewed their processes for obtaining this information, and made changes to support improvements. These changes are beginning to have an impact on the completeness of data. The information will continue to be used to inform the services we provide, and ensure we are reaching groups of individuals who may be having difficulty accessing our services.

5. Consent Audits were undertaken to gather evidence to inform clinicians and managers 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 was developed to manage telehealth consultations during the COVID-19 pandemic.

6. Gender Identity Development audit programme: The Trust children's gender services have a programme of clinical audit that aligns with the Trust wide programme. Audits undertaken during the year linked to the Safeguarding Standard Operating Procedure and to the Consent Standard Operating Procedure. Audits were shared with the whole team through the clinical quality and governance meetings.

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 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 403 across 4 studies.

CPMS Study ID	IRAS ID	Short Name	Trust Name	Recruitment
42109	260379	LOGIC	Tavistock and Portman NHS Foundation Trust	379
45621	282858	Psychological Impact of COVID-19	Tavistock and Portman NHS Foundation Trust	17
43047	262518	Gender dysphoria and Autism	Tavistock and Portman NHS Foundation Trust	7
39861	242383	Specialist Services Study	Tavistock and Portman NHS Foundation Trust	0
			Total	**403**

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 2020/21

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

As a result of the Covid-19 pandemic, there were no CQUIN's agreed for 2020/21 and the CQUIN values for 2020/21 were rolled into block contract values. There are therefore no finances directly associated with CQUINs.

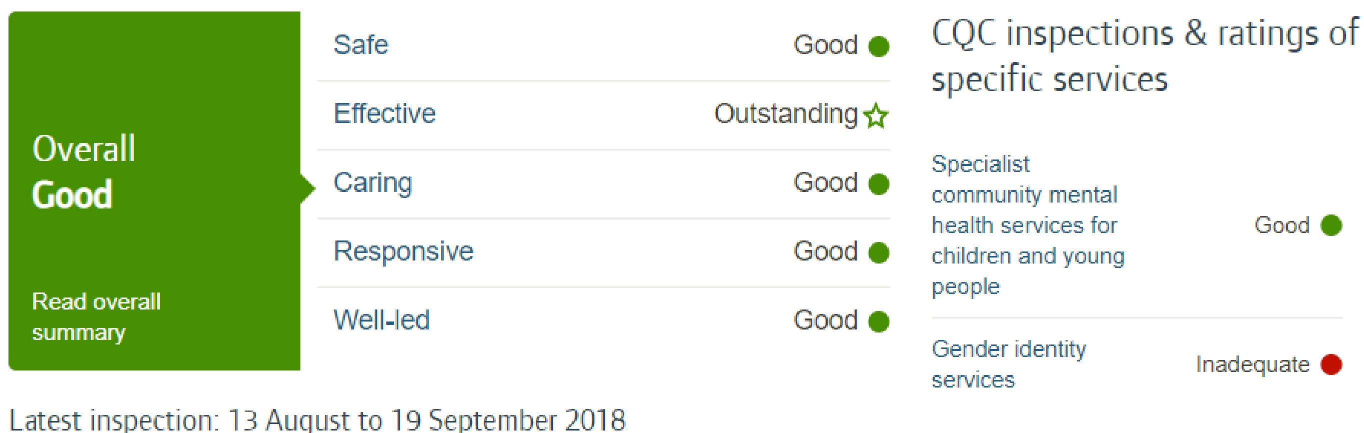
Regulatory compliance – Care Quality Commission (CQC)

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

The Tavistock and Portman NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2020/21.

In October 2020 the Trust underwent an announced, focused inspection of the Gender Identity Development Service (GIDS) by the Care Quality Commission, with an overall rating of 'inadequate', and individual ratings as follows: 'requires improvement' for the 'Safe' and 'Effective' domains, a rating of 'good' for the 'Caring' domain, and an 'Inadequate' for 'Responsive' and 'Well-led' domains. Following the focused inspection in October 2020 the Care Quality Commission took enforcement action against the Tavistock and Portman NHS Foundation Trust imposing a condition upon registration. This required the Trust to report to the CQC on a monthly basis so that they could monitor progress with improving waiting times.

The full report is available on the CQC website, www.cqc.org.uk. The overall Trust assessment of domain compliance is unchanged.



The Gender Identity Development Service (GIDS) was last inspected in 2016 and the 2020 inspection was undertaken due to concerns reported to the CQC by healthcare professionals and the Children's Commissioner for England.

The overall CQC summary found:

- The GIDS service was difficult to access with over 4600 young people on the waiting list and waiting times of over two years for a first appointment;
- Staff did not always assess and manage risk well;
- Staff did not develop holistic care plans for young people or sufficiently record reasons for clinical decisions in case notes;
- The competency, capacity and consent of patients referred for medical treatment before January 2020 was not consistently recorded, but decisions subsequent to that date were;

- Teams did not always include the full range of specialists to meet individual patient needs and did not always work well together as a multidisciplinary team;
- Staff did not always feel respected, supported and valued;
- The service was not consistently well-led. Areas for improvement had been identified with some improvements but these had not been fully implemented.

However:

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

The Trust is delivering on a comprehensive action plan to address the issues identified. In respect of waiting times work is also being undertaken across the Trust and this is a Trust quality priority for 2021/22.

Data security and quality

The Tavistock and Portman NHS Foundation Trust did not submit records during 2020/21 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.

The Data Security & Protection Toolkit submission deadline has been extended and is currently June 2021. The Trust will make its submission before the deadline. Last year's submission was made at the end of September 2020 and our status was 'Standards not fully met – Plan agreed'.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21.

Data Quality Maturity Index (DQMI)

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

DQMI – Data Quality Maturity Index	Q1 2020/21	Q2 2020/21	Q3 2020/21	January 2021
Tavistock and Portman NHS FT	95.8%	95.7%	95.8%	96.6%
National Average	81.5%	82.8%	82.3%	82.0%

N.B. At time of publishing, January 2021's official DQMI scores were the most recently published scores

The importance of having high quality data on which to base decisions, whether clinical, managerial, or financial, is recognised by the Trust. An ongoing focus on having robust systems, processes, data definitions and systems of validation helps assure us of our data quality. Whilst the Trust has key processes in place for assuring the quality of data it recognises that further work is required, particularly in respect of timely data submissions by staff, and further improving data validation and completeness. The Tavistock and Portman NHS Foundation Trust has taken and will be taking the following actions outlined below, to continue to improve data quality.

Trust Developments - Infrastructure and Results

Significant work has been undertaken over the last 12 months to improve data validation and completeness, continuing and developing internal and interrelated processes to support high levels of data quality. This has included changes to Carenotes and the updating of protocols and data collection tools in order to support communication and information requirements of staff and service users.

As an example, work on assessing procedures and performance rates on Care Plans has continued throughout 2020/21 with signs of improvement in Initial and Review Care Plan completion. In the last year the generation of Initial Care Plans improved by 5% and Review Care Plans by 14%. Further work continues on the quality of information provided on Care Plans and the completion of Assessment Summaries. In addition a strategy to improve the completion rates of Crisis Plans has also been developed.

	2019/20	2020/21
Initial Care Plans produced	47%	52%
Review Care Plans share with GP	24%	38%

In 2020/21, we linked our quality priorities to certain areas of continuing data challenges, and will continue this focus in 2021/2 for outcome measures. Our services 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:

- CORE OM is the main outcome measure in our Adults directorate. In 2020/21 we developed a new report to measure and understand service performance. We now assess improvement rates of all discharged patients with two or more CORE OM forms completed and this has significantly increased the cohort of patients we evaluate, providing a wider understanding of our services.

- Goal Base Measure (GBM) is one of our main measures, 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 several areas for improvement, including making the interface form more user-friendly and producing a more flexible reminder system. This has been positively tested will be rolled out across the trust in 2021.

Finally, to better inform Board level discussions on data matters there have been significant graphical data presentation improvements over the past financial year within the quarterly Quality and Commentary Board report. These include:

- Clear comparative data spread over 2 years on referrals, patient contacts, waiting times, DNA rates and MHSDS data;
- The development of dashboard graphics and improved visuals to increase understanding of data across different services and divisions;
- The use of trends versus status snapshots;
- The development of summary commentaries alongside the graphics.

Overall Oversight

- Quality Assurance Board. This group was established during last financial 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 dashboard.

Quality assurance work

- Continuation of an established monthly Quality Assurance Group which reports to the Quality Assurance Board and includes clinicians, lead administrators, data and contracting leads. This group meets to analyse and assess data from the patient administration system (Carenotes).
- 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

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

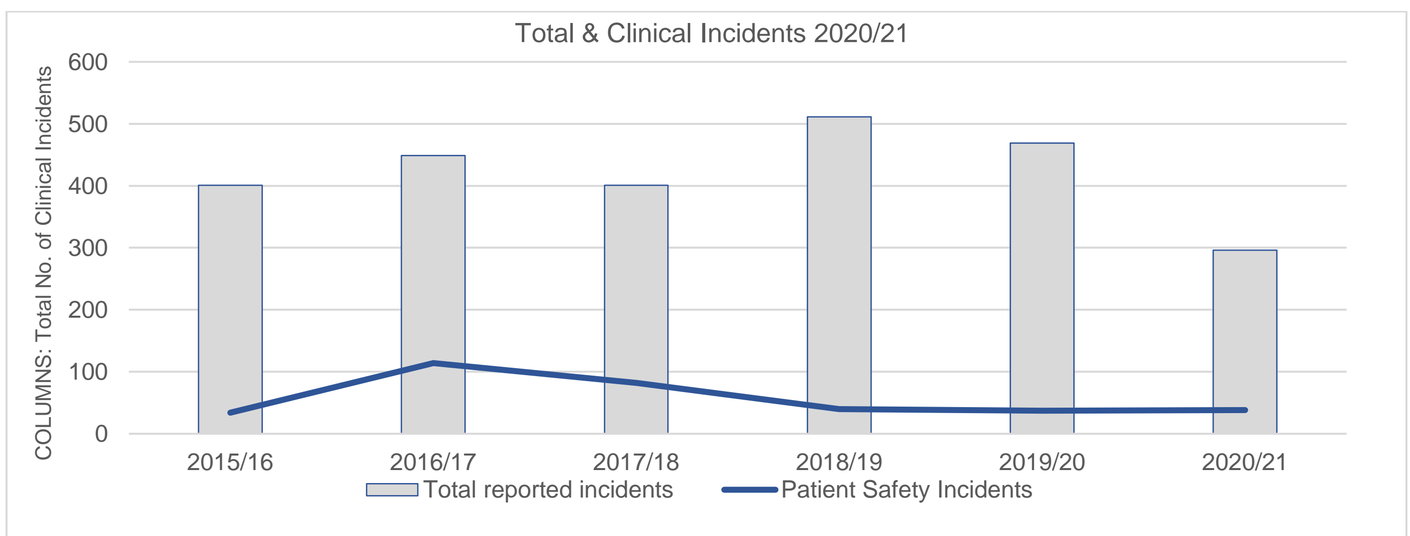
Patient Safety Incidents (PSIs)

The number and rate of patient safety incidents reported within the Trust during 2019/20 are below.

