NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 19th May 2020

Please refer to the agenda for timings.

Meeting held online

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 19th MAY 2020, 2.00pm – 3.30pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 28th April 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report and COVID-19 Briefing	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	Verbal
3 Items for noting				
3.1	Board Assurance Framework (BAF)	Chief Executive	2.35pm	3
3.2	Quality Dashboard (Q4)	Medical and Quality Director	2.45pm	4
3.3	Serious Incident Annual Report	Medical and Quality Director	3.05pm	5
3.4	Guardian of Safer Working	Medical and Quality Director	3.15pm	6
4 Board Committee Reports				
4.1	Audit Committee	Committee Chair	3.20pm	7

		Presenter	Timing	Paper No
4.2	Education and Training Committee	Committee Chair	3.25pm	8
5. Any other matters				
5.1	Any other business	All		
6 Date of Next Meeting				
	28th July 2020, 2.00pm – 4.00pm – Online / The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			

Board of Directors Meeting Minutes (Part 1)
28th April 2020, 2.00pm – 3.00pm, via Zoom

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

AP	Item	Action to be taken	Resp	By
1.	1.3.1	Amendments to the minutes of the previous meeting	CdS/FF	Immed
2.	1.4.1	Carried forward from previous meeting Narrative to be provided on mitigation plans for ongoing T1 and T2 delays in TAP	TK	On hold
3.	1.4.1	Carried forward from previous meeting Inconsistencies in data formatting to be resolved in preparation for Health Information Exchange go live date in May 2020.	SH	closed
4.	3.1.5	Meetings to be arranged for NEDs and Directors	FF	Immed

1. Administrative matters

1.1 Welcome and apologies

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

1.2 Declarations of interest

1.2.1 No declarations of interest were declared.

1.3 Minutes of the previous meeting

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

1.4 Matters arising and action points

1.4.1 All the actions were noted as completed, with the exception of two actions which were have been put on hold. **[AP2 & AP3]**

1.4.2 Responding to a question from Mr Holt, Dr Hodges noted that Gloucester House is running a combination of remote working and face to face with social distancing in place.

2. Operational items

2.1 Chair and non-executives' reports

2.1.1 Prof Burstow reported that he had been sitting in on most of the staff briefing sessions and it is a fascinating glimpse into the heart of the organisation and extremely impressive on how the tempo and content has evolved, and the number of staff who join in.

2.1.2 Dr Colson noted that she found the virtual all staff sessions very interesting and was struck by the emotional engagement and that staff felt supported.

2.1.3 Prof Bhugra noted that he found attending the all staff sessions very useful as it enabled him to find out what was going on. He added that it was very important to ensure that staff did not feel inhibited.

2.1.4 The board of directors noted the report.

2.2 Chief executive's report

2.2.1 Mr Jenkins presented the report and highlighted:

- The directorate of education and training had a successful launch of term 3 and that it was a great achievement shifting to online teaching and the despite the challenges, the service will be delivering approximately 3,500 courses.
- There were plans to evaluate the impact of the online teaching approach to inform the Trust's strategy for future educational delivery, specifically through the digital academy.
- Dr Sinha would lead a quality improvement project to assess the impact of the shift to remote working across all of the organisation's services.
- Executive colleagues had done a very good job of responding to the pandemic and had shown good leadership through all this.
- The Trust was beginning to plan for the recovery phase from the pandemic.

2.2.2 In response to a query from Prof Bhugra, Dr Sinha noted that personal protective equipment (PPE) was required for any face to face consultation. He emphasised that the Trust had an excess PPE (aprons and face masks) some of the stock had been redistributed to other acute Trusts. Dr Hodges noted that masks had been made available to staff who were travelling to and from the Trust using public transport and Gloucester House had also been issued with PPE.

2.2.3 In response to a question from Prof Burstow, Dr Sinha noted that he had been liaising with the NHC about collecting the excess PPE stock. He added that the cleaning staff have also been provided with PPE.

2.2.4 In response to a question from Dr Colson, Dr Sinha noted that from reports he had received from colleagues outside of the Trust, that the PPE supplies were flowing however there was a shortage of visors. He emphasised that the Trust does not require full gowns.

