The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 28 May 2019

1.30pm–3.55pm
Lecture Theatre, 5th Floor
Tavistock Centre,

120 Belsize Lane,
London,
NW3 5BA

The Tavistock and Portman
NHS Foundation Trust

AGENDA Part 1

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 28TH MAY 2019, 1.30pm – 3.55pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Items for discussion				
1.1	Freedom to Speak Up Guardian Report	Freedom to Speak Up Guardian	1.30pm	1
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Deputy Chair	2.00pm	Verbal
2.2	Board members' declarations of interests	Deputy Chair		Verbal
2.3	Minutes of the meeting held on 26 March 2019	Deputy Chair		2
2.4	Action log and matters arising	Deputy Chair		Verbal
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Deputy Chair and Non-Executive Directors	2.20pm	Verbal
3.2	Chief Executive Report	Chief Executive	2.30pm	3
3.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.40pm	Verbal
3.4	Quality Dashboard (Q4)	Director of Quality & Patient Experience / Associate Director of Quality & Governance	2.45pm	4
4 Items for decision or approval				
4.1	NHS Improvement Licence Self Certification	Director of HR & Corporate Governance	3.05pm	5

5 Items for information		Presenter	Timing	Paper No
5.1	Board Assurance Framework	Chief Executive	3.10pm	6
5.2	Serious Incidents Quarterly Report (Q4)	Medical Director	3.20pm	7
5.3	Guardian of Safe Working Report (Q4)	Medical Director	3.25pm	8
5.4	People Strategy Report	Director of HR & Corporate Governance	3.30pm	9
5.5	Annual Operational Plan – Review of outcomes 2018/19	Deputy Chief Executive / Director of Finance	3.35pm	10
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.40pm	Verbal
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.45pm	11
6.3	Training and Education Committee	Committee Chair	3.50pm	12
7 Any other business				
8 Date of Next Meeting				
	30th July 2019 – 1330 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 May 2019

Report from the Trust's Freedom to Speak up Guardian, April 2017 to date.

Executive Summary

This report is an update from the Trust's Freedom To Speak Up Guardian (FSUG) since the last report presented in March 2017.

Details include, first, an overview of the contact with staff and the concerns raised during that time as well as the role of the FSUG.

Secondly, the Board is asked to consider a number of issues that warrant further discussion at the in-depth review meeting on raising concerns which is due to be arranged shortly by the Trust's HR Director.

Recommendation the [Board / Committee]

The Board is asked to approve this report.

Trust strategic objectives supported by this paper

The Trust's strategic objective People 2 links to the role of the FSUG.

Author	Responsible Executive Director
Gill Rusbridger	Paul Jenkins

SERVICE LINE REPORT – TRUST WIDE

1. OVERVIEW OF THE SERVICE

1.1 The 2015 Francis Review recommended that all NHS Trusts should appoint Freedom to Speak up Guardians as an additional, confidential person available for staff to turn to if they wanted to raise concerns.

1.2 Our Trust Board appointed me to this role in October 2015, very soon after the Francis Review's recommendation. The FSUG is available to meet with all staff in the Trust, whatever their role and wherever they are based. Meetings can be held both in person and over the phone, and/or in a location that feels safe to the person wishing to speak. Most staff opt to come to meet me face to face in my room. Some staff have chosen to come as a group.

1.3 During the past two years staff have continued to contact me regularly to discuss concerns. I have met with staff from most service lines in the Trust, women and men, white and from BAME backgrounds. Sometimes a concern will arise in a particular service and a number of staff may consult with each other and come to see me either together or separately. On average, I continue to meet with 2- 4 staff members each month. No concerns were raised anonymously with me. During this time, all staff who contacted me reported an element of feeling not listened to or bullied by managers. There was an increase in some staff reporting an element of concern about patient safety in their wishing to speak up. This number peaked around the time of concerns in GIDS. This was partly due to a large group meeting that took place. Two staff reported that they would be concerned about speaking up again due to the perceived threat of possible repercussion.

1.4 The full records of my speaking up data since April 2017 can be seen on the National Guardian's office website under Speaking up Data.

1.5 On the whole, staff continue to be primarily concerned about feeling under pressure and not listened to by managers, rather than about issues concerning patient safety. Sometimes this may extend to feeling bullied and harassed and discriminated against. Staff are almost always very distressed about the breakdown in communication and wish to find a solution rather than to escalate the difficulty. They can be concerned about the impact that any issues between managers and staff may be having on patient safety and care, especially if staff feel they are not able to do their jobs effectively and with enough attention.

1.6 There have been two occasions when issues of patient care and safe practice have been more openly raised, although on neither occasion was a formal whistleblowing complaint made. One occasion was part of the concerns raised by staff in the TAP service, and another was part of the concerns raised by staff in GIDS. There have been no other formal whistleblowing complaints made during this time.

2. KEY INTERACTIONS WITH OTHER PARTS OF THE TRUST

2.1 As well as meeting with staff I arrange regular meetings with other staff in the Trust who are available to hear about staff concerns. These staff are mainly the same as those whom I detailed in my last report. It is very helpful to link with others in the Trust who have responsibilities for staff wellbeing and/or patient safety. Sharing information about what is currently being raised by staff is, I think, one of the most helpful ways to monitor organisational anxiety, and its impact on patient safety.

2.2 I keep in touch with Paul Jenkins, CEO and with Craig deSousa, Director of HR and Corporate Governance. I arrange regular meetings with Helen Farrow, Non-Executive Director as the FSUG link on the Board. Until recently, Helen and I also met together with Louise Lyon as both Director of Quality and Patient Experience and in her role as Chair of the Equalities Committee, until Louise's

change in role. I meet with Angela Haselton from Staff side and with Lisa Tucker and the Trust's Mental Health First Aiders. More recently, the Medical Director and I have spoken about arranging regular meetings together. I have also been making attempts contact with Sheva Habel in her role as the Trust's Guardian of Safer Working Hours for junior doctors and with Caroline McKenna as the Trust's Caldicott Guardian. I have regular contact with Sally Hodges and Julian Stern. I make a point of attending staff wellbeing and thinking space events and any Chief Executive question time meetings that Paul Jenkins arranges that relate to hearing about staff concerns and wellbeing.

2.3 I display posters in common areas and notice boards in the Trust and posters and leaflets are sent to other sites. A leaflet was attached to the payslip of all staff again earlier this year. An article about the role appeared in the Trust's *In Mind* magazine. Regular messages are sent via the Trust Intranet. I speak at Inset days and arrange to speak with managers and services.

2.4 I have made links with other FSUG's and the National Guardian. The National Guardian's office is now very well established and has become a very helpful and active channel for meeting and linking with other local and national FSUGs. There is an annual national conference, as well as regular meetings arranged with both a London FSUG group and one for Mental Health Trust Guardians, all of which I attend when I can. It has been helpful to share experiences with other FSUGs and to think about peer supervision and consultation. Many FSUGs are the only Guardian in their Trust, and there is recognition that we need support that is independent of one's Trust in order to remain neutral. This has the backing of the National Guardian. The role is positioned between staff and management and the Guardian has to be available for any and all staff to consult with. It is very important to try to remain impartial to all sides but holding this position can be difficult and unwelcome by both sides. I was able to use the National Guardian's helpline for support when thinking about best practice around staff wishing to raise concerns anonymously.

3. AREAS OF RISK AND / OR CONCERN AND RELATED ACTION PLANS

3.1 How the Trust might respond to concerns that are being raised.

3.2 This section is an opportunity to highlight two particular areas for further discussion, but I recognise the time limit for the Board and I envisage that we will discuss this section as part of the review currently being organised by the head of HR.

3.3 Our most recent 2018 staff survey reports that of the 60% of staff who responded, 71.5 % felt that they would feel secure about raising concerns about unsafe clinical practice. This score was just above the average for all Trusts (71.4 %) and close to the best score for Trusts (75.6 %). The survey indicates that our worst scores have centred around our BAME staff feeling discriminated against, and concerns about lack of career progression opportunities for BAME staff this year. Some structural changes have added to low staff morale and feelings of pressure due to the need to take on change. There is a perception of a management that at times is not listening, combined with an increased perception of criticism from both inside and outside the Trust. This means in my view that the Board and senior leadership group should be alert to the need for more frequent and varied communication with staff.

3.4 A group of staff raised a concern anonymously via a staff governor. It would be easy to feel attacked by complaints being raised anonymously. Anonymous complaints can be some indication of a group, or groups, of staff feeling unsafe in a climate of not being believed or dismissed. We have to accept that anonymous raising of concerns may at times be necessary and may happen again.

3.5 Staff need to feel free to raise concerns wherever and with anyone they feel safe to do so with. The Trust may need to be clearer about how these concerns go forward, if necessary, in a way that follows clear guidelines.

3.6 Concerns about patient care and freedom to speak up issues have for the first time been exposed to the press, and this has understandably caused enormous distress. I think we need to give more attention to how to be seen to welcome any raising of concerns, while at the same time defending the Trust's services.

3.7 I think that the majority of the concerns that have been raised continue to be about managers not listening or being perceived to be unable to respond to staff difficulties in a way that leads to resolution. Further mandatory training for middle management staff needs to be offered, perhaps as part of an induction for new staff and as a regular update for those already in post.

3.8 There is a continuing perception that there are some staff about whose behaviour it is not possible to raise concerns, as they seem immune or untouchable. This is something that needs further attention.

3.9 As always, a culture of easy and receptive listening and rapid response to staff raising concerns is the ideal. The Trust has been implementing many new initiatives to reach out and communicate to staff, and this needs to continue in both small and large ways. My impression is that following the raising of concerns about GIDS, many staff continue to feel worried about speaking in open groups, partly for fear of attack from within the Trust but also due to a fear of leakage to external sources. These beliefs are not based necessarily in reality but have a strong anxiety attached to them and changing perceptions may take much longer to work on.

4. ADDITIONAL CONSIDERATIONS FOR A NEW FSUG

4.1 The FSUG currently receives a stipend for carrying out the role. The CEO has given agreement for the role to be advertised as also having sessional time attached to it. I think that this will enable

the next FSUG to be more proactive in linking with all staff groups and managers on and off site than is currently possible.

4.2 I do not think that the Trust needs to employ more than one FSUG. It may be helpful however, to strengthen the link with some Mental Health First Aiders in the Trust, with whom some staff may find it easier to speak initially. This may also particularly apply to staff who are based outside the Tavistock Centre, who may be less sure about their knowledge of a FSUG who is based there.

4.3 I think that it will be helpful for the NED with responsibility for speaking up to be a more visible and approachable additional person for staff to use should they wish to. This has always been the case but it may be important to strengthen and promote this as it could help with staff understanding and recognising that someone at this higher level is also available to them.

Gil Rusbridger,
Trust Freedom to Speak up Guardian,
May 2019.

Board of Directors Meeting Minutes (Part 1)
26 March 2019, 1.30pm – 4.50pm

Present:			
Prof Dinesh Bhugra Vice Chair	Mr David Holt Senior Independent Director	Ms Helen Farrow Non-Executive Director	Dr Deborah Colson Non-Executive Director
Ms Jane Gizbert Non-Executive Director	Dr Rekha Elaswarapu Associate Non-Executive Director	Mr Paul Jenkins Chief Executive	Mr Terry Noys Deputy Chief Executive / Finance Director
Mr Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Dr Sally Hodges Director of Children, Young Adults and Family Services	Dr Julian Stern Director of Adult and Forensic Services	Ms Louise Lyon Director of Quality and Patient Experience
Dr Chris Caldwell Director of Nursing	Dr Dinesh Sinha Medical Director		
Attendees:			
Craig de Sousa Director of HR & Corporate Governance (notes)	Katie Argent Portfolio Manager (Item 1.2)	Bhavna Tailor Finance Manager (Item 1.2)	Marion Shipman Associate Director – Quality and Governance (Items 6.3 and 6.4)
Celestine Keise Governor			
Apologies:			
Prof Paul Burstow			

Actions

AP	Item	Action to be taken	Resp	By
1	2.3.1	Minor amendments to the minutes	CdS	Immed

1. Patient Experience Stories and Service Reports

1.1 Fraud Awareness Training

1.1.1 Ms Parker-Carn delivered a training session to all of the board members and specifically highlighted the types of risks and issues that they should be aware of specific to their roles.

1.1.2 The board of directors noted the training session.

1.2 Service Line Report – Psychoanalytical Applied Portfolio

1.2.1 Ms Argent, Ms Tailor and a student from course M7 were attendance for this item.

1.2.2 The presentation was opened by the student who shared their experiences of studying with the Trust. She particularly highlighted:

- That prior to studying with the Trust she had held a range of positions within women's refuges, art therapy, child protection services and CAMHS.

- The reflective nature of the courses she had attended had been of great benefit.

- The infant observation course was exceptionally beneficial.

- Tutor support and interaction was much greater than her previous experiences with other educational providers.

- The courses offer value for money, but there are hidden costs to participation.

1.2.3 Building on the students reflections, Ms Argent and Ms Tailor presented the report and emphasised:

- The courses do offer value for money and that many participants find the programmes worthwhile.

- Programmes within the portfolio are demanding.

- That work had been undertaken to develop blended learning approaches for the M7 course.

- The portfolio is keen to establish more blended versions of its courses and programmes to increase participation.

- That the portfolio performing in a consistent way, financially, and that further work is needed to increase student numbers.

1.2.4 Responding to Dr Sinha, Ms Argent noted that the portfolio's priority is to ensure that quality is maintained when developing blended learning approaches.

1.2.5 Mr Rock noted that the portfolio has done a lot of work assessing how it uses its people resources, specifically visiting lecturers. He emphasised that the focus has been to increase consistency of staff and also to maximise potential for succession planning using new roles.

1.2.6 Responding to a question from Ms Farrow, the student explained that some of the hidden costs of studying at the Trust include taking time out of the day job to attend and also the travel costs of coming to the centre.

1.2.7 Reflecting on a question from Mr Jenkins, Ms Argent noted that the portfolio offers a range of courses from access through to full qualifying programmes. Reflecting further, she noted that more work does need to be done to help prospective students identify the right course for them.

1.2.8 The board of directors thanked Ms Argent, Ms Tailor and the student and noted the report.

1.3 Service Line Report – Psychological Therapies

1.3.1 This item was deferred to a future meeting.

2. Administrative Matters

2.1 Chair's Opening Remarks

2.1.1 Prof Bhugra welcomed all of those in attendance.

2.1.2 Apologies were noted, as above.

2.2 Declarations of Interest

2.2.1 There were no interests declared for items noted on the agenda.

2.3 Minutes of the Previous Meeting

2.3.1 The minutes of the previous meeting were agreed as an accurate and true record, subject to minor amendments.

2.4 Action Log and Matters Arising

2.4.1 All of the actions on the log were noted as completed.

2.4.2 There were no matters arising.

3. Operational Items

3.1 Chair and Non-Executive Reports

3.1.1 Prof Bhugra reported that since the previous meeting he had delivered a presentation at a mental health conference in Sweden, with Dr Stern and Dr Yakeley. He also noted that he had attended a meeting of Hong Kong Psychiatrists.

3.1.2 The Board of Directors noted the report.

3.2 Chief Executive's Report

3.2.1 Mr Jenkins presented the report and particularly highlighted that the graduation event took place the Saturday prior to the board and that a number of other directors were also present. He emphasised that it was a very special occasion representing the achievements of both our students and faculty.

3.2.2 The board of directors noted the report.

3.3 Finance and Performance Report

3.3.1 Mr Noys presented the finance and performance report and particularly highlighted:

- The Trust had achieved a year to date surplus of £1.2m, being £486k positive to budget.
- Income was behind budget, accounted for by a lower than budgeted achievement of new business.
- Cost improvement programmes were positive to budget.

3.3.2 Responding to Mr Holt, Mr Noys noted that the Trust will be carrying approximately £2m on the balance sheet in to the coming financial year for the relocation programme.

3.3.3 In response to a further question from Mr Holt, Mr Noys noted that provider sustainability funding was allocated on a cash matching basis.

3.3.4 The board of directors noted the report.

4. Items for Decision or Approval

4.1 Trust Strategic Objectives

4.1.1 Mr Jenkins presented the draft objectives, highlighting that they had been developed by the executive management team following the October 2018 board away day. When approved the objectives will be used as part of the Trust's appraisal process.

4.1.2 Dr Hodges and Dr Sinha noted that in the coming year it would be important for the board to consider how to gain the contributions of wider staff when developing the future year objectives.

4.1.3 Responding to Mr Holt, Mr Jenkins noted that progress against the milestones will be reported to the board on a quarterly basis.

4.1.4 The board of directors approved the strategic objectives.

4.2 CQC Action Plan

4.2.1 Ms Lyon presented the action plan and highlighted:

- Following the production of an initial plan, the CQC inspection team had asked the Trust to develop the plan in more detail.
- The executive management team would review progress against the action plan on a monthly basis.
- The clinical, quality, safety and governance (CQSG) committee will receive quarterly reports on progress.

4.2.2 Dr Sinha noted that an important part of implementing the action plan is keeping staff engaged with the action plan. Dr Hodges noted that it would be helpful to establish quality forums for each of the service lines.

4.2.3 Responding to a challenge from Prof Bhugra, Ms Lyons noted that the board will receive reports on progress via the CQSG committee reports that are currently provided.

4.2.4 The board of directors noted the action plan and approved the reporting arrangements for the action plan.

4.3 Annual Operational Plan

4.3.1 Mr Noys presented the annual operational plan noting that the board had been provided with a draft version at the January 2019 meeting.

4.3.2 The board of directors approved the annual operational plan subject to the correction of a minor typographical error.

5. Items for Discussion

5.1 Gender Pay Gap Report

5.1.1 Mr de Sousa presented the statutory report and particularly highlighted that the results remain consistent with the previous year in the main reporting area but the bonus pay gap had decreased.

5.1.2 Responding to Mr Holt, Mr de Sousa noted that the pay gap report draws data from 31 March 2018 and that it is possible for the Trust to look at data for this financial year in around May 2019.

5.1.3 In response to a question from Dr Caldwell, Mr de Sousa noted that the Trust does employ a higher than average number of women in the top pay grades.

5.1.4 The board of directors noted the report.

6. Items for Information

6.1 Serious Incidents – Quarterly Update

6.1.1 Dr Sinha presented the update report and highlighted:

- That various internal report templates were being updated.
- A learning lessons event took place on 21 March 2019.
- An incident panel had been constituted and that in the future themes of issues would be reported to the CQSG committee.

6.1.2 The board of directors noted the report.

6.2 Research Strategy Update

6.2.1 Dr Sinha gave a verbal report on this item, he highlighted that a small research working group had been established to identify what activity was currently being undertaken across the organisation. He noted that following a further two meetings a set of recommendations would be developed how to take forward our research endeavours.

6.2.2 Responding to a question from Dr Caldwell, Dr Sinha noted that the group will look at the ambitions within the people strategy for increasing research capacity in the organisation.

6.2.3 The board of directors noted the update.

6.3 Board Assurance Framework

6.3.1 Mr Jenkins presented the framework and invite Ms Shipman to expand on the content. She particularly emphasised:

- There were no risks scored as 12 or above.
- Six risks were scored between two and ten.
- Two risks had reduced in score.
- Two risks had increased in score.
- A new electronic management system was being developed for the framework, which is anticipated to be ready in May 2019.
- The framework would be refreshed in July 2019 to reflect the risks against the new strategic objectives.

6.3.2 Responding to Mr Holt, Mr Jenkins noted that a number of our strategic risks relate to factors within the external environment,

6.3.3 The board of directors noted the board assurance framework.

6.4 Operational Risk Register

6.4.1 Ms Shipman presented the operational risk register and highlighted that item number 105 had been incorrectly categorised and should be red.

6.4.2 Responding to Ms Farrow, Ms Shipman noted that operational managers are responsible for scoring their risks against the standard matrix and noted that her team assist with consistent categorisation but more work could be done on this. Mr Jenkins noted that the new quality and performance review meetings would be a good forum to explore this in more detail.

6.4.3 The board of directors noted the operational risk register.

6.5 NHS Staff Survey Results

6.5.1 Mr de Sousa presented the paper and particularly highlighted:

- The Trust received a very high response rate with 60% of eligible staff submitted a survey.
- Whilst not being statistically significant, there were indications of a decline in our results from previous years.
- NHS England had changed the reporting format to give a better view on result trends.

- That our results indicate we need to do more to support and develop our middle managers.

- The Trust's HR business partners were currently working with senior managers to develop local action plans.

6.5.2 Dr Caldwell noted that a recent report from Listening in to Action confirmed the analysis that the small decline may indicate that unless we respond to the action we could see further decline in future years.

6.5.3 Responding to Ms Farrow, Mr de Sousa noted that members of the equality, diversity and inclusion (EDI) committee were exploring the result areas for specific protected characteristics.

6.5.4 Responding to Mr Holt, Dr Hodges noted that the increasing level of working hours was a concern. She emphasised that we have very many dedicated clinicians who do challenging work and that they are exceptionally committed.

6.5.5 Mr Jenkins noted that the new style of reporting was particularly helpful and has helped us understand in greater detail where some our challenges lie. He particularly noted that whilst we have high engagement, we need to give focus on how we improve moral.

6.5.6 The board of directors noted the report.

7. Committee Reports

7.1 Audit Committee

7.1.1 Mr Noys and Mr Holt presented the committee report.

7.1.2 The board of directors noted the report.

7.2 CQSG Committee

7.2.1 Dr Sinha presented the report from the committee.

7.2.2 The board of directors noted the report.

7.3 Education and Training Committee

7.3.1 Mr Rock noted that the recently scheduled meeting was not quorate. A meeting took place with members present, but no decisions were made. He highlighted:

- Since the committee meeting, the Trust had undergone a spot inspection from the Home Office in relation to its processes for recommending the award of Tier 4 (student) visas.

- A discussion had taken place about how to bring TSP closely in to the Trust.

- Ms Tanner, deputy director of education and training, would be retiring at the end of April 2019.

7.3.2 The board of directors noted the report and asked that their thanks be conveyed to Ms Tanner for her contribution to the Trust.

8. Any Other Business

8.1.1 Professor Bhugra noted that this would be Ms Gizbert's and Ms Elaswarapu's last board meeting and thanked them for their contributions.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	28 May 2019

Chief Executive's report

Executive Summary

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

Recommendation to the [Board / Committee]

The board is asked to [note / discuss this report

Trust strategic objectives supported by this paper

All Trust strategic objectives

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Louise Lyon

1.1 In the wake of her decision to step down from her current role as Director of Quality and Patient Experience, this will be Louise Lyon's last Board meeting. I would like to put on record appreciation of the very significant contribution Louise has made to the work of the Board and the Trust, most notably in recent times in leading our preparations for inspections by CQC, supporting the introduction of quality improvement into the organisation and leading our work on the Race Equality Strategy and other equalities issues.

1.2 I am very pleased that Louise will be continuing at the Trust to lead work on our preparations for the Tavistock Centenary and the work to consolidate the Tavistock charities.

2. GIDS Review Action Plan

2.1 The GIDS Review Action plan was published on 29th March and work has started to implement its recommendations. The GIDS project manager and team members have developed a framework to complete the recommendations in the review covering:

- Pathways & Complex Pathway
- Audit & Metrics
- Waiting List
- Quality Forum ToR
- Clinical quality
- Effectiveness
- Outcomes and Audit
- Safeguarding
- Induction & Consent
- Physical Interventions, fertility + support with protocols on pair working and cross supervision
- Dialogue / collaboration with NHSE

2.2 A GIDS Quality Forum has been established and will meet shortly. The forum will have oversight of the programme of audit work recommended by the Review to look into consistency of practice across the service and address unwarranted variation. The forum will also provide an overview of all serious incidents and complaints in the service.

2.3 Work is also progressing with pulling together operational clinical protocols across the service with the aim of producing a dynamically updated operational protocol.

2.4 Progress on the implementation of the Action Plan is being overseen by the GIDS Task and Finish group. A full report will be made to the July meeting of the Board of Director.

3. Senior Management Changes

3.1 On 30th April I announced changes in senior management arrangements in the Trust following the decisions of Louise Lyon and Julian to step down from their current Board roles.

3.2 As part of these:

- Sally Hodges will extend her role and take overall responsibility for the management of all our clinical services. To reflect this extension in her role Sally will take the title of Chief Clinical Operating Officer.

- In carrying out this role Sally will be supported by three Divisional Directors responsible for Adult and Forensic Services, Children Young Adult and Families Services and Gender Services. The Divisional Directors will report to Sally but will attend the Trust Board in their own right.

- Dinesh Sinha will take on a wider brief for quality within the organisation including leadership on both quality assurance and quality improvement and he will have responsibility for leading the Trust in taking the steps we require to secure an overall outstanding rating from CQC. Chris Caldwell will work with him on quality improvement and will take on responsibility for patient engagement and involvement.

- Craig de Sousa will take over the Executive Lead for work on Equalities and Diversity including the leadership of work on the Race Equality Strategy.

- Given the importance of our work on the development of new opportunities Rachel Surtees, our Director of Strategy will also attend the Board.

3.3 Recruitment processes for the substantive Divisional Director roles are progressing but as a short-term measure I am asking Ailsa Swarbrick to take up an interim role for Gender Services with particular responsibility for taking forward the delivery of the GIDS Review Action Plan.

4. Stress and Resilience Framework

4.1 As part of their work programme, the National Workforce Skills Development Unit has developed a Stress and Resilience Framework to help address issues around mental health and wellbeing in the NHS workforce. The framework takes a holistic approach with a focus on organisational responses and understanding the impact of the work rather than just looking at individual resilience.

4.2 The Framework was published by HEE on 4th April to coincide with a well-attended national conference for Sir David Behan HEE's Chair was the key note speaker.

4.3 The Unit has been identifying a number of organisations across the NHS who are interested in testing the Framework. We are in the process of agreeing which teams in the Trust will pilot the Framework.

5. Charities

5.1 As I have previously reported we have been exploring the scope to bring together the two charities related to the Trust: the Tavistock and Portman Charitable Fund and the Tavistock Clinic Foundation to create a new charitable vehicle which we could use to expand charitable work related to the Trust's mission. The aim would be to align the launch of a new charity with the arrangements to mark the centenary of the Tavistock Clinic.

5.2 On 30th April Trustees both charities met and agreed to recommend to their respective Boards a decision to merge the charities. The discussion was informed by a paper produced by Bates Wells Braithwaite a specialist firm of charity lawyers on the options for taking forward such a merger. The paper is attached as an annex to this report.

5.3 The paper was separately considered by the Tavistock and Portman Charitable Fund Committee on 16th May which endorsed the decision and recommends it to the Board of Directors as Trustees of the Charitable Funds for endorsement.

Paul Jenkins
Chief Executive
20th May 2019

Annex A – Merger of Tavistock and Portman Charitable Fund with the Tavistock Clinic Foundation

PROPOSED MERGER WITH TAVISTOCK CLINIC FOUNDATION

Query	Proposed Response
1 How should the merger be structured?	Option 1, that is the creation of a new incorporated entity
2 What will the objects of the merged charity be?	The objects will be those noted in paragraph 4.3 of the BWB paper, that is: *"For the prevention, relief, treatment and cure of sickness, ill health and infirmity of every kind of mental health and infirmity of every kind of mental health and well-being and, in particular, but without prejudice to the generality of the foregoing, to pay or apply the same in furthering or supporting the work of* ***the Tavistock and Portman NHS Foundation Trust*** *in any ways which shall for the time being be charitable."* It is the Trustees understanding that these objectives would allow the charity to fund research and education and training activities. Further, it is the Trustees understanding that these objectives would allow the charity to fund any activities of the Tavistock and Portman NHS FT ("Trust"), provided that these activities were charitable in nature and not part of the core activities undertaken by the Trust
3 Who will be the Trustees of the merged entity?	It is proposed that the merged / new charity will have up to 10 trustees of whom half will represent the interests of the Trust and the other whom who shall be independent of the Trust. A Trustee who is independent of the Trust shall be anybody who works for

	no more than one day a week at the Trust. A Trustee who represents the Trust shall be anybody who works for more than one day a week at the Trust. The Chair of the board of the Trustees shall not be a Trustee who represents the interests of the Trust.
4 What will be the name of the merged charity?	The Tavistock and Portman Charity
5 Following the merger, will the transferor charities be retained as shell charities?	Yes, for an initial period of two years, at which point the matter will be reconsidered
6 Will the new charity be a company limited by guarantee or a charitable incorporated organisation?	Further advice to be sought
7 Should the incorporated entity be structured as a foundation model or an association model?	On the foundation model

Subject to the Trustees of both TPCF and TCF agreeing to the above, BWB are to be asked to progress the work on the merger.

The Trustees are also asked to note that, once the new charity has been created, the Trustees of TPCF will need the permission of the Department of Health for the merger to go ahead.

Merger of the Tavistock Clinic Foundation and the Tavistock and Portman Charitable Fund

Options paper for discussion at the "Futures of the Charities" meeting on 30 April 2019

1. Introduction

1.1 It is proposed that the Tavistock and Portman Charitable Fund ("**T&PCF**") and the Tavistock Clinic Foundation ("**TCF**") should merge and become one charity.