During the past year we submitted 16 incidents to the National Reporting and Learning System (NRLS) that caused severe harm or death. The majority of deaths are reported from GIC patients mostly died of medical factors.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Total reported incidents	401	449	401	511	469	298
Patient Safety Incidents	34	114	82	40	37	38

Source: Quality Portal (QP), PSIs reported 1 April 2020 to 31 March 2021



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

The Tavistock and Portman 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;
- The majority of patient safety incidents reported resulted in no harm;
- Deaths of all Gender patients, even if on a waiting list / not yet seen, or not discharged are reviewed;
- The importance of incident reporting and learning is promoted across the trust in order to support the management, monitoring and learning from all types of incidents. Staff are reminded 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 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 at least quarterly by the Medical Director and open to all staff.

Learning from Deaths

An incident form is completed for all patient deaths at the Trust and recorded on the Incidents/Serious Incidents section of the Trust Quality Portal. All deaths are subject to review at the monthly Incident Panel chaired by the Medical Director. Deaths will be investigated as either a serious incident and/or through a concise report or a mortality review.

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

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

Concise reports: These are internal reports requested following the unexplained/untimely death of a patient. Such reports are also used for a broader selection of reasons, for any incidents that need a review but where we are not requiring or needing to lead on a serious incident review. These may also be uploaded to the Strategic Executive Information System (StEIS) (NHSI). The report includes details of the most recent risk assessment, any safeguarding concerns, details of the incident if known and of any relevant antecedents. The clinician must give an account of actions taken, any support offered to the family and to staff. Duty of Candour is applied where appropriate.

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

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

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

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

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

During 2020/21 the deaths occurred of 18 patients known/previously known to the Trust. This comprised the following number of deaths which occurred in each quarter of the reporting period:	
Quarter 1	4
Quarter 2	5
Quarter 3	5
Quarter 4	4

By 31 March 2021, 12 concise reviews, 4 mortality reviews and 1 serious incident investigation have been carried out in relation to 17 of the deaths above. The number of deaths in each quarter for which a case record review or an investigation was carried out was:	
Quarter 1	3 x concise reports and 1 x mortality review
Quarter 2	3 x concise reports and 2 x mortality reviews
Quarter 3	4 x concise reports and 1 x serious incident investigation (STEIS logged)
Quarter 4	1 x mortality review and 2 x concise reports; awaiting 1x mortality review

All deaths of patients on the waiting list and/or where death was thought to be due to medical causes have been reviewed.

Inquests that took place: The Trust may not necessarily know that an inquest has taken place and clinicians may not have been requested to provide witness statements to the Coroner. Trust clinicians were involved as witnesses in 1 inquest during 2020/21.

0 cases representing 0 % of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

During 200/21, 2 deaths were recorded on the Strategic Executive Information System (STEIS). 1 incident was de-escalated because after review at the Incident Panel it was established that the patient had been actively managed at another Trust and that particular Trust was leading the serious incident investigation.

Brief narrative of all deaths

1. April 2020. Death of patient who had been seen for assessment and was on waiting list for treatment. Incident recorded on STEIS and subsequently de-escalated. Concise report completed.
2. May 2020. Suspected suicide which occurred in February 2020. Trust not informed until May 2020. Concise report completed.
3. May 2020. Death of patient on waiting list; cause of death unknown. Mortality review completed.
4. May 2020. Death of patient previously known to the Trust, but case closed for several years. Concise report completed.
5. August 2020. Death of patient from natural causes. Mortality review completed.
6. August 2020. Trust informed of death of person who had not been seen and had been discharged. Concise report completed.
7. September 2020. Death of patient from natural causes. Concise report completed.

8. September 2020. Death of patient from natural causes. Mortality review completed.
9. September 2020. Trust informed that patient died by suicide earlier in the year. Concise report completed.
10. October 2020. Trust informed by family member of death of patient. Cause of death yet to be confirmed. Concise report completed.
11. October 2020. Trust informed by family member of death of patient by suicide. Concise report completed. Serious incident investigation being led by another Trust.
12. November 2020. Death of patient - suspected suicide. Incident recorded on STEIS. Trust undertook serious incident investigation.
13. November 2020. Death of patient presumed medical cause. Concise report completed.
14. December 2020. Trust informed by family member of death of patient, likely by suicide. Concise report completed. Serious incident investigation is being led by another Trust.
15. January 2021. Death of patient from medical causes. Mortality review completed.
16. January 2021.Trust informed of death of patient following serious illness. Mortality review requested.
17. January 2021. Trust informed of death of patient, likely by suicide. Concise report completed. Serious incident investigation being led by another Trust.
18. March 2021. Trust informed of death of patient, likely by suicide. Concise report completed. Serious incident investigation being led by another Trust.

Actions taken in the reporting period:

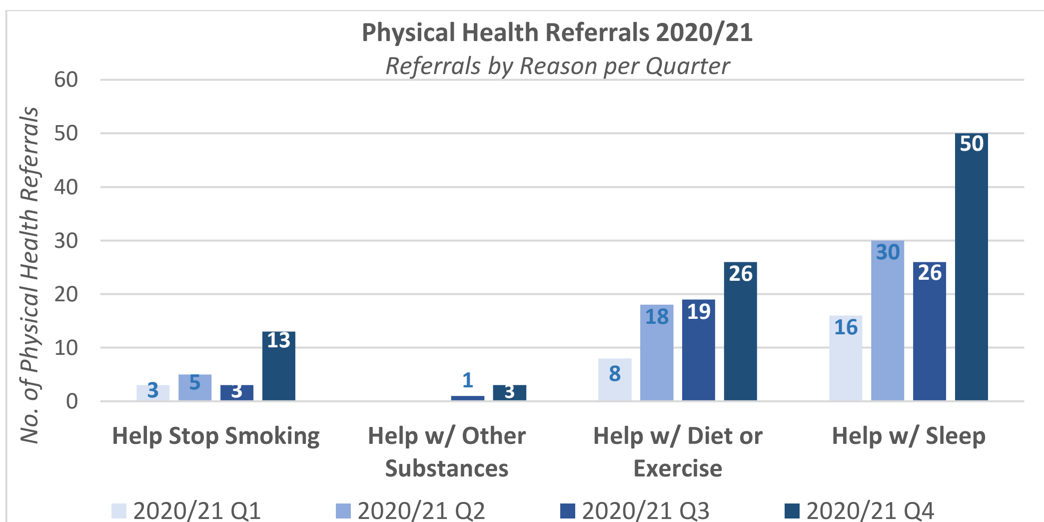
- An incident panel is convened monthly, chaired by the Medical Director. All deaths are discussed, and any reports reviewed. Action plans are brought back for review and updating.

- There is a programme of learning lessons events during the year some of which pertain to learning from deaths. A learning lessons event reviewing deaths by suicide during 2020/21 is planned for Q1 2021/22.

Improving the physical health of patients

The Living Well Service provides evidence-based treatment for smoking, drinking, substance use, healthy weight and sleep. This programme of work is led by the Physical Health Specialist Practitioner (PHSP), an Assistant Psychologist and a Lead Administrator who processes the referrals. It is widely recognised that people with mental health conditions are likely to die an average of 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 improve the health and wellbeing of the population we serve a work around sleep programme was conducted as a quality priority in 2019-2020 and has developed further in 2020/21. 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 aged 13 years and above in order to support the delivery of holistic care to patients. Referrals are made to the PHSP for an appropriate assessment and, if required, one to one or group treatment or, if appropriate, onward referral into existing community services.



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 17*). 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 2020/21, 98% of patients rated help they had received from the Trust as 'good'.

	Q1	Q2	Q3	Q4
Patient rating of help received as good during 2020/21	**99%**	**98%**	**100%**	**98%**

* Yearly averages: 2020-21 = 98%; 2019-20 = 97%; 2018/19 = 98%; 2017/18= 99%; 2016/17 = 93%; 2015/16 = 94%; 2014/15 = 92%.
Please note, the logic surrounding the calculation of the percentages changed in 2017/18 to improve data quality.
Numerator = 'certainly true' + 'partly true' Denominator = certainly true' + 'partly true' + 'not true'.
Source: Quality Team, Data received and calculated: 07/04/2021

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.

	Yearly Averages						
	2014/15	*2015/16*	*2016/17*	*2017/18*	*2018/19*	*2019/20*	*2020/21*
Patient Rating of Help Received as 'Good'	**92%**	**94%**	**93%**	**99%**	**98%**	**97%**	**98%**

A shorter version of the ESQ was tested over three clinical teams from 2019-2021 to improve patient response rates and feedback. This shortened version was developed with patients as part of a quality improvement project and was a Trust Quality Priority. Work to implement the changes more widely across the Trust was accepted by the Clinical Operations Board and implementation of the newly designed ESQ form is being undertaken in Q1 2020/21.

Key themes from the tests were:

- Higher response and completion rates in all tests and feedback from the Primary Care Psychological Service suggests that using a shorter questionnaire may encourage service users/clinician engagement in completing the experience of service questionnaire.
- An increase in the number of completed open-ended questions allowed respondents across all three services to provide richer, more in-depth comments about their experiences.
- Clinicians also welcomed more space for service users to provide free-text feedback suggesting that it gave them better insights into the priorities of patients/parents.

Co design and delivery with patients

The Patient and Public Involvement (PPI) Team have continued to work closely with patients, family members and ex-service users to continue to embed the PPI strategy which has also been updated over 2020 -2021. The strategy is key to embedding meaningful PPI activity at service and local team level as well as supporting service user co-designed and delivered workshops, information sessions and training.

Other projects co-designed and delivered with service users over the year include:

- Regular interview panel training, in order to support our patients to be a part of or interview process for new staff recruitment;
- A quarterly trust wide forum, co-chaired by the PPI team Manager and a rotating service user;
- A primary care psychotherapy service adult photography group Exhibition at Swiss cottage Library and the Trust art board;

- A monthly adult trauma service PPI group has been established with good attendance and clinical input from the service;
- A PPI training programme for the Department of Education and Training is being developed by PPI coordinators with patient involvement to share PPI values with colleagues and trainees;
- The Gender Identity Clinic (GIC) has an active patient forum which is developing helpful feedback mechanisms for service pathways and improving access to information on the website.

Several team level projects are underway to improve service delivery within the CYAF directorate supported by PPI coordinators and involving patients, these include The Level Up project, IThrive development, Looked after children, NCL partners involvement work and refugee service user forums. The CYAF acting lead joins the Clinical Governance meeting to provide updates on projects and support recruitment to involvement activity.

Pan London Forum/ Payments

Throughout the pandemic the PPI team have continued to host a Pan London Involvement forum, this is a space for other involvement professionals from mental health services in London to come together to share experiences and best practice. As a result of consultation with the forum the trust has updated service user payment policies and procedures. In January 2021 the PPI team in consultation with the Trust have been able to put a case forward to increase our hourly involvement rates from £11 per hour to £15 per hour to reflect best practice nationally, recognise the Patient experience voice and make clear our investment in valuing the complex and meaningful nature of the work. This has been agreed with our finance department and has been implemented by the PPI project support staff officer and finance department.