2.2.5 Responding to a question from Prof Burstow, Dr Hodges noted that most of the young people seen at the crisis hubs were known to local child and adolescent mental health services (CAMHS).

2.2.6 Responding to Mr Holt, Mr Rock noted that there were very few incidents of students finding difficulty in paying the fees.

2.2.7 Responding to Ms Farrow, Mr Rock noted that the DET had engaged with students and have put in place ways where they can raise concerns. He emphasised that Mr de Sousa has extended the employee assistance programme to students

2.2.8 Responding to Mr Holt, Mr Rock noted that a review was being undertaken surrounding fees, however, the delivery model of education remained unchanged. He emphasised one problem area which needed to be resolved was surrounding clinical placements.

2.2.9 Mr de Sousa noted that a large proportion of the workforce were working remotely (approx. 85%) and footfall within the Tavistock Centre was being monitored. He emphasised that desktop personal computers had been delivered to staff homes.

2.2.10 Responding to Prof Bhugra, Mr Jenkins noted that he had a call with the chief executive at Great Ormond Street Hospital for Children NHS Foundation Trust and passed his thanks for the support that they were providing surrounding paediatric inpatient beds.

2.2.11 Dr Caldwell noted that she has visited North Middlesex University Hospital the day prior to the board meeting and met with the Chief Medical Officer, Chief Nurse and HR Director who all expressed their thanks and support that the Tavistock had provided through the Together In Mind Programme.

2.2.12 The board of directors noted the report.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- At the end of February, the Trust had net cash balances of £7.6m
- The Trust expected to achieve its control total and achieve a surplus of circa £180k, subject to external audit.
- Legal costs would be incurred for the Judicial Review and relocation in February/March.
- The Trust has been granted £216k related to the Mental Health Investment Standard and which would improve the Trust' net surplus.
- COVID-19 had an impact on relocation, however competitive dialogue would continue.
- The Trust had not received guidance surrounding capital funding allocations for 2020/21.

- The Trust had applied for re-imbursement of £93k of costs relating to responding to the pandemic.

2.3.2 Prof Burstow noted that the STP will be a significant player in the decision making concerning capital allocations.

2.3.3 Responding to Mr Levenson, Mr Noys noted that as not everyone had used their annual leave it would be carried forward and would be accrued in the 2019/20 financial year.

2.3.4 The board of directors noted the report.

3. Items for discussion

3.1 Governance Arrangements

3.1.1 Mr de Sousa presented the report and noted that the paper reflected the discussion at the last board meeting. He added that he had conducted a thorough assessment of the constitution, board of directors' standing orders and council of governors' standing orders and the proposed changes to the governance arrangements did not represent any actions which could be determined as ultra vires.

3.1.2 Responding to Mr Holt, Mr de Sousa noted that although business development activity continues, there was no substantive business for the strategic and commercial committee to scrutinise. Ms Surtees noted that although bids were being submitted these did not yet require further discussion within the committee but added the next committee meeting would take place.

3.1.3 Responding to Mr Holt, Mr de Sousa agreed that point 2.3 of the paper 'reduced governance' should be changed to 're-focussed governance'.

3.1.4 Responding to Mr Levenson, Mr de Sousa noted that Ms Fernandes would be arranging the meetings for the non-executive directors and executive directors. **[AP4]**

3.1.5 The board of directors noted the report and agreed to the approach.

4. Any other matters

4.1 Any other business

4.1.1 There was no other business discussed.

4.1.2 The meeting closed at 3.00pm.

Report to	Date
Board of Directors	19 May 2020

Chief Executive's Report

Executive Summary

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

Recommendation to the Board

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

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Overall response

1.1 The Trust has continued its response to the pandemic.

1.2 Operational oversight of the incident is being maintained through a EPRR Gold meeting which meets 3 times a week and which I chair. I and other members of the Executive Team are plugged into a range of other groups in our STP and across London.

1.3 In the wake of the Prime Minister's announcement on 10th May and national guidance from NHS England we have shifted the focus to planning for the first phase of recovery.