1.2 T&PCF and TCF are both currently unincorporated charities governed by Trust Deeds.

1.3 This note sets out a list of the questions which the trustees and representatives of T&PCF and TCF should discuss at the "Futures of Charities" meeting on 30 April 2019.

1.4 In particular, there are there are two possible options for structuring the proposed merger:

(a) **Option 1**: Set up a new incorporated charity and then transfer the assets and liabilities of both of the unincorporated charities into the new incorporated charity; or

(b) **Option 2:** Transfer the assets and liabilities of one of the unincorporated charities into the other and then, going forward, the merged charity would continue to be structured as an unincorporated charity.

2. Questions to consider at the "Futures of the Charities" meeting

We have set out in this note, a list of questions on which a consensus will need to be reached in order for us to begin work on the process of merging the two charities. We have listed each of these questions (without the subsequent explanation) at **Appendix 1**, for ease of reference.

3. Q1: Should the merger be structured in accordance with Option 1 or Option 2?

3.1 Option 1: Set up a new incorporated entity and merge both existing charities into the new entity

3.1.1 Option 1 is to set up a new incorporated entity (either a company limited by guarantee or a charitable incorporated association) and then transfer the assets and liabilities of each of the unincorporated charities into the new incorporated entity.

Advantages of Option 1

3.1.2 At present, both T&PCF and TCF are structured as unincorporated charities. This means that they have no separate legal identity and therefore that the trustees of the charities could be personally liable if anyone made a claim against the charity which is worth more than its total assets.

3.1.3 A company limited by guarantee (CLG) or a charitable incorporated organisation (CIO) is an incorporated entity with its own separate legal personality. This would mean that the new charity could hold assets and liabilities in its own name. If anyone were to bring a claim against the new charity, the claim would be made against the CLG /CIO as opposed to the individual trustees. If the CLG/CIO did not have sufficient reserves or insurance to meet a claim, it would become insolvent. The trustees would be shielded from liability except where it can be shown that they had breached their duties as trustees. It is also easier for CLGs/CIOs to enter into contracts, such as a contract to provide services, or receive funding, because a CLG/CIO can enter into the contract in its own name (as it has separate legal personality).

3.1.4 Operating as an incorporated entity, is a particular advantage for charities which are carrying out more risky operations such as working directly with beneficiaries, carrying out public fundraising or entering into corporate sponsorship arrangements.

Disadvantages of Option 1

3.1.5 The disadvantage of proceeding with Option 1 will be that it will be a more time consuming and expensive process than Option 2 because we will need to set up a new entity and register the new entity with the Charity Commission and it will be necessary to carry out two transfers (and therefore two sets of due diligence) in order to transfer the assets and liabilities of each of the unincorporated charities into the new entity.

Estimated legal costs for Option 1

3.1.6 We estimate that our costs for implementing Option 1 will be in the region of **£9,250 to £10,250 plus VAT**. This will include our fees for approaching the Charity Commission for consent to amend the objects of T&PCF (and TCF, depending on your decision in relation to Question 2) but not for entering into protracted correspondence with them in relation to this amendment, and for drafting the Deeds of Variation to amend the existing Trust Deeds of T&PCF and TCF.

3.1.7 A summary of the process for implementing Option 1 is set out in **Appendix 2** of this note.

3.2 <u>Option 2: Merge the Tavistock and Portman Charitable Fund into the Tavistock Clinic Foundation</u>

3.2.1 Option 2 is to merge one of the unincorporated charities into the other existing charity. The merged charity would then continue to be structured as an unincorporated trust.

3.2.2 We assume that it would make most sense to transfer the assets and liabilities of T&PCF into TCF because TCF is the larger charity (it holds the most assets).

Advantages of Option 2

3.2.3 The advantage of Option 2 is that it is a simpler process than Option 1 because there is no need to set up a register a new entity and there will only need to be one

transfer agreement. This will mean that the process will be quicker and less expensive.

Disadvantages of Option 2

3.2.4 The disadvantage of Option 2 is that it will mean that following the merger, the charity will continue to operate as an unincorporated charity. This will mean that it will have no separate legal personality and therefore that the trustees of the charity could be personally liable if anyone made a claim against the charity which is worth more than its assets. It will also be unable to hold assets or enter into contracts in its own name.

Estimated legal costs for Option 2

3.2.5 We estimate that our costs for implementing Option 2 will be in the region of **£4,750 to £5,750 plus VAT**. This will include our fees for approaching the Charity Commission for consent to amend the objects of T&PCF and TCF, depending on your decision in relation to Question 2) but not for entering into protracted correspondence with them in relation to this amendment, and for drafting the Deed of Variation to amend the existing Trust Deed of T&PCF.

3.2.6 A summary of the process for implementing Option 2 is set out at **Appendix 3** of this note.

4. Q2: What will the objects of the merged charity be?

4.1 The existing objects of the two charities are set out in **Appendix 4** of this note.

4.2 We recommend basing the objects of the charity following the merger broadly on the existing objects of TCF, because TCF's objects are more flexible and wide-ranging than the existing objects of T&PCF. We expect that these objects will be sufficiently broad to capture any activities which you may wish the merged charity to undertake because the objects will allow for the charity to carry on any work related to the prevention, relief or treatment of poor mental health. In particular, the inclusion of "prevention" makes these objects relatively broad.

4.3 You may wish to make a small tweak to the existing objects of TCF in order to replace the words "Tavistock Clinic" with "Tavistock and Portman NHS Foundation Trust (as set out below) in order to be explicit that the funds of the charity can be used for any elements of the Trust's work (which we understand is nowadays broader than just the Tavistock Clinic, for example, it now encompasses the work of the Portman Clinic):

"For the prevention, relief, treatment and cure of sickness, ill health and infirmity of every
kind of mental health and infirmity of every kind of mental health and in particular, but
without prejudice to the generality of the foregoing, to pay or apply the same in furthering or
supporting the work of ***the Tavistock and Portman NHS Foundation Trust*** *in any ways*

which shall for the time being be charitable."

4.4 However, it is not strictly necessary to make this change to the wording because the words "without prejudice to the generality of the foregoing" allow for the charity's funds to be used in any way relating to the relief and treatment of illnesses relating to mental health (which would naturally include all aspects of the Tavistock and Portman NHS Foundation Trust's work).

4.5 In order to ensure that any unrestricted funds held by the two existing charities can continue to be held on an unrestricted basis following the merger, it will be necessary to:

(a) Apply to the Charity Commission for its consent to amend the objects of T&PCF. This will be the more contentious application as it will amount to a significant broadening of the charity's objects – which are currently focussed "wholly or mainly" on the Tavistock and Portman clinics; and

(b) If you wish to make the small tweak to the wording of TCF's objects, in order to refer to the "Tavistock and Portman NHS Foundation Trusts" rather than the "Tavistock Clinic", it will also be necessary to apply to the Charity Commission for its consent to amend the objects of TCF. We anticipate that this will be a relatively straightforward application as we will simply need to explain the ways in which the work of the Tavistock Clinic has developed since the TCF was established in 1982 and the fact that the work of the Tavistock Clinic and the Portman Clinic is now both carried out under the umbrella of the Tavistock and Portman NHS Foundation Trust.

4.6 In terms of timescales, we recommend allowing up to three or four months for the Charity Commission to deal with an application for consent to amend a charity's objects.

5. Q3: Who will be the trustees of the merged charity?

5.1 At present, the Tavistock and Portman NHS Foundation Trust is the sole corporate trustee of T&PCF.

5.2 TCF's trustees are Margaret Rustin, Louise Lyon, Amanda Hawke, Craig de Sousa, Angela Greatley and Ailsa Swarbrick.

5.3 If you decide to proceed with Option 1:

(a) It will not be possible for the NHS Foundation Trust to be the sole corporate trustee of merged charity. Companies must have at least one natural person as a director (and in the near future, a law will come into effect which means that there can be no corporate directors of companies).

(b) If there will be a degree of overlap between the trustees of the merged charity and the current trustees of TCF, we may need to apply to the Charity Commission for a s105 order in order to authorise conflicts of interest relating to the merger transfer. It is important that you inform us

who the trustees of the merged charity will be as soon as possible so that we can make a timely request to the Charity Commission.

6. Q4: What will be the name of the merged charity?

6.1 This is a strategic question rather than a legal question. If you would like any advice on how best to protect the name and brand of the merged charity, then we can put you in touch with our trademarks team.

7. Q5: Following the merger, will you retain the transferor charities as shell charities?

7.1 Following a merger, the options are to either:

(a) Retain the transferor charity as a shell charity; or

(b) Register the merger on the Register of Mergers and then wind up/dissolve the transferor charity.

7.2 We note from the 2017/18 accounts of both of the unincorporated charities, that each of the charities receives some income through legacies, for example, T&PCF received a legacy of nearly £150,000 in May 2018.

7.3 The effect of registering a merger on the Register of Mergers is that "*any gift which is expressed as a gift to the transferor and takes effect on or after the date of registration of the merger, takes effect as a gift to the transferee" (s311 Charities Act 2011).*

7.4 However, this is not a failsafe means of ensuring that legacies left to the dissolved charity can be received by the merged charity because Wills are sometimes drafted in a way which specifically states that the named charity must still be in existence. There can also be problems if testators choose to list a "back up" charity as a recipient in the event that the original chosen charity has ceased to exist.

7.5 Therefore, given that the unincorporated charities have both historically received significant funds from legacies, we would recommend retaining the transferor charity (or charities) as a shell charity in order to best mitigate the risk of losing out on future legacies.

7.6 In order to retain the transferor charity (or charities) as a shell charity, we will need to:

(a) Ensure that the transferor retains a nominal sum of money (around £100); and

(b) Amend the constitutions of the shell charity in order to appoint the merged charity as its sole trustee and to allow for it to transfer any received legacies to the merged charity.

7.7 There will be some additional administration involved with keeping the shell charity (or charities) in existence; however, we think that this additional burden is

worthwhile given the risk of losing out on potentially significant sums of money from future legacies.

8. **Q5: <u>If you decide to proceed with Option 1</u>, would you prefer for the new charity to be a company limited by guarantee or a charitable incorporated organisation?**

8.1 Both CIOs and CLGs are incorporated legal forms. Both have separate legal personality and both forms offer limited liability status.

8.2 A CIO is a bespoke vehicle for charities and has been designed with charities in mind. CIOs are only regulated by the Charity Commission.

8.3 CLGs are subject to dual regulation from both the Charity Commission and Companies House and are subject to company law.

8.4 We can provide you with further information about the differences between a CIO and a CLG, if that would be helpful. We do not think that there are any obvious benefits to choosing one of the incorporated legal forms over the other in these circumstances and therefore it will likely to come down to which form of entity the trustees and employees of the new charity will be most comfortable with administering.

9. **Q6: <u>If you decide to proceed with Option 1</u>, should the incorporated entity be structured as a foundation model or an association model?**

9.1 CLGs and CIOs have a two-tier governance structure with members and trustees. The trustees are the people with overall responsibility for the day to day management and control of the charity.

9.2 Members have few obligations under the Companies Act or the CIO Regulations, but have ultimate control of the charity through their rights to attend, speak and vote at general meetings and certain decisions reserved to members, such as changing the constitution. Members also have a statutory power to remove directors. These members' rights are set out in statute and cannot be taken away.

9.3 The trustees and members of a CLG or CIO can be the same of different people. Where they are the same, this is referred to as a "foundation model" and where there is a different membership (typically a wider membership) it is referred to as an "association model".

9.4 A foundation model (where the trustees are also the members) would be simpler to manage and administer than an association model. A foundation model provides for an efficient governance structure, allowing the trustees to appoint their successors and decisions reserved to members to be taken by the same individuals in their capacity as members.

9.5 Our understanding is that the existing charities do not currently have a wider membership and therefore we expect that a foundation model will be the most appropriate model for the merged charity.

APPENDIX 1 – LIST OF QUESTIONS

1. Should the merger be structured in accordance with Option 1 or Option 2?

2. What will the objects of the merged charity be?

3. Who will be the trustees of the merged charity?

4. What will be the name of the merged charity?

5. Following the merger, will you retain the transferor charities as shell charities?

Questions relevant to Option 1 only:

6. Would you prefer for the new charity to be a company limited by guarantee or a charitable incorporated organisation?

7. Should the incorporated entity be structured as a foundation model or an association model?

APPENDIX 2 - SUMMARY OF THE PROCESS FOR OPTION 1

By way of a high level overview of the process, we would need to take the following steps:

1. Set up a new incorporated entity and register it with the Charity Commission. In order to achieve this, it will be necessary to:

   (a) Decide on a name for the new charity;

   (b) Decide who will be the trustees of the new charity;

   (c) Draft governing documents for the new charity; and

   (d) Complete the Charity Commission online application form to register the new charity. It is difficult to predict how long the Charity Commission will take in order to process this application. Some applications are processed within one to two weeks whereas others can take between four to six months.

2. Apply to the Charity Commission for consent to amend the objects of the existing charities to the same objects as the new charity. It can take around three to four months to obtain the consent of the Charity Commission.

3. Draft Deeds of Variation in order to amend the Trust Deeds of T&PCF and TCF in order to add an explicit power to merge (the consent of the Charity Commission is not required for these changes).

4. Carry out due diligence on TCF and T&PCF in order to ascertain which assets and liabilities are held by the charities and will need to be transferred over to the new incorporated entity. Review any contracts held by the unincorporated charities to check whether any consents will be required to novate the contracts over to the new entity.

5. Draft two transfer agreements in order to transfer across the assets and liabilities:

   (a) From TCF to the new entity; and

   (b) From T&PCF to the new entity.

6. If a majority (or more) of the trustees of TCF will also be trustees of the new charity, apply to the Charity Commission for a s105 order to authorise the conflicts of interest in relation to any indemnities which will be provided by the new entity to the trustees of the unincorporated charity.

7. Hold a TCF trustee meeting in order to approve the draft Transfer Agreement and resolve to carry out the transfer. The Tavistock and Portman NHS Trust (as sole corporate trustee of T&PCF) will pass a resolution to approve the Transfer Agreement and resolve to carry out the transfer.

8. Hold a trustee meeting of the new incorporated entity in order to approve the draft Transfer Agreement and resolve to accept the transfer.

9. Complete the transfer deed and carry out any post-transfer formalities such as changing bank accounts and novating contracts across to the new entities.

10. Amend the Trust Deeds of both of the unincorporated charities in order to make the new entity their sole corporate trustee. This will allow the unincorporated charities to be retained as shell charities in order to collect legacies.

APPENDIX 3 – SUMMARY OF THE PROCESS FOR OPTION 2

By way of a high level overview of the process, we would need to take the following steps:

1. Apply to the Charity Commission for consent to amend the objects of T&PCF (and TCF, depending on your decision in relation to Question 2). It can take around three to four months to obtain the consent of the Charity Commission.

2. Decide who will be the trustees of TCF after the merger and draft any necessary deeds of appointment and retirement in order to appoint the new trustees.

3. Draft a Deed of Variation in order to amend the Trust Deed of T&PCF to add in an explicit power to merge;

4. Carry out due diligence on T&PCF in order to ascertain its assets and liabilities which will need to be transferred over to TCF. Review any contracts held by T&PCF to check whether any consents will be required to novate the contracts over to the new entity.

5. Draft a transfer agreement between TCF and T&PCF in order to transfer across the assets and liabilities of T&PCF to TCF.

6. The Tavistock and Portman NHS Trust (as sole corporate trustee of T&PCF) will pass a resolution to approve the Transfer Agreement and resolve to carry out the transfer.

7. Hold a trustee meeting of TCF in order to approve the draft Transfer Agreement and resolve to accept the transfer.

8. Complete the transfer deed and carry out any post-transfer formalities such as changing bank accounts and novating contracts across to the new entities.

9. T&PCF adopts an amended Trust Deed in order to make the trustees of TCF its trustees and to allow for T&PCF to be retained as a shell charity in order to collect legacies.

APPENDIX 4 – EXISTING CHARITABLE OBJECTS

Objects of the Tavistock Clinic Foundation

1. For prevention, relief, treatment and cure of sickness, ill health and infirmity of every kind of mental health and in particular, but without prejudice to the generality of the foregoing, to pay or apply the same in furthering or supporting the work of the Tavistock Clinic in any ways which shall for the time being be charitable.

2. **Objects of the Tavistock and Portman Charitable Fund**

   For any charitable purpose or purposes relating to the National Health Service, wholly or mainly, for the services provided by the Tavistock and Portman clinics.

The Tavistock and Portman NHS Foundation Trust

Board of Directors: May 2019

Report to	Date
Board of Directors	May 2019

Quality Dashboard and Commentary

Executive Summary

Introduction

The purpose of this report is to provide a summary and narrative for quarter 4 quality metrics, identifying key trends and where possible, triangulating data from various sources. Key points are highlighted by Directorate, with Gender services being presented separately owing to their size. Staff data has been updated in the Quality Well-Led section. Team Around the Practice (TAP) data has been provided and is included.

A number of new graphics have been included in the Commentary section of the report, including waiting times and DNA run charts to view data over time and support discussions. Service data is presented by directorate – AFS; CYAF and Gender Services. Summary action plans for how services are managing issues with waiting times are included. This information was previously included in a separate Seen Waiters Analysis report – presented on a six monthly basis.

There are also two new graphics which present performance and staff data together, 'comparative waiting time data and sickness rates', and 'waiting time compliance against the number of referrals received'.

Finally, Quality Priority and CQUIN information for the full year is presented under section 2.7 and 2.8 of the Commentary section. It is proposed that summaries only are provided in Q1-3 reports.

Gender services

- Referral rates remain high in both GIDs and GIC services and continue to impact on the waiting time to first appointment. Both services continue to actively recruit staff help reduce timescales. There was an 8% increase in patients seen in GIC between 2017/18 and 2018/19 (3980 cf 4305) with 1.2% increase in GIDs (2685 cf 2717).
- Q4 also saw a slight increase in DNA rates in GIC. SMS appointment reminders continue to be sent to patients who give consent in both services, with an increase in reminders within GIDs. GIC has mapped out a new appointments system which should help.
- GIC saw a small resurgence in complaints relating to 'access to treatment' and 'waiting times' in Q4 n=11 compared with 6 or fewer in Q1-3. There has been a lot of positive feedback about the services from patients.

CYAF services (CAMHs/Other CAMHS)

- There has been a 23% increase in the number of patients seen in Adolescent services this year (275 vs 338 in 2017/18) compared with 3.2% increase in 'Other Camhs' services. Waiting times in both services remain above target with some variation in other services. There is an ongoing pilot in Adolescent services to try and reduce

waiting time breaches and a similar project in 'Other Camhs'. Both services have seen a decrease in DNAs which is positive for patient engagement, but has reduced the number of new patients seen.
- CYAF complaints relating to waiting times and access to treatment increased in Q4 = 17, compared with Q3 = 12; Q2 = 3 and Q1 = 7.

Adult & Forensic Services (AFS)
- Waiting time performance in the Portman increased in Q4 but declined further in Adult Complex Needs. This was due to a significant number of referrals for which information is awaited and capacity issues due to sickness and maternity leave.
- DNA rates have increased to 20% for the TAP service. It is difficult to accurately link this to any specific issue. The service has undertaken an extensive liaison with other, local services and continues to build relationship links to increase service integration.
- There are few (≤6) complaints across any of the AFS services in a quarter although a significant number of PALS enquiries are received concerning the Adult Complex Needs service.

Comparative waiting time information
Information is presented showing waiting time compliance against sickness levels. As compliance has decreased over the past 3 quarters, sickness rates have increased. Availability of staff has an effect on the availability of appointment slots.

Information is also presented showing waiting time compliance against referrals received. In Q2 we saw a drop in referrals and corresponding positive impact on waiting time compliance. Conversely in Q3 and Q4 we have seen increasing referrals and subsequent increase in waiting times.

Communications / Media
The Trust has seen a slightly lower volume of overall print media coverage in Q4 compared to Q2 and 3 however, the sentiment has been slight more positive (80% cf 76% Q3). The Engagement Rate for our twitter accounts is higher this quarter than last.

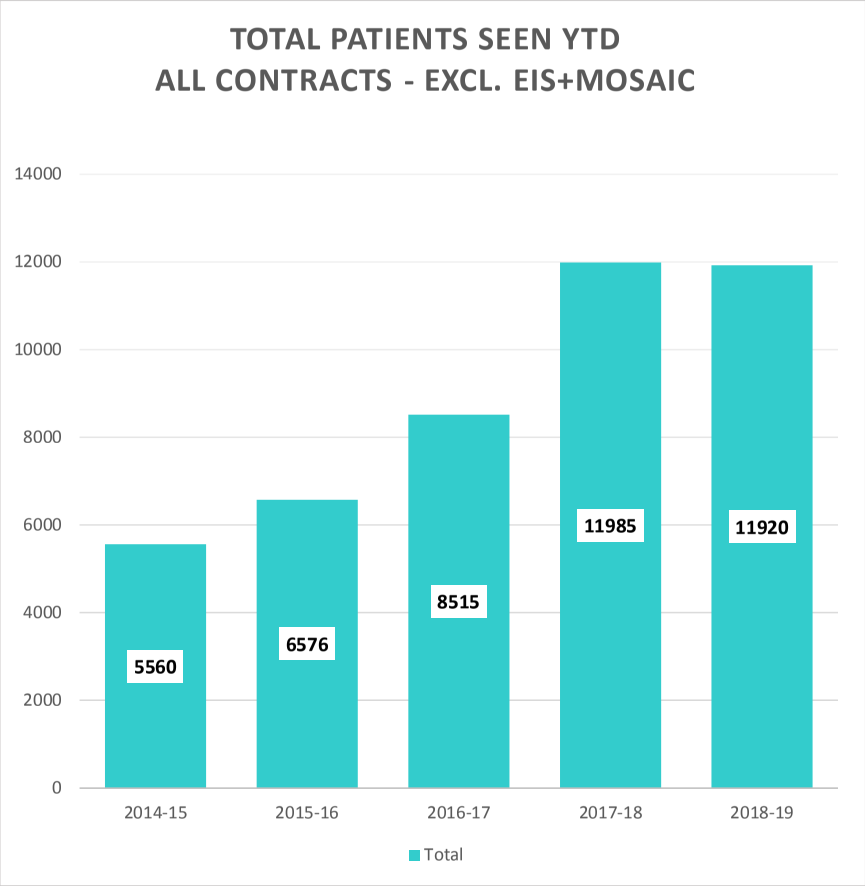
Department of Education and Training
The next student survey opened 24th April 2019

This report was reviewed by the Clinical Quality and Patient Experience Workstream Meeting.

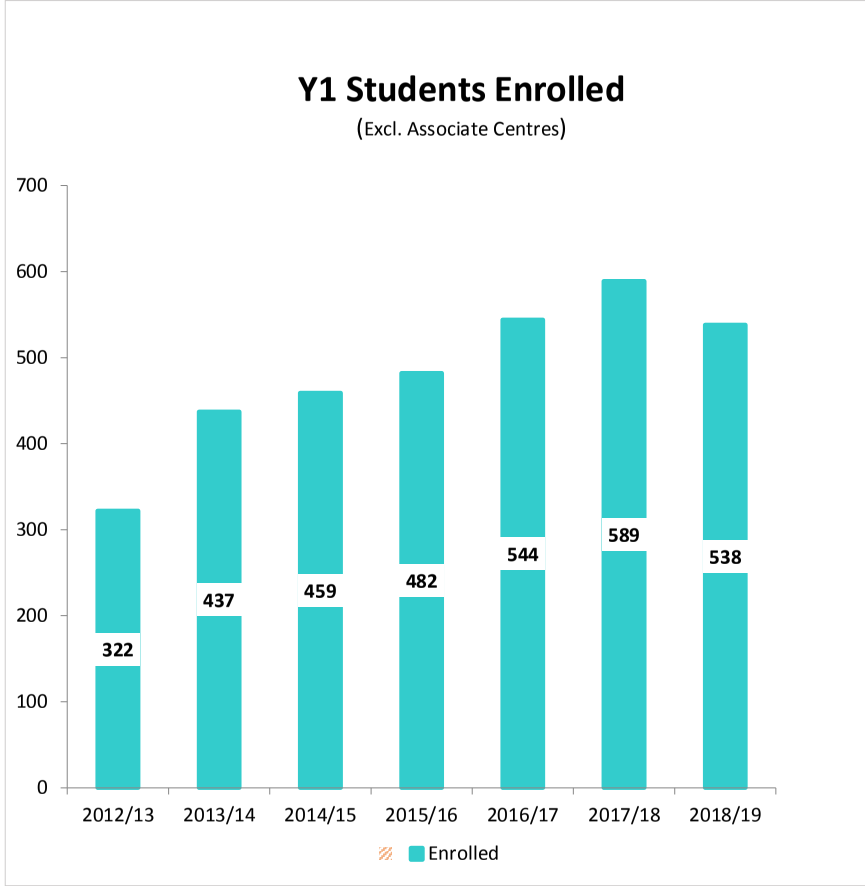
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.
Trust strategic objectives supported by this paper
Finance and Governance

Author	Responsible Executive Director
Associate Director Quality and Governance, Data Quality Manager and Data Officer	Director of Quality and Patient Experience

Q4 2018/19: Trust Reach



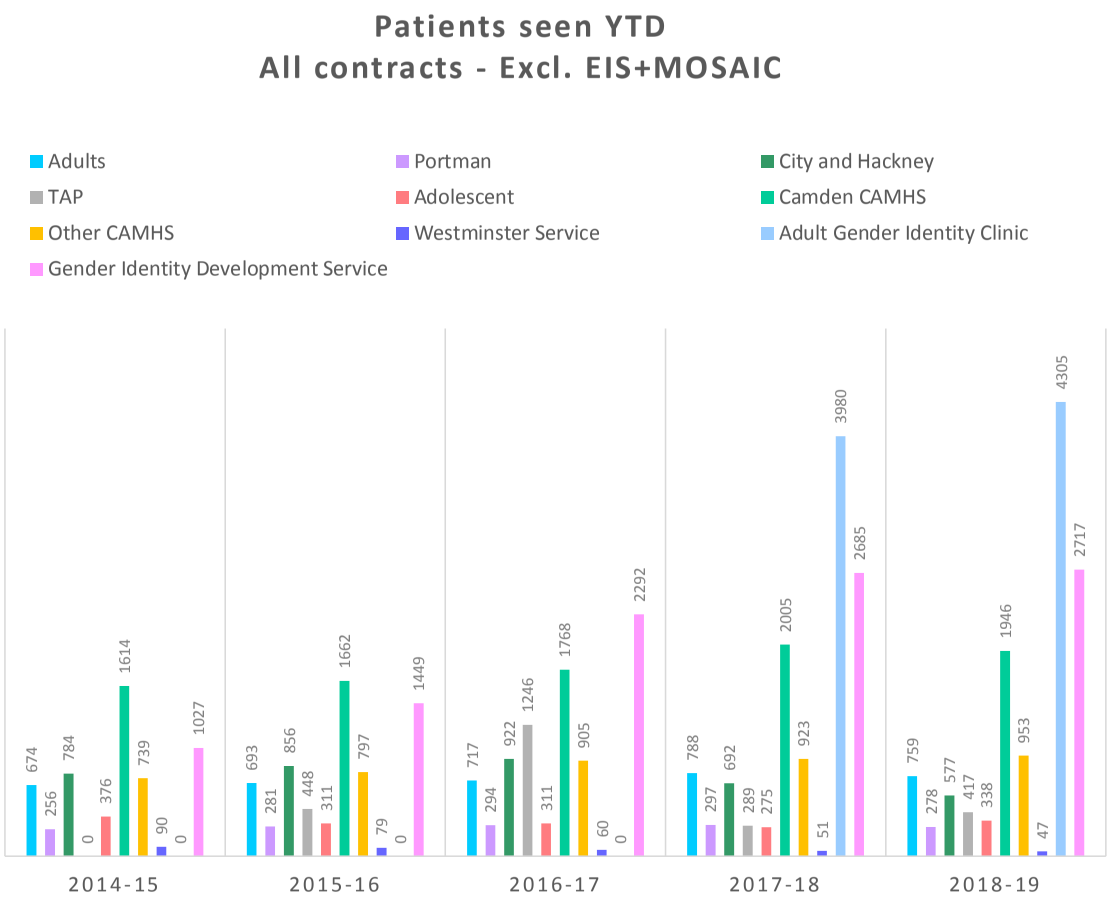
Data source: Data warehouse, informatics team. 15/04/2019
Telephone appointments that are listed as an appointment with significant work done with the patient

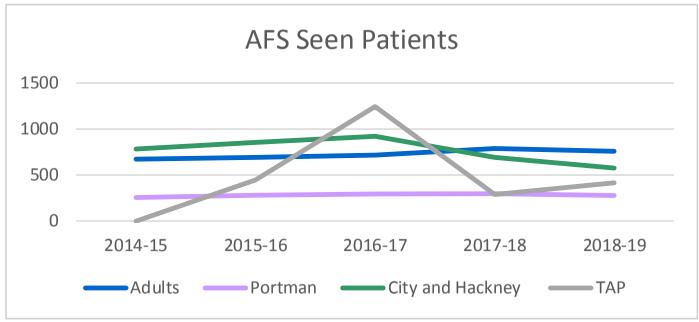


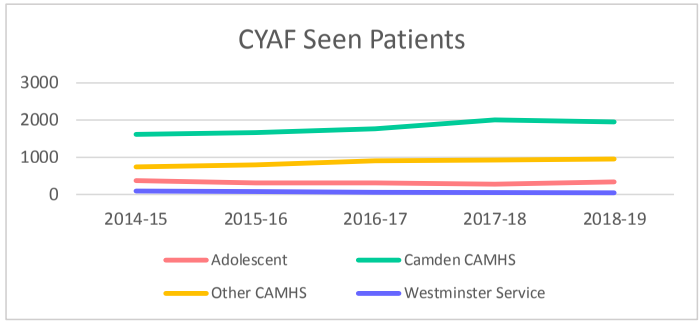
Data source: DET There are 5 students on PRV status (Provisional) i.e. not yet fully enrolled. The Trust has also seen a slight decrease in 2018/19 academic year (October 2018 to August 2019) in the number of students enrolled on its courses owing to some students withdrawing since the start of enrolment.