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%	98.97	98.99	99.16	99.60
Valid Postcode	95%	99.79	99.70	99.72	99.53
Valid Date of Birth	95%	100	100	99.99	100
Valid Organisation code of Commissioner	95%	99.14	99.13	99.14	99.13
Valid Organisation code GP Practice	95%	98.55	98.28	98.33	99.12
Valid Gender	95%	99.38	98.80	98.50	99.98
Ethnicity	85%	75.94	75.82	73.88	88.77
Employment Status (for adults)	85%	56.68	55.94	54.92	66.98
Accommodation status (for adults)	85%	55.48	54.69	53.63	66.59
Primary Reason for Referral	-	99	99%	100%	100%*
Ex-British Armed Forces Indicator	-	53	58%	62%	68%*

MHSDS Data is published monthly. Quarterly data is represented by April, July, October and January figures.
**Please note the figures for primary reason for referral and ex-British armed forces indicator for Q4 (January 2021) are only provisional at the time of reporting.*

Ethnicity completion rates have been one of the most challenging owing to the number of service users awaiting first appointment as the data is not usually collected until that appointment. A focus on this data over the year has finally seen an increase in Q4. Ethnicity data will continue to be included in the Race and Equality Quality Priority 2 for 2021/22 where we will be looking to analyse service user Experience of Service Questionnaire (ESQ) responses by ethnicity to better understand how we can improve our services.

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 2020/21, 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 2020/21 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 2020/21. Monitoring has also been undertaken through our divisional quality review monitoring, operational clinical governance and quality improvement processes.

Quality Improvement (QI)

The Trust's clinical quality strategy covers the period 2017-2021. There have been continuing improvements and growth in delivering quality improvement (QI) across the Trust over the past year. QI support structures and capability to enable staff to become actively involved in this approach and for it to become part of everyday work. The Trust QI work continues to be overseen by the QI Board and operationally by the QI Group.

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 2020/21 were to:

- Train staff in QI methodology
- Embed QI into Trust infrastructures
- Engage staff in a calendar of events to raise awareness of QI developments
- Support staff to use QI methods by providing infrastructure and resources to support their learning and development needs

Progress has been made in all areas including:

- Establishing introductory QI training delivered internally by trust quality improvement leads;
- Appointing Quality Improvement staff across all clinical divisions and the Department of Education and Training;
- Establishing Quality Improvement Forums to provide support for those with an interested in quality improvement and/or undertaking quality improvement projects;
- Delivered a trust quality improvement learning event to share work being undertaken across the Trust;
- Undertook a remote working quality improvement project across the whole Trust, in order to explore how to continue to work over the COVID-19 pandemic;
- Continuing to present patient data over time in order to help better identify trends, understand where there are areas requiring improvement and recognise when this has occurred. Such data continues to be 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;

All the objectives are carried forward and the strategy into 2021 seeks to build further on the work to date.

Patient safety

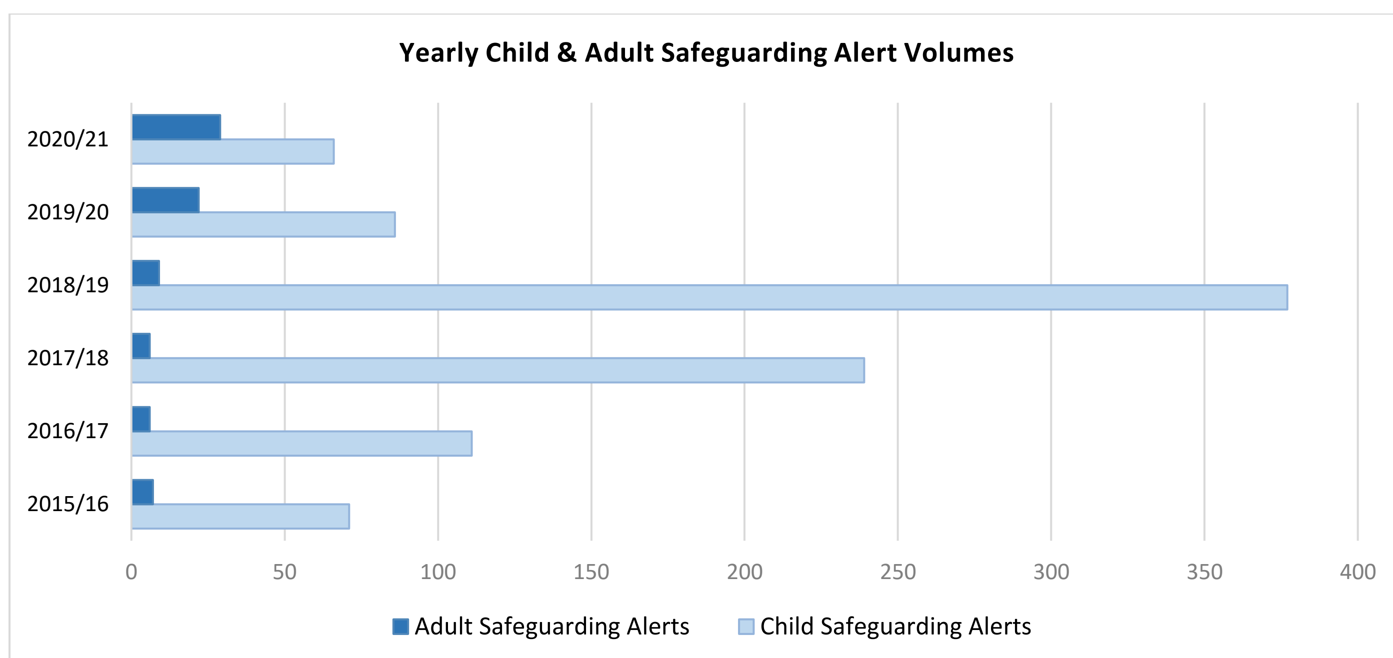
Patient Safety Incidents (PSIs)

This information is included on page 17 of this document.

Safeguarding

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

Source: Clinical Governance Report



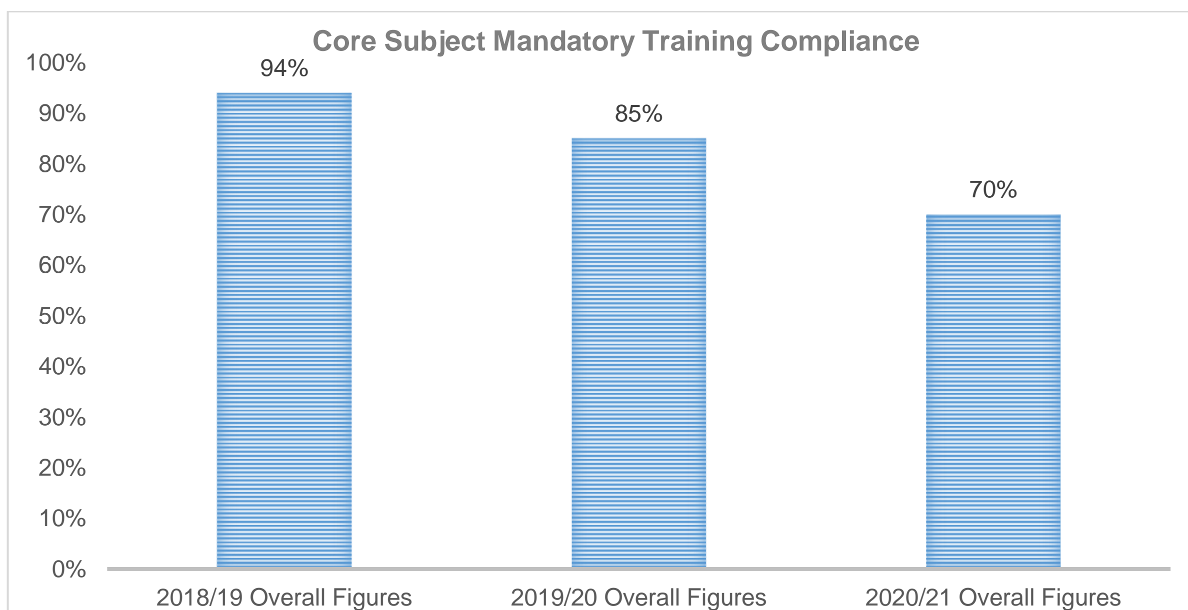
The 2020/21 children's safeguarding data shows a lower incidence of referrals in comparison to 2019/20 which may be explained by a positive impact due to Covid-19 and lockdown but an analysis has also revealed possible data issues with referral numbers lower than expected, given the number of consultations. Further analysis is ongoing.

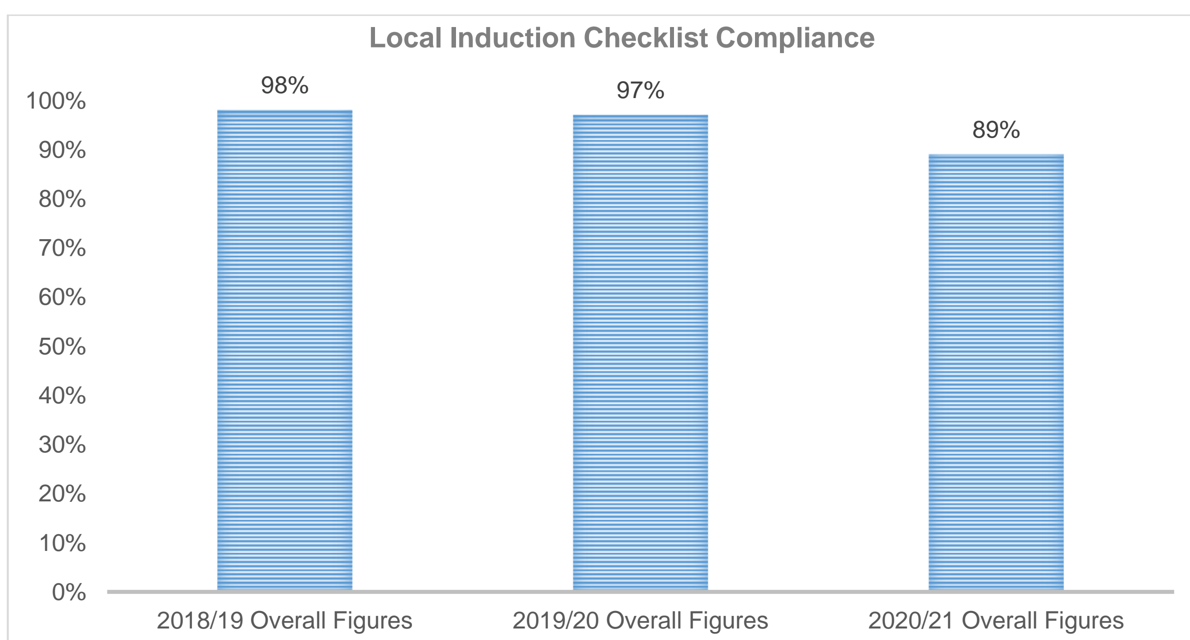
The increase in recording adult safeguarding concerns during 2020/21 resulted from the previous Adult Safeguarding Lead's changes to the Adult Safeguarding over-18 form to improve recording of concerns. There have been eight sessions of Safeguarding adults Level 3 training delivered during 2020/21 and a session on Domestic abuse was delivered in December 2020. The work undertaken by Adult Safeguarding Lead and the Patient Safety Officer to raise awareness on the importance of recording concerns has also continued. The increase in concerns has slowed but continued during 2020/21.