2. Our first phase of Recovery

2.1 We have defined the first phase of recovery as operating up to the end of August. Dinesh Sinha has been leading a workstream to identify the key actions we need to take in this period

2.2 Our first priority will be to increase, by the middle of June, the face to face capacity of our clinical services. We are beginning to see a return in the level of demand for services and expect this to continue. There is also an appreciation that, for some patients, remote activity, while of great help in the initial period of the pandemic, needs to be supplemented by greater access to face to face care.

2.3 To enable us to do this safely:

- We will be supporting teams to make an assessment of their work to decide where they need to increase face to face activity to strengthen the scale and effectiveness of support to patients. The results will be moderated by Divisional Directors.

- We will be asking line managers to undertake an assessment of individual vulnerabilities (addressing both health and social factors). We will draw the results of this together to inform decisions about the deployment of staff. The assessment tool, which has been developed with our Occupational Health provider and which is similar to those being used in other organisations in North Central London

- We are undertaking a review of the use of space in the building to allow us to identify ways in which we can be support social distancing and other infection control measures. We will also be looking at rostering as a means of reducing footfall in the building and the impact on individual members of staff.

- We are looking at the scope to use greater access to testing to support the safety of staff.

2.4 We are communicating with staff through the all staff briefing sessions and other channels about these proposals.

2.5 For the current period, and with the aim of minimising unnecessary footfall in the building, we are not planning to encourage other activities to move back into the building. Term 3 teaching is continuing to operate on a fully online basis. This has progressed very successfully.

2.6 Gloucester House is already open, and children are attending in a carefully managed way.

3. Long term work on Recovery

3.1 We are progressing long term work around recovery:

- Engaging with NCL and London level work on recovery.

- Planning the design of provision for the next Academic Year.

- Undertaking work with staff and stakeholders to refresh our organisational vision in the light of the consequences of the pandemic.

- Beginning to address the financial uncertainties created by the pandemic with a particular focus on a sustainable position from 2021/2 onwards.

3.2 In my role as Chair of the Cavendish Square Group, I have been working with other stakeholders to support the development of the Mayor's Strategy on mental health which aims to join up public health and service responses to the psychological consequences of the pandemic. This has included developing a consistent framework for communicating messages about seeking help.

4. Remote working – QI project

4.1 A key aspect of our decisions about the path for the organisational recovery from the pandemic will be a considered review about the impact of remote working.

4.2 Our QI project is now underway. We have organised a programme of expert support for participating teams both on QI methodology but also covering issues relating to environmentally sustainable models of healthcare.

4.3 It will be important we take a thoughtful approach to these decisions. There are significant opportunities in increasing the scope of remote delivery in training and education and some aspects of clinical work, but it will not be a panacea in all cases and the challenge will be to agree a blended model which maximises efficiency, effectiveness, reach and environmental impact.

5. Staff Engagement

5.1 We have been continuing with twice weekly all staff briefings. These have continued to be well attended, with attendance back to over 100 in the session we held on May 11th after the Prime Minister's announcement.

5.2 From the beginning of June, I am proposing moving to a regular weekly slot on a Monday. We are also looking at how we can use surveying and other tools to get a wider range of staff views and perspectives.

6. Together in Mind

6.1 We have been continuing to co-ordinate Together in Mind as the staff wellbeing programme for health and care staff in North Central and North East London. We have collected an impressive range of online resources which are refreshed in the light of feedback from staff through the HAY (How are You) survey.

6.2 We are undertaking work, in partnership with other mental health Trusts in NCL, to plan for a second phase of the programme. This recognises the likelihood of the ongoing impact of trauma on the workforce and the need to develop wider programmes of support to address this.

7. Support for Schools

7.1 We are working with partners in London Borough of Camden to provide a framework of support for when young people return to schools, now expected to start from the beginning of June. We are expecting this will follow a similar format to Together in Mind with central managed resources and links to other sources of help.

8. Future Learn

8.1 We have been working with leading social learning provider, Future Learn to provide a range of online courses in areas related to the pandemic. As a first product we have teamed with Maudsley Learning to create a special free online course about the psychological impact of COVID-19. *COVID-19: psychological impact, wellbeing and mental health*, which will equip participants with an understanding of the psychological impact of the COVID-19 pandemic and help them to cope with the challenges it brings.