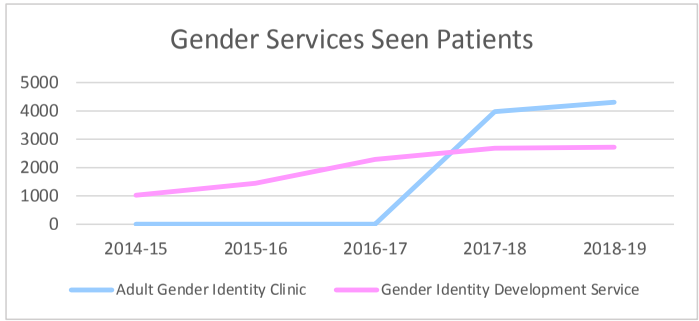
1

Q4 2018/19: Trust Reach



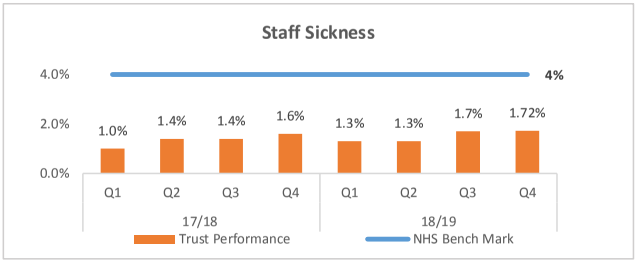


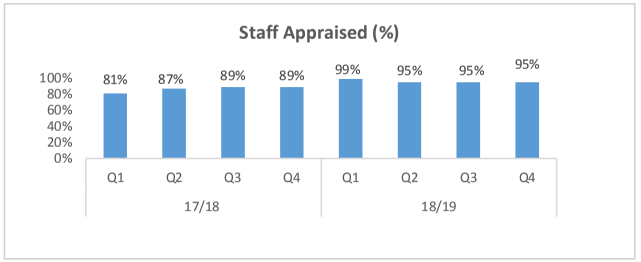


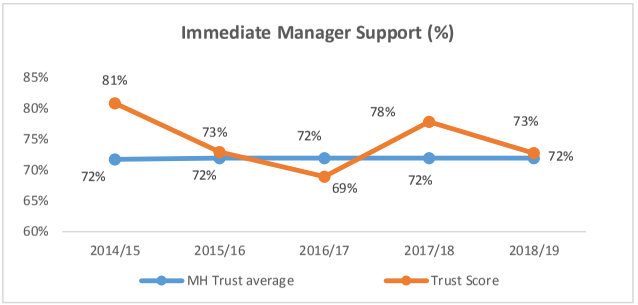


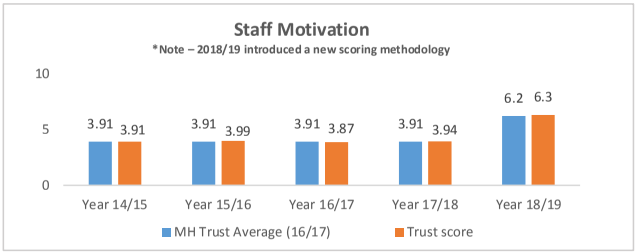
Data source: Data warehouse, informatics team. 15/04/2019
Telephone appointments that are listed as an appointment with significant work done with the patient

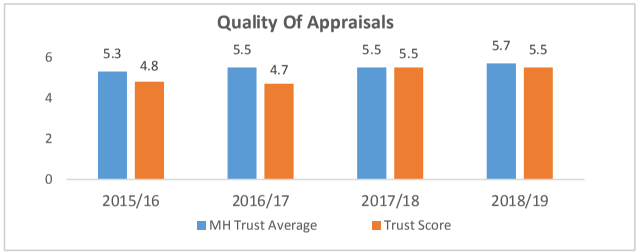
Q4 18/19: Quality Well-Led

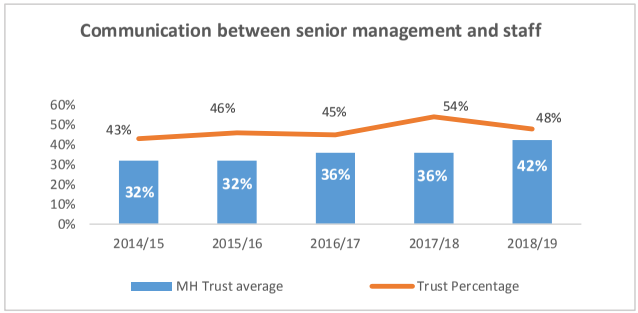


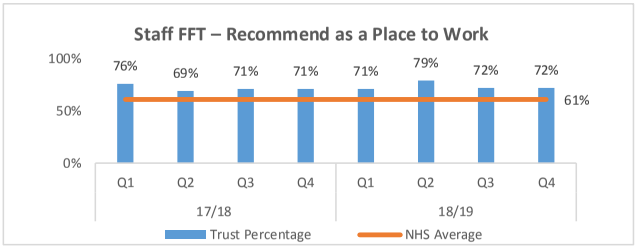


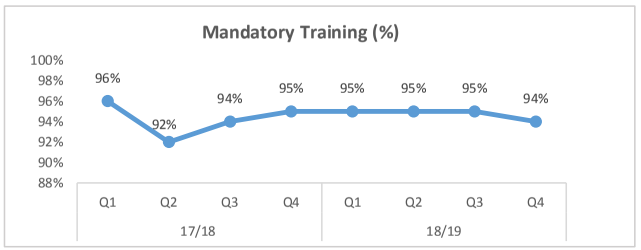


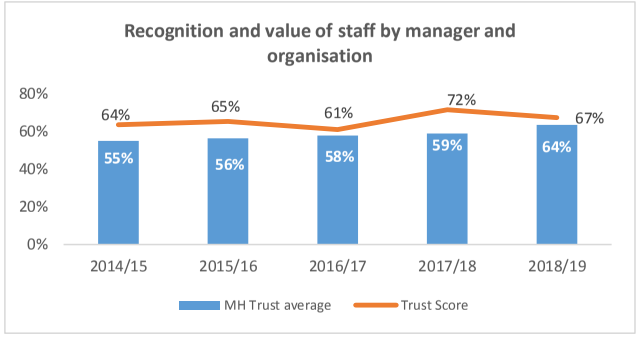


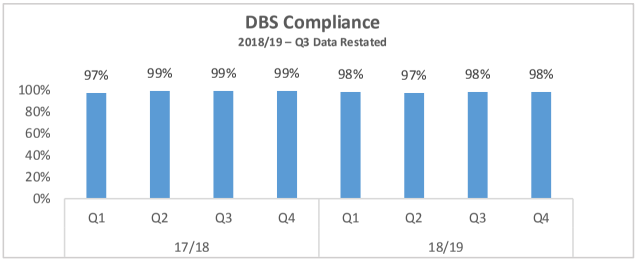


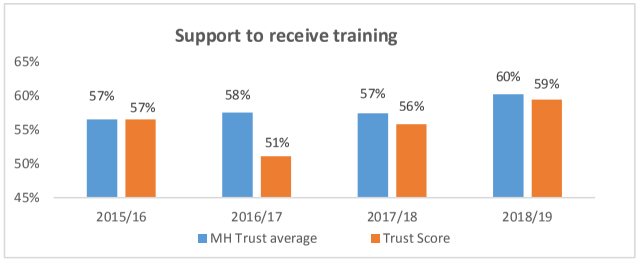






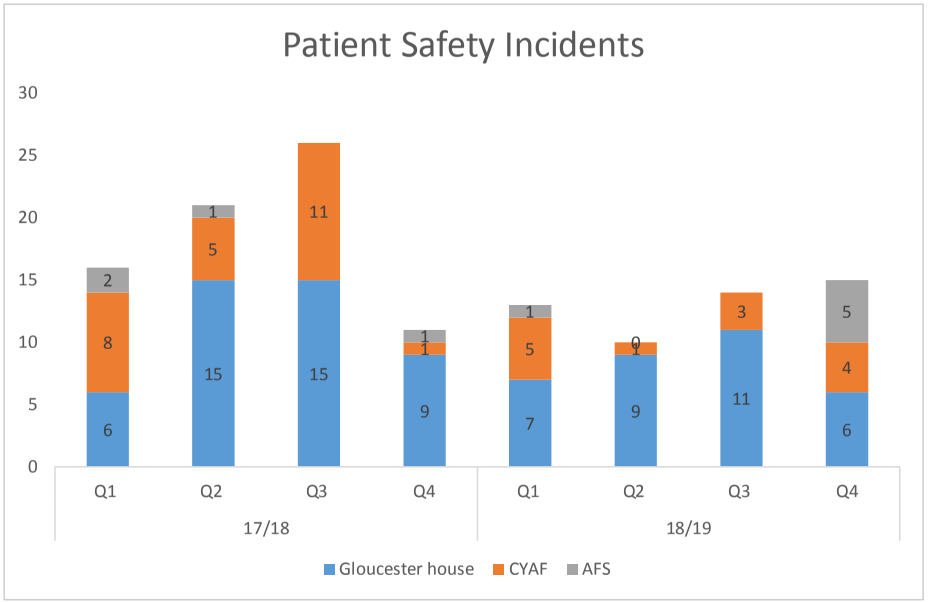


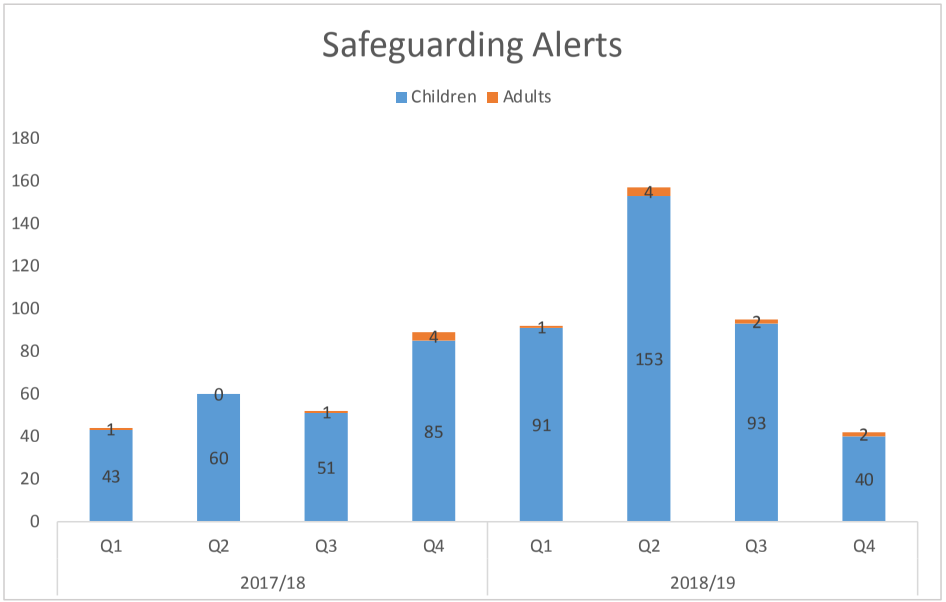




Data source: Human Resource Department 17/04/19

Q4 2018/19: Quality Safety





Incidents Reported by Risk Level – Trust wide	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19
15+	2	0	0	0	0	0	1	1
9-12	6	3	0	1	7	7	3	8
6-8	29	24	79	20	20	42	38	22
1-4	70	79	18	70	75	81	117	85
Total	107	106	97	91	102	130	159	116

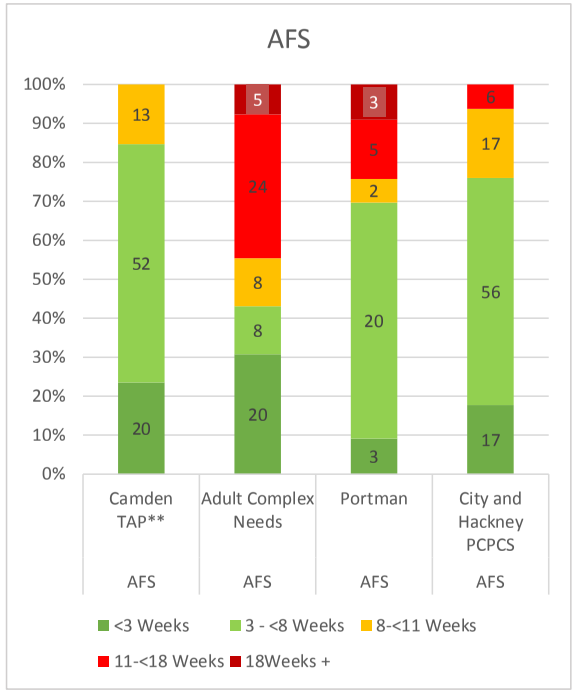
Data source: Quality Portal – Incidents 17/04/2019

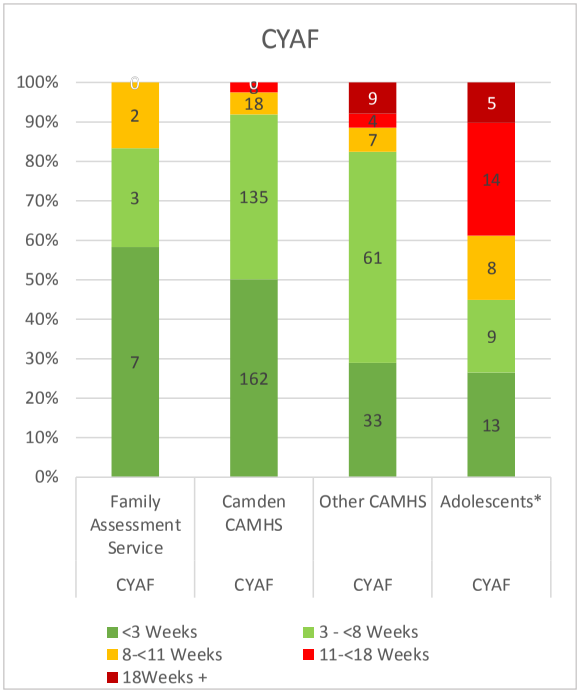
* Some cases have more than one type of concern and were counted as one for accurate reporting

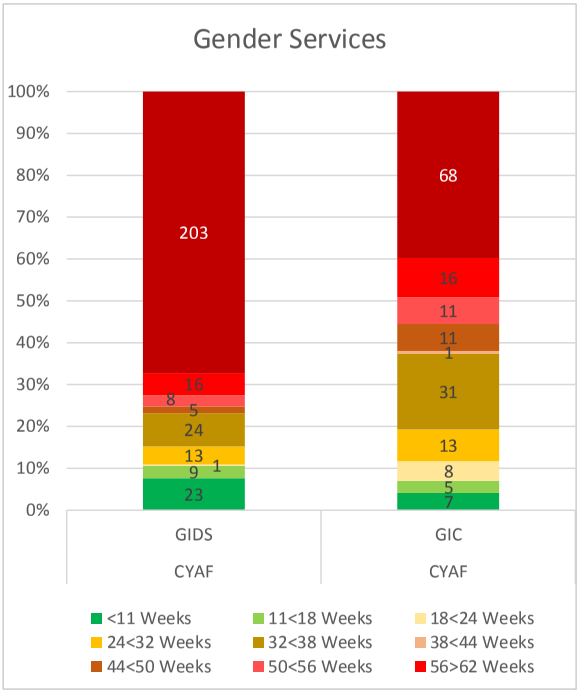
** There is a significant change in under 18 alerts in Q4 compared to previous quarters. Previously, when one would complete a new form, the form used to pull over the data filled in the most recent form. The staff member would change only the parts of the form that needed changing. Recently we have changed the form so that this particular section of the form, recording an alert, would not pull over anymore and a clinician would only complete this section if they needed to record a concern/ alert. There is a possibility that previously the clinician would leave this section of the form unchanged rather than delete it, which would in turn affect our reporting values. Finally since the form has changed there is also a possibility that a clinician would not know where to record this information. Training and support is being offered to all who require it and this change has been announced. An audit of Q2 2018/19 data will be undertaken to confirm data, following changes to the reporting form.

Waiting Times - Referral to Assessment – First Appointment

Each bar shows the percentage of patients seen in Q4 breakdown into blocks of weeks from the referral to treatment







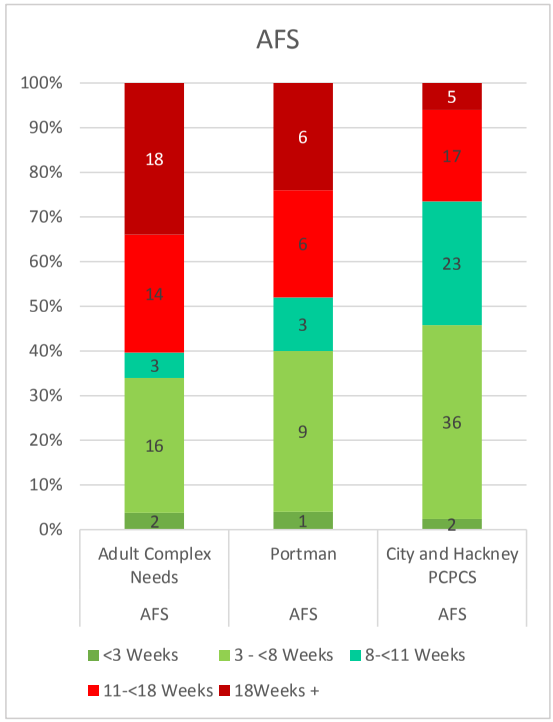
Data run and validated: 5/4/19

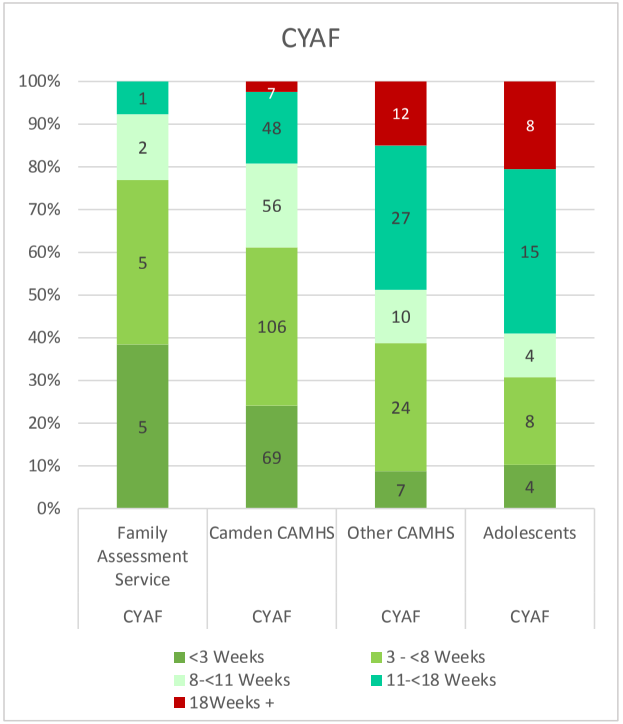
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

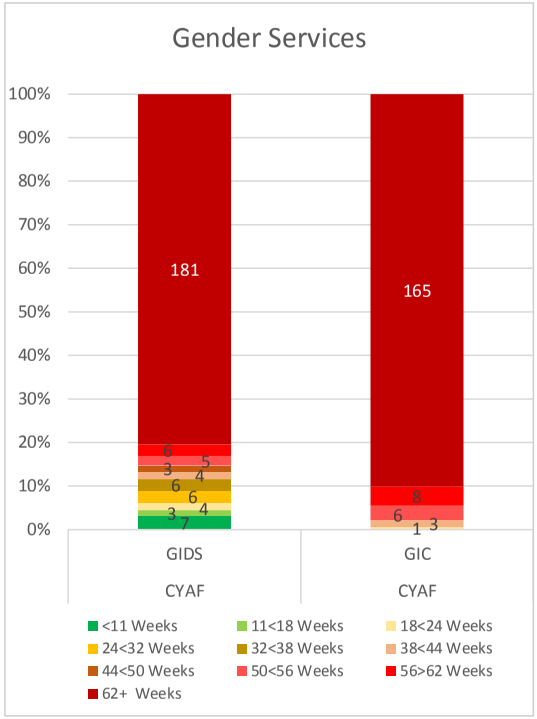
Q4 2018/19: Quality Responsive

Waiting Times - Referral to Treatment - second appointment

Each bar shows the percentage of patients seen in Q4 breakdown into blocks of weeks from the referral to treatment





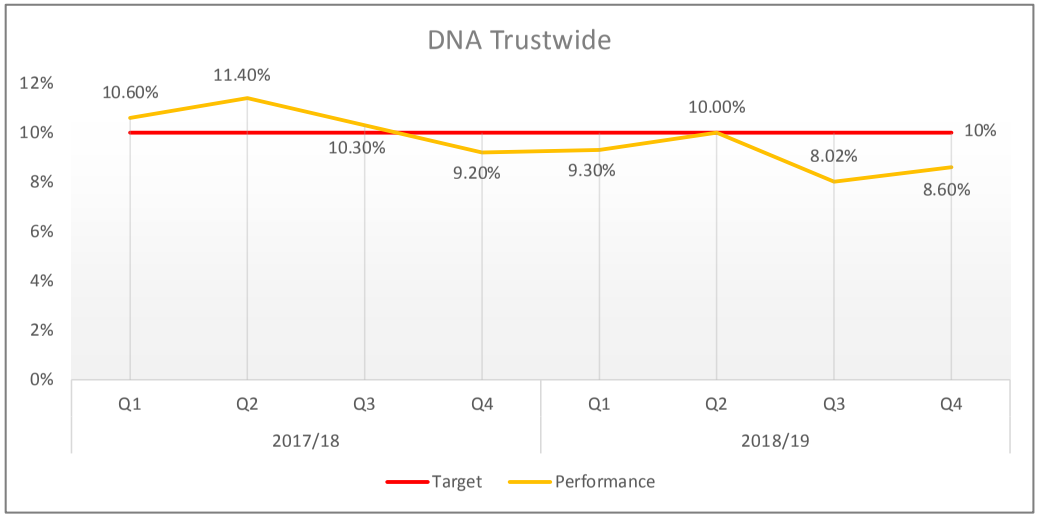


Data run and validated: 5/4/19

Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Q4 2018/19: Quality Effective

DNA – Trustwide								
	2017/18				2018/19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Target	10%	10%	10%	10%	10%	10%	10%	10%
Performance	10.60%	11.40%	10.30%	9.20%	9.30%	10.00%	8.02%	8.60%



Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Q4 2018/19: Quality Responsive

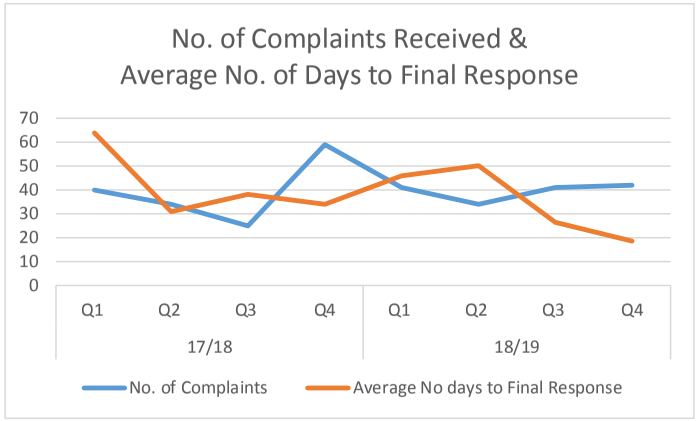
Total PALS enquiries 01/10/2018 to 31/03/2019

Quarter	Total
17/18 Q3	204
17/18 Q4	193
17/18 18/19 Q1	190
18/19 Q2	226
18/19 Q3	175
18/19 Q4	221

Top PALS enquiries for Q4 2018/19 remain unchanged

- Access to treatment
- Communications
- Appointments

GIC, Adult Complex Needs, CYAF and GIDS continue to be the services receiving most enquiries.

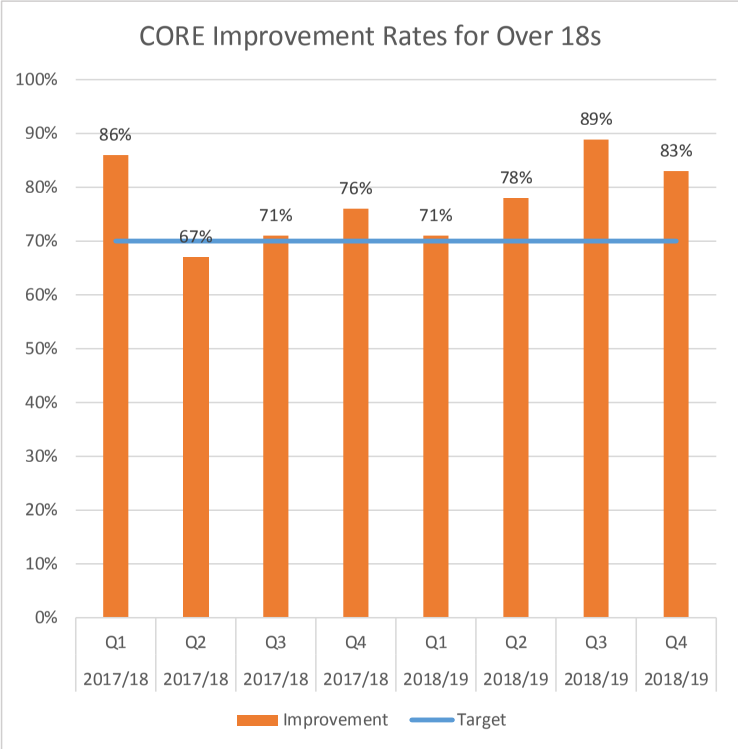


Directorate	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
Adult and Forensic Services (A&F)	4	2	6	3	5	4
Children, Young Adult and Families (CYAF)	20	55	35	29	36	36
Corporate	1	1		1	1	2
No Directorate		1				
Total	25	59	41	33	42	42

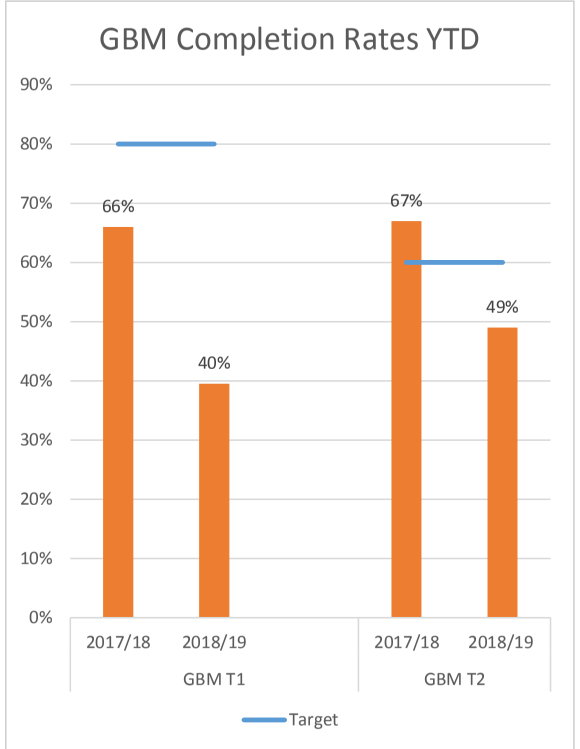
Complaints Commentary- The increase in complaints through the year was most predominately in Q4 of 2017/18. These were due to the changes in administration processes at the GIC. The decrease in complaints received in Q2 is as a result of these administration processes becoming established and improving the service for our patients. Action plans are put in place for complaints where the outcome is 'upheld' or 'partly upheld'.