Training 2020/21

	2018/19 Overall Figures	2019/20 Overall Figures	Quarter 1 *(Apr – Jun 20)*	Quarter 2 *(Jul – Sep 20)*	Quarter 3 *(Oct – Dec 20)*	Quarter 4 *(Jan – Mar 21)*	2020/21 Overall Figures
Core Subject Mandatory Training Compliance	**94%**	**85%**	*78%*	*63%*	*64%*	*70%*	**70%**
Local Induction Checklists Completed	**98%**	**97%**	*86%*	*88%*	*92%*	*89%*	**89%**

Source: Electronic Staff Record, 09/04/2021





Every member of staff employed by the Trust is required to be compliant with a range of mandatory and statutory training requirements. The organisation has a consistent approach and has adopted the requirements and curriculum for each topic area in line with our partner Trusts in north central London. The Trust has continued to accept training delivered at other NHS organisations for the purpose of consistency. The Trust, along with many other Trusts has changed the method of training delivered from face-to-face (classroom based) to online e-learning modules through the Oracle Learning Management (OLM) module of the Electronic Staff

Record (ESR). The staff member's personal ESR self-service account also provides data including current compliance rate and completion / expiry dates of modules. This approach has enabled staff members to complete training as and when required at their own pace and within the comfort of their own homes.

Compliance throughout the year had been lower than expected and this was a reflection on the difficult year the nation had due to pandemic.

Disclosure and Barring Service (DBS) compliance 2020/21

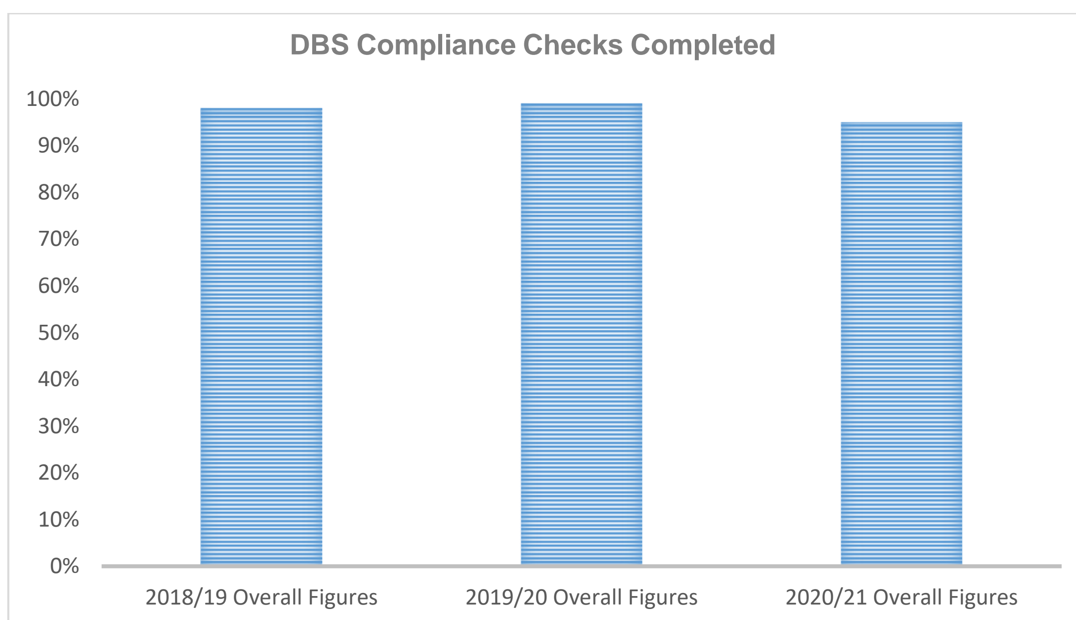
	2018/19 Overall Figures	2019/20 Overall Figures	Quarter 1 *(Apr – Jun 20)*	Quarter 2 *(Jul – Sep 20)*	Quarter 3 *(Oct – Dec 20)*	Quarter 4 *(Jan – Mar 21)*	2020/21 Overall Figures
DBS Compliance Checks Completed	**98%**	**99%**	*98%*	*97%*	*97%*	*95%*	**95%**

Source: Electronic Staff Record, 09/04/2021

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

The Trust continued to maintain a high level of compliance to the required standards. For the purpose of transparency staff that are on maternity leave or a prolonged absence are included in the denominator for this metric which accounts for the 5% 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. The Trust ensures that all staff are rechecked every three years. The Trust accepts DBS compliance from any staff member or potential candidate who is part of the update service which is an online subscription that allows the staff member to keep certificate up to date on an annual basis. We have also taken the necessary precautions by implementing ESR notifications as part of our internal messaging / workflow systems within ESR. The workflow notifications relating to DBS compliance enables the team to respond and act on this information. Role-based notifications support internal processes and helps maintain the ESR system and its data.

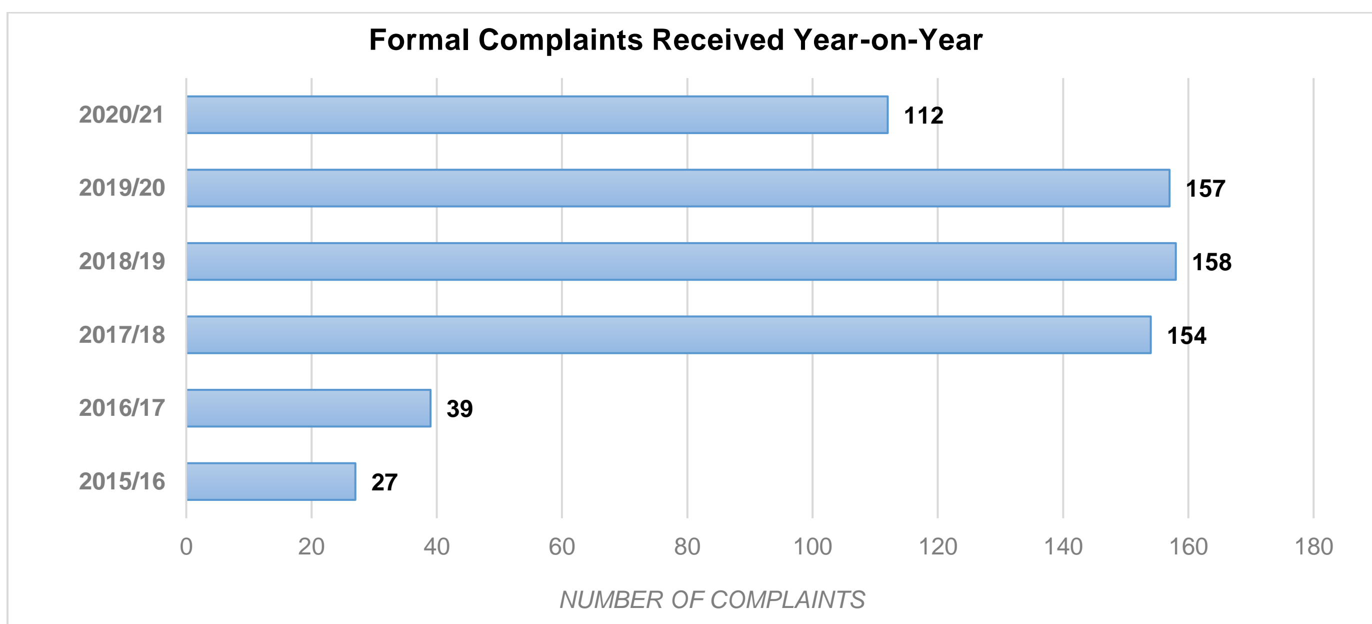


Patient Experience

Formal complaints received

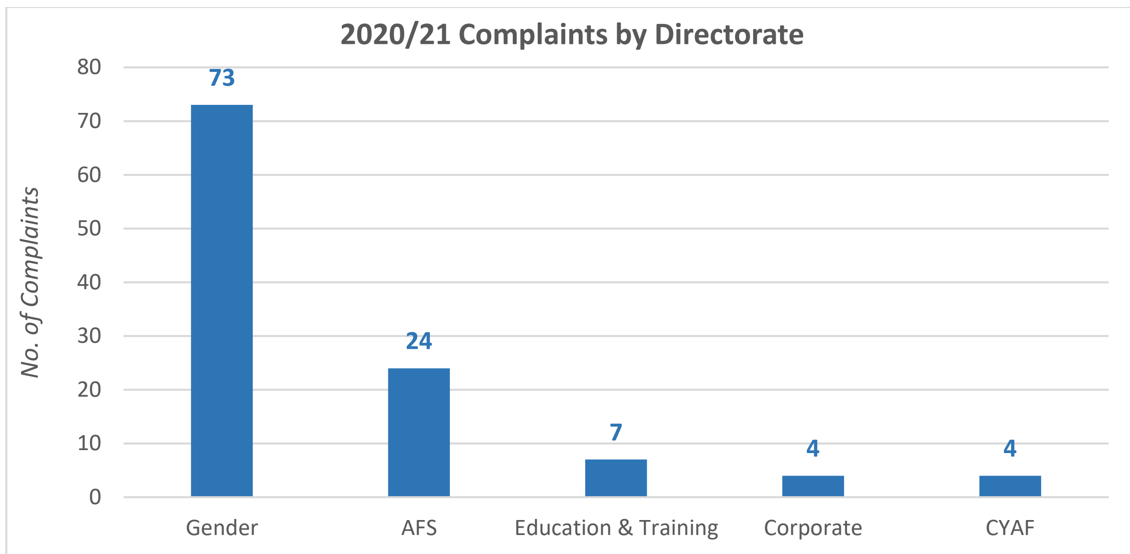
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Formal Complaints Received	27	39	154	158	157	112

Source: Quality Portal 09/04/2020



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. Complaints rose between 2016/17 to 2017/2018 due to the Trust's acquisition of the Charing Cross Gender Identity Clinic and have decreased in the past financial year. For 2020/21 we received 112 complaints of which 58 related to the Gender Identity Clinic. The two services receiving the next largest number of complaints were the Gender Identity Development Service for those under 18 years of age and the Adult Complex Needs Service, each of which received 15 complaints.

Complaint Category	No. of Complaints
Clinical	**26**
Waiting Times	**21**
Communications	**20**
Access to Treatment or Drugs	**15**
Trust Administration	**10**
Other	**9**
Values & Behaviours	**7**
Appointments	**2**
Admissions Discharges	**1**
Information Governance	**1**



Due to the current COVID-19 crisis there was a pause on responding to complaints between April and June 2020 whilst staff focused on assisting with the pandemic.

Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During 2020/21 information was requested by the Health Service Ombudsman on two complaints. This has been supplied but no further action has been taken so these cases have been closed. No complaints referred to the Health Service Ombudsman have been upheld within the year.