Paul Jenkins
Chief Executive
15th May 2020

Report to	Date
Board of Directors	19 May 2020

Board Assurance Framework

Executive Summary

The following Assurance Framework (BAF) identifies key risks to achieving the Trust's strategic objectives. In view of the current COVID-19 pandemic and impact on the organisation which is wide reaching and will be long lasting, the Executive Management Team (EMT) have taken the opportunity to review and update the strategic risks.

The wording in most risks has been updated, three risks have been closed with one new risk being added and two of the closed risks combining with other risks.

EMT recommended combining Risks 2 and 3. Risk 3 has been closed and the Risk 2 description updated.

Risk 9 has been closed as the GIDs action plan has been progressed well. There remains a different risk within GIDS which is defined as a new risk 9b.

EMT recommended combining Risks 10b and 13. Risk 13 has been closed and the Risk 10b description updated.

The BAF was reviewed by the Executive Management Team 12th May 2020.

Recommendation to the Board

The Board are asked to discuss 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 will be included in the next quarterly BAF report.

1.5 The new electronic risk management system currently testing is ongoing. It is not proposed to have a new look BAF until the New Year.

2. APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

3. RISK SUMMARY [risk descriptions are shortened]

3.1 There was one new risk added

- Risk 9b: If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19

3.2 There were two risks which combined together and resulted in updated risk description wording

- Risk 2 (incorporating Risk 3): The risk that the pandemic and pressures on leadership have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.
- Risk 10b (incorporating Risk 13): The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.

3.3 There are two risks rated 16

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

3.4 There is one risk which increased from March 2020 to May 2020

- Risk 10b (see above), risk description wording updated. Risk increased from 9 to 16.

3.5 There are four risks rated 12 as follows:

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

3.6 No risks reduced in May 2020

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

3. CONCLUSION

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

May 2020 BAF HEAT MAP

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

March 2020 BAF HEAT MAP

Likelihood	Risk Matrix		Consequence				
			Negligible	Minor	Moderate	Severe	Extreme
			1	2	3	4	5
	Very unlikely to occur	1					
	Unlikely to occur	2			4	1, 12	
	Could occur	3		7	10b, 13	3, 11	
	Likely to occur	4		6	2, 5	8, 9	
	Almost certain to occur	5					

Board Assurance Framework 2019/20 – Summary –

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

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
	the National Training Contract with Health Education England									
5	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	DoF	People	5	15 (3x5)	15 (3x5)	15 (3x5)	12 (4x3)	12 (4x3)	**Amber (2x5)**
6	The risk of insufficient staff capacity to keep activity within contracted levels across all services and manage all regulatory requirements because of a range of factors including morale, staff sickness, staff shielding and system pressures. This may also lead to poor engagement with the quality agenda with a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care	CCOO	Services: Clinical	6	6 (3x2)		6 (3x2)	8 (4x2)	8 (4x2)	**Green (2x2)**

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

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
	agenda, which now includes addressing the impact of COVID 19.									
10b	~~The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total.~~ The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.	DoS	Growth and Development	11			9 (3x3)	9 (3x3)	16 (4x4)	**Yellow (2x4)**
11	The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision	DoET/ DeanPGS	Services: Education	12	12 (3x4)		12 (3x4)	12 (3x4)	12 (3x4)	**Amber (3x3)**
12	If the Trust fails ~~to meet its regulatory responsibilities to CQC and QAA there will be~~ to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation and	~~CEO~~ MD	Finance and Governance	14	8 (2x4)		8 (2x4)	8 (2x4)	8 (2x4)	**Green (1x4)**

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
	the quality of patient and student experience									
~~13~~	~~Failure to deliver the Trust financial plan will negatively impact on the delivery of our Control Total and quality of our services due to funding limitations resulting in possible external sanctions~~	~~DepCE~~	~~Finance and Governance~~	~~15~~	~~15 (3x5)~~	~~15 (3x5)~~	~~15 (3x5)~~	~~9 (3x3)~~		~~Amber (2x5)~~