ESQ		2017/18				2018/19			
Patient Satisfaction	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Q4 from ESQ - Quality Responsive Views and worries were taken seriously		100%	98%	99%	99%	99%	99%	99%	99%
Q13 from ESQ - Quality Responsive Involved in important decisions about my care		97%	97%	99%	98%	97%	98%	97%	97%
Q6 from ESQ - **Quality Effective** 'The information I received about the trust before I first attended was helpful'	75%	94%	90%	96%	95%	96%	94%	95%	88%
Q15 from ESQ - **Quality Effective** 'The overall help I received here is good'	100%	99%	99%	100%	100%	99%	97%	99%	98%
Q11 from ESQ - **Quality Effective** 'If a friend or family member needed this sort of help, I would suggest to them to come here'	80%	98%	97%	97%	99%	98%	97%	98%	98%

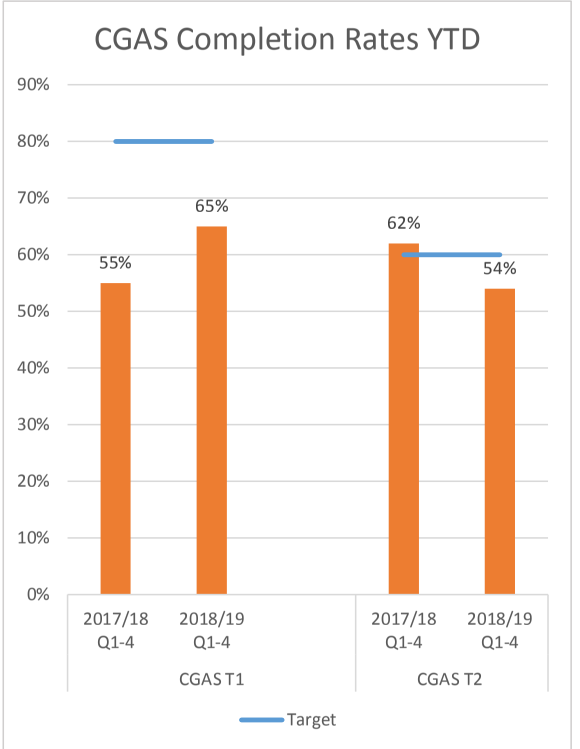
Q4 2018/19: Quality Effective



In Q4 18/19 we had 6 Core T1 and T2 to be able to compare improvement rates – out of those 6 patients 5 showed improvement



In Q4 18/19 we completed 157 GBM T1 and of those 73 had a T2



In Q4 18/19 we completed 259 CGAS T1 and of those 140 had a T2

Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Q4 2018/19: Directorate of Education and Training (DET)

	Year	13-14 FY Actual	14-15 FY Actual	15/16 FY Actual	16/17 FY Actual	17/18 FY Actual	18/19 FY to date	Comments
Course numbers	**CPD Portfolio**	45	58	70	94	93	100	
	Bespoke work	14	18	10	38	45	33	focus on larger, higher value contracts this yr
	Visitors Programme / international					23	14	Focus on group visits and programmes in 18-19 rather than individual visits.
	HEE additional in year funding						6	New income streams from HEE around perinatal and nursing training, equating to c. £200K income
Students	**CPD Portfolio Student Nos**	2079	2738	2063	2279	2300	2193	Not including bespoke or international
						Identified Income to Date		
Income	**Income**	501,917	556,261	493,090	£692,710	£854,710	£1,271,641	
	Income growth on previous year	35%	16%	-11%	40%	23%	49%	
	Contribution	160,769	158,104	123,616	£197,122	£527,123	£645,292	
						17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution		

* Forecast figures based on current scheduled activity. Excludes unconfirmed pipeline activity and income

Q4 2018/19: Directorate of Education and Training (DET)

The last academic year the response rate to the Trust's student survey to 59% increased. This gives a greater measure of confidence that the results are truly indicative of the student experience. The inclusion of further branching questions gives further granularity and credibility to the data. This provides us with a better opportunity to respond in a dedicated and effective way. DET is working on the question set for this year's survey particularly looking at broadening the student support questions to incorporate student mental health.

Directorate of Education and Training (DET)

The next annual Student Survey (2019) is commencing on 24th April 2019.

Student Experience and Outcomes

Satisfaction: "Overall, I am satisfied with the quality of the course"	Benchmark	Tavistock	Change from previous year
2014	87.0%	93.0%	
2015	83.0%	94.0%	↑
2016	86.0%	90.0%	↓
2017	84.0%	81.0%	↓
2018	83.0%	83.0%	↑

Personal Development /Prepared: "I feel better prepared for my future career"	Benchmark	Tavistock	Change from previous year
2014	77.9%	86.2%	
2015	81.0%	91.0%	↑
2016	82.0%	89.0%	↓
2017	78.0%	86.0%	↓
2018	78.0%	84.0%	↓

Effectiveness "I have been able to apply my learning on the course to my job"	Benchmark	Tavistock	Change from previous year
2014	77.0%	81.3%	
2015	78.0%	87.0%	↑
2016	80.0%	96.0%	↑
2017	81.0%	87.0%	↓
2018	80.0%	86.0%	↓

Notes for 2018:

Benchmark data from National Student Survey (2018)

Overall on a par with Benchmark statistics for England. Small improvement on last year

University Partner ratings:-
University of Essex 87%
University of East London 85%

Student experience
This has improved since the implementation of a new student record system in 2017 and improved access for students to their student record via their MyTAP portal. The adjustments to the course administration team have been successful and resulted in a positive impact on student experience.

Benchmark data from Higher Education Academy Postgraduate Taught Experience Survey (2018)

Better than the national benchmark but a decline from last year

University Partner ratings:-
There is no comparison data split by University, other than the overall satisfaction rating.

Benchmark Question
From NSS 2018 results: "My course has provided me with opportunities to apply what I have learnt"

Overall higher score than Benchmark statistics for England but lower than the previous year's score for the Trust

University Partner ratings:-
There is no comparison data split by University, other than the overall satisfaction rating.

On the whole there is not much shift in the measures from the student survey. In the identified KPIs the decreasing trend for overall satisfaction has reversed with a slight increase in the last year.

DET continues to focus on areas showing most dissatisfaction and specific actions have been drawn up by faculty and key supporting committees.

There was a marked increase in satisfaction around Equalities and Student Support which are areas where DET and the Trust have been focusing efforts recently.

Q4 2018/19: Single Oversight Framework

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

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers, with the indicators acting as a trigger to detect possible governance issues and identify potential support needs. The framework looks at five themes. MHSDS data is viewed alongside other quality of care information e.g. formal complaints, staff FFT, patient safety incidents (reported externally), and operational performance.

Quality of care
Finance and use of resources (covered separately)
Operational performance
Strategic change
Leadership and improvement capability (well-led)

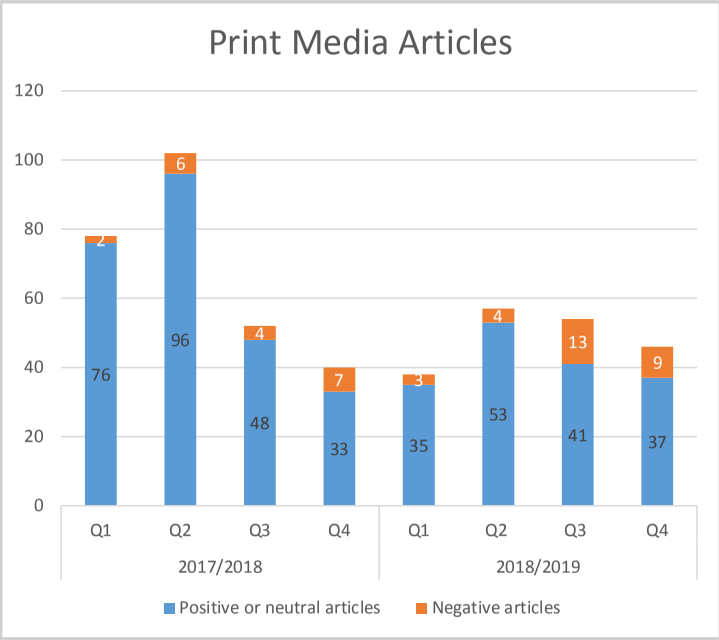
Ethnicity recording: It has been noted that the Ethnicity data recorded on CareNotes and submitted to NHS Digital as part of our MHSDS submission has been progressively decreasing but this last entry shows a slight improvement. The Clinical Data Quality Review Group (CDQRG) has been addressing this issue working with the team representatives, analysing the issues and developing strategies to improve compliance. There are differences in the coding used by some services which is negatively impacting on data, work to amend this has started to take place. Initial investigation shows the majority of missing Ethnicity information relates to Gender Services and First Step service where most of their patients have not been seen and therefore are not asked. An action plan will be monitored via the CDQRG.

Mental Health Services Data Set (MHSDS)	Target (%)	Month 1 2017/18 (%)	Month 4 2017/18 (%)	Month 7 2017/18 (%)	Month 10 2017/18 (%)	Month 1 **April** 2018/19 (%)	Month 4 **June** 2018/19 (%)	Month 7 **October** 2018/19 (%)	Month 10 **January** 2018/19 (%)
Valid NHS number	95%	**96.20%**	**96.20%**	**99.10%**	**98.60%**	**98.60%**	**98.70%**	**98.90%**	**98.90%**
Valid Postcode	95%	**99.80%**	**99.80%**	**99.80%**	**99.70%**	**99.80%**	**99.80%**	**99.80%**	**99.80%**
Valid Date of Birth	95%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Valid Organisation code of Commissioner	95%	**99.50%**	**99.50%**	**99.50%**	**99.10%**	**99.00%**	**99.20%**	**99.00%**	**99.00%**
Valid Organisation code GP Practice	95%	**99.10%**	**99.20%**	**99.20%**	**98.20%**	**97.80%**	**98.00%**	**98.10%**	**98.20%**
Valid Gender	95%	**99.80%**	**99.80%**	**99.80%**	**99.80%**	**99.80%**	**99.70%**	**99.40%**	**99.40%**
Ethnicity	85%	**83%**	**83.10%**	**79.60%**	**78.40%**	**77.30%**	**76.00%**	**75.80%**	**76.10%**
Employment Status (for adults)	85%	**26.30%**	**26.30%**	**36.90%**	**43.40%**	**49.10%**	**50.50%**	**51.60%**	**54.00%**
Accommodation status (for adults)	85%	**26.10%**	**26.10%**	**36.60%**	**42.90%**	**48.50%**	**49.90%**	**51.00%**	**53.20%**
ICD10 coding	85%	**NA**	**N/A**	**NA**	**NA**	**NA**	**NA**	**N/A**	**N/A**

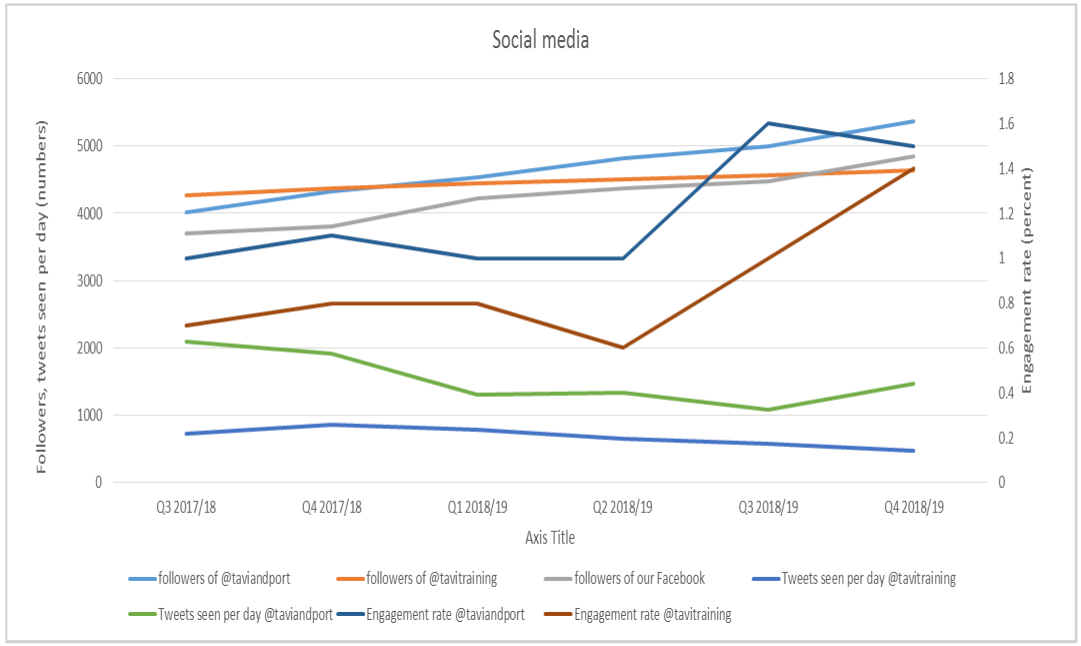
*The trust is working towards a 99% target

Data source: Data warehouse, informatics team.

Q4 2018/19: Media



This is a slightly lower volume of overall coverage compared to Q2, and the overall sentiment increased slightly – 80% positive or neutral coverage, compared to 76% in previous quarter



The Engagement Rate is for our twitter accounts only. Facebook is not included. Traffic to our website and number of visitors were both higher this quarter than last quarter.

Our social audiences are increasing in size although the amount of engagement we get and the amount our tweets are seen is about the same.

About half of all website traffic goes to our course pages, half goes to the whole of the rest of the site.

Stories around GIDS are our most popular news items.

Data source: Communications department

Quarterly Quality Report Commentary Q4 2018/19

1. Introduction

1.1 This report refers directly to the Quarterly Quality Report submitted to commissioners which includes KPIs, CQUINs, quality priorities and other performance related indicators. This report does not directly refer to all of the data collected in the above dashboard.

1.2 As requested by the Board of Directors the following paper provides a summary and narrative for quarter 4 quality metrics currently within the Quality Report. This report specifically covers those metrics where we are not meeting targets or where the trajectory suggests a worsening position. Service level updates and actions are provided by the Service Leads. Some significant improvements are also highlighted. Please note the data in this report is for Trust wide, with the exception of CQUINS that apply to London Contracting or NHSE contracts only.

1.3 The following metrics are summarised below:

Waiting times

Did not attend (DNAs)

MHSDS data

Outcome Data

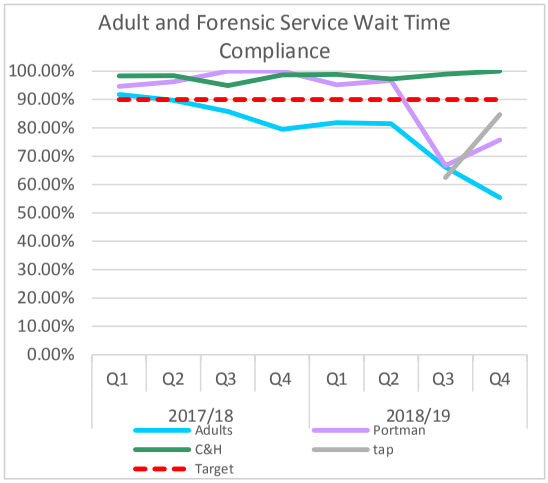
Quality Priorities

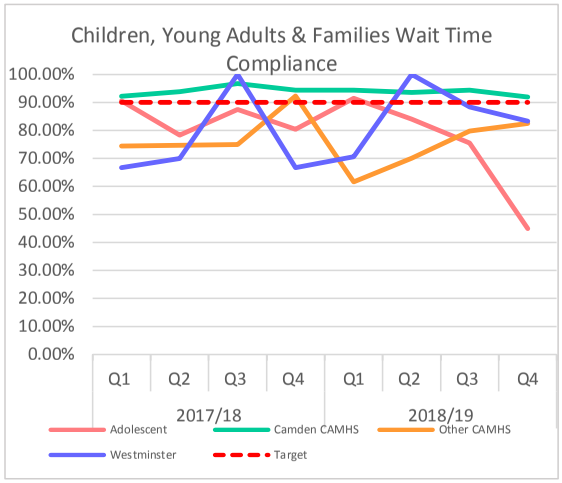
CQUINS

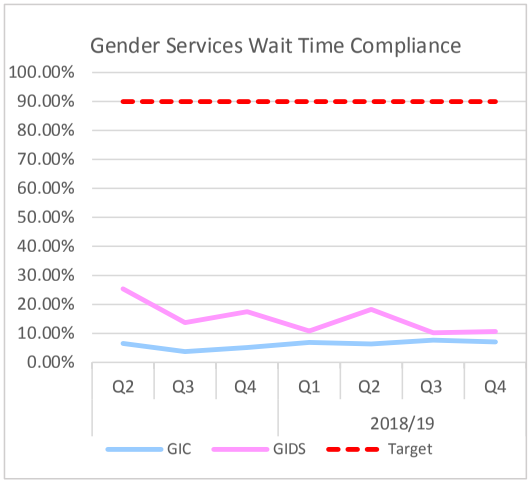
2. Summary Metrics

2.1 **Waiting Times – Referral to First Appointment**

Data is validated by services. The validation and reliability of the data has improved due to the introduction of new checklists and validation processes within the Quality Team and services, including the use of Standard operating procedures (SOPs). The percentages below show the number of people seen within the waiting time target.







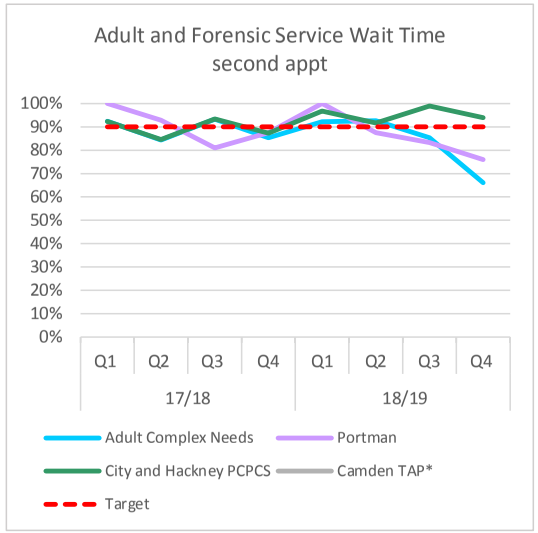
2.1.1 AFS teams: **Adult Complex Needs** Service has seen 55.38% within 11 weeks from referral, out of 65 patients seen for first time 36 we seen on target also the number is patients seen for first time is lower than in Q3. Adults team analysed the breaches and a considerable amount of them are caused by GP delays providing necessary data. **Portman Service** has seen 75.76% of their patients within 11 weeks, this is a improvement compared to Q3. Portman also highlighted that a significant number of breaches (6 cases) were because after the referrals were received (start clock for WT) actual acceptance of these referrals for assessment was postponed due to a need for more information from the referrer. **C&H** is maintaining a good performance 100% of their first appointments were on time. TAP is has also improved performance from Q3 to Q4 meeting a 84.71%

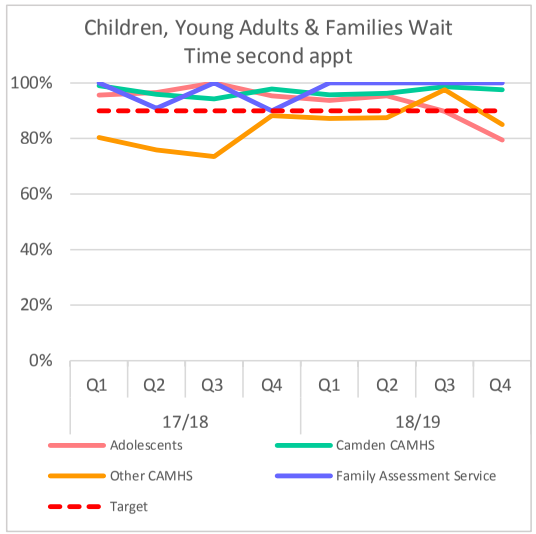
2.1.3 CYAF Teams: **Camden CAMHS** performed consistently well throughout 2017/18 in to 2018/19. **Other CAMHS** have seen 82% of patients within expected times, their performance has improved consecutively both in Q2, Q3 and Q4. **FAS (Westminster service)** have seen 83% of their patients within their waiting time target, but this can fluctuate due to patient population. **Adolescent services** have drop their compliance during the last 3 months due to a significant increase of referrals, staff recruitment issues and a knock on effect decrease of DNAs.

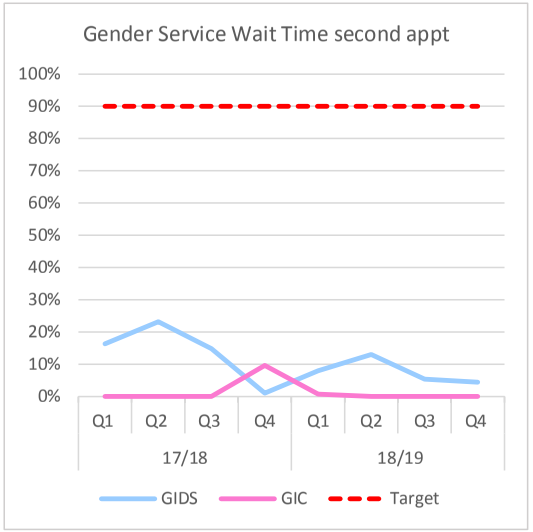
2.1.3 Gender Service Teams: Both the Gender Identity Clinic (Over 18) and Gender Identity Development Service (under 18) have action plans in place and liaise closely with commissioners. **GIDS**'s waiting time in Q4 had a slight decrease, GIDs have been addressing the WT through recruitment drive, through internal waiting list steering groups and waiting list management initiatives. We are expecting a gradual improvement on the waiting times as the new recruits start to see patients. **GIC** compliance has marginally decreased as it continues to be under immense pressure with the volume of referrals that come to the clinic. GIC is trying to shorten the gap between appointments but also continues to take some first appointments and will be prioritising those who are currently in care from our GIDS service to ensure there is not a gap in their care.

2.2 **Waiting Times –Referral to Treatment - second appointment**

Data on the dashboard is showing percentages of patients seen during Q3 in each of the blocks of weeks. For further information please see below total of treatment for each team. The table below shows the total number of patients waiting for treatment in Q3 for each service line.







AFS: Within the Adults service the teams where patients have to wait for a longer for treatment are PATH, PTU, Portman Glasser and the Trauma unit. Quality Team Manager will have discussions with AFS with the clinical governance lead.

CYAF: The other teams with high waiting times for treatment are Family Service, Adolescent Camden Team, South service,

Gender Services: As the Trust is aware of GIDS and GIC are the teams with longer waiting times for treatment. Teams are aware and they will continue to develop ways to improve this.

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

Waiting Times feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q4	Objective / plan for next Quarter	Lead
Adult Complex Needs	Of the 26 breaches, 6 were due to awaiting further information from the referrer. The remaining 20 breaches are due to clinical capacity and lack of resources with a few clinician's going on long term sick and maternity leave	We are looking to liaise with commissioners about how best to manage referrals for which information is still awaited.	Sukhjit Sidhu, Assistant Psychologist
Portman:	Of the 8 cases for whom the data suggests that patients waited for more than 11 weeks, in 6 cases the referrals were categorised as 'referral accepted' on the system, whereas the actual acceptance of these referrals for assessment was postponed due to a need for more information from the referrer, or the patient. Of the remaining two cases, one patient cancelled their first two appointments, and this appeared on the system as having breached the 11 week period. One referral was accepted as a consultation to professionals, and so the patient was not deemed suitable for assessment.	We are reviewing our current system for recording the progress of such referrals so that the data accurately reflects the progress of the referral.	Andrew Williams, Clinical Governance Lead for Portman Clinic
City and Hackney PCPS	PCPCS are very satisfied with our waiting times figures for Q4. A substantial majority of patients were seen within 8 weeks, and no patients had to wait longer than 18 weeks. We have had reduced staffing numbers over the past quarter, so it is especially satisfying that this has not come at a cost to patient experience. Seeing patients within an appropriate timescale, particularly within a primary care setting, has many benefits: it can reduce risk, mean less mental pressure on staff, and encourage GPs to refer, as they can expect their patients to be seen by the service in good time.	Continue the expedient processing of referrals, intake, and initial appointment booking.	Chris Newlove Horton, Service Administration Manager
TAP	After a period of hiatus in 2018 when TAP referrals were on pause due to the uncertain contract situation with a 6 month delay (as well as previously very high referrals) we are once again open and from the start of April 19 part of the new PCMH . With GP becoming increasingly aware that the resource is again open and for patients they find challenging we are not surprised at the statistical trend, especially as TAP was also cut by 30% by Camden CCG is our last round of contracting.	We are working very closely with service and clinical leads in C&I who now manage the Primary Care contract which TAP is subcontracted to. We have developed a joint intake system for better managing referrals and making sure they find the right clinical home. We continue to monitor referral trends in the 'new' service so that we do not become overwhelmed again.	Tim Kent

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

Waiting Times feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q4	Objective / plan for next Quarter	Lead
Adolescent /AYAS	Adolescent /AYAS: A combination of factors have contributed to the increase in breaches for Q4, as follows: 1) The significant increase in the number of referrals into the Service towards the end of Q3, a trend which has continued through Q4; 2) a reduction in staff sessions (because of a staff member reducing their sessions in the service and the time delay before a new member of staff was appointed to fill these sessions and because of another member of staff leaving the service); 3) although a positive development and a proxy for good patient engagement, the reduction in the DNA rate for this quarter means that clinicians have been less available to take on new cases compared, for example, with a service where patients are less engaged and so more likely to be discharged sooner, and 4)as the 6 month pilot project to address the WT breaches was only rolled out on 4/2/2019, it will only have had a partial impact on the WT breaches this quarter.	On-going implementation of the 6-month Pilot Project, to try to reduce the percentage of patients breaching the WT targets. (Lois Thomas will oversee the WT pilot project).	Justine McCarthy Woods, AYAS Lead
Camden/Other CAMHS	There have been a number of breaches this quarter the majority of which are a result of a lack of capacity for clinical staff to take on new patients. There was an increase in referrals in November and December compared to the rest of the financial year which increased pressure on teams We will continue to monitor referral numbers and work with teams to find ways of managing their caseloads.	Complete job planning for parts of Camden CAMHS before considering roll out to other teams/services	Lois Thomas will oversee the WT pilot project
FAS Westminster	There are several factors that impact on waiting times in the service. As the service mainly delivers Court ordered multidisciplinary assessments, on a significant number of cases information (Letter of Instruction) is not readily available at the point of case allocation. As such, the start of any clinical work is delayed until this information becomes available. In addition to that, the referrer's capacity for a Professionals Meeting and the patient's capacity for a Service Planning Agreement Meeting have a direct impact on the clinician's ability to start the clinical work.	We have reviewed and introduced more tight timescales in the Service to deal with the delays caused by the lack of capacity in the referrer and the service user in agreement with our Commissioners and external stakeholders.	Fiona Hartnett, CYAF Service Manager
GIC	The wait times for the London GIC continue to rise due the extremely high number of referrals which are received every month, regularly more than 250 referrals every month. Since the Tavistock and Portman has been managing the clinic, we have averaged 140 first appointments every month meaning that we receive more than 2 months of first appointments in new referrals every month. The number of patients that are open to the clinic has been deemed to be clinically unsafe. The current gap between appointments is between 12-18 months when the ideal is 3-4 months with a 6 month gap being the maximum gap which is considered clinically safe. In order to bring the gap down between open case appointments, the clinic will start to limit the number of first appointments starting in Q1 2019-20 to 60 first appointments per month. There will be 30 appointments that are reserved for GIDS patients who have been in treatment, and a remaining 30 appointments offered to the waiting list.	We are working with the Tavistock and Portman Comms team to draft a message to go on the website to explain the current situation.	Frances Endres, General Manager Gender Services
GIDS	We note that 2% of YP meet the target for waiting times. Our recruitment drive should have a positive impact on this, especially as those staff newly recruited pick up become fully inducted, pick up new cases and build caseloads. We also feel there may be a seasonal element of the particularly low wait time in this quarter – which can also be seen reflected in Q4 last year.	We will continue work on DNA and cancellations in GIDS, which involves data analysis and review of policy.	Kathleen Hughes GIDS Service Manager

2.3 Comparison of Waiting Times (WT) Trust compliance

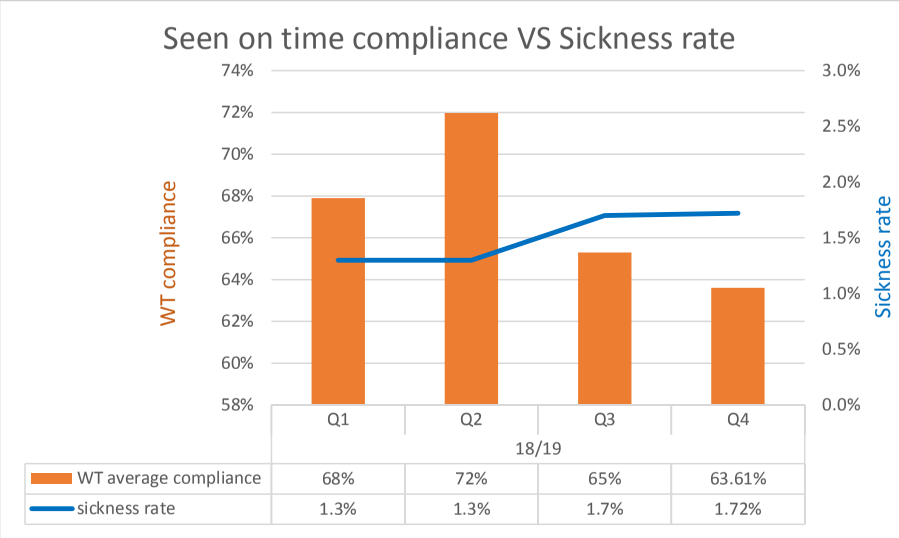
Comparing Waiting Times Trust Compliance % against sickness rates

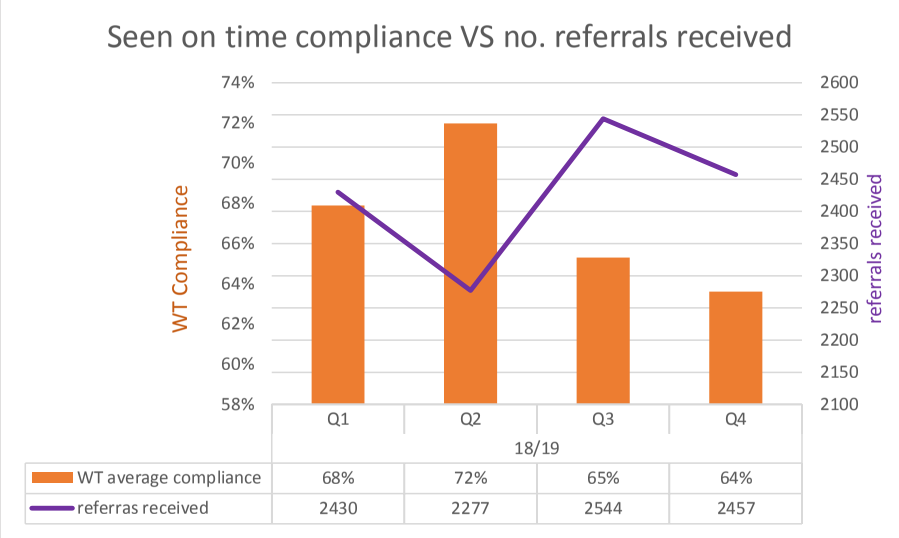
The waiting time compliance is been decreasing gradually over the last 3 quarters. One of the reasons for this it could be the increased sickness rate. As shown in the graph below Q3 and Q4 sickness rate is considerable higher than in Q1 and Q2. Sickness rates has an effect on availability of appointment slots hence it could be influencing the waiting times.