We were advised by the Ombudsman that in view of the COVID-19 pandemic 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 Experience and Care Quality subcommittee and quarterly reports are provided to service leads to share with teams.

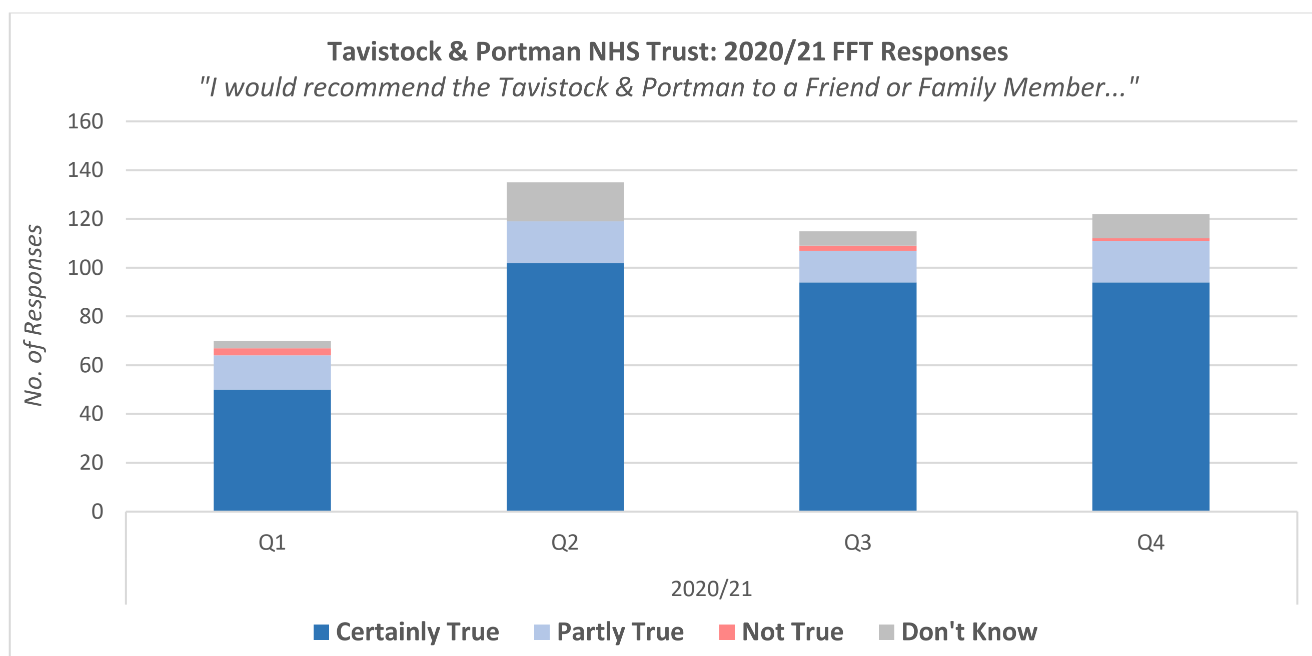
Due to COVID-19, as it was not possible to give Complaints presentations at Induction and INSET days, videos of the complaints presentation were made available to staff. Team meetings both within CYAF and AFS were attended via Zoom to talk to staff about the complaints procedure and how to advise patients who wish to make a complaint. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

Experience of survey questionnaire: friends and family test

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

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

Breakdown of 2020/21 Responses



Source: Quality Team, Data received and calculated: 07/04/2021

The Trust received a reliably positive response to the FFT questions over the course of 2020/21, with 91% of patients answering ‘Certainly True’ or ‘Partly True’ to the FFT prompt and only 6 negative responses returned over the course of the year.

Patient satisfaction

This information is included under reporting against core indicators covered on page 21.

National Staff Survey 2020/21

The NHS Staff Survey for 2020 took place between September – November 2020. All staff employed on 1 September 2020 were offered the opportunity to respond. Agency, bank, seconded out staff and students on placement are not offered the opportunity to participate (a separate bank staff survey was run in 2020 for the first time).

Since 2016, the Trust has used Picker Institute to run its NHS Staff Survey. In 2020, 26 Mental Health (MH) & Learning Disability (LD) and Mental Health, Learning Disability and Community trusts used Picker Institute to run their staff survey.

63% of eligible staff responded to the survey which is up from the level of participants the previous year (60% in 2019). The trust is above average for the mental health and learning disability trust which stands at 49%.

Significance Testing – 2019 vs 2020 Theme Results

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.7**	428	**8.4**	466	Not significant
Health & wellbeing	**5.7**	434	**6.0**	468	Not significant
Immediate managers †	**7.1**	435	**7.3**	468	Not significant
Morale	**6.2**	423	**6.1**	464	Not significant
Quality of care	**7.4**	343	**7.1**	382	Not significant
Safe environment - Bullying & harassment	**8.3**	432	**8.4**	447	Not significant
Safe environment - Violence	**9.5**	430	**9.8**	465	↑
Safety culture	**6.9**	427	**6.7**	464	Not significant
Staff engagement	**7.3**	439	**7.1**	470	Not significant
Team working	**7.1**	434	**6.9**	464	Not significant

The Tavistock & Portman NHS Foundation Trust has improved against its own 2019 figures in 4 of the survey's 10 themes:

- Health and wellbeing
- Immediate managers
- Safe environment - bullying and harassment
- Safe environment – violence

Looking below the main themes - other highlights:

- Direct line management interest in health and wellbeing has increased and is now at its highest since 2017.
- Support from line managers has increased.
- Satisfaction with flexible working patterns has increased.
- Number of staff who believe the trust takes action on errors and near misses has increased
- On a positive note, the number of staff who have indicated that they know how to report unsafe clinical practice has increased from 89.3% in 2019 to 93.5%
- However, it must be noted that the Trust is one of the poorest performing nationally on this indicator.
- Only 69.1% of staff say they would feel secure raising concerns about unsafe clinical practice (this has shown a steady decline since our high point of 78.0% in 2017).
- Crucially, the Trust is bucking the national trend which is showing a steady increase in staff feeling secure about raising concerns (the national 2020 figure is 72.5%, up from 71.7% in 2019).

Trust performance compared with other Mental Health Trusts

When measured against our comparator trusts, we were better than average in 3 themes:

- Health and wellbeing
- Bullying and harassment
- Violence against staff

And average for a fourth:

- Immediate managers

Trust performance has declined against its own 2019 figures in 6 of the survey's 10 themes:

- Equality, diversity and inclusion
- Morale
- Quality of care
- Safety culture
- Staff engagement
- Team working

When measured against our comparator trusts, we were below the average in all 6 of these themes.

'Friend and Family Test'

- The Trust is one of poorest performers in the recommendation as to a place to work, this score has dropped from 2018 at 71.4% to 63% in 2020
- We were one of only two MH Trusts which saw a drop in this score in 2020
- Despite some MH Trusts improving their score by 12% to 14% and with our score declining we remain in position 45 out of 54 Trusts

We take these results very seriously. 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.

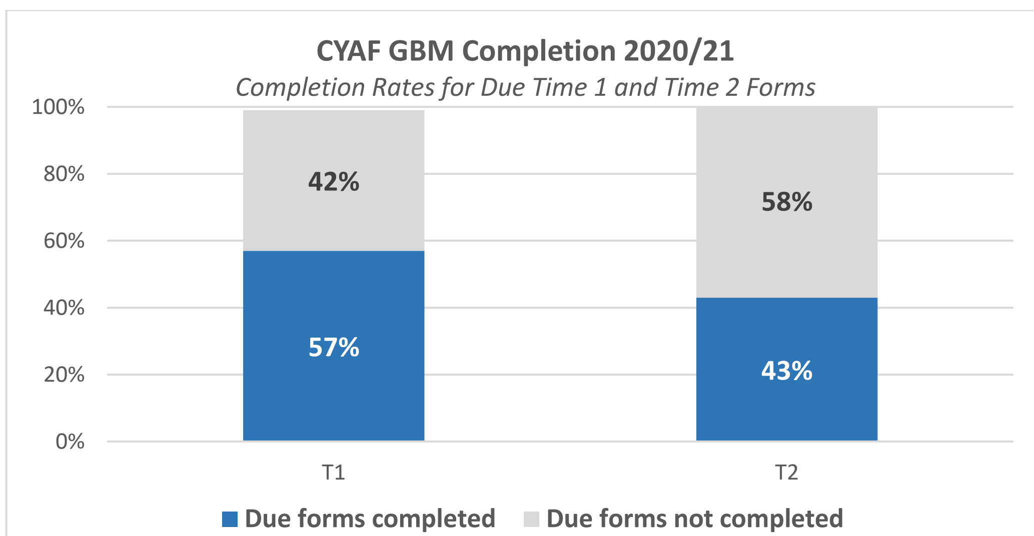
Outcome monitoring data

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

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 first time the patient agrees goals with their clinician, normally done at assessment and completed within the first two appointments. The GBM goals are agreed jointly between the clinician and the patient and reviewed after three months, or earlier if clinically appropriate. This is known as Time 2 and the information is scored to indicate whether the patient has 'improved', 'not improved' or there has been 'no change' in the achievement of their goals.

Over the last year we have adjusted the GBM logic to allow clinical teams to have earlier access to Time 2 GBM forms, and as result the time between completed forms is expected to decrease. As a result, the improvement rates from Time 1 and Time 2 could be less significant. Below we show the completion rates for open patients for the first form being completed (Time 1), second form being completed (Time 2).



The above graph shows us that a significant proportion of the GBM forms aren't currently being completed. Targeted work will be undertaken during the 2021/22 financial year to improve completion rates for OM forms. A Quality Priority project will run throughout the year looking at embedding meaningful use of outcome measures (see p.11), and the aim is to increase return rates by 25% by the end of the year.

	2020/21
% of qualifying Camden CAMHS patients who reported an improvement in their GBM scores from first to last completed form	**36.6%**

The improvement rates are taken from the first to last form in record (Time Last) and allow us to evaluate the whole patient's pathway. 36.6% patients in the year 2020/21 saw an improvement.

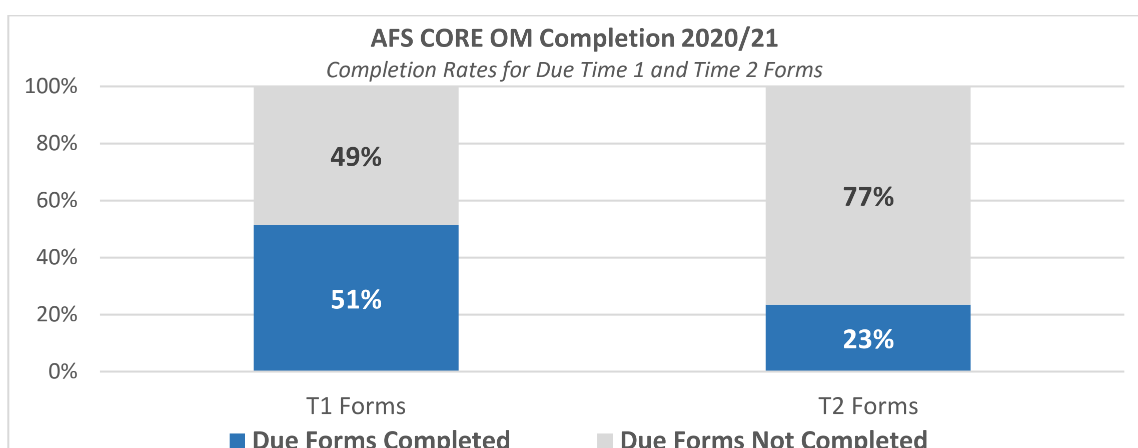
Adult services: Clinical Outcomes for Routine Evaluation (CORE) outcome monitoring for adult services

The main outcome measure used across all adult services (patients over 18 years old) is the CORE. This is designed to provide a routine outcome measuring system for psychological therapies covering four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm.