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

Strategic Aim: People
Corporate Objectives:

1. Increase equality of opportunity across the organisation with focus on implementing the next stage of the Race Equality Strategy **Director of HR and Corporate Governance**
2. Continue to strengthen engagement with staff addressing issues highlighted in staff survey and further strengthening arrangements for Trust response to concerns. **Chief Executive**
3. Refresh the Trust's People Strategy with a focus on future workforce needs including supporting the resilience, development and performance of our staff: **Director of HR and Corporate Governance**
4. Position the Trust as a respected authority on workforce development: **Director of Nursing**
5. Establish clarity about long-term plans for the Tavistock Clinic site **Deputy Chief Executive**

<table>
<tr><td colspan="2">RISK 1): The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.</td></tr>
<tr><td><u>Risk Owner</u>: Craig de Sousa</td><td>Date reviewed 17 April 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 2 x Consequence 4 = 8 (Current risk rating unchanged)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
The Trust has established a race equality strategy to a number of recurrent themes around black, asian and minority ethnic staff experience.</td></tr>
<tr><td><u>Controls/Influences</u> (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 HR and Corporate Governance 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.</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):

Workforce Race Equality Standard annual report (+/-)
Staff survey 2019 (-)
November CQC report confirmed that staff remain concerned about the pace of progress (-) Revised action developed in consultation with BAME network, approved by the Board March 2019 (+)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Further training for managers who have attended Thinking Space events to ensure clarity about action necessary to implement the strategy at local level</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Develop further training plan for managers, (DoHRCG, May 20)</td></tr>
</table>

	Using funds allocated by the Tavistock Clinic Foundation, review the implementation and impact of the bursary scheme to support individuals to gain access to Trust professional qualifying programmes (DoHRCG, Sept 2020) Increase capability and confidence of senior leaders, across the organisation, to engage in conversations about race, culture and difference (DoHRCG, May 2020) Review and implement ways of integrating discussion on health inequalities and access issues within clinical and training team meetings (CCOO, ongoing)

RISK 2): **If we are unable to maintain good ~~The risk that there is a deterioration in~~ staff morale and engagement there is a risk of negatively ~~with a potential~~ impacting on patient and student experience and the quality of services delivered**	
Risk Owner: Paul Jenkins/ Craig de Sousa	Date reviewed May 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x 3 = 6
Rationale for current score: ~~Recognition of pressure of workload across all parts of the organisation combined with negative impact of external media attention around gender work.~~ Recognition of negative impact of COVID-19 on staff morale and engagement with work	
Controls/Influences *(what are we currently doing about this risk?)*: CEO question time and other engagement events with staff Trust inter-professional meetings Piloting in CYAF of Stress and resilience Framework Follow through of 2017 staff survey results Refresh of people strategy including further action on middle management training Engage with staff to develop new organisational narrative linked to the Centenary.	Assurances received *(independent reports on processes; when; conclusions)*: Staff survey (+/-) Staff feedback (formal and informal) (+/-)
Gaps in controls/influences: Strengthen staff engagement More formal strategy for addressing staff morale and wellbeing	Action plans in response to gaps identified: *(with lead and target date)* Develop staff engagement events building on experience of new formats during pandemic (31/07) CEO) Relaunch extended staff wellbeing offer (31/05) DHRCS ~~Pilot stress and resilience framework (31/12/ 2019 CCOO)~~ Refresh people strategy (September 2020 DoHRG) ~~Design~~ Deliver engagement ~~for~~ to develop~~ing~~ a new organisational narrative linked to Centenary (RS) ~~(31/01/20)~~ (31/07)

RISK 3): **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.** **EMT recommendation to combine with risk 2. Risk 3 CLOSED,**	
Risk Owner Craig de Sousa	Date reviewed:
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	TARGET risk rating 2 x 4 = 8
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 2019 (+ /-) 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 / portfolio manager level. Increased media attention impacting morale of staff	Action plans in response to gaps identified: *(with lead and target date)* OD and People Strategy delivery plan (DoHRCG Mar 2020) Staff survey plans developed (DoHRCG May 2020) Staff Education Programme (DoHRCG Mar 2020) New OD and People Strategy 2020 – 2023 (DoHRCG September 2020)