Comparing Waiting Times Trust Compliance % against no of referrals received

We have also compared the trust wide waiting times compliance for first appointments with the number of referrals received during this financial year. In Q2 we saw a drop in referrals which we believe had a positive impact on WT compliance. During Q3 we had the highest number of referrals during 2018-19 during this quarter we also saw a significant drop on WT compliance – 7% decrease. In Q4 we had the second highest number of referrals and the WT dropped a further 1 percent.

We will carry on collecting this date over the next financial year.

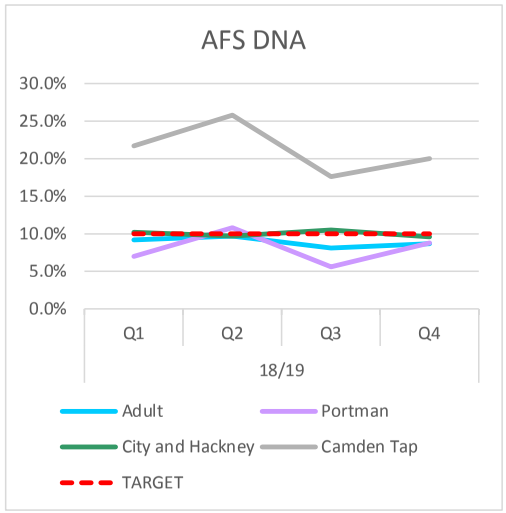


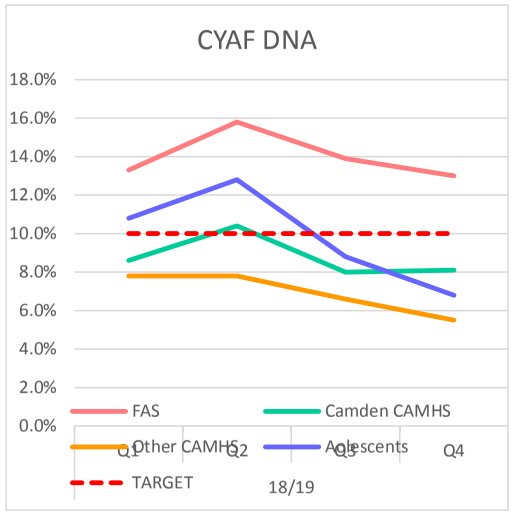


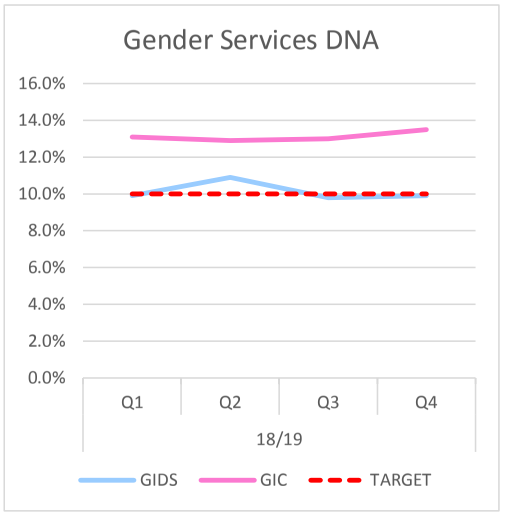
2.4 **Did Not Attend (DNA)**

DNA rates performance is expected to be no higher than 10% -The overall Trust rate in Q2 was 9.96% which has improved to 8% for Q3. This represents a decrease on the DNA rate of 1.98%. The definition used for DNA figures is **Numerator:** Total DNA / **Denominator:** Total Appointments (Total Attended + Total DNA appointments). CYAF, Adult Complex Needs, Portman services and GIDS all stayed under the 10% trust wide target. GIC, Camden TAP, Westminster (FAS) and City and Hackney all breached the 10% DNA target but all have plans in place to address these issues.

Service	Q3 17/18 Performance	Q4 17/18 Performance	Q1 18/19 Performance	Q2 18/19 Performance	Q3 18/19 Performance	Q4 18/19 Performance	Trajectory (+/-)
Adult Complex Needs and Portman	11.2%	8.9%	8.6%	10%	7.4%	8.8%	**Worsened**
City and Hackney PCPCS	10.6%	11.7%	10.2%	9.7%	10.5%	9.7%	**Improved**
Camden CAMHS, Other CAMHS and Adolescent	7.6 %	8%	8.7%	10%	7.7%	7.2%	**Improved**
GIDS	9.6%	10.2%	9.9%	10.9%	9.8%	9.9%	**Worsened**
GIC	15%	13%	13.1%	12.9%	13%	13.5%	**Worsened**
Westminster	5.8%	12.2%	13.3%	15.8%	13.9%	13.%	**Improved**







2.5 **MHSDS Data**

In order to improve on MHSDS (Mental Health Service Data Set, Single oversight Framework Section) completion the Trust reports internally on a monthly basis to see where demographics of patients are not collected. This is shared with services.

MHSDS is submitted externally twice for each month. The most recent analysis presented is for January submission. The reason for this is that it is the refreshed data is sent nationally 3 months after collection. For many of the categories, including gender, date of birth, referral information, GP information, contract information, marital status and current postcode, targets were met. However, areas of concern were completion of 'accommodation status' and 'employment status'; these were around 26% at the beginning of 2017/18 and have now improved achieving above 53%. Every month there is an increment and we expect this trend to continue.

The Quality Team use the data warehouse information (which is used for external reporting), and data is now in line with what is externally reported. The internal systems are still used to identify gaps in reporting.

MHSDS Data is a recurrent agenda item in the CDQRG meeting for the last 3 months. CDQRG have started implementing some changes on ethnicity recording and as a result we have started to see some symbolic changes in some teams and the overall trust performance. Work in this area will continue over the next few months.

2.6 **Outcome Data**

2.6.1 CORE the improvement of scores for CORE is performing well, above the target for the last 3 quarters. This OM shows an improvement on the scores of 83% during Q4. however this only reflects rates for those collected. Collection rates of this outcome measure are concerning and are to be reviewed in 2019.

2.6.2 New targets for OM data have been agreed with the commissioners for the CYAF data with increasing targets up until 2020/21. The new CYAF targets are visible in the trust wide dashboard and focus on data for any patient with a thrive category of 'getting help' or 'getting more help'

2.5.1 The collection of GBM or CGAS Time 1, for any patient with a thrive category of 'getting help' or 'getting more help'.

2.5.1.1 **GBM Time 1**, is 40% - please note that this figure is 'year to date', several changes to the Carenotes system will ensure better collection going forward

2.5.1.2 **CGAS Time 1**, is 65% - please note that this figure is year to date, several changes to the Carenotes system will ensure better collection going forward

2.5.1.3 Do note that GBM figures have slightly decreased since last quarter, however, our CGAS percentages have stable over the past quarter. Recently Informatics has implemented changes to the assist panel on CareNotes this should help compliance overtime. The Quality Team are working together with the CYAF teams on two QI Projects to improve our overall OM collection and assessment summaries operational issues.

2.6.3 The collection of GBM or CGAS Time 2 for any patient with a thrive category of 'getting help' or 'getting more help' and been open longer that 6 months or discharged.

2.5.2.1 **GBM Time 2** - 49% - please note that this cohort only includes those patients who were discharged with a Time 1 and a Time 2 / end of treatment GBM

2.5.2.2 **CGAS Time 2** - 54% - please note that this cohort only includes those patients who were discharged with a Time 1 and a Time 2 / end of treatment CGAS

2.5.2.3 the rate has increased significantly – the assist panels improvements in addition to the QI GBM has helped to see this positive changes. We are planning to expand the use of Patient view which will help to share information with patients on progress. The patient survey feedback is being undertaken and we will report back in Q4 with a review and performance review

2.6.4 Half way through of quarter four the changes to the assist panel were implemented, and reporting brought in line with this. In addition to this there is a QI project being developed on GBM T1 and T2. This should see the trust moving towards meeting the end of year targets for 2019/20

2.7 **Quality Priorities**

2.7.1 **<u>Quality Priority 1:</u> Provide effective sleep management information and support to patients and carers of those with sleep disorders**

Quarterly milestone:	**Progress:**
Develop information guides on sleep hygiene with patient, carer and patient representative input	The PPI team have taken the guide out for feedback and feedback has been implemented.
Provide sleep hygiene information to Trust practitioners and patients / Carers.	Sleep hygiene information has continued to be promoted across the Trust to practitioners via staff induction, as well as on the intranet and the refresher training schedule. New staff members are also being trained on sleep hygiene.
Work with parents and carers of children under the age of 13 years with sleep issues to support them in improving sleep.	A written guide has been developed and presented to the PPI forum for feedback. This guide has been approved.

2.7.2 **<u>Quality Priority 2:</u> Improve waiting time access from end of assessment to first treatment session in the Adult Complex Needs Lyndhurst service**

Quarterly milestone:	Progress:
Develop and pilot a new model of care	The brief intervention model is now firmly in place, with senior clinicians who supervise assessments frequently making recommendations for suitable patients to be offered the 16 session intervention. Since 19th November 2019, 7 clinicians have commenced the treatment, with two clinicians having now completed treatment. We are due to collect outcome and qualitative (patient interview) data with patients who have completed. We are also planning to establish a dedicated supervision workshop to support clinicians offering the treatment, so that we can develop learning and expertise regarding the intervention. This will be facilitated by a senior member of staff who already has expertise in this area.
Reduce the number and % of patients waiting more than 9 months for treatment	Since the introduction of the brief intervention model, there has been a reduction in the waiting time between assessment and treatment. Following the introduction of the model November, during the Nov 2018 -March 2019 period, the median waiting time reduced from 7.7 months to 1.6 months, a reduction of nearly 80%. The median waiting time for 16-week treatment during this period was approximately 3 weeks, and the median time for 18-month treatment was 5.36 months. There is therefore an early indication that the benefit of offering brief treatment is two-fold. First, suitable patients can rapidly access treatment through the brief treatment model, and secondly, the wait for 18-month treatment is reduced. The waiting time data will need to be monitored over a longer period in order to confirm a definite correlation.
Obtain feedback from service users about the new model	We have adapted a semi-structured interview for patients who have completed brief treatment from a post-treatment interview for patients completing 18 months of treatment. The interviews will be conducted by telephone, by our assistant psychologists, under supervision by a senior clinician. We have decided to allow 4 weeks post-treatment to elapse before interviewing the patient, or to do so following a review by the patient's assessing clinician. As our two completed patients have not yet reached this point as yet, we have not completed qualitative interviews as yet but will have done so by the next quarter.

2.7.3 **<u>Quality Priority 3:</u> Improve patient and carer involvement in care planning in children, young adult and family services.**

Quarterly milestone:	**Progress:**
Improve quality of patient and / or carer involvement in the development of care plans.	We ran the two focus groups in February 2019 - one for parents/carers, of which 3 attended, and the other for young people, which unfortunately just had one attendee. Despite the low numbers, we collected a significant amount of data from the service users, which is in the process of being evaluated. However, early themes included: the importance of co-creating care plans with children, young people and their parents/carers, having integrated care plans across providers where appropriate, and sharing care plans across agencies, clarifying some of the language within the care plans, providing information about the skill-mix of professionals involved in the care plan.
Increase the quality of data recorded of care plans shared with patients and referrers	This quality priority has enabled us to identify that there is a data quality issue with the data relating to care plan completion rates, and percentages of care plans shared with patients and referrers. As part of a QI project due to be implemented in 2019/20, we are in the process of improving the reporting structure, which will put us in a better position to monitor performance and compliance in a sustainable way.
Increase the percentage of care plans shared with patients and referrers	In response to the targeted work over Q4, the compliance rates for care plan completion increased significantly for all the teams across the service line in Q4 with the following completion rates: FMHT 94%, FAKT 71%, Lifespan 77%, AYAS 52%. We have developed driver diagrams and a project charter to implement QI methodology in assessing the impact of procedural changes within the family Mental Health Team to take forward into Q1 of 2019-20 with a view to increasing the percentage of care plans shared with patients and referrers when consent to do so has been given.

2.7.4 **<u>Quality Priority 4:</u> Embed meaningful use of outcome measures in services**

Quarterly milestone:	**Progress:**
80% of children and young people with Thrive categories, 'getting help' and 'getting more help' have a Time 1 goal recorded for the Goal Based measure (GBM) and CGAS measure.	Given the low response rates across the services was decided to carry out a QI project in South Camden focusing on the barriers to completion of Time 1 and Time 2 GBM to understand better why returns are low and inform the service of the best way to increase return rates. Currently the return rate in South Camden is 50%. The processes for completing Time 1 have been improved and the project is ready to move on to looking at Time 2 issues.
Obtain service user feedback on the use of outcome measures to feedback on progress.	This project has still not been undertaken. It is going to be added to the South Camden QI project. There are still some issues with the graphs that need to be ironed out with informatics (if subscales are not completed then they are scoring on the charts a 0)
60% of closed cases or cases open longer than 6 months with Thrive categories, 'getting help' and 'getting more help' have a paired Time 2 Goal Based measure and Time 2 CGAS measure.	The QI project in South Camden will move on to looking at issue related to collecting Time 2 data in the next month, and will report back
Develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress and opportunities for review.	As Q3 but there are still some issues with the graphs that need to be ironed out with informatics (if subscales are not completed then they are scoring on the charts a 0)

2.7.5 **Quality Priority 5: Improve identification and management of high risk patients**

Quarterly milestone:	Progress:
Implement an electronic version of the Camden Adolescent Intensive Support Service (CAISS) crisis plan on the electronic patient record system (Carenotes)	We partially achieved this: A Focus group has been completed with young people and the Crisis plans have been updated in line with feedback from teams and focus group. Currently awaiting confirmation to be take forward change to electronic patient system (CareNotes).
Establish online clinical risk assessment training across the Trust and develop processes to ensure robust recording of training compliance procedures	We partially achieved this: Online clinical risk presentation available with reporting. Face to face workshop continuing three times per year in CYAF. Patient safety lead visits teams to discuss risk assessment. Online training to be set against individual staff groups – this is to be aligned to North Central London work in 2019.
Ensure 80% of crisis plans in Adult and Forensic services (AFS) have been reviewed / updated in the last six months	We achieved this All open cases in Adult Complex needs were looked between May - September 18 and clinicians were ask to update risk assessment/ crisis plans. 100% of cases were contacted and updated as a result. This has been audited recently and the compliance target met.
Launch Trust's suicide prevention plan and evidence implementation of the action plan	The Trust's suicide prevention training event took place in March 2019 and the suicide prevention plan has been completed.

2.8 **CQUINS**

2.8.1 **CQUINS - 1. NHS Staff health and wellbeing CQUINs (1a)**

Target	Detail of indicator	Reported	Target	Q4 18-19 Progress	RAG
Introduction of health and wellbeing initiatives The NHS Annual Staff survey (Baseline period Year 2 - 2016 staff survey- released in 2017)	Question 9a: Does your organisation take positive action on health and well-being? Yes, definitely/ Yes, to some extent/ No response.	Q4 Only (No externally reportable CQUIN targets but internal report required as update on progress to deliver Q3 requirements)	n/a	26% of staff responded 'Yes definitely' which is a 5% decrease from the response in 2016	
	Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Yes/No response.			77% responded 'No' which is a 2% improvement on the response rate in 2016	
	Question 9c: During the last 12 months have you felt unwell as a result of work related stress? Yes/No response.			53% responded 'No'. This is a 2% improvement on the response rate in 2016	
	Final indicator reporting date - Year 2 – Publication of 2018 staff survey – expected in March 2019)			Not met	
	Final indicator value (payment threshold) Achievement of the 5% point improvement in 2 of the 3 questions in the staff survey results or achievement of the absolute targets in 2 of the 3 questions			Not met	

2.8.2 **CQUINS - 1. NHS Staff health and wellbeing CQUINs (1b)**

Target	Detail of indicator	Reported	Target	Q4 18/19 progress	RAG
Healthy food for NHS staff, visitors and patients	Introducing three new changes to food and drink provision: The CQUIN will also be aligned with the national SSB voluntary reduction scheme which started during 18/19. Toza and Connect Vending has signed to this scheme. 1. Outlets will be eligible for the CQUIN where they have signed up to the national SSB reduction scheme,2 and total litres of SSBs sold account for 10% or less of all litres of drinks sold in 2018/19. (Target 18-19= 90% - previous year performance 73% achieved). 2. 80% of confectionery and sweets do not exceed 250 kcal. (Previous year performance 95%). 3. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g. (Previous year performance 100%).	Q4 Only	n/a	requested	

2.8.3 **CQUINS - 1. NHS Staff health and wellbeing CQUINs (1c)**

Target	Detail of indicator	Reported	Target	Q4 18-19 Progress	RAG
Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	Achieving an uptake of flu vaccinations by frontline clinical staff of 75% Numerator Number of front line healthcare workers who have received their flu vaccination by February 28th 2018. Please refer to the Seasonal Influenza Frontline Healthcare Workers Vaccine Uptake Survey 2016/17 Guidance for detailed information on definitions. If organisations believe a significant proportion of staff are receiving their flu vaccines from other providers, they can include this in their returns if they wish to create an auditable scheme to demonstrate it. Denominator Total number of front line healthcare workers. Please refer to the Seasonal Influenza Frontline Healthcare Workers Vaccine Uptake Survey 2016/17 Guidance for detailed information on definitions.	Q4	70%	The Trust has 507 Frontline Healthcare workers. 312 have been vaccinated this year which is equal to 61.5% Numerator 312 Denominator 507 31% of frontline healthcare workers declined the vaccine.	

2.8.4 **CQUINS - 2. Living Well Programme**

Target	Detail of indicator	Reported	Target %	Q4 18/19	RAG
Living Well Programme (18-19)	1) Quarterly referrals to PHSN for further intervention - smoking, alcohol for all new patients aged 13 and above who are to be seen for treatment. 2) Quarterly report - numbers, issues and outcomes, (number of 1:1 /group sessions / external referrals) with evidence of GPs being informed within 2 weeks of attending appointment (improvement would be monitored against Q1 as baseline). 3) Maintain use and completion of physical health form details (current baseline at end of 2017/18 was 80%). Those with a IThrive Category of 'getting advice' and 'getting risk support' and 'not applicable' can be excluded from this cohort, the exclusion numbers should recorded.	Q1-Q4	n/a	1) Referrals for further intervention have been provided to the PHSP throughout the quarter, either through direct referrals or via Carenotes. 2) A quarterly report has been produced to meet this requirement. 3) Use and completion of the physical health form has been maintained at 82% with the exclusion of IThrive category of 'getting advice' and 'getting risk support' and 'not applicable' can be excluded from this cohort, the exclusion numbers to be recorded.	
	1) Develop self-help written material on first aid to manage stress and place on Trust website 2) Implement physical health service with behavioural sleep 3) Refresh staff training programme 4) Provide feedback report to CQPE	Q4	n/a	1) 1)Self-help material on drinking has been designed according to NICE Guidelines and the up-to-date evidence base. This information has been published on the Trust Website (https://tavistockandportman.nhs.uk/care-and-treatment/treatments/physical-health/) as well as the staff intranet. Please see Appendix 2 for an example of this guide. 2) Evaluation of the Living Well program has been completed. Please see Appendix 3 for more information 3) PPI feedback has been evidenced within the CQPE Workstream as held by the Director of Quality and Patient Experience. 4) A feedback report has been provided to the CQPE in January 2019.	

2.8.5 **CQUINS - 3.** Transitions out of Children and Young People's Mental Health Services (CYPMHS)

Target	Detail of indicator	Reported	Target %	Q4 18-19 Progress	RAG
Transitions out of Children and Young People's Mental Health Services (CYPMHS) Reported in Q2 and Q4	Sending Provider to undertake case note Audit assessing those who transitioned out of CYPMHS from Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.	Q4	80%	There are two sending providers, Tavistock & Portman Trust for the London Borough of Camden and Whittington Health for the London Borough of Islington. The T&P Trust (Camden) identified that 33 young people transitioned from CAMHS in Q3-Q4; of whom 27 were discharged to Primary Care and 6 to AMH. into primary or second The case note audit confirmed that all 33 cases transitioned as a result of their age. There is a good level of discharge planning for cases going to primary care and that there is a good level of Joint Agency Transition Planning for cases transitioning between CAMHS and AMHS. All of the 33 transitions cases had evidence of the young person and a parent or carer was involved at some point with the transition planning and process. 100%	
	Sending Provider to undertake assessment of discharge questionnaires for those who transitioned out of CYPMHS in Q3- Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.		80%	Most of the clinicians felt it was clinically inappropriate for the young people to complete a questionnaire at their last clinical appointment. However three young people were identified and consent was gained to approach them. We were however only able to make contact with only one of them by phone. This young person indicated that they had met their AMHS key worker before the transition whilst open to CAMHS and had felt 'quite ready' for transition. This participant understood that the reason they were moving into adult services was as result of their age. The other two who had consented to interview but were unreachable by phone were sent questionnaires by post but did not respond. . 33%	
	Receiving Provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS from CYPMHS through Q3-Q4. Performance rewarded as per rules for partial achievement of the indicator; Reward to be applied to all providers subject to this CQUIN.		70%	In Camden 6 YP were identified who had transitioned to AMHS services. 2 refused or did not respond to calls and 4 were interviewed. All 4 participants in Camden were unhappy with their transition and felt their experience highlighted a lack of knowledge about the AHMS service 100%	
	Sending & Receiving Providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via CQUIN Consolidated data collection.			Joint report outlining overall CQUIN progress to date provided	

2.8.6 **CQUINS - 4. GIDS Telemedicine / Virtual Patient Sessions**

Target	Detail of indicator	Reported	Target %	Q4 18-19 Progress	RAG
GIDS Telemedicine / Virtual Patient Sessions	Trust to begin offering online sessions.	Q3	N/A	Given the technical problems of the original Telemedicine platform that resulted in ongoing frequent, episodic loss of sound and/or picture, the GIDS service is investigating alternative cloud based solutions and has tested one of these in both Leeds and London. The Service has submitted proposals to the Trust for acquisition of other products and trialing in GIDS. Further to the limited survey data included in the Q3 report (with four positive service user responses), additional discussion with the clinicians involved in the pilot has raised important points worthy of note and reflection: GIDS clinicians believe that Telemedicine is a potentially clinically effective mode of therapeutic delivery for select, low risk service users and their families in the follow-up stages of the treatment phase. From the outset, face-to-face meetings were considered crucial to the endeavor of the assessment phase. This remains the belief of clinicians. Clinicians have highlighted the need to think further about confidentiality and about how written guidance and verbal agreement with young people may need strengthening in response to occurrences in some pilot sessions. There were occasions in pilot sessions when siblings were seen on camera or heard speaking in the background. As part of any further Telemedicine trial, GIDS will review all guidance and documentation attending this pilot to ensure they reflect the lessons learned and lived reality of the pilot sessions so as to better inform service users of expectations and the reasons for and importance of these expectations to the clinical and therapeutic efficacy of the Telemedicine sessions. One clinician spoke passionately about a Telemedicine session that she believed was deeper and more fruitful than any face-to-face session she had had with the young person. Being at home, sitting on the bed with the pet cat close had a profound effect on the young person who was far more relaxed and open as a consequence. GIDS remains committed to Telemedicine as a modality capable of improving service user experience, particularly as it can eliminate the need for parents, siblings and the young person themselves from needing to take time off work or school to attend appointments. Clinicians are frequently asked about the possibility of telephone and videoconferencing appointments and feedback from ESQs have also highlighted service users' desire for virtual appointments. GIDS clinical staff in both London and Leeds are enthusiastic about Telemedicine. If a glitch-free, fully functional system is acquired, there will be many clinicians eager to take part in further tests and trials. Several have already identified families who would particularly benefit from Telemedicine sessions. Some clinicians have begun using Skype for Business for professional only network meeting and consultations with colleagues in CAMHS in keeping with Trust IG protocols and have found this application of videoconferencing to be incredibly useful.	
		Q3	N/A		

2.8.7 **CQUINS - 5.** GIDS Transfer arrangements across the Gender Identity Pathway 1/2

Target	Detail of indicator	Reported	Target %	Q4 18-19 Progress	RAG
GIDS Transfer arrangements across the Gender Identity Pathway	Instigate patient feedback process in line with what was agreed in Q2	Q4	NA	Negative patient feedback on transitions confirms that very long waiting times and confusion about the varied operations of adult services have an ongoing, significant negative impact on patient experience. What is currently being done to progress the CQUIN and recommendations for future practice to improve patient experience: **Developing relationship between GIDS and Charing Cross GIC:** Staff in both services continue to meet and communicate regularly to identify better means of easing the transition of service users. In Q4 administrative and managerial staff from GIDS visited the Charing Cross clinic, some for the first time, and met with colleagues there.As processes supporting effective collaboration are being enhanced, closer examination of difficult transition cases and of complaints will be jointly undertaken in an effort to gain additional learning and further improve practices and procedures. **Relationship building between GIDS and other Adult Services in England:** The GIDS Service Director and senior clinicians based in London, Leeds and Bristol continue to develop closer links with the six other adult services in England and to provide regular updates at All Team Meetings, Away Days and so forth. On the whole, the results of relationship building have been very positive. **Communications with service users:** GIDS has drafted an informational leaflet and text for its website that offers young people key information relating to the transition to adult services. The text has been reviewed by clinical and managerial staff in both GIDS and Charing Cross GIC and will soon be shared for consultation with adult services outside London and service users in GIDS and GIC. We anticipate widely disseminating this information in Q1 19/20 and building regular fact checking and cyclical updating protocols into GIDS service and communications procedures going forward. **Communications with 17 year olds on the waiting list:** In Leeds in Q4 17 year olds and their parents were invited to a pilot group event providing information about adult services and the referral process as well as providing the opportunity for young people and parents to meet one another, network and participate in group discussions. In London in Q3 GIDS implemented protocols to support piloting an initiative to call those on the waiting list aged 17 years and 10 months or above. In Q4, the pilot was broadened and a further 20 young people were telephoned. **Data Collection:** Although GIDS does not currently collect service user survey data on Transitions, this will be given further consideration in the near future. The forthcoming procurement of the online survey platform Qualtrics for GIDS will offer new, more efficient and user-friendly possibilities for collecting data from current service users and those who have used the service in the past across all pathways.	