Over the course of 2020/21, new reporting tools were developed to allow us to have better insight into clinical outcomes for patients. We are, for first time, able to analyse completion rates **and** improvement rates. This brand-new report was used to produce the data below.

Whilst developing this new reporting tool and sharing data with clinical teams and service leads, there has been a gradual improvement over the course of the year in the number of patients who are completing multiple CORE OM forms by the time they are discharged – from 28% in Q1 to 36% in Q4. Increasing all OM return rates across all services is one of the goals for the outcome measures quality priority for 2021/22. Quality Improvement methodology will be used to achieve completion in all OM returns by 25% above the baseline by 31 March 2022.

	2020/21
% of qualifying patients who completed 'Time 1' CORE OM forms	51%
% of qualifying patients who completed 'Time 2' CORE OM forms	23%



Having patients complete multiple instances of the same OM form means that we are able to directly compare changes in score between their first and last completed form, which gives us good insight into the outcome of their treatment. Annual data for 2020/21 showed that 72% of patients who attended at least 2 appointments, and had at least 2 CORE OM forms completed at discharge experienced an improvement in their CORE score, which suggests good clinical outcomes for the majority of patients.

	2020/21
% of Discharged patients who reported an improvement in CORE score from first to last completed form	72%

In addition to the above, 26% of patients recorded a decrease in score and 2% of patients experienced no change in score from first to last completed CORE OM form.

Over the course of 2021/22 more work will be undertaken to further refine and improve upon this new reporting tool and to increase the reach of the reporting to ensure that clinical teams are routinely given insight into the outcomes associated with CORE OM forms.

Did not attend (DNA) rates

The National target is for DNA rates to be below 10% which the Trust has once again met this year, with an overall Trustwide DNA rate of 8.4% (incl. first and subsequent appointments). When looking at DNA rates for first and subsequent appointments separately, the DNA rate for first appointments was 8.7%; slightly higher than the DNA rate for subsequent appointments which was 8.4% for the year. All Trust DNA rates for 2020/21 are the lowest that they have been for the last 6 years access improved as a result of more of the interventions moving to online consultations.

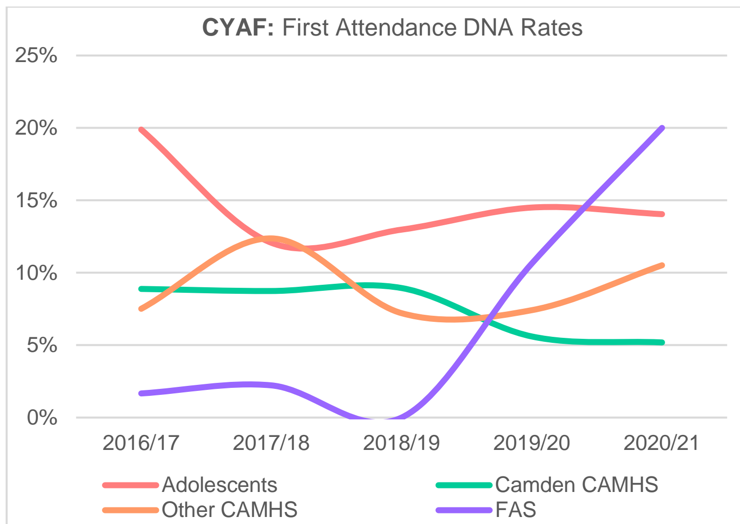
The outcome of all patient appointments is monitored to improve the engagement of patients, and where possible to minimise wasted NHS time. The Trust continues to offer choice concerning the times and location of appointments; emailing patients and sending them text reminders for their appointment, or phoning patients ahead of appointments as required. The Trust continues to work with clinical and administrative teams, support services and Quality Improvement groups to identify methods of further reducing DNAs.

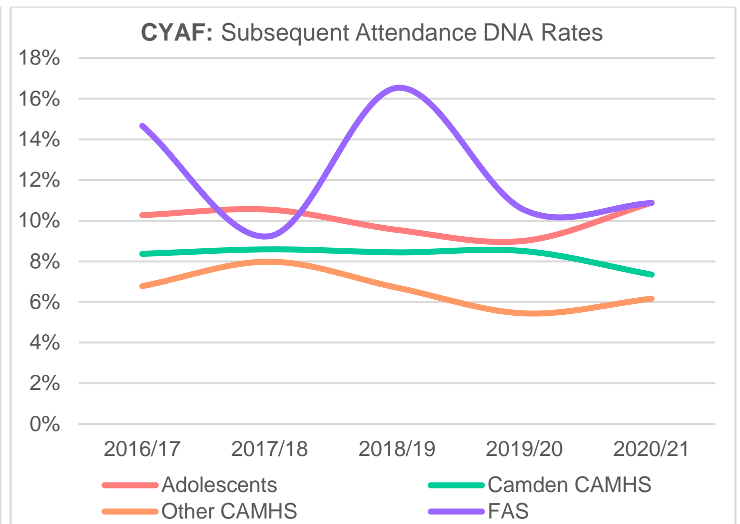
	2016/17	2017/18	2018/19	2019/20	2020/21
Trustwide Total					
First Attendance DNA %	11.3%	12.1%	12.2%	10.4%	8.7%
Subsequent Appointments DNA %	9.0%	9.7%	8.8%	8.8%	8.4%
Adolescents & Young Adult					
First Attendance DNA %	19.9%	12.1%	13.0%	14.5%	14.0%
Subsequent Appointments DNA %	10.3%	10.5%	9.5%	9.0%	10.9%
Adult Complex Needs					
First Attendance DNA %	17.9%	20.7%	23.2%	18.2%	19.8%
Subsequent Appointments DNA %	7.9%	9.4%	8.4%	8.0%	7.3%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)					
First Attendance DNA %	8.9%	8.7%	8.9%	5.6%	5.2%
Subsequent Appointments DNA %	8.4%	8.6%	8.4%	8.5%	7.3%
City & Hackney Primary Care Psychological Services (PCPCS)					
First Attendance DNA %	15.6%	18.6%	19.5%	21.3%	12.6%
Subsequent Appointments DNA %	12.8%	11.1%	8.9%	9.5%	9.9%
Family Assessment Service (FAS)*					
First Attendance DNA %	1.7%	2.2%	0.0%	10.6%	20.0%
Subsequent Appointments DNA %	14.7%	9.2%	16.5%	10.5%	10.9%
Gender Identity Clinic (GIC)					
First Attendance DNA %	10.0%	12.3%	11.5%	8.2%	11.6%
Subsequent Appointments DNA %	14.4%	14.7%	12.6%	12.8%	14.3%
Gender Identity Development Service (GIDS)					
First Attendance DNA %	12.8%	11.5%	13.4%	12.6%	6.2%
Subsequent Appointments DNA %	8.7%	10.2%	9.8%	10.2%	9.7%
Other CAMHS					
First Attendance DNA %	7.5%	12.4%	7.2%	7.4%	10.5%
Subsequent Appointments DNA %	6.8%	8.0%	6.7%	5.4%	6.2%
Portman					
First Attendance DNA %	6.3%	5.6%	8.7%	7.4%	6.4%
Subsequent Appointments DNA %	8.5%	9.4%	7.9%	10.5%	8.8%

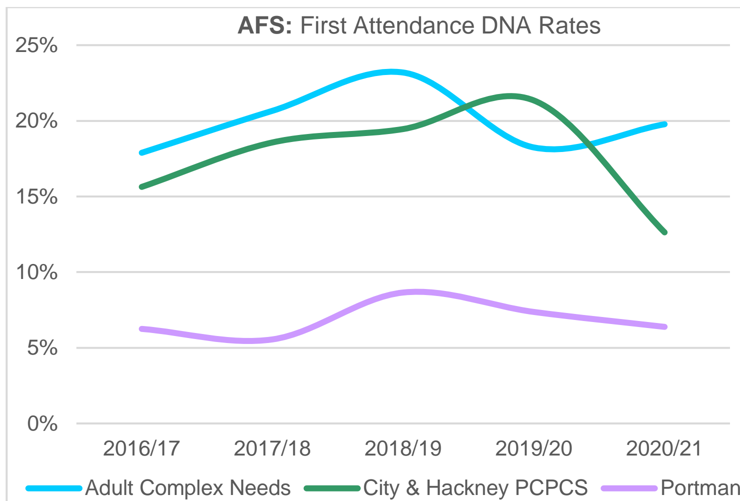
**Please note, the Family Assessment Service (FAS) closed in December 2020. The service undertook reduced activity over the year up to that point as a result of the Covid-19 pandemic and so each DNA had a significantly larger impact on the overall DNA rate; hence the higher than usual DNA rate for first attendances.*

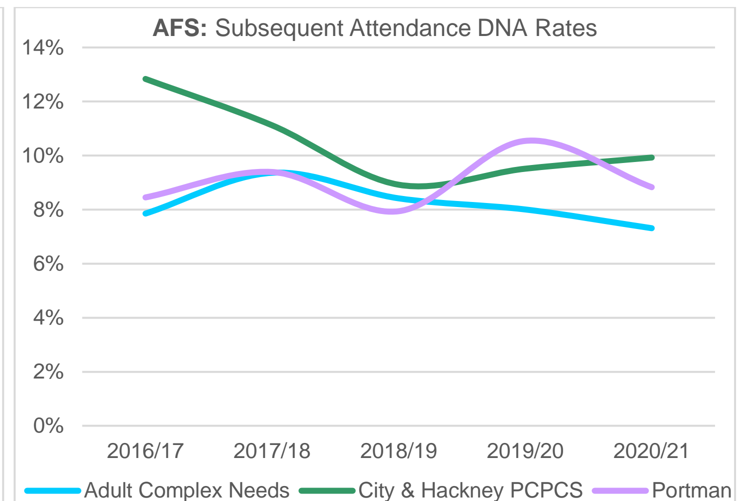
There was a decrease in the number of first appointments carried out across the Trust during 2020/21, with a corresponding decrease in DNA's from 10.4% last year to 8.7% this year.