RISK 4): **The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England**	
Risk Owner: Chris Caldwell	Date reviewed: 22 April 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6 (Current risk score unchanged)	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE decreased from risk level 9 to 6 following: 1. Positive review of the Unit by HEE MH Delivery Board and recommendation to HEE national Board that the Unit element of the NTC is rolled continued and rolled into the NTC annually renewable contract. 2. Feedback from HEE London (contact managers) that they are recommending no change to the NTC contract for 2021/22 The NWSDU has maintained a profile and exposure in year through conferencing and the engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity. DET recruitment and CPPD profile has been positive and demonstrated measurable contribution to increased supply and upskilling of MH workforce. If HEE national Executive agree 'no change' position risk rating will be reduced to 1x3 at review date we have not received this confirmation	
Controls/Influences *(what are we currently doing about this risk?)*: NWSDU and NMHWDC Communications strategies and Plans in place NWSDU/ IJT /CC Objectives: Planned conference delivered to March 2020 IJT attendance at Pan ALB Health & Wellbeing Group CC profile in MH workforce and wider nursing agenda locally and nationally T&P presentation of work to HEE national MH Delivery Group meeting in Jan 2020 IJT Engagement in Pearson 'Learner MH & Wellbeing' HEE Workstream Exposure of Stress & Resilience work to Cavendish Square and 'Top Leaders' groups IJT presentation to HSJ workforce leaders conference and subsequent HSJ follow up article.	Assurances received *(independent reports on processes; when; conclusions)*: Coms Strategy and Plan documents in place (+) Conference evaluation and end of project report (+) Communications support proposal and contract (+)
Gaps in controls/influences: None identified	Action plans in response to gaps identified: *(with lead and target date)* Communications support in place from July19 (IJT July 19) Communications action plan in delivery (IJT April 20) NWSDU delivered on presence at NHS Employers Health & Wellbeing conference - May 19 NHS Confed – June 19 and PWP conference Sheffield June 19. (IJT July 19)

	Confirmed presence and conference presentation at NHS Expo Sept 19, Presence at NHS Providers Oct 19. (CC March 2020) Agreement and ongoing work for development of shared communications strategy with HEE Mental Health Programme Board (IJT April 20) Completed work with Pearson Commission Group and Pan ALB H&WB group (IJT April 20) Planned attendance at conference season 2020 – COVID allowing – IJT April 20)

RISK 5): **If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy**	
Risk Owner: Terry Noys	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12 (Current score unchanged)	TARGET risk rating 2 x 5 = 10
Rationale for current score: Outcome of Competitive Dialogue process remains uncertain whilst NHSI/E capping of capital expenditure makes delivering internal (non JTR) solutions difficult.	
Controls/Influences *(what are we currently doing about this risk?)*: Tavistock Centre Strategic Programme Scheduling Project Estates Strategy 67 Belsize Lane Finchley Road	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of Tavistock Centre Strategic Programme Board (+/-) Minutes of Scheduling Project Programme Board (+/-) Estates and Facilities Work stream reporting into CQSGC (+/-)
Gaps in controls/influences: Uncertainty over Relocation project Uncertainty over impact of Scheduling project	Action plans in response to gaps identified: *(with lead and target date)* Competitive Dialogue process (IG 31 December 2019) Remodelling of space at Tavistock Centre (IG 31 Dec 2019)

Strategic Aim: Services: Clinical
Corporate Objectives:

3. Continue to delivery high quality clinical services adopting QI processes across the Trust to ensure continuous improvement **DoCYAF/DoAFS**
4. Explore use of technology and other approaches to develop more sustainable models of care with defined outcomes **DoCYAF**
5. Actively contribute to the development of integrated care models in Camden and NCL **Chief Executive**
6. Implement recommendations of GIDS Review and wider lessons from review of Trust's services with clearly measurable outcomes **DoCYAF**