2.8.7 **CQUINS - 5. GIDS Transfer arrangements across the Gender Identity Pathway 2/2**

Target	Detail of indicator	Reported	Target %	Q4 18-19 Progress	RAG
GIDS Transfer arrangements across the Gender Identity Pathway	Continue to provide quarterly patient flow reports concerning transition over 2018/19	Q3	NA	In addition to continuing to provide flow reports, in Q4 GIDS staff and colleagues in the Trust's Informatics team developed new data capture protocols in Carenotes that track service users' referrals to endocrine services and, subsequently, to adult services. This will enable reporting directly from Carenotes and replace less robust recording in shared spreadsheets. The new data capture and reporting facility went live on 01.04.19.	
	Continue to provide transition workshops for patients over 2018/19			A number of forthcoming transition clinics involving clinical colleagues from Charing Cross GIC will be offered to GIDS service users on a biweekly basis. In Q4 the GIDS Team further clarified the criteria for acceptance and inclusion in transition clinics and Carenotes is being modified to record transition clinic appointments as distinct from other types of appointments. In GIDS in Leeds, clinicians are soon to pilot clinician-to-clinician transition clinics with clinicians in Newcastle adult gender services via Skype for Business using anonymized patient data relating to young people referred by GIDS to Newcastle in the last six months.	

2.8.8 **CQUINS - 6. GIC Transfer arrangements across the Gender Identity Pathway**

Target	Detail of indicator	Reported	Target %	Q4 18-19 Progress	RAG
GIC Transfer arrangements across the Gender Identity Pathway	Instigate patient feedback process in line with what was agreed in Q2	Q3	N/A	Developing relationship between GIDS and Charing Cross GIC: Staff in both services continue to meet and communicate regularly to identify better means of easing the transition of service users. In Q4 administrative and managerial staff from GIDS visited the Charing Cross clinic, some for the first time, and met with colleagues there. As processes supporting effective collaboration are being enhanced, closer examination of difficult transition cases and of complaints will be jointly undertaken in an effort to gain additional learning and further improve practices and procedures. Communications with service users: GIDS has drafted an informational leaflet and text for its website that offers young people key information relating to the transition to adult services. The text has been reviewed by clinical and managerial staff in both GIDS and Charing Cross GIC and will soon be shared for consultation with adult services outside London and service users in GIDS and GICs. Communications with 17 year olds on the waiting list: In Q3 GIDS developed protocols to support piloting an initiative to call those on the waiting list aged 17 years and 10 months or above. In Q4, the pilot was broadened. Because of this new process, the London GIC will only be offering priority appointments to GIDS patients who have had two clinical appointments or more. The patients who receive a single appointment will transfer to the London GIC waiting list and their GIDS referral date will be honored.	
	Continue to provide quarterly patient flow reports concerning transition over 2018/19			As a matter of standard treatment plan, all GIDS graduates now have an endocrine appointment with the London GIC Endocrine team. This is a new development and was put in place as a safety precaution as many GIDS graduates come to the GIC having some experience of endocrine treatment previously.	
	Continue to provide transition workshops for patients over 2018/19			A limited number of transition clinics involving clinical colleagues from Charing Cross GIC continue to be offered to GIDS service users. As in all aspects of service delivery in gender, demand far outstrips capacity. One of the Psychiatrists in the GIC has been nominated to take these clinics over from Dr. Barrett so that these clinics can happen more frequently and consistently which will benefit both clinics. It is anticipated that this colleague will begin these clinics in late Q1 2019-20 after a handover transition clinic with Dr. Barrett.	

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2019/20 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Following the Trust's CQC well-led inspection, a review is being undertaken of the organisation's clinical, quality, safety and governance committee.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Paul Burstow

Signature _____ **Name** Paul Jenkins

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A [ ] Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | 2019/20 | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Burstow	**Name**	Paul Jenkins
Capacity	Trust Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

The Tavistock and Portman NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7" | **Financial Year to which self-certification relates** | 2019/20 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Burstow	**Name**	Paul Jenkins
Capacity	Trust Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	May 2019

Board Assurance Framework

Executive Summary

The Assurance Framework identifies key risks to achieving the Trust's strategic objectives as set out in the Current Annual Strategic Plan. Amendments are highlighted in red. There are two risks rated 16 (Risk 4 & 12) summarised below, and four risks rated 12. Risks 2, 7, 9 and 10. These concern: pressures on leadership and impact on staff; wider financial pressures in NCL; tension between demand and resources in gender service and reactive communications work.

Two risk scores have increased this quarter: Risk 4, 'Risk to the deliverability of appropriate Estates solutions' from 12 to 16 and Risk 12, 'that the Trust fails to deliver its financial plan', from 8 to 16.

Two risk scores have reduced this quarter. Risk 5, '…Risk of insufficient staff capacity with negative consequences in relation to service quality or ability to bid for and deliver future developments' from 12 to 8, and Risk 1, relating to the viability of the National Training Contract with HEE reduced from risk level 12 to 6.

The BAF is brought to the Board in May having been updated and reviewed by the Executive Management Team on 14th May 2019. The risks in the July BAF will be against the 2019/20 strategic objectives along with a reviewed Risk Appetite statement and Risk Appetite Assessment for approval.

Recommendation to the Board

The board is asked to note the board assurance framework

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

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

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

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

1.3 The BAF Heatmap presents all BAF risks on a single page as an overview of the current position. The direction of travel for each risk from last assessment is also included.

1.4 Ongoing work is continuing, reviewing individual risks against agreed risk appetites.

1.5 The new electronic risk management system is not due to be 'live' until July. It is likely that a new look BAF will not be implemented until the autumn.

2. APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

3. RISK SUMMARY

3.1. Risks 4 and 12 are both now rated 16.

3.2. There are four risks rated 12 – Risks 2, 7, 9 and 10.

Risk Level Reductions

3.3. Risk 1, 'Risk relating to the viability of the National Training Contract with HEE' reduced from risk level 12 to 6 due to the increased positive profile of the NWSDU and engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy.

3.4. Risk 5, 'Risk of insufficient staff capacity with negative consequences in relation to service quality or ability to bid for and deliver future developments' reduced from risk level 12 to 8 following confirmation the Trust had met its financial targets.

Risk Level Increases

3.5 Risk 4, 'Risk to the deliverability of appropriate Estates solutions' increased risk level from 12 to 16 with confirmation that long-term relocation is looking more difficult.

3.6. Risk 12, 'Risk that the Trust fails to deliver its financial plan' saw an increase in the likelihood following External Auditor challenge to the end of year Accounts.

3.7. No other risk levels have changed although action plans and assurances have been updated.

4. RISK APPETITE

4.1 Risk Appetite Statement:

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

Overarching risk appetite descriptions

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

Risk Appetite assessment against Strategic Aims

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

5. CONCLUSION

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

MAY 2019 BAF HEAT MAP

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

MARCH 2019 BAF HEAT MAP

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

Board Assurance Framework 2018/19 – Summary

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
1	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	Chris Caldwell	People	9 (3x3)	9 (3x3)	9 (3x3)	6 (2x3)	**Green (1x3)**
2	The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	Craig de Sousa	People	12 (3x4)	12 (3x4)	12 (3x4)	12 (3x4)	**Yellow (2x4)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
3	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.	Louise Lyon	People	8 (2x4)	8 (2x4)	8 (2x4)	8 (2x4)	**Green (1x4)**
4	The risk that the Trust fails to deliver affordable and appropriate Estates solutions with a negative impact on patient, staff and student experience.	Terry Noys	People	16 (4x4)	12 (3x4)	12 (3x4)	16 (4x4)	**Yellow (2x4)**
5	The risk that there is insufficient staff capacity with negative consequences in relation to quality of current activities or the ability to bid for and deliver future developments.	Julian Stern/ Sally Hodges/ Brian Rock	Services	12 (3x4)	12 (3x4)	12 (3x4)	8 (2x4)	**Yellow (2x4)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
6	The risk that issues with the quality use of data impact on decision making and the quality and effectiveness of the Trust's services.	David Wyndham Lewis	Services	9 (3x3)	9 (3x3)	9 (3x3)	9 (3x3)	**Yellow (2x3)**
7	The risk that wider financial pressures in North Central London with consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	Paul Jenkins	Services	12 (4x3)	9 (3x3)	12 (4x3)	12 (4x3)	**Yellow (2x3)**
8	The risk that Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability.	Rachel Surtees	Growth	12 (4x3)	9 (3x3)	6 (2x3)	6 (2x3)	**Yellow (2x3)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
9	The risk that it is not possible to reconcile tension between demand and resources in respect of gender services with consequences for safety and patient experience.	Sally Hodges	Growth	12 (4x3)	12 (4x3)	12 (4x3)	12 (3x3)	**Amber (3x3)**
10	The risk that the pressure of reactive communications work means that the Trust lacks capacity to deliver the External Affairs Strategy, failing to raise its external profile on the range of issues where it aims to influence public policy	Laure Thomas	Growth	12 (4x3)	9 (3x3)	12 (4x3)	12 (4x3)	**Yellow (4x2)**
11	The risk that the Trust fails to meet its regulatory responsibilities to CQC and QAA with negative consequences for our reputation and the quality of patient and student experience.	Louise Lyon Brian Rock	Finance / Governance	8 (2x4)	8 (2x4)	8 (2x4)	8 (2x4)	**Green (1x4)**

				Current Risk Score				
	Risk	**Owner**	**Strategic Aims**	**July 2018**	**Nov 2018**	**Mar 2019**	**May 2019**	**Target Risk** L = likelihood C= consequence Risk = L x C
12	The risk that the Trust fails to deliver its financial plan with negative consequences for the delivery of our Control Total and an impact on the quality of our services.	Terry Noys	Finance /Governance	16 (4x4)	12 (3x4)	8 (2x4)	16 (4x4)	**Yellow (2x4)**

Strategic Aims 2018: People; Services, Growth and Development; Finance and Governance

Strategic Aim: People

Corporate Objectives:

1. Position the Trust as a respected authority on workforce development: **Director of Nursing**
2. Implement the People Strategy with the aim of supporting the resilience, development and performance of our staff: **Director of HR and Governance**
3. Implement the Race Equality Strategy: **Director of Quality and Patient Experience**
4. Develop our Estates to deliver the right Estates solution for the work of the Trust: **Director of Technology and Transformation / Deputy CEO**

RISK 1): *The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England.*	
Risk Owner: **Chris Caldwell**	Date reviewed: May 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: • The NWSDU and National MH Workforce Development Collaborative are now firmly established. • The Collaborative is being evaluated well by those attending and has delivered some ~~early~~ positive work, member participation is appropriately interest based in working groups but engagement can be variable at Steering group level. • The NWSDU has established a positive profile and early project outputs are being well received by the HEE National Mental Health, LD & Dementia Board and associated delivery group. • The implementation of the MH workforce Strategy at national regional and STP level is now more than one year into implementation and whilst there are still significant financial challenges and uncertainties potentially impacting against its successful delivery albeit that locally and regionally there is good engagement and evidence of significant service improvement and expansion is now emerging	

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- The Unit is engaged with the ALBs in the development of the Long Term Plan People Strategy
- National Training Contract (NTC) is annual and HEE have funding pressures which may impact on this, this impact may be wider than just the work and future of the NWSDU

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Controls/Influences *(what are we currently doing about this risk?)*:

Effective governance communications and engagement strategies and process in place

Trust represented at key groups nationally regionally and locally (STP) in relation to MH Workforce strategy and FYFV implementation

Processes to monitor impact in place

PDC monitors NWSDU project plans monthly

HEE steering group established (monthly x 10 per year)

Regular Review of Collaborative performance

Refreshed approach to NTC management and monitoring

</td><td>

Assurances received *(independent reports on processes; when; conclusions)*:

NWSDU Steering Group with HEE now established to ensure effective governance, engagement and buy in at national level & membership of all appropriate groups/committees (+) Strategy launched for NWSDU (including the Collaborative) with Communications workshop run, website launched and conference planned for Spring (+)

NWSDU project plans in place with risks and milestones (+) HEE steering group minutes (+)

Collaborative and NWSDU communications strategies and plans developed and in delivery (+)
Delivery of National Mental Health Workforce conference April 4th 2019 positively evaluated (+) Direct engagement with ALBs on NHS Long term plan to raise profile completed via pan ALB health and wellbeing group (+)
National Training Contract successfully negotiated (+)

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Gaps in controls/influences:

Early stages of work
Beginning to create outputs which are attracting interest – e.g. Stress and resilience framework
Competing pressures on people resources in Trusts and Collaborative limiting activity

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Action plans in response to gaps identified: *(with lead and target date)*

Developing rollout of national training roadshows in collaboration with lead commissioner & identified regional contacts – (Brian Rock FY19/20)

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Mechanisms for measuring impact of STP work still being established nationally Impact of NHSI / HEE closer working and potential changes in strategy and priority with impact on NTC currently unknown Impact of the NHS LTP is currently unknown NWSDU projects now attracting interest & engagement of key national stakeholders; NWSDU now invited to attend key national groups	

RISK 2): *The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.*	
Risk Owner: Paul Jenkins/Craig de Sousa	Date reviewed: May 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	
Rationale for current score: There are continuing signs through the NHS Staff Survey and from feedback from our staff there continues to be work based pressure which is resulting in stress and a long hours working culture.	
Controls/Influences *(what are we currently doing about this risk?)*: OD and People Strategy Implemented Localised actions plans following each staff survey Leadership Development Programmes launched to improve capacity, capability and resilience Business Development Group established to provide structured oversight of growth opportunities. Quality improvement programme launched. Quality Impact Assessments launched at directorate and service level. Revised appraisal process linked to corporate objectives. Reducing the burden programme launched	Assurances received *(independent reports on processes; when; conclusions)*: NHS Staff Survey 2018 (+ /–) Quarterly Friends and Family Test Results (+) Quarterly HR & OD Assurance Reports (+)
Gaps in controls/influences: Capacity to engage with structured development. Succession plans to cope with long periods of absence at service director level. Increased media attention impacting morale of staff	Action plans in response to gaps identified: *(with lead and target date)* OD and People Strategy – **HR Director –** 2020 Staff survey action plans – **All Directors** – 2019 Staff Education Programme – **HR Director –** 2019

RISK 3): *The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.*	
Risk Owner: Louise Lyon	Date reviewed May 2019
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	
Rationale for current score: The Race Equality Strategy was approved by the Board in September 2017. Whilst good progress has been made in delivering on the action plan, we will fail to deliver if we do sufficiently engage staff at all levels, especially white staff currently occupying the more senior positions, in understanding the strategy and implementing those elements which are within their responsibility and authority to do so. Consequence is rated at 4 because if the Trusts fails deliver, BAME staff will lose confidence that the trust is fully committed to equality which could lead to BAME staff disengagement and all staff may lose confidence in management's capacity and integrity which could impact negatively on service delivery	
Controls/Influences *(what are we currently doing about this risk?)*: Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee Race Equality Champion appointed and BAME network established: regular communication between the Champion and the Director of Quality and Patient Experience and the Director of HR provides feedback on the implementation as the Strategy is under review in the BAME network 2019 action plan developed and approved by the Trust board.	Assurances received *(independent reports on processes; when; conclusions)*: Workforce Race Equality Standard annual report (+/-) Staff survey (+ / -) November CQC report confirmed that staff remain unconfident about progress (-) Revised action developed in consultation with BAME network, approved by the Board March 2019 (+)
Gaps in controls/influences: Further training for managers who have attended Think Space events to ensure clarity about action necessary to implement the strategy at local level	Action plans in response to gaps identified: *(with lead and target date)* Develop training plan for managers, (Director of HR and Governance, October 2019)

	RES reviewed at Board seminar attended by Board, Management Team BAME champion and further action agreed at Management Team. EDI to review progress at November Committee meeting.

RISK 4): *The risk that the Trust fails to deliver affordable and appropriate Estates solutions with a negative impact on patient, staff and student experience.*	
Risk Owner: Terry Noys	Date reviewed: 13 May 2019
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (up from 12 previously)	
Rationale for current score: Score reflects balance of short, medium and long term issues. Long term Relocation is looking more difficult, whilst remaining at the Tavistock Centre brings its own challenges in terms of health and safety; maintenance back-log; and possible refurbishment / reconfiguration. Need for Scheduling project to succeed and need to overcome cultural inhibitors if real progress to be made. Also challenge around accommodation for Gender Identity Clinic and other activities located in satellite sites.	
Controls/Influences *(what are we currently doing about this risk?)*: Relocation project in train. Medium / long term planned preventative maintenance programme in place. Scheduling Project in train. Revised / updated policies on Health & Safety, Fire Safety and Water Safety in place. Estates and Facilities Compliance and Risk Work Stream of the CQSGC established. On-going discussions with London Borough of Camden	Assurances received *(independent reports on processes; when; conclusions)*: Asset / stock condition surveys in place. (+) Tavistock Centre / Relocation Programme Board reports to main Board (+ / -) Premises Assurance Report received (+)
Gaps in controls/influences: Affordability of Relocation still being evaluated. Affordability of solutions for GIC	Action plans in response to gaps identified: *(with lead and target date)* Market testing of Relocation / Refurbishment options ***Ian Garlington, Dec 2019*** GIC Accommodation Task and Finish Group. *Ian Garlington, June 2019*

Strategic Aim: Services

Corporate Objectives:

5. Implement the Clinical Quality Strategy: **Director of Quality and Patient Experience**
6. Strengthen our collection and use of data to inform decision making and improve the effectiveness and quality of our services: **Director of Quality and Patient Experience**
7. Extend existing and develop new services in AFS/ CYAF /DET to respond to changing demand / new opportunities including, where appropriate, the use of technology: **Director of AFS; Director of CYAF; Director of DET**
8. Contribute to the development of North London Partners in Health and Care: **CEO**

RISK 5): *The risk that there is insufficient staff capacity with negative consequences in relation to quality of current activities or the ability to bid for and deliver future developments.*	
Risk Owner: **Julian Stern/Sally Hodges/Brian Rock**	Date reviewed: **May 2019**
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	
Rationale for current score: The environment that the Trust is operating within is constrained financially and has high expectation requirements to deliver against commissioner orientated performance standards. Added with the Trust's ambition to grow and concurrently undertake transformational change is putting pressure on staff at all levels across the organisation to balance delivering business as usual and to pursue growth. However, we did meet year end within our financial target so the likelihood has reduced.	
Controls/Influences *(what are we currently doing about this risk?)*: Clinical quality strategy to set out the direction of travel.	Assurances received *(independent reports on processes; when; conclusions)*: HR & OD Quarterly Assurance Report (+ -) Finance and Performance Report Monthly (-)

Strengthen business development functions to conduct due diligence and support growth in a planned way. Established a business development group to provide operational oversight to growth and contract maintenance. Established directorate executive teams (AFS, CYAF and DET) to operationally manage challenge. Appointment to DET senior management role with Nov 2018 start date focusing on increased delivery of existing and development of new product areas Board Away day focused on preferred growth areas to enable directors to plan ahead for capacity	Quality Dashboard (+) Waiting Times Report (+ -)
<u>Gaps in controls/influences</u>: Staff survey results highlight continued pressure on staff Gaps within the cost improvement programmes Several relevant bids coinciding drawing on the same leaders	<u>Action plans in response to gaps identified</u>: *(with lead and target date)* DET Task and Finish Group focusing on changes to the delivery model for long course provision to reduce cost base and review course profitability including fee reviews. AY19/20 focussed on increasing group sizes and introducing Associate Lecturer roles. ***Brian Rock / Terry Noys – AY 2019/20*** Include central resources for all new bids

RISK 6): *The risk that issues with the quality use of data impact on decision making and the quality and effectiveness of the Trust's services.*	
Risk Owner: David Wyndham Lewis	Date reviewed: May 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	
Rationale for current score: The Trust Board has received reports over an extended period that indicate a perception that poor data quality is proving a challenge to delivery of operational objectives, as well as limiting the opportunity for detailed understanding on existing performance of Trust services as a means of both performance management and quality improvement. Initial investigations, summarised as a paper to be presented to EMT in July 2018, indicate that there are challenges at each stage of the clinical pathway. Equally the implementation of MyTAP is highlighting similar issues present in our education and training services. Initial investigations indicate the primary cause for the data quality issues is unwarranted variation in practice in both clinical directorates and DET.	
Controls/Influences *(what are we currently doing about this risk?)*: Ongoing monitoring and reactive improvement works undertaken by the Data Quality Team for clinical data. Ongoing monitoring and reactive improvement works undertaken by the Contracts Team for performance management covering clinical directorates. Interim improvements to management and consistency of reports made available by Informatics team to Trust using existing legacy data warehouse. Data Quality Project commissioned and initial report on problem areas produced.	Assurances received *(independent reports on processes; when; conclusions)*: Initial data quality report created for presentation to EMT in July 2018 (+) Documentation of problem areas, including indication that most are already subject to some iterative improvement work being led by Data Quality Team (+)

Data Quality Improvement Project Board has commenced workstream to prioritise outstanding issues against improvements made to date and Trust objectives.	HESA have now declared our submission credible and signed off the data so we have successfully completed the return within the deadline (Nov 2018) (+) Assurance on clinical data quality received following audit January 2019 (+)
Gaps in controls/influences: Data Quality Improvement Project ongoing and focussed primarily on clinical activity. While problem areas are highlighted and an approach where remediation is achieved vertically by clinical team rather than horizontally across the organisation, no structured work streams have started. Work commencing to review practice and data quality within MyTAP to understand where issues exist within DET. This will be associated to the HESA and HESIS reporting currently required and evolving as we move from HEFCE to OfS.	Action plans in response to gaps identified: *(with lead and target date)* Data Quality Improvement Project – project has continued to progress with workstream defined. QI approach agreed but not yet resourced. Project update alongside resource requirements to be presented back to EMT in May 19. BAU improvements by Data Quality Team are proving successful, notably with the operational performance reports now provided to clinical governance meetings in CYAF. Completion of agreed projects for clinical activity expected to be twelve months starting with approval of revised brief – so estimated February 2020. Sign off of proposal to implement data warehouse link from MyTAP. This will allow similar data quality and performance reporting for DET, notably for HESIS and HESA returns.

RISK 7): The risk that wider financial pressures in North Central London with consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	
Risk Owner: Paul Jenkins	Date reviewed: **May 2019**
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	
Rationale for current score: Wider financial pressures across the STP require the development of a 3-year medium term financial plan to restore balance across the sector. While there is greater protection post the Long-term Plan for mental health investment it will have an impact on the overall environment in which we are operating.	
Controls/Influences *(what are we currently doing about this risk?)*: Strong engagement with the STP with CEO as SRO for Mental Health Work close with partner provider organisations Modified Delivery Plan for focus on areas of greatest priority Focus on collecting evidence across workstreams to show positive economic impact of mental health interventions. Understanding future ambitions/plans for organisational change to support integrated working. Task and Finish Group on MH Liaison established Autumn 2018	Assurances received *(independent reports on processes; when; conclusions)*: Updated MH Delivery plan (+) Agreement on new arrangements for mental health liaison (+) ; Outcome of TAP economic evaluation; Action plans on CAMHS crisis provision drafted (+) Agreement reached on Mental Health Liaison model across NCL but some financial issues with implementation (+/-)
Gaps in controls/influences: Decisions of the regulators Wider financial position across the STP	Action plans in response to gaps identified: *(with lead and target date)* Involvement in development of medium-term financial plan (Summer 19); Further refresh of priorities in line with NHS Long Term Plan (Summer 19); Development of mental health compact in NCL including CAMHS (Summer 19) Involvement integrated care model in Camden (ongoing) Action plans on local commissioning of Tier 4 TBA

RISK 8): *The risk that Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability.*	
Risk Owner: Rachel Surtees	Date reviewed: 13 May 2019
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6	

Rationale for current score:

The 19/20 new business contribution target is achievable but ambitious. Converting new business prospects into full credible proposals requires high levels of resource from Business Development and clinical/DET teams. Clinical and DET staff have limited dedicated development sessions, meaning work towards the growth agenda needs to be fitted in 'on top of the day job'. For tendered opportunities in particular, resource needs to be made available at short notice to be able to meet externally driven deadlines.

An area being actively explored is the development of new revenue streams through the commercialisation of 'products' developed through our services or courses. The Trust does not have the in-house skill sets to lead commercial contract or partnership negotiations in relation to IP; revenue/royalty shares etc. If identified as a viable major growth area this will need to be addressed, however, 'new product sales' are not currently being considered in the new business income forecasts.

Implementation of new services is a resource intensive process generally lasting ~6 months. Every 'win' therefore reduces senior leadership, BD and operational capacity to maintain momentum to deliver the new business pipeline as resource is diverted to support service mobilisation.

Experience and skills in CYAF, AFS and DET to support business development opportunities is typically held by the senior management teams. Limited clinical and training capacity remains a risk, but is currently slowing the rate of growth as opposed to blocking growth.