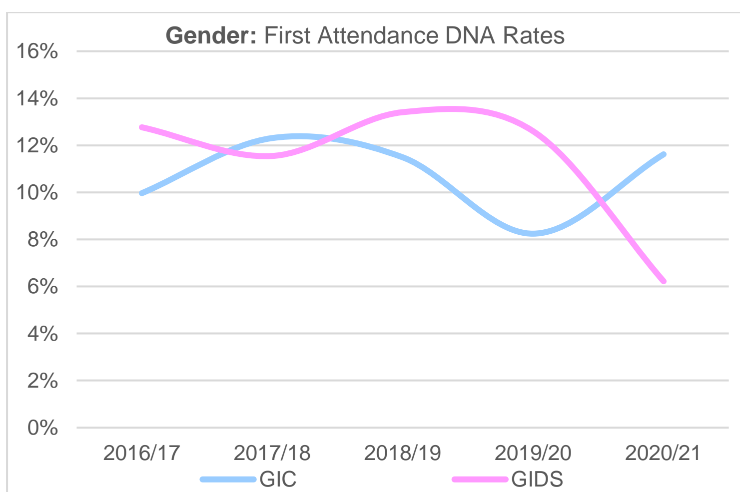
Although there was an increase in the number of subsequent appointments carried out across the Trust during 2020/21, there was actually a reduction in the number of DNA's for subsequent appointments from 8.8% last year to 8.4% this year. This is a good indicator that processes are being put in place to ensure that as little clinical time is wasted as possible.

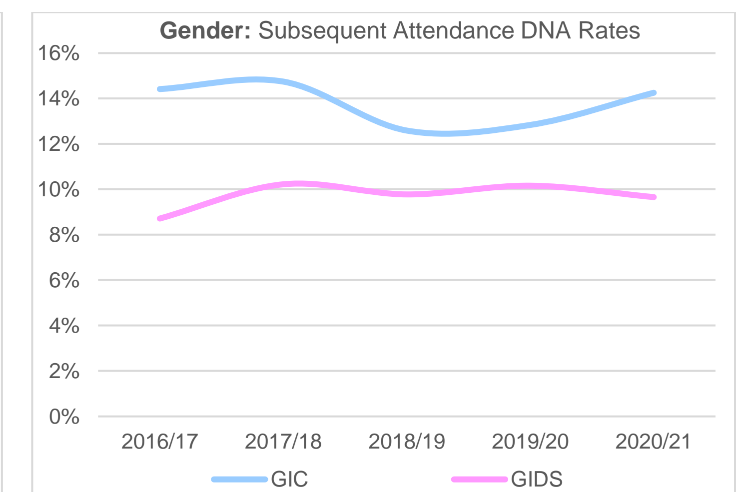












Definitions used for DNA's for percentages are as follows:
1st DNA(%) = Total 1st DNA / (Total First Attended + Total 1st DNA appointments)
Subsequent DNA (%) = Total sub DNA / (Total subsequent attended + Total subsequent DNA appointments)
Total DNA(%) = Total DNA / (Total Attended + Total DNA appointments

Waiting Times

Compliance with Waiting Time Targets for 1st Appointments

Two out of the Trust's eight clinical service areas increased compliance with waiting time targets. The greatest challenges continue to be in our gender services, owing to the number of referrals. The Trust undertook a Quality Priority project over the 2020/21 financial year that focused on reviewing Waiting Times across Trust services to better understand waiting times between teams and intake procedures. A focussed piece of work looking at demand, capacity and wait list management is ongoing within the Gender Services.

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.

Particular decrease in the Adult Complex Needs waiting time compliance this year was due to a number of factors. An increase in the number of first appointments attended during 2020/21 compared with 2019/20 combined with reduced clinical staff capacity and poor internal processes for patient referral allocation led to the decrease in compliance. Additional staffing resources were identified later in the year and internal processes have been updated to focus on meeting waiting time targets in this service.

		2017/18	2018/19	2019/20	2020/21
	Waiting Time 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**	**% Patients Seen for 1st Appt within Target**
Adult Complex Needs	*< 11 Weeks*	88.1%	73.7%	44.4%	31.7%
City & Hackney	*< 18 Weeks*	97.7%	98.6%	98.3%	96.5%
Portman	*< 11 Weeks*	99.0%	85.4%	94.3%	93.2%
Adolescent *(Under 18's)*	*< 8 Weeks*	74.2%	50.0%	52.8%	83.3%
Adolescent *(Over 18's)*	*< 11 Weeks*	86.2%	82.1%	73.6%	82.3%
Adolescent Total		83.8%	79.8%	70.9%	82.4%
Camden CAMHS	*< 8 Weeks*	96.6%	94.1%	95.7%	93.9%
Other CAMHS	*< 8 Weeks*	76.1%	72.4%	77.9%	75.4%
GIC	*< 18 Weeks*	4.9%	6.1%	5.8%	8.6%
GIDS	*< 18 Weeks*	21.3%	12.4%	12.7%	6.6%

Source CareNotes.13/04/2021

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:

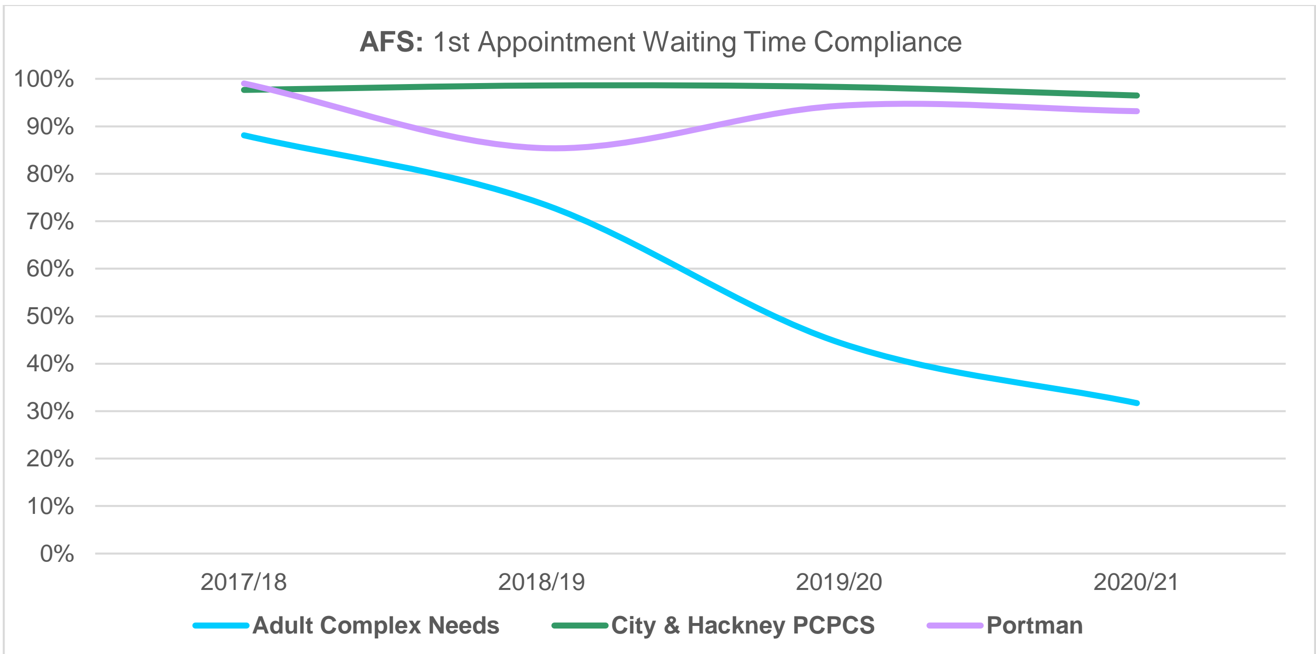
The numerator for the quarterly calculations is the sum of:

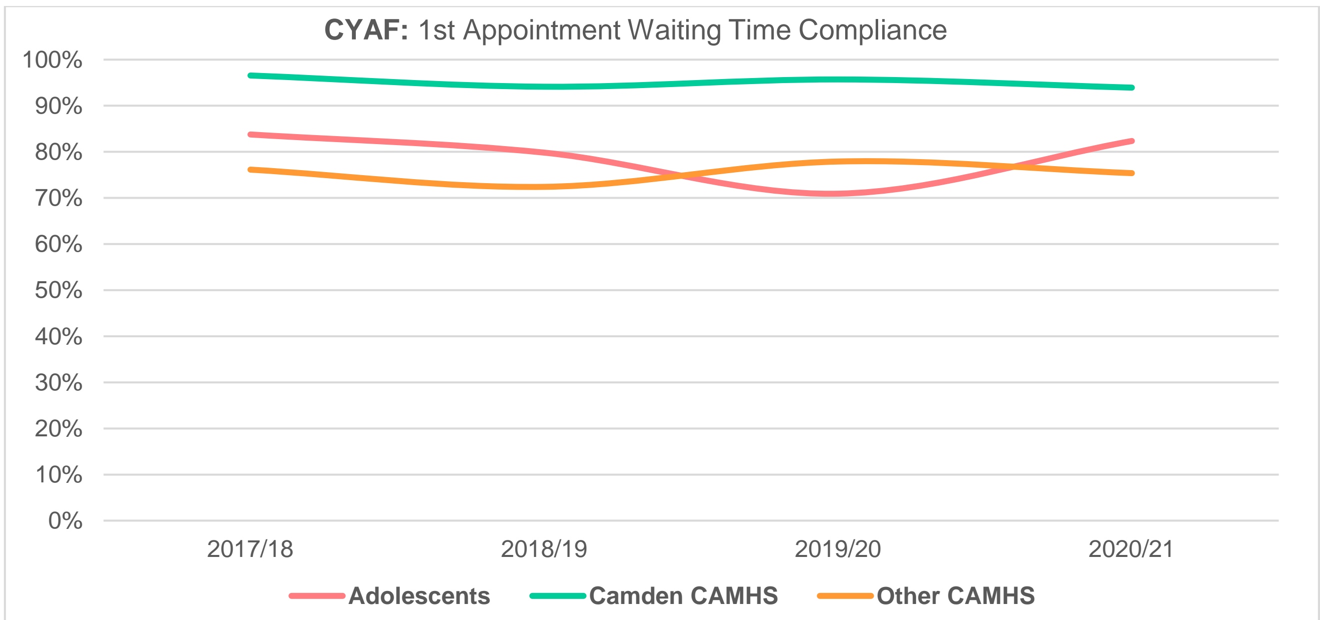
- Number (n) of referred patients who had attended a first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received;