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

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

RISK 8): **The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives**	
Risk Owner: Paul Jenkins	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	TARGET risk rating 3 x 3 = 9
Rationale for current score: Wider financial pressure across the STP with increased disruption owing to COVID-19.	
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 Engage in development of Medium-Term Financial Plan Commitment on protecting MH investment	Assurances received *(independent reports on processes; when; conclusions)*: Agreement by Regulators of Medium-Term Financial Plan (+/-) STP plan for mental health (+)
Gaps in controls/influences: Decisions of the regulators Wider financial position across the STP Impact of changes in governance arrangements Changes in priorities in the STP in the light of the pandemic	Action plans in response to gaps identified: *(with lead and target date)* Implementation of medium-term financial plan (PJ Ongoing) ~~Agreement of STP investment plan for mental health with agreement over use of ring-fenced investment for mental health~~ Reset of me priorities and financial plan (PJ ~~Mar~~ Sep 2020) Successful implementation of Tier NCEL Provider Collaborative (SH Ongoing)

RISK 9): **The risk inadequate staff capacity may lead to poor morale with possible failure to deliver the GIDS action plan resulting in negative impact on the reputation of the Trust** **Risk CLOSED and new risk drafted as 9b below**	
Risk Owner: Sally Hodges	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	TARGET risk rating 3 x 3 = 9
Rationale for current score: GIDS action plan has been progressed well. Risk CLOSED.	
Controls/Influences *(what are we currently doing about this risk?)*: Alisa Swarbrick has been appointed as Divisional Director for Gender and she is setting up structures to systematically embed the actions from the review	Assurances received *(independent reports on processes; when; conclusions)*: Ailsa is reporting back on progress through the trust management structures (+)
Gaps in controls/influences: Work needs to be done to get plan in place	Action plans in response to gaps identified: *(with lead and target date)* Structure to be implemented (AS, Dec 2019 onwards)

RISK 9b): If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19 [New Risk]	
Risk Owner: Sally Hodges	Date reviewed: 7 May 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4= 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	TARGET risk rating 2 x 4 = 8
Rationale for current score: It was agreed that BAF risk 9 should be closed. This had addressed a GIDS risk that inadequate staff capacity and poor morale may lead to failure to deliver against the GIDS Action Plan and lead to Trust reputational damage. While the action plan has now progressed well, risks around GIDs still remain.	
Controls/Influences *(what are we currently doing about this risk?)*: Regular internal meetings and support from Trust; routine data monitoring, routine Trust governance	Assurances received *(independent reports on processes; when; conclusions)*: Regular feedback sought; staffing levels; routine monitoring data on activity
Gaps in controls/influences: Careful post covid planning; reviewing workload and tasks clinical and admin staff do; further engagement and feedback from staff	Action plans in response to gaps identified: *(with lead and target date)* Post COVID-19 planning (31 May, AS) Review staff workload and tasks (31 May, AS)

Strategic Aim: Growth and Development
Corporate Objectives:

7. Progress the Trust's longer-term priorities for new service development and meet the target for new growth in 2019/20 **DoS**
8. Develop opportunities to broaden the reach and target audiences of the Trust's training and educational work including international work and development of the Trust's Digital Academy **DoE&T/DPGS**
9. Develop, in preparation for the organisation's 2020 Centenary, a narrative for the role of the Trust's work and expertise in the 21st Century **DoC&M**

RISK 10b): ~~**The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total**~~ **The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term. [Risk combined with Risk 13 and updated]**	
Risk Owner: Rachel Surtees	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	TARGET risk rating 2 x 4 = 8
Rationale for current score: The Trust has a strong record of good financial performance which has allowed it to maintain the quality and safety of our patient and education services. This has been achieved each year through a combination of modest cost improvement programmes; new income generation through the development of new courses and services; and annual contract activity uplifts. However whilst the organisation's overall financial position has been balanced, there is significant variation between services which has been exacerbated by a number of contract losses. In addition, costs have been incurred to support development and infrastructure work, and contribution from new business has been significantly affected by instability in the external commissioning environment. With the move towards the development of Integrated Care Systems, the impact of the pandemic, and the move towards 'digital first' it is anticipated that opportunities for growth will reduce and the pressure to reduce costs will increase.	
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).	Assurances received *(independent reports on processes; when; conclusions)*: - Pipeline report to Business