Controls/Influences *(what are we currently doing about this risk?)*: -Active management of pipeline to have even spread of prospects across the three directorates and at different stages of development (prospect development; proposal writing; in implementation). -Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG). -Named target market areas to enable better focus and prioritisation on our target routes to growth. -Moving away from a culture of pursuing high numbers of smaller prospects that deliver incremental gains, to focus on larger or scalable opportunities	Assurances received *(independent reports on processes; when; conclusions)*: Pipeline report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Contribution forecast report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Regular Business Development representation at CYAF; AFS & DET Executive Management Team meetings (+/-)
Gaps in controls/influences: Increasingly fewer opportunities to 'free up' CYAF; DET or AFS staff without impacting clinical/training delivery. Pipeline heavily impacted by external factors outside of the Trust's control. Dedicated implementation unit is likely to be required to support mobilisation of any successful large-scale tenders	Action plans in response to gaps identified: *(with lead and target date)* -Identifying staff from clinical and DET working in key growth areas who could be trained and supported to take up more active role working with BD – Sally Hodges; Julian Stern; Brian Rock (July 19) -Identified staff to be trained and supported for active role with BD – Rachel Surtees (Sept 19) – maintain a varied pipeline without over-reliance on politically vulnerable new opportunities – Rachel Surtees (ongoing) – develop updated service mobilisation process to support large scale implementations – Rachel Surtees (subject to outcome of submitted tenders)

Strategic Aim: Growth and Development

Corporate Objectives:

9. Develop the Trust's position in national and transnational education including the launch of a Digital Academy: **Director of DET**
10. Develop an effective model for systemic support for organisational wellbeing and secure its implementation in at least one setting: **CEO**
11. Respond to the national procurement of gender identity services with the aim of establishing the Trust as an international centre of excellence for gender work: **Director of CYAF; Director of Strategy**
12. Implement our social investment model for FDAC and explore other opportunities for innovative financing of our services: **CEO**
13. Raise our public profile as a thought leader and influencer in line with our External Affairs Strategy and building on the outputs from research: **Director of Communications and External Affairs**

RISK 9): *The risk that it is not possible to reconcile tension between demand and resources in respect of gender services with consequences for safety and patient experience.*	
Risk Owner: **Sally Hodges**	Date reviewed: May 2019
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	
Rationale for current score: Referrals are still coming into both Gender Services at a rate and number greater than predicted and therefore funding has continued to be less than required to meet access targets A focus on achieving first appointments (reducing wait times), particularly in the adult gender service, has put huge pressure on the service leading to increasing length of time between appointments. This has increased risk as we cannot ensure continuity and smooth process through the service. In the children's service, the profile of children and young people has shifted, meaning that increased	

resources need to go into managing risk, putting further pressure on the growing waiting list. The intense focus on GIDS over the last quarter has impacted on activity and staffing levels	
Controls/Influences *(what are we currently doing about this risk?)*: **For GIDS;** running waiting list groups, providing as much information about waiting list services as possible, communicating regularly with NHS England about the issues, developing telemedicine approaches, building the research basis about outcomes to better inform practice going forward. NHS E will be allocating a resource to GIDS from December to look at all possible influences as they consider how best to support the service with this. **For GIC;** Running information workshops for patients on the waiting list, providing information on the website and communicating regularly with NHSE about the issues. Weekly review of referrals to both services to identify changes to profiles	Assurances received *(independent reports on processes; when; conclusions)*: Board oversight of the waiting list with a regular report (+/-) Quarterly meetings with NHSE (+/-) Both services have regular governance meetings (+/-) The Service manager in both services reviews the referral numbers and rates on a weekly basis in order to ensure early identification of any change in profile of referrals (+/-)
Gaps in controls/influences: Numbers of referrals continue to rise, with no possibility of determining when flow may reduce Profile of children and young people referred is increasingly risky Staff leaving the service on a regular basis reduces the capacity Recruiting and training also reduces capacity over a significant period Current focus on the service through the service review and media interest is taking up additional resources. Media and trust focus on the service is impacting on morale and capacity NHSE are reviewing service and may make additional changes to the provision	Action plans in response to gaps identified: *(with lead and target date)* The service is working closely with local CAMHS to improve capacity to manage risk – Service Director and CYAF Director (ongoing), Work with NHSE to develop training programmes to ensure greater recruitment field – Service Director and CYAF Director (April 2020); Both services have an ongoing recruitment programme. GIDS over recruits because of the recent profile of staff turnover GIDS and GIC Directors (Ongoing); Additional leadership and ongoing communications support to the team is in place (ongoing)

	Increased central support to GIDS as we stabilise environment (all in EMT/Ongoing) Working closely with NHSE to ensure any impact is recognised and appropriately funded (SH, Ongoing) Implementing the GIDS action plan (SH and others)

RISK 10): *The risk that the volume of reactive communications work in the area of gender means that the Trust would not have the capacity to deliver the External Affairs Strategy, failing to raise its external profile on the range of issues where it aims to influence public policy*	
Risk Owner: Laure Thomas	Date reviewed: 14 May 2019
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood ~~3~~4 x Consequence 3 = 12	
Rationale for current score: The Medical Director's review of GIDS along with the initial concerns raised by a former staff governor were leaked to the media and certain groups which has led to a high level of reactive communications, both media and FOI based. We expect this interest will continue and there will be great scrutiny of our research and implementation of the Action Plan. The external environment continues to be highly polarised with groups seeking earlier / quicker intervention and others seek a stop on physical intervention in CYP and greater regulation. The FDAC NU moving to the Centre for Justice Innovation is complicating our proactive communications work in this space.	
Controls/Influences *(what are we currently doing about this risk?)*: Maintaining close and strong relationships with our commissioners & Govt. Developing a Gender Communications Strategy – going to the T&F group in April. Developing a GIDS Data Strategy, inc. updated FOI sign off process, to streamline responding to queries. While we hope this will make this activity less onerous, given the volume of questions, we are not anticipating a reduction in activity. Making communications & external affairs a key workstream of the Gender Task and Finish Group.	Assurances received *(independent reports on processes; when; conclusions)*: Reporting back to External Affairs Committee Communications representation on the Gender Task and Finish Group, inc. draft GIDS Data Strategy presented. Taking part in GIDS sounding board. Working closely with commercial team on tenders. Sourcing external support to cover staff absences at expected busy time. Dedicated resources in the team for non-gender work have led to resource being available for proactive

Keeping all internal stakeholders sighted on new and emerging gender-related issues & continuing to adopt a positive and thoughtful approach to communications. Direct communications lines established between FDAC London, FDAC Coventry, the Trust and Century Films. Speaking to other production companies about other topics (e.g. ViPP). Actively working with Dr Felicitas Rost on the Depression Guidelines campaign. Ensuring cover for communications for a period of short-staffing coming up and looking to work with this agency on proactive comms going fwd.	communications work around trailblazers and Child House and other relevant External Affairs Strategy topic areas.
Gaps in controls/influences: Potential for extra gender comms resource needed in the event of a successful NU bid or secure school bid. Ensuring all staff (mainly across gender services) are aware of lines and plans and do not comment publicly on gender related issues. Loss of expertise, links and support with FDAC NU closure.	Action plans in response to gaps identified: *(with lead and target date)* Gender communications strategy drafted and to go to Task and Finish Group for sign off (M Smith L Thomas May 19) GIDS Data Strategy (DSinha and LThomas May 19)

Strategic Aim: Finance and Governance

Corporate Objectives:

14. Continue to meet regulatory standards with QAA: **Director of DET**
15. Continue to meet regulatory standards with CQC: **Director of Quality and Patient Experience**
16. Meet our Control Total for 2018/2019: **Director of Finance**
17. Develop the Governance and leadership of the Trust, implementing effectively the review of Board Business: **CEO**

RISK 11): *The risk that the Trust fails to meet its regulatory responsibilities to CQC and QAA with negative consequences for our reputation and the quality of patient and student experience.*	
Risk Owner: Louise Lyon/Brian Rock	Date reviewed: **May 2019**
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	
Rationale for current score: For CQC, compliance is regularly monitored internally but potential gaps have emerged in the course of more detailed preparation for inspection which it may not be possible to address before the inspection is completed in September 2018. Failure in compliance with CQC standards would raise serious questions about the safety and quality of our services which would in turn undermine public confidence and negatively impact on our reputation. For QAA, compliance is monitored through annual monitoring visits through reviewing progress our QAA action plans. Student engagement is a key influencer here, so the monitoring and addressing of areas of satisfaction and improvement through our annual student survey is another important area. Institutional reviews conducted by our university partners contribute to our understanding of areas of positive performance and areas requiring improvement. Concerns in relation to the QAA requirements would undermine confidence in our educational provision and negatively impact our reputation.	

Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:
We completed a well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps. We are actively working through on our action plans from our QAA review and have established plans from recent university partner institutional reviews (Essex and UEL). Annual student survey completed and is being reported through Education 7 Training Committee in December 2018. Early indications are positive with high levels of student engagement.	Work streams reporting to the Board level Clinical Quality Safety and Governance Committee provide assurance of compliance and raise issues of risk to compliance with CQC(+) Informal CQC rating Good overall, Outstanding Effective. All other ratings are good in all areas with Requires Improvement in gender services for Responsiveness because of waiting times Formal CQC report received November 2018 confirming informal ratings above (+) Excellent outcome from 2018 QAA monitoring visit (+) Positive university partner institutional reviews commending course provision and faculty expertise and commitment (+) HESA have now declared our submission credible and signed off the data so we have successfully completed the return within the deadline (Nov 2018) (+) MyTaP triple upgrade successful with implementation of system developments (+) Detailed action plan to address areas identified by CQC for improvement drawn up and approved by the CQC, the Board CQSGC and the CQRG. Progress monitored via EMT and CQSGC (+)
Gaps in controls/influences: Risk management maturity	Action plans in response to gaps identified: *(with lead and target date)*

Information flow from bottom to top/ top to bottom of the Trust HESA data processes and reporting requires improvement to satisfy university partner and Office for Students (OfS) requirements.	Continue to roll out risk management training across the trust to embed risk management culture, Associate Director of Quality and Governance (Ongoing) Information flow review and clarification, Medical Director and Associate Director of Quality and Governance (Sept 18) Data warehouse capabilities being scoped to support HESA data returns through more timely reporting to drive operational compliance – Brian Rock / David Wyndham-Lewis (Dec 18)

RISK 12: *The risk that the Trust fails to deliver its financial plan with negative consequences for the delivery of our Control Total and an impact on the quality of our services.*	
Risk Owner: Terry Noys	Date reviewed: 13 May 2019
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (up from 8 previously)	
Rationale for current score: Draft statutory accounts show net surplus of £2.7m, after PSF monies of £2.2m. However, the external auditors are challenging the Trust's approach to capitalisation of relocation costs. Currently, the auditors are seeking a write-off to the I&E of around £200k, although their eventual demand could be substantially higher. Potentially, this could put place the Control Total at risk (being £1,034k including PSF of £703k).	
Controls/Influences *(what are we currently doing about this risk?)*: Board approved Budget (setting out key assumptions) Management accounts reviewed monthly by EMT and Board Regular reforecasting of full year out-turn Business Development Group and Strategic and Commercial Committee review new business pipeline	Assurances received *(independent reports on processes; when; conclusions)*: Management accounts reviewed monthly by EMT and Board (+ / -) Reforecast out-turn reviewed by EMT and Board (+ / -) Reports by DET Task and Finish Group (+ / -) Additional controls placed around recruitment (+)
Gaps in controls/influences: DET savings target not yet achieved Uncertainty over income from TAP	Action plans in response to gaps identified: *(with lead and target date)* Full year reforecast to be undertaken (TN: Nov 2018) Additional income opportunities being sought (RSt)

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	20th may 2019

Serious Incidents – Quarterly Report – Q4

Executive Summary

This quarterly serious incident summary report for the Board covers Q4 2018-19.

Clinical Serious Incidents

There were 26 clinical incidents logged in Q4. Sadly there was one patient death reported during Q4 and this patient was on the waiting list for treatment but died of cancer in a hospice.

In addition, 4 patient deaths (all GIC service) were reported externally on STEIS although all deaths occurred in Q1 and Q2 2018-19 but were reported in Q4. These cases are all subject to an internal concise report, which allows the Incident Panel to determine what type of investigation is required. Of these 4 deaths, one has now been de-escalated on the external reporting system StEIS after confirmation from the external lead Trust determined the death was from natural causes and did not warrant further investigation. It is extremely likely that we will be requesting the other 3 GIC historical deaths are also de-escalated on StEIS, once all the internal concise reports have been reviewed at the May Incident Panel.

An internal concise report was also completed following an incident involving an ex-patient of the Primary Care Services who called the service threatening to commit suicide while at a train station. The staff of this service were able to speak with the ex-patient over the phone and keep him safe until help reached him at the station.

It has been noted that there has been a sharp increase in patient aggression towards staff and this is being reported more frequently across Trust services. There were several incidents involving patients being abusive towards staff members and this is an area that will be monitored going forward. A working group has been set up to look at the issues and come up with recommendations to add to the previously issued guidance from the Medical Director on managing difficult behaviours, which will also be reported to the September CQSGC meeting.

Inquests

There was one inquest held during this quarter in relation to the death in 2016 of a young person previously known to one of the community CAMHS teams. The former medical director who commissioned the serious incident report at the time gave evidence to the inquest which was reported by local media.

Information Governance (IG) Serious Incidents

IG breaches continue to occur predominantly letters being sent to the wrong address. However, there was an incident in Q4 pertaining to a patient file (file requested by patient) which contained information relating to another patient.

There was also a complaint (not formal) related to an out of area request for a person to be seen at TPNHSFT as the person worked in locality MH services. The person's confidentiality was breached in relation to seeking out of area funding. This incident had been reported to the ICO and once investigated the ICO confirmed it had been responded to appropriately and that no further action would be taken by the ICO, and the incident was closed.

Gloucester House School Incidents

A total of 57 incidents were reported during Q4. The incidences predominantly relate to verbal/physical abuse to staff and damage to property.

Although none were considered as serious incidents it was noted that there continues to be concerns with the children climbing onto the external Monroe building adjacent to the school. This relates to the SI in Q3 where two children had used the Monroe roof to climb over the scaffolding and get into the derelict building next door. To negate this, the area has been made safe but the children continue to climb on the roof, this is being managed within Gloucester House risk management.

Incident Panel

All relevant serious incidents continue to be discussed at the monthly Incident Panel, chaired by the Medical Director. This panel reviews all serious incidents, both clinical and non-clinical, with a view to ensuring that any lessons that can be learned from these incidents are highlighted and disseminated. A learning lessons event is also held quarterly.

The serious incidents reported to the panel are discussed for suitability for further review and learning along the lines of externally reported SI, internal concise reports and mortality review, in case of natural deaths.

WE have also agreed that 4 questions should be asked for any death that becomes known. including deaths on the waiting list, which help guide the level of enquiry:

- Is there a known cause of death (CoD)?
- Is the case going to inquest?
- What were the circumstances leading to and the actual death being discovered?
- Has the death been registered on STEIS and is there to be a review?

These questions will also allow the Trust to review the death and its predictability and preventability.

Recommendation to the Board
The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper
Services

Author	Responsible Executive Director
Clinical Governance and Quality Manager	Medical Director

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Trust Board	May 2019

Guardian of Safer Working Hours 2018 – 2019 Quarter 4

Executive Summary

The number of exception reports has increased significantly resulting in an increase in the fines issues to the 3 acute trusts covered by the non-resident on call rota. The trainees will use the accrued fines to provide them with additional training opportunities.

The impact of the extent of the out of hours work continue to be monitored.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Sheva Habel	Dinesh Sinha, Medical Director

Guardian of Safe working hours Q4 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q3

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
January	7	2	3	2
February	3	1	3	0
March	17	7	3	6
Totals	27	10	9	8

Reasons for increase in exception reports:

a) Urgent CAMHS workload has increased across all three sites at all times.
b) Increase in Section 136 admissions
c) Trainees submitting more exception reports in response to encouragement and experience that reporting for additional hours worked results in payment of these hours.

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 12.
- It is possible that a work schedule review will be requested in relation to the NROC rota in the next quarter.

2.3 Vacancies

There will be one vacancy on the Child and Adolescent Psychiatry Higher training scheme in the summer.

There will be three vacancies on the Adult Medical Psychotherapy Higher Training scheme in the summer.

2.4 Locum

The NROC is currently being staffed by Trainees and by other doctors working in the trust or on bank contracts offering Locum cover.

	Number of shifts	Number Covered	Number Vacant	Clinicians
January	3	3	0	Sprs
February	1	1	0	
March	4	4	0	

2.5 Fines

	Extra hours worked	Total fine	Amount paid to trainees	Fine Remaining
January	6.5 hours @ (22.1545x4) = 576.02 6.5 hours @ (30.34 x4) = 788.8	£1364.82	£511.81	£853.01
February	13.1 @ (£22.15 x 4) = £1160.66 8.5 @ (£30.34 x 4) = £1031.56	£2192.22	£822.09	£1,370.13
March	15.5 @ (22.15 x 4) = £1373.30 2 @ (30.34 x 4) = 242.72	£1616.02	£514.99	£858.51
Totals	24.6 hours at normal rate 17 hours at enhanced rate	£4930.34	£1848.89	£3081.50

As a result of the fines Junior Doctors claiming these additional hours are paid 1.5 x the hourly rate. The rest of the fine is kept for the trainees by the GOSWH and a decision will be made as to how to spend it once an amount has been accrued.

3. Junior Doctors Forum (JDF)

This quarter I have met with the Child and Adolescent psychiatry trainees to clarify when and how to make an exception report.

The JDF was held on 1st April 2019 and will be attended by the BMA industrial relations officer.

The sustainability of the NROC rota was discussed and the need for consistent exception reports to be made so that the nature of the NROC work can be understood.

In addition to the JDF there are also a number of forums in which the CAP trainee reps meet with the GOSWH, Head of Psychiatry, CAP TPD and Consultant Psychiatrists from the three acute trusts to work on pathways to manage the workload out of hours.

4. Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC on 15th April 2019

5. Conclusions and Recommendations

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

5.2. GOSWH will continue to work with Trainee and HR on the NROC rota to ensure that trainees are working in a safe and supported environment.

Dr Sheva Habel

Guardian of Safer Working Hours, 21st April 2019

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	28 May 2019

Organisational Development and People Strategy Assurance Report

Executive Summary

In April 2017 the Trust launched and commenced implementing its ambitious three year organisational development and people strategy. This report provides the 2018/19 quarterly update on progress against the, refreshed, delivery plan.

The report also provides oversight of the Trust's workforce indicators including mandatory and statutory training compliance.

Recommendation the Workstream

The workstream is asked to note this report.

Trust strategic objectives supported by this paper

People

Author	Responsible Executive Director
Director of HR & Corporate Governance	Director of HR & Corporate Governance

Organisational Development and People Strategy Assurance Report Quarter 4 – 2018/19

1. Introduction

The organisational development and people strategy was launched in April 2017 and set a direction of travel for the next three years. An initial delivery plan was developed setting out the specific actions across the life time of the strategy.

Now in the strategy's second year, the delivery plan has been incorporated in to this report and refreshed reflecting the work undertaken in the previous year and new emerging requirements for this year.

2. Quarter three strategy delivery plan summary

In the final quarter of the year some of the work programmes identified in the people strategy have slowed down and whilst activity to deliver the actions remains in place, a number of running to a later timescale than initially planned.

Career pathways

The clinical role review project has now reached a conclusion with revised job descriptions having now been developed for all types of posts within the organisation.

This marks the conclusions a large programme of work which has been informed by participation from senior clinical operational leaders across both the adult and forensic and children, young adult and family services directorates.

The final phase of this programme of work is for all of the roles to be evaluated through the Trust's job grading process.

Occupational health

Following work with the Trust's procurement consultant, a new contract for occupational health and wellbeing services has been completed. The Trust has awarded a three year contract to Team Prevent Ltd who will take over the service from September 2019.

The new provider has experience of working with a large number of NHS organisations across England and currently holds contracts in the London region. The Trust will benefit from a provider which is better placed to provide services at distance which will include digital consultations.

The Royal Free will continue to provide the service up until the service transfer date.

LGBTQI+ champion

Following an open recruitment process the Trust has now appointed an LGBTQI+ champion. The individual will take up post on 01 April 2019 and they will be working closely with the director of HR and corporate governance the director of quality and patient experience to agree an induction and work programme for the year coming.

3. Work programmes not featured on the strategy

NHS staff survey – 2018

The HR Business Partners met with service directors to discuss the staff survey results for their respective areas. The meetings followed a structured conversation format. The purpose of this was two-fold: to identify the positive messages managers would want to share with their staff and to explore the red and amber scores to start identifying how managers will address the concern areas.

Following conversations with service directors, the red and amber areas of concern were collated. Having reviewed these, the key Trust-wide themes which occur most frequently can be categorised as follows:

- Middle manager capability (in relation to leadership and people management)

- Value of appraisal process (link between appraisal process and organisational objectives and values is still not clear to many staff)

- Lack of effective communication between senior managers and staff

- Lack of involvement in decision making/shared objectives

The HR Business Partners, in discussion with service directors, have pulled together a number of initial suggestions for action planning. The ideas below are broad-brush at present and would require further development.

Initial Suggestions

- Middle manager development programme aimed at new managers (using, e.g. competency based scheme, e-learning and practical workshops).

- Senior leadership development (e.g. structured through coaching/mentoring and the NHS Leadership Academy).

- Review appraisal process and links to organisational objectives (eg random audit of appraisals and direct feedback as to the quality of the conversation; workshops on what good appraisal looks/feels like).

- Use team meetings to gather local intelligence and develop specific action plans (e.g. ask for nominated champions from each area so the results are owned by the business rather than HR).

- Host drop in sessions for staff to share their views.

- Shift of focus from attaining high response rate to why it's important for staff to respond linked to engaging staff and capturing staff

insights/pulse of organisation throughout the year rather than just during survey period.

- Greater breadth in tailored communications from senior manager to staff (e.g. social media based messaging).

- Team building to understand where each team is in terms of maturity and to assist in defining shared objectives (e.g. Aston OD).

- Use the workplace stress and resilience framework within two services to test whether its application can result in longer term impacts on staff experience.

None of this precludes action plans being developed by individual service lines where they have identified specific areas of concern which do not warrant a Trust-wide action plan.

Pay and conditions changes

In January 2019, NHS Employers confirmed that it had not yet been able to reach an agreement with the national trade unions on a process for implementing pay progression linked to performance.

As a result of this, it was confirmed that new arrangements will be developed in the coming financial year with transition to new arrangements happening in April 2021.

Workforce information and self service

In quarter four a large piece of work to cleanse the quality of our workforce information was conducted, specifically around the use of the national occupational coding structures for our workforce information.

ESR employee self service was fully rolled out to all staff and used as the method for undertaking data security training.

Implementation of manager self service remains behind plan, this will be rectified by the creation of an ESR optimisation project to oversee the implementation and maximisation of the benefits that the national HR solution can offer.

Sustainability and transformation partnership (STP) work

The Trust's HR directorate continue to engage with the STP streamlining programme. In the quarter the Trust has now aligned its mandatory and statutory training to the footprint framework.

Our organisation is one, of very few, who have also completed all of the mandatory steps to allow portability of training records between partner organisations in the footprint.

4. Progress against the organisational development and people strategy delivery plan

The following table presents the 2017/18 element of the organisational development and people strategy delivery plan and details that planned delivery dates and what progress is being made against each of the areas.

	On target / complete
	Progressing but behind target
	Significantly behind target
	Not started

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Attract, recruit and select talent in to the organisation	Workforce planning	Develop and agree a service led workforce planning methodology and process		X		
		Implement the workforce planning processes to inform the annual operational plan			X	X

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
	Market our offering	Explore opportunities to case study careers at the Tavistock and Portman using video and digital media				X
Develop, promote, reward and recognise our existing workforce	Career pathways	Engage the heads of discipline in planning an approach to map the Trust's existing and future career pathways	X			
		Develop a clinical rotation programme to support career diversity and longer term retention.		X	X	
		Commence recruitment to rotational roles.				X
	Succession planning	Undertake an initial review of executive level succession plans.	X			
		Expand the succession planning process to director's direct line reports.		X		
		Review the Trust's appraisal process to incorporate performance measurement.			X	

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
		Launch the 2019/20 appraisal process with the performance rating methodology.				X
	Leadership and Management Development	Conduct the annual learning needs analysis informed by the 2018/19 appraisal data and commission requirements.		X		
		Launch and deliver the annual staff education, learning and development programme.			X	X
	Tavistock and Portman Academy	Review the pilot foundation teaching programme		X		
		Plan and launch the expansion of the academy programme to other core disciplines.			X	X
		Explore and agree the future year priorities.				X
	Health and Wellbeing Group	Develop the annual staff wellbeing plan	X	X		

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Protecting the health and wellbeing of our workforce	Occupational Health Service	Develop and agree a new health at work service tender specification for commencement in 2019/20.	X			
		Conduct and conclude service procurement.		X	X	
		Plan and prepare for service transitioning to new contract.				X
Respect and value diversity	Race equality strategy	Produce, analyse and publish WRES and agree the action plan	X	X		
		Train and develop race diversity interviewers to participate on selection processes.			X	
		Transition from HR business partners to the new arrangements			X	X
		Launch and deliver a series of cultural intelligence workshops for senior managers.			X	X
	LGBTQI+	Develop a role specification for an LGBTQI champion.		X		

			2017/18			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
		Seek applications and conduct a selection process.			X	
		Appoint and induct the new champion,				X
	Disability	Undertake scoping work about best practice and challenges that individuals with ASD face in employment.		X		
		Establish links with appropriate partners (e.g. charities) and develop a work programme.			X	
		Launch a series of activities to implement the work programme.				X

5. Workforce indicators

The following workforce indicators are obtained from ESR with each data item being accurate at the last day of each month.

Period: April 2018 - March 2019																
Report Title	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sep**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**Mar**	**Q4**
Staff in Post																
Full Time Equivalent Staff in Post (FTE)	590.35	593.31	591.04	591.57	592.69	589.28	594.28	592.08	604.29	613.03	616.83	611.38	628.67	643.54	652.14	641.45
Headcount	713	713	711	712.33	711	707	716	711.33	730	739	743	737.33	760	775	784	773.00
Vacancy Rate	11.49%	11.05%	11.39%	11.31%	11.14%	11.65%	10.90%	11.23%	9.40%	8.09%	7.52%	8.34%	5.75%	3.52%	2.23%	3.83%
Turnover	19.79%	19.28%	19.79%	19.62%	20.68%	20.20%	19.01%	19.96%	18.94%	18.85%	18.50%	18.76%	19.37%	18.00%	17.58%	18.32%
Stability Index	81.57%	82.70%	81.67%	81.98%	82.13%	81.78%	81.77%	81.89%	80.91%	80.90%	80.93%	80.91%	81.34%	82.46%	82.59%	82.13%
Health, wellbeing and morale																
Sickness Absence Spot Month	2.11%	2.22%	1.42%	1.92%	0.81%	0.99%	0.80%	0.87%	1.72%	2.16%	1.20%	1.69%	2.25%	2.29%	2.47%	2.34%
Sickness Absence 12 month rolling average	1.54%	1.69%	1.68%	1.64%	1.56%	1.51%	1.45%	1.51%	1.46%	1.52%	1.50%	1.49%	1.66%	1.68%	1.76%	1.70%
Training and compliance																
DBS Compliance	98%	98%	97%	98%	98%	98%	96%	97%	98%	98%	98%	98%	98%	98%	99%	98%
Appraisal Compliance	5%	17%	48%	23%	89%	89%	92%	90%	95%	95%	95%	95%	95%	95%	95%	95%
Establishment FTE (From Finance)	**667**	**667**	**667**		**667**	**667**	**667**		**667**	**667**	**667**		**667**	**667**	**667**	

6. Mandatory Training Compliance

The trust has now aligned all its mandatory and statutory training requirements with other provider organisations in the north central London footprint.

Compliance with the mandatory and statutory training that applies to all staff remains high.

Description	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19
Mandatory Training Compliance INSET Attendance	94%	94%	94%	94%
Trust-wide Induction	96%	93%	95%	95%
Local Induction Checklists Completed	97%	96%	97%	96%

The table below provides an overview of role specific mandatory and statutory training. There are a number of areas with low compliance which are the result of a number of staff having now gone beyond their refresher period.

During this period, a number of staff have become non-compliant with data security training. This level of compliance drops at this point each year with all staff being required to refresh their competence using the national e-learning platform.

For adult safeguarding training, a training programme for quarter four is now in place and the level of compliance will increase further by the end of quarter 4.

Basic life support training compliance, for clinical staff, remains low. The medical director wrote to all non-compliant staff reminding them of the statutory requirement and failure to attend a coming course will result in formal disciplinary action commencing.

Description	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19
Basic Life Support – First Aiders	100%	100%	100%	100%
Basic Life Support – Medical & Nursing	63%	63%	63%	63%
Clinical Risk Training	31%	22%	22%	22%
Conflict Resolution Training	100%	100%	100%	100%
Data Security Awareness	95%	94%	40%	95%
Ladder Safety	48%	48%	48%	48%
Manual Handling	0%	40%	40%	40%
Safeguarding Adults – Level 2	65%	65%	65%	65%
Safeguarding Adults – Level 3		0%	5%	5%
Safeguarding Children – Level 2	94%	90%	90%	89%
Safeguarding Children – Level 3				
WRAP (PREVENT L3)	89%	90%	90%	90%

7. Conclusions and recommendations

Members of the relevant committees are asked to note the contents of this report.

Craig de Sousa
Director of HR & Corporate Governance
April 2019

Report to	Date
Executive Management Team Board	14 May 2019 28 May 2019

2018/19 Strategic Objectives - Outcomes

Executive Summary

This paper provides a review of the outcomes against the Trust's 2018/19 Strategic Objectives.
Of the 19 actions:

- 7 were achieved in full
- 10 Were achieved in part
- 1 was not achieved
- I is 'in train'.

The action not achieve was the creation of the FDAC SIB.
The 'in train' action relates to the procurement of gender services.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Services / Growth and Development / Finance and Governance

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

The Tavistock and Portman NHS
NHS Foundation Trust

OUTCOMES OF
2018/19 STRATEGIC PLAN
AND
ANNUAL OPERATIONAL PLAN

May 2019

Introduction

This plan for the Trust's strategic objectives for 2018/9 reflect the 4 longer term aims for the Trust being:

- To look after and develop the Trust's people including clinicians, educators and our administrative staff, building equality of opportunity across the Trust and positioning us an authoritative voice on wider workforce issues in mental health and the NHS.

- To strengthen and extend the quality of the Trust's clinical and educational services, building on our unique traditions and ensuring our activities are adaptive and resilient at a time of significant external pressures on resources.

- To broaden the Trust's influence and income by extending what we do beyond our traditional areas of activity in health and care and developing international opportunities in training and education.

- To continue to function as a sustainable, well led and independent organisation, meeting our financial and regulatory responsibilities.

Progress against the actions / objectives is provided below.