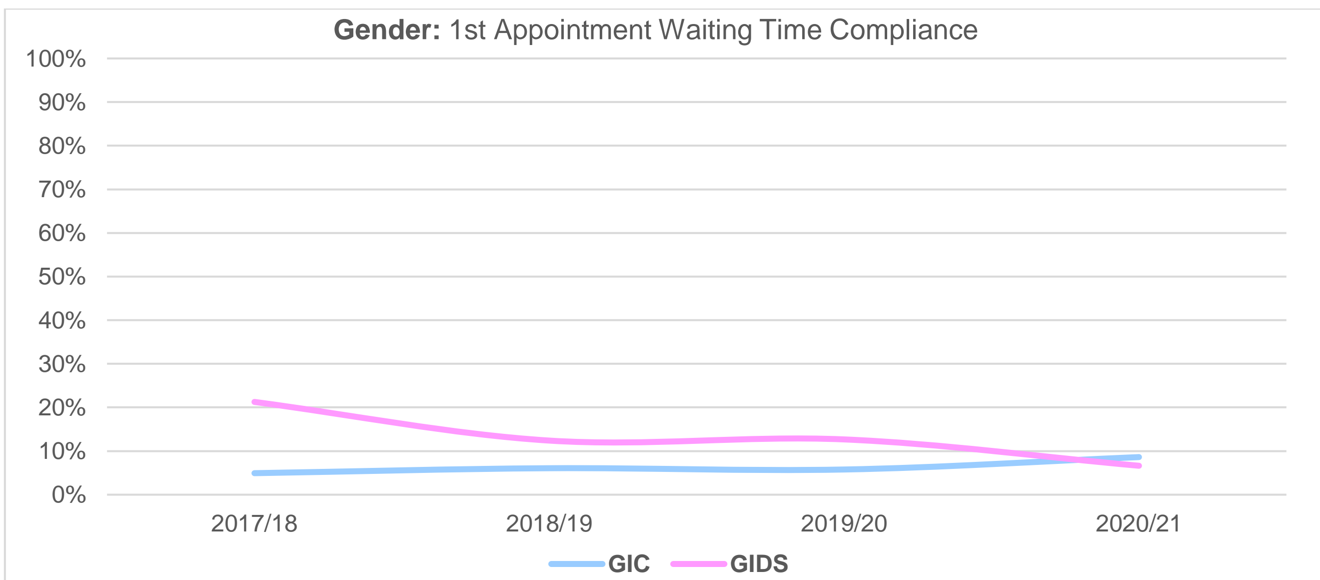
The denominator for the quarterly calculations of the indicator is the sum of:

- 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


AFS: 1st Appointment Waiting Time Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2017/18
2018/19
2019/20
2020/21
Adult Complex Needs
City & Hackney PCPCS
Portman


CYAF: 1st Appointment Waiting Time Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2017/18
2018/19
2019/20
2020/21
Adolescents
Camden CAMHS
Other CAMHS


Gender: 1st Appointment Waiting Time Compliance
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2017/18
2018/19
2019/20
2020/21
GIC
GIDS

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.

The Trust continues to thoroughly review its processes and systems for raising concerns. Although the freedom to speak up: raising concerns and whistleblowing procedures was updated back in 2019 the procedure will be reviewed again in 2021 with further amendments and changes as required. Following on from the national guardian’s office on good practice the trust continues to ring fence time for the role of FTSUG. 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. On 7th December 2020, Sarah Stenlake, took over from Dan Sumpton as the Trust FTSUG after he undertook the role for 1 year.

The trust was in the top ten of Trusts seeing the greatest overall decrease in our FTSU index score published by the national guardian’s office report in 2020. This index was based on a review of 4 questions in the NHS annual staff survey for 2020 which related to the percentage of staff "agreeing" or "strongly agreeing" that:

- their organisation treats staff who are involved in an error, near miss or incident fairly;
- that their organisation encourages them to report errors, near misses or incidents;
- that if they were concerned about unsafe clinical practice, they would know how to report it and
- that they would feel secure raising concerns about unsafe clinical practice.

These results were disheartening as the Trust strongly promotes a culture where people can feel able to speak up about any concerns they may have and there has been great amount of work undertaken by the FTSU role to support this position. A review of the same questions in the NHS annual staff survey results for 2020 also showed a general decline in how positively staff responded to the questions with a varying degree of percentage change and impact. The FTSUG index including CQC overall and well led ratings for the trust remain ‘Good’. The Trust acknowledges the findings and is seeking to understand the detail and work with staff across the Trust to take action to make a difference.

There were two whistleblowing complaints raised in the reporting period, both are currently ongoing investigations pending outcomes.

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 is something to be aimed for in all Trusts and needs a flexible approach; the pressures on staff working in different areas of the Trust constantly fluctuate and change and it is not always easy to anticipate and respond to perceived difficulties effectively. However, the Trust has a duty to try to learn from issues that are raised and to work 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. They are also a member of the London and East of England Regional Group. The national guardian’s office is now well established and arranges regular conferences and training events. The FSUG 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.

Staff Rota Information

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

In the latter part of the year the vacancies on our rotation for the Core Adult Psychiatry placements were delayed by one month due to the Covid 19 Pandemic. Following extensive work from our training programme director and working collaboratively with the London reginal team at Health Education England (HEE) the Trust has reached the finacial year end with no vacancies within our training allocation. The Trust will be going into the new financial year with no vacancies for the August 2021 rotation.

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

The SARS-CoV-2 (COVID-19) pandemic has presented unprecedented challenges to how we delivered our health and care services, bringing intense pressure and fundamental changes to systems, organisations and to all of us as individuals.

We have worked closely with the Tavistock & Portman NHS Foundation Trust, to ensure we have the right level of assurance regarding commissioned services, obtained through regular discussions with individuals, attending the Trusts Integrated Governance Committees and the Quality Improvement Group. The CCG welcomes the opportunity to provide this statement on the Trust's 2020/21 Quality Account.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to the CCG in May 2021). 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 (CQC) undertook a focused inspection of the Trust's Gender Identity Development Service (GIDS) in October 2020. The report, published in January 2021, rated the service 'inadequate', driven by 'inadequate' ratings for the responsive and well led CQC domains. The service was rated "good" for the caring domain, with patients and families interviewed by the CQC providing positive feedback about the understanding, compassion and kindness of staff.

Waiting times for initial appointments into the service is a key area of concern identified by the CQC. We are very pleased to see the responsive actions taken by the Trust in response to the CQC findings and the collaborative work underway with NHS England's Specialised Commissioners, who commission the national GIDS service.

It is reassuring to see the progress the Trust has made over the past 12 months, through the work of The Trust Race Equality Network and an Allies Forum as part of their commitment to improve staff experience among Black, Asian, Minority Ethnic (BAME) staff.

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 Feedback

Thank you very much for your commissioner statement and your continued support. We look forward to continuing to work with you over the next year.

Camden Local Authority Health and Adult Social Care Scrutiny Committee

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

Firstly, I would like to congratulate the Trust in maintaining many services in what has been such a difficult year due to Covid-19. It is incredible to read that more than 22,000 patient contacts were made in the past year, similar to pre-pandemic figures.

The report is well structured, and clearly sets out how the Trust performed against priorities in 2020/21. The report demonstrates the Trust acknowledges areas requiring improvement, and sets out plans to improve areas of concern.

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

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

The Quality Accounts listed the following priorities for 2020/21:

- focusing on enhancing patient safety and communications by standardising the use of Alerts on our electronic patient records;
- reviewing and updating our experience of service (ESQ) patient questionnaires with service users, to improve completion rates and provide richer qualitative data;
- improving waiting times across the Trust
- embedding the meaningful use of patient completed outcome measures

The accounts show significant progress was made in delivering on the priorities, in particular by achieving all indicators of success for the priority to update the experience of service patient questionnaire.

However, the lack of progress in reducing waiting times is concerning, it is reassuring to see this priority will remain for 2021/22.

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

It is concerning to read the Trust being one of the poorest performers in the recommendation as a place to work among staff, but encouraging to see the staff survey shows improvements in health and wellbeing.

The results of the staff surveys should be taken into consideration in trying to achieve the 2021/22 priority, to embed a revised job planning process, which aims to improve staff productivity.

Part 2.2 of the report that sets out the priorities for the coming year is clear.

3) Working collaboratively.

The report is full of interesting examples of working positively with patients. In particular the section on Co design and delivery with patients lists several projects detailing how the Patient Public Involvement (PPI) team are embedding meaningful PPI activity at service and local team level, as well as supporting service user co-designed and delivered workshops, information sessions and training.

NHS staff survey results show the Trust's performance on team working and staff engagement has declined. However, it is encouraging to see the Trust have continued to host the Pan London Involvement Forum, where mental health professionals come together to share best practice.

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

It is promising to see the Trust is committed to developing services to meet the needs of the communities it serves by refreshing the race equality strategy, and that a priority for 2021/22 is to improve race and equality data.

Healthwatch Camden

Confirmation that Healthwatch Camden will not be commenting on the Quality Accounts this year.

Statement from our Governors

These Quality Accounts evidence the commitment of the Trust, at all levels, to deliver and continue to improve its services at a time of significant challenge. The Council of Governors notes the real progress the Trust has made to meet its quality priorities and welcomes its honest appraisal of and plans for addressing those wider issues and concerns referenced in these Accounts.

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:

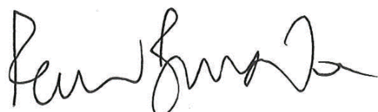
The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2010/20.

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 2020 to 31 March 2021
- papers relating to quality reported to the board over the period 1 April 2020 to 31 March 2021
- feedback from commissioners dated 12 May 2021
- feedback from governors dates dated 13 May 2021
- feedback from Healthwatch Camden dated 12 May 2021
- no feedback received from Health Scrutiny Committee
- the trust's complaints data published in the quarterly quality report. The annual complaints report will be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 on 27 July 2021
- the 2020 national staff survey 11 March 2021
- CQC inspection report dated 20 January 2021
- 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.

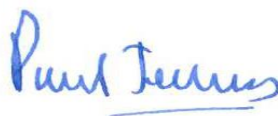
By order of the board



Rt Hon Prof Paul Burstow

Trust chair

9th June 2021



Paul Jenkins

Chief executive

9th June 2021

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 2021/22 Quality Accounts.

The Ta
stock Centre

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 were created under the Health and Social Care Act 2012. They 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 along with the commissioning of specialist and national services.

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

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

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

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

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

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

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

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

CGAS – Children's Global Assessment Scale

CYAF – Children, Young Adults and Families services.

CORE – Clinical Outcomes in Routine Evaluation

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

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

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

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

EMT – Executive Management Team

EPRS – Electronic Patient Record System

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

ESR – Electronic Staff Record

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 3 months, or at a later point in time).

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

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

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

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 NHS Resolution and the Care Quality Commission Standards for Better Health. It is a requirement for staff to either attend this training once every 2 years or to complete training using the staff electronic training system, as offered by the Trust.

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.

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

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

Level Up Project – A Youth Endowment Fund programme called Level Up – Safe Steps to Secondary School. A clinical team made up of psychologists and nursing staff have created an online platform that can seamlessly connect with parents and children to support children who are at risk of having a difficult transition from primary to secondary school.

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

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

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

MAST – Mandatory and Statutory Training

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

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

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

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

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

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

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

NCL – North Central London

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.

OM – Outcome Measure.

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

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

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

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

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

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

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

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

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

PPI – Patient & Public Involvement

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

PTSD – Post Traumatic Stress Disorder

QI – Quality Improvement

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

will we know that a change is an improvement? This concerns regular real time measurement, and (iii) What changes can we make that will result in improvement? This concerns the development of ideas to make improvement, and testing these.

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.

StEIS - Strategic Executive Information System

STP – Sustainability and Transformation Plan

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

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

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

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

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