SUMMARY OF OUTCOMES

Action	**Description**	Accountable Director	**Outcome**
1	Position the Trust as a respected authority on workforce development	Chris Caldwell	**Achieved**
2	Implement the People Strategy with the aim of supporting the resilience, development and performance of our staff	Craig de Sousa	**Partially achieved**
3	Implement the Race Equality Strategy	Louise Lyon	**Partially achieved**
4	Develop our Estates Strategy to deliver the right facilities for the work of the Trust	David Wyndham Lewis	**Partially achieved**
5	Implement the Clinical Quality Strategy	Louise Lyon	**Partially achieved**
6	Strengthen our collection and use of data to inform decision making and improve the effectiveness and quality of our services	Louise Lyon	**Partially achieved**
7a	Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology	Sally Hodges	**Achieved**
7b	Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology	Julian Stern	**Partially achieved**
7c	Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology	Brian Rock	**Partially achieved**
8	Contribute to the development of North London Partners in Health and Care	Paul Jenkins	**Partially achieved**
9	Develop the Trust's position in national and transnational education including the launch of a Digital Academy	Brian Rock	**Partially achieved**
10	Develop an effective model for systemic support for organisational wellbeing and secure its implementation in at least one setting	Paul Jenkins	**Achieved**
11	Respond to the national procurement of gender identity services with the aim of establishing the Trust as an international centre of excellence for gender work	Sally Hodges	**In train, services currently out to tender**
12	Implement our social investment model for FDAC and explore other opportunities for innovative financing of our services	Terry Noys	**Not Achieved**
13	Raise our public profile as a thought leader and influencer in line with our External Affairs Strategy and building on the outputs from research	Laure Thomas	**Partially achieved**
14	Continue to meet regulatory standards with QAA	Brian Rock	**Achieved**
15	Continue to meet regulatory standards with CQC	Louise Lyon	**Achieved**
16	Meet our Control Total for 2018/2019	Terry Noys	**Achieved**
17	Develop the Governance and leadership of the Trust, implementing effectively the review of Board Business	Paul Jenkins	**Achieved**

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **PEOPLE**

Action 1: **Position the Trust as a respected authority on workforce development**		**Accountable Director: Chris Caldwell (Director of Nursing)** Key supports: Ian Tegerdine (AD NWSDU) Craig de Sousa (HR Director)
Key Success Criteria **Key Success Criteria** 1. The National Workforce Skills Development Unit (NWSDU) continues to deliver its objectives to HEE 2. The National Mental Health Workforce Development Collaborative (NWDC) is effective in supporting the work of the NWSDU and enabling the Trust to demonstrate a national reach 3. The NWSDU / NMHWDC participates in communications, engagement and conferencing to promote work underway and completed in workforce development 4. The Trust is regarded as being effective in leading and influencing the development and delivery of the national Mental Health workforce plan within North Central London STP 5. The Trust is able to maximise on any potential opportunities from its national work whilst ensuring robust governance processes are in place to avoid conflicts of interest		**Outcome** 1. The NWSDU delivered its agreed 18/19 portfolio of projects on time and on budget. Annual Report delivered in March 2019 2. The NWDC continues to meet bi monthly and has reviewed its ToR and contribution to NWSDU activity in year 3. Comms and engagement strategies were developed for both the NWSDU and NWDC, active internal and external coms delivered and the Conference was delivered in early April 19 4. The Trust has continued to be active in the NCL STP and has attracted development funding for a range of projects in 18/19 5. The governance and reporting mechanisms that were put in place to report to the Trust Board through the TEPMB have proved to the fit for purpose in year, close working across NWSDU, DET and the Business Development Unit has ensure that potential conflicts of interest have been identified, explored and resolved effectively.
RATING		**ACHIEVED**

Notes

Together key success criteria and milestones should be SMART: Specific, Measurable, Attainable, Realistic, Timebound

Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **PEOPLE**

Action 2: **Implement the People Strategy with the aim of supporting the resilience, development and performance of our staff**		**Accountable Director: Craig de Sousa (HR and Corporate Governance Director)**
Key Success Criteria 1. Deliver a comprehensive set of, service led, workforce plans which map the Trust's existing skill mixes, planned skill mixes, labour market conditions and workforce development requirements. 2. Develop and document career pathways, across clinical professional groups, to support both talent management and succession planning. 3. Develop a detailed talent management process, starting with the most senior positions, and then cascade the approach through the organisation 4. Expand the Tavistock and Portman Academy training programme to other professional staff groups across the organisation. 5. Document and develop our research career offering. 6. Continue actions on staff wellbeing including actions to address pressures identified in 2017 staff survey on long hours etc		**Outcome** 1. Working with service directors the HR business partners have engaged with informal conversations about workforce planning throughout the year. A method for conducting future year workforce planning has been developed and will be more formally introduced in the coming financial year. 2. A comprehensive review of all clinical roles has been conducted and job descriptions have been developed. More work will be done in the coming year to ratify the grades for each post and then start a process of wider consultation. 3. The Trust's director of human resources and corporate governance has been engaged on a regional programme of work drawing on organisational best practice to inform a consistent approach that all provider Trusts will adopt as part of the Regional Talent Board's work. 4. The Teaching and Learning Programme has passed its pilot phases and is being developed and rolled out further. 5. Work on this area has not been taken forward in the financial year. 6. The health and wellbeing group continues to progress with its work in this area. Disappointingly, there was not any improvements on our staff survey results in this area.
RATING		**PARTIALLY ACHIEVED**

Notes

Together key success criteria and milestones should be SMART: Specific, Measurable, Attainable, Realistic, Timebound

Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **PEOPLE**

Action 3: **Implement the Race Equality Strategy**		**Accountable Director: Louise Lyon (Director of Quality and Patient Experience)**
Key Success Criteria 1. Evidence of increase in BAME staff progression to more senior posts 2. Increase in staff confidence in equal access to training and development opportunities as evidenced in annual staff survey 3. DET race equality strategy approved by EDI committee and action plan developed and agreed with relevant stakeholders 4. Clinical strategy approved by EDI and action plan developed and agreed with relevant stakeholders		**Outcome** 1a) Implementation of Race Equality Strategy reviewed in EDI quarterly 1b) WRES figures reviewed in July 2018 and further action identified if required 1c) Progress on Race Equality Strategy reviewed by the Board in Q2 2018 2a) Staff training and development opportunities promoted and access to them reviewed 2b) Training for managers and Thinking Space events implemented from Q4 2017-8 and ongoing 3 DET equalities lead appointed and action plans developed. Student survey feedback showed that students had more confidence that equalities were being addressed 4 Clinical strategy still to be developed. JDs for clinical directorate equalities leads developed to clarify roles.
RATING		**PARTIALLY ACHIEVED**

Notes

Together key success criteria and milestones should be SMART: Specific, Measurable, Attainable, Realistic, Timebound

Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **PEOPLE**

Action 4: **Develop our Estates Strategy to deliver the right facilities for the work of the Trust**		**Accountable Director: David Wyndham Lewis (Director of Technology and Transformation)**
Key Success Criteria 1. Continue the work of the Relocation programme to the currently agreed programme timeline. 2. Complete the work of the Trustwide Scheduling project up to and including : (a) the operation of the end of the 2018/19 financial year; and (b) planning of the 2019/2020 academic year. 3. Develop, implement and embed a revised oversight model for statutory compliance including health and safety. 4. Develop, agree and complete an in year plan for remediation of high priority items of backlog maintenance across all existing freehold estate. 5. Develop, agree and implement a schedule of annual planned preventative maintenance and demonstrate successful completion at year end. 6. Develop, agree and implement and interim accommodation improvement plan seeking to provide adequate interim space through to Relocation		**Outcome** 1. Heads of Terms progressed but not yet signed. Approval for commencement of competitive dialogue, seeking a commercial partner for the programme, sought and received from Trust Board. 2. Scheduling system in operation for the 2018/19 academic year with clinical services utilising an interim booking model. Project plan for the 2019/20 and 2020/21 years developed and to be presented for approval in April 2019. 3. Statutory compliance reporting now in place as Estates and Facilities Compliance Workstream, via CQSGC to Trust Board. 4. In year plan complete, with all items other than structural electrical infrastructure now assessed as green. 5. PPM schedule developed, service scoped and procured with new PPM service commenced 1st April 2019. 6. Immediate tactical solutions developed and approved by EMT. Market opportunities being considered with a view to developing a broader interim plan in 2019/20.
RATING		**PARTIALLY ACHIEVED**

Notes

Together key success criteria and milestones should be SMART: Specific, Measurable, Attainable, Realistic, Timebound

Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 5: **Implement the Clinical Quality Strategy**		**Accountable Director: Louise Lyon (Director of Quality and Patient Experience)**
Key Success Criteria 1. 20 staff trained in IHI Model for improvement and supported to deliver quality improvement projects developed with clinical teams, patients and other relevant stakeholders 2. In house training capacity developed 3. Measurable improvement on key priorities, effectiveness, waiting times and patient experience of treatment decision 4. DET adoption of QI in training courses and for trainees working within the trust		**Outcomes** 1. Further 28 staff attended introductory training, 14 completed intermediate level course in IHI Model for Improvement and 17 staff completed IHI on-line basic certificate in QI provide through UCLP CYAF forum developed to support QI projects. AFS forum in development. Quality Portal provides system for logging and tracking QI projects. Quality Advisory Group contributes to the development of trust quality priorities some of which can be delivered through QI. 2. In house staff contributed to Haelo training delivered in January 2019 in order to develop in house- capacity 3. Progress on implementing strategy reviewed in September 2018 which led to work to map QI resources across Trust in terms of staff trained from basic to expert level, development of resources on the intranet including handbook. Evidence of progress on key priorities in annual report- quality account 4. QI not yet adopted in training courses but discussion in progress with Director of ET. In clinical teams , trainees contribute to QI projects
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 6: **Strengthen our collection and use of data to inform decision making and improve the effectiveness and quality of our services**		**Accountable Director: Louise Lyon (Director of Quality and Patient Experience)** Key support: David Wyndham-Lewis (Director of Technology and Transformation)
Key Success Criteria 1. Dashboards available at Board and team level 2. Dashboards developed with commissioners 3. Improved quality of data through implementing data quality project 4. Improved quantity and quality of data in key performance areas		**Outcomes** 1. Static dashboard available to the Board with improved data presentation using clearer visual display and plotting data across time where possible. Dashboards not routinely available for clinical teams as Dashboard and data warehouse project deferred from 18 – 19 following prioritisation of IMT projects 2. Dashboard development supported by commissioners but not progressed in year. 3. Data quality improved through projects undertaken via the Clinical Data Quality Reviewed Group. Internal audit confirmed status of data quality. Clinical Data Quality Project brief refined and focussed in the light of improvements. Key areas for improvement identified and improvement projects in development. 4. Data quality improved for incident reporting through the implementation of the Quality System developed with Promatica
RATIN G		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 7a: **Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology**		**Accountable Director: Sally Hodges (Head of CYAF)**
Key Success Criteria 1. Ensure the trust is able to influence direction of development for adult gender services and to maintain our reach in this area i.e. to maintain CX contract and grow this beyond April 2019 2. To hold a leadership role with the NCL crisis and out of hours developments for NCL, and to develop this service for implementation within 2018-2019 3. To take a leadership role with the CAMHS in Schools developments across NCL, and to ensure that NCL is a trailblazer site 4. To take a leadership role within NCL on thrive implementation, particularly within the Barnet CCG area 5. To support FNP with developing a sustainability programme that builds on system wide approaches		**Outcomes** 1. We have made significant changes to the provision at charing cross which have improved aspects of user experience and safety. Waiting times have not decreased as numbers of referrals have increased however feed back from users and commissioners has been positive about changes made. 2. The Tavistock has made significant contribution to the development of CAMHS across the STP and has lead discussions in relation to crisis and T4. We hosted a successful crisis peer review with very positive feedback. There has been a delay in taking forward the T4 STP model but it is an ongoing priority 3. We were fully successful with gaining first wave trailblazer status for both the schools and wait time projects 4. We have been successful in influencing THRIVE implementation across the STP 5. FNP has worked hard at developing sustainability models, however PHE have decided to take the service back in house from April 2020.
RATING		**ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 7b: **Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology**		**Accountable Director: Julian Stern (Head of AFS)** Service leads: • Tim Kent (Primary care) • A Williams (Adult Complex Needs) • J Yakeley (Portman)
Key Success Criteria 1. To Continue to search for new business opportunities in primary care, both using the PCPCS/TAP model and going forward with scoping the potential for involvement in IAPT services 2. To develop working relationships/ partnerships with digital providers 3. To grow Complex Needs services, especially in the field of trauma 4. To grow Portman services, especially regarding Returning families , and if possible ,child services		**Outcomes** 1. We (AFS) did achieve success re Forensic CAMHS bid in 2018, and the service is now operational and well regarded. 2. We were not able to secure a new service (Prim care and/or IAPT) in the financial year (2018/9) 3. We continue to search for and strengthen new relationships with other providers. However we have not achieved any substantial new business beyond FCAMHS.
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 7c: **Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology**		**Accountable Director: Brian Rock (Head of DET)**
Key Success Criteria 1. Increase in income and contribution through: - new student recruitment - short courses and bespoke provision - digital provision 2. Further establish Tavistock Consulting's offer and develop basis for securing higher value contracts. 3. Explore feasibility of NHS levy as funding source for existing provision to increase student numbers. 4. Establish feasibility of social care apprenticeships and embark on development of specific products. 5. Improve product development cycle.		**Outcomes** 1. Decrease in long course Y1 student recruitment for AY18/19. The primary issue has been in lower conversion rates on certain courses though demand for programmes remains high with overall application numbers higher than previous year. 2. Overall growth in income levels for CEDU however higher costs incurred through increase use of VLs and accommodation costs. Further work is required in FY19/20 to understand and improve cost control. Significant line management and team changes with expected improvement in 19/20. 3. Improvement in TC operations with clearer operating processes for team and better engagement with Associates. Higher contribution level than in previous years though higher value contracts not achieved. 4. Thorough and conclusive exploration of feasibility of social care apprenticeships with clear recommendation not to proceed. 5. Long course development is progressing with Essex university for the domestic market. Appointment of AD, Delivery & Development with a remit for overall responsibility for product development strategy and process but this was not achieved.
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **SERVICES**

Action 8: **Contribute to the development of North London Partners in Health and Care**		**Accountable Director: Paul Jenkins (CEO)**
Key Success Criteria 1. Delivery of agreed work programme 2. Mental health has strong voice in STP and collaborative working supports additional investment in mental health 3. Development and delivery of NCL mental health workforce plan		**Outcomes** Tier 4 proposal submitted but unsuccessful – work in hand to develop CAMHS OOH service secured – implementation delayed but now progressing NCL workforce plan development and HEE investment secured for key projects. Agreement secured on standardised approach for mental health liaison across NCL
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **GROWTH AND DEVELOPMENT**

Action 9: **Develop the Trust's position in national and transnational education including the launch of a Digital Academy**		**Accountable Director: Brian Rock (Head of DET)**
Key Success Criteria 1. The Trust will increase activity and income and contribution for national and international provision 2. Digital Academy supports transformation of delivery model for education and training and ability to access new markets in the UK and internationally.		**Outcomes** 1. We have agreed with HEE the delivery of national roadshows. The format has been agreed and signed off by HEE. The delivery has been delayed due to HEE reorganisation to 7 regions. We are waiting for HEE to confirm implementation schedule. 2. International development has developed well with the achievement of doubling income from this activity based on the previous year to circa £150k. MOU signed with key Beijing Foundation and further visitor programmes are scheduled. A second scoping trip has been successfully concluded, and we are now part of the NHS Confederation's International group. 3. The work on scoping the feasibility of the Digital Academy has taken more time due to the level of evidence required to support investment in the programme. Further external market research has been undertaken and the procurement of an external partner is being concluded. There is far better engagement with the project in the Trust. Currently the delay in the final presentation to the Board is not expected to impact the launch date in 2020.
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **GROWTH AND DEVELOPMENT**

Action 10: **Develop an effective model for systemic support for organisational wellbeing and secure its implementation in at least one setting**		**Accountable Director: Paul Jenkins (CEO)/Rachel Surtees – Director of Strategy**
Key Success Criteria 1. Agreed Tavistock model for organisational support on staff wellbeing and resilience 2. Credibility of approach with potential customers/partners and opinion leaders 3. Investment secured in rollout of model at scale in at least one setting.		**Outcomes** ADD Wellbeing model developed. DHSC/DWP Challenge Funding secured to work with SMEs. Implementation in progress.
RATING		**ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **GROWTH AND DEVELOPMENT**

Action 11: **Respond to the national procurement of gender identity services with the aim of establishing the Trust as an international centre of excellence for gender work**		**Accountable Director: Sally Hodges (Head of CYAF)**
Key Success Criteria 1. Ensure the trust is able to influence direction of development for adult gender services and to maintain our reach in this area i.e. to maintain CX contract and grow this beyond April 2019 2. To work with clinics across the south east area, and greater dependent on the NHS E vision on implementing a Tavistock model to both GIC and transition work, as well as associated input such as psychology and SALT.		**Outcomes** 1. Successful growth achieved in both adult and childrens gender services. We have made many service improvements in both services and commissioner and service user feedback has been very positive. We have actively grown support services to gender in line with our agreed model. The CQC re inspected our adult service and it's rating moved from requires improvement across the board to good across the board with an outstanding for effectiveness 2. We have engaged with gender clinics nationally and formed a strong relationship with Notttingham who we intend to bid for the national unit with.
RATING		**In train, services currently out to tender**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **GROWTH AND DEVELOPMENT**

Action 12: **Implement our social investment model for FDAC and explore other opportunities for innovative financing of our services**		**Accountable Director: Paul Jenkins (CEO)** Key support: Terry Noys (DoF)
Key Success Criteria 1. Agreement on governance and financial model for FDAC social investment vehicle 2. Successful role out of FDAC SIB model 3. Identification of other opportunities to secure social investment		**Outcomes** Failure to agree financial and governance model meant SIB not launched. No other social investment opportunities identified.
RATING		**NOT ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **GROWTH AND DEVELOPMENT**

Action 13: **Raise our public profile as a thought leader and influencer in line with our External Affairs Strategy and building on the outputs from research**		**Accountable Director: Laure Thomas (Director of Communications and External Affairs)**
Key Success Criteria Implement the External Affairs Strategy, specifically: 1. Influencing the outcome of the Government's review of child and adolescent mental health services. 2. Deliver a TV documentary on our Family Drug and Alcohol Court working with Century Films. 3. Conduct profile raising activity in each of the 4 key areas outlined in the External Affairs Strategy. 4. Successfully promote research by our gender services and continue to promote the Trust as a global centre of excellence and expertise in gender work and point of reference for the upcoming gender recognition legislation. 5. A clear plan for the 2020 centenary celebrations. 6. Establish closer partnerships with a broader range of partners including learned societies, professional bodies and voluntary sector organisations to champion a reflective / supervision approach in joint campaigns focusing on staff wellbeing and resilience building.		**Outcomes** 1. Respond both formally and privately to the CAMHS Green Paper and conduct relevant follow-up external affairs activity to engender policy which will champion a Tavistock approach to CYP mental health. ACHIEVED a. Collaborate with Camden around CYP green paper consultation (including event + social media). ACHIEVED b. Run a roundtable event around the delivery of schools-based CYP mental health provision. ACHIEVED c. Influencing key policy makers (formal and informal responses to GP + follow-up activity – March). ACHIEVED d. Promoting Thrive. (March grid promotion) PARTIALLY ACHIEVED e. Speaking at relevant conferences (inc Feb HCUK) ACHIEVED f. Continue to partner with HE sector to work towards better Mental Health for students. (PJ lead) ONGOING 2. Convince key partners (mainly LAs) to proceed with plans with Century Films for a TV documentary around our Family Drug and Alcohol Court Service, ensure series commission and begin filming. ONGOING, plans are progressing and all but one London LAs are on board in principle. 3. Widely promote a special issue research journal issue edited by Bernadette Wren featuring research from across the team covering a number of aspects of gender work and establish the Trust as an international centre of excellence in this field. ACHIEVED with a further event in planning at the Science Media Centre. 4. Work with RSM, RCN and other partners around supporting NHS staff wellbeing and resilience. ONGOING [Comms not really involved apart from 2 articles, but CC has been very active here]. 5. Increase proportion of media coverage about our non-gender work, with goal of achieving 10 pieces of coverage related to non-gender

		work in each quarter of 18/19. NOT ACHIEVED. It was all going so well and then we sabotaged ourselves. Structures are in place to achieve this, we just need to not shoot ourselves in the foot.
RATING		**PARTIALLY ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **FINANCE AND GOVERNANCE**

Action 14: **Continue to meet regulatory standards with QAA**		**Accountable Director: Brian Rock (Head of DET)**
Key Success Criteria 1. Complete and submit annual return 2. Annual return accepted as showing progress and without give rise to cause for concern 3. Positive outcome from annual monitoring visit		**Outcomes** The Trust continues to be part of the review mechanism overseen by the QAA. The review by the QAA in 2018 had a successful outcome and affirmed that the Trust is continuing to make progress with the enhancement of its higher education programmes. Representatives of the QAA visited the Trust in April 2019 to meet with key staff and some students. This visit was thought to go well and we expect to receive the draft report on 16 May 2019. In this FY we have successfully concluded two university institutional reviews that have resulted in the renewal of our validation arrangements for five years.
RATING		**ACHIEVED**

Notes

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TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **FINANCE AND GOVERNANCE**

Action 15: **Continue to meet regulatory standards with CQC**		**Accountable Director: Louise Lyon (Director of Quality and Patient Experience)**
Key Success Criteria 1. Maintain 'Good' rating with CQC 2. Remain prepared for inspection during 2018-19 through regular review of quality and safety in CQSG 3. Succeed when inspected by CQC		**Outcomes** 1. Overall Good rating maintained with improvement in Effective domain from Good to Outstanding following inspection in September 2018 2. Action plan to address areas for improvement identified and approved by Board and CQC, January 2019- reviewed in Management Team and CQSGC 3. Inspection took place across summer 2018 with Well-led inspection in September 2018. Good rating maintained as above and pathway to potential Outstanding rating clarified.
RATING		**ACHIEVED**

Notes

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TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **FINANCE AND GOVERNANCE**

Action 16: **Meet our Control Total for 2018/2019**		**Accountable Director: Terry Noys (DoF)** Key support: Wider Management Team
Key Success Criteria 1. Board approved Budget with Control Total of £950k 2. On-going tracking / review 3. Audited year end accounts confirming Control Total met		**Outcomes** Control Total met / exceeded
RATING		**ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

TAVISTOCK AND PORTMAN 2018/19 STRATEGIC OBJECTIVE: **FINANCE AND GOVERNANCE**

Action 17: **Develop the Governance and leadership of the Trust, implementing effectively the review of Board Business**		**Accountable Director: Paul Jenkins (CEO)**
Key Success Criteria 1. New pattern of Board business implemented 2. Positive outcome from external well led review 3. Positive feedback from external/internal audit		**Outcomes** New cycle of Board meetings implemented Good rating from CQC for well led domain Improved internal assurance rating from Internal Audit and clean opinion from External Audit
RATING		**ACHIEVED**

Notes

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Please identify specific / named individuals with responsibility for particular action items

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 09 May 2019

Key items to note

The recent EDI committee was the first formal meeting following a facilitated away morning. We welcomed Jos Twist to their first formal meeting of the committee in their role as LGBTQI+ Diversity Champion.

The following items were discussed by the committee.

Strategy development

The away morning identified that we have done a number of things over recent years, some successful and others where we need to do more work. In January 2020 the Trust will need to reset its public sector equality duty priorities and the committee felt that this is a good point commence developing a fuller strategy.

The committee agreed that the process for development should involve a number of staff across the organisation and will be provided to the Board of Directors for approval by the new year.

Disability access survey

The Trust's estates and facilities directorate commissioned a review of the Tavistock Centre specifically around accessibility. We considered the initial report and agreed that once we have published our workforce disability equality standard data we will be in a position to have an informed discussion around priorities.

Terms of reference

The terms of reference for the committee were reviewed and it was agreed that further work would be required before these are re-presented to the Board for ratification.

Actions required of the Board of Directors

There are no actions required of the Board.

Report from	Dinesh Bhugra, Committee Chair
Report author	Craig de Sousa, Director of HR & Corporate Governance
Date of next meeting	11 July 2019

The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 2nd May 2019

Key items to note

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

Student Recruitment

The committee noted that there were a higher number of applications as compared this time last year, and that work will be needed to ensure these convert into offers and acceptances. The main focus in this cycle is on conversion rates and working with portfolio Managers and Course Leads to process applications in a timely manner, and the involvement of the Head of Student Recruitment & Marketing and Student Recruitment Team Lead working with faculty will be key.

Scheduling and Timetabling

The committee noted the considerable thought that has been put into the required arrangements to create and publish the timetable for AY19/20, including the appointment of one course administrator to take a leadership role in working with the scheduling team to develop timetable templates for all the courses, piloting one of our largest and more complex programmes as a test case. The committee noted the indicative trends from the annual student survey in relation to the impact of scheduling on them specifically and on the quality of the learning experience generally. The information presented was based on a very small sample. A fuller update will be provided to the July ETC.

Associate Dean, Learning and Teaching

The committee were informed that Paul Dugmore has been appointed into the role of Associate Dean, Learning and Teaching. The recruitment process for his replacement as Portfolio Manager, Social Care Leadership and Management has commenced. The committee were pleased to note the priority and focus given by all internal candidates through the appointments process to the priority of race, equality and inclusion.

HESAS/HESES

The committee noted the review and response to the University of Essex's internal audit on our HESA reporting capability including systems, processes, staffing resource and governance arrangements. The tone and approach of the report has been positive, collaborative and enabling. The Director of Education and Training will be bringing a report to the next committee to update on progress on the action plan and developments on our readiness for the next HESA submission in October and the next HESES submission in December.

National Training Contract

There was a contract meeting for our national training contract on 1st April and the committee noted that David Marston, Planning and Performance Manager (HEE) acknowledged how numbers of learners enrolled on courses matched the contract plan, and this was strong evidence of our effective market understanding and planning. One area for development is our reporting of numbers against our continuing education portfolio, including where learners are coming from. A plan is in place to address the gaps.

Fee Review
The committee reviewed and approved the action plan for implementing the fee review.

QAA
The QAA undertook its Annual Monitoring visit on 30th April, and we received the draft report on 16th May. The review team concluded that the Trust is making commendable progress with continuing to monitor, review and enhance its higher education provision since the visit in May 2018.

Digital Academy
It was confirmed that market research concluded the Digital Academy's subject choices are very appealing to potential learners, however feedback on price was more mixed, with the longer duration courses perceived as too expensive. The market's preferred price for the Digital Academy's products would not make the initiative viable. As such, selecting an appropriately experienced online learning partner through the project's procurement process would provide crucial input to help develop a compelling product portfolio, at an appropriate price, and with a review of a number of existing assumptions in relation to volume forecasts and internal / external costings. The committee endorsed the proposal to continue commercial modelling once an online learning partner had been selected in order to inform product planning. The project was supported to continue the work to bring a full business case to the Board in July 2019. There will be an update at the SCC in May and at the May Board.

Annual Course Reports/Student Survey
The committee discussed the annual student survey and noted that whilst we identify areas that require improvement year after year, we have not been having the impact we would have hoped. In order to have a more systematic approach to monitoring and progressing action plans, the committee welcomed the development that action plans generated from the annual student survey have been integrated into the Quality Action Plan overseen by the Academic Governance & Quality Assurance Unit. The annual review of courses based on the Essex model is fairly new to faculty, and the committee noted the development of additional training for staff on how to incorporate actions out of the student survey into this process in a more meaningful way.

International Strategy
The committee received an update on the visit to China undertaken by Brian Rock, Karen Tanner and Xiao Wang in February 2019. This trip focused on further engagement with enablers who were able to help us develop our thinking, intelligence, networks, partnerships and relationships in China. BR will be drawing up a formal plan for the international strategy, which will include a plan for resourcing. It was acknowledged that time and resource need to be put in to learning more about the market, how we negotiate, and how we understand the market.

Key elements of the plan are: there is a third senior leadership programme with the Foundation in June, and they are interested in continuing these; the Foundation have also asked us to look into delivery of observerships within the UK and we are investigating the possibility of this with our collaborative partners; we are progressing discussions about delivery in country and online; we are exploring with the University of Essex the possibility of delivering foundation programmes in China; we are investigating the possibility of streamlining the visitors programme and creating two visitors programmes per year (summer and winter) to provide an opportunity to demonstrate our clinical and educational expertise. A detailed report and resourcing plan will be received at the next committee meeting in July.

Operations Director role
The committee approved a proposal for the appointment of an Operations Director within DET, allowing for the resetting of the management and leadership structure of DET along Higher Education lines, allowing the Associate Deans and the Dean to engage with the strategic priorities with faculty, and gathering up professional service functions along the student journey under one operational management role.

UKVI Audit
The committee noted the need to review tier 4 visa processes once we have received the report from the UKVI following an audit.

Essex Long Course Development
The committee discussed two possible programmes of study which are being explored with our university partner, the University of Essex.

Deputy Director of Education and Training
The committee were informed that Elisa Reyes-Simpson, Associate Dean Academic Governance and Quality Assurance has been offered and accepted the Deputy Director role within DET.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	04 July 2019

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 28TH MAY 2019, 1.30pm – 3.55pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Items for discussion				
1.1	Freedom to Speak Up Guardian Report	Freedom to Speak Up Guardian	1.30pm	1
2 Administrative Matters				
2.1	Chair's opening remarks and apologies	Deputy Chair	2.00pm	Verbal
2.2	Board members' declarations of interests	Deputy Chair		Verbal
2.3	Minutes of the meeting held on 26 March 2019	Deputy Chair		2
2.4	Action log and matters arising	Deputy Chair		Verbal
3 Operational Items				
3.1	Chair and Non-Executives' Reports	Deputy Chair and Non-Executive Directors	2.20pm	Verbal
3.2	Chief Executive Report	Chief Executive	2.30pm	3
3.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.40pm	Verbal
3.4	Quality Dashboard (Q4)	Director of Quality & Patient Experience / Associate Director of Quality & Governance	2.45pm	4
4 Items for decision or approval				
4.1	NHS Improvement Licence Self Certification	Director of HR & Corporate Governance	3.05pm	5

		Presenter	Timing	Paper No
5 Items for information				
5.1	Board Assurance Framework	Chief Executive	3.10pm	6
5.2	Serious Incidents Quarterly Report (Q4)	Medical Director	3.20pm	7
5.3	Guardian of Safe Working Report (Q4)	Medical Director	3.25pm	8
5.4	People Strategy Report	Director of HR & Corporate Governance	3.30pm	9
5.5	Annual Operational Plan – Review of outcomes 2018/19	Deputy Chief Executive / Director of Finance	3.35pm	10
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.40pm	Verbal
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.45pm	11
6.3	Training and Education Committee	Committee Chair	3.50pm	12
7 Any other business				
8 Date of Next Meeting				
	30th July 2019 – 1330 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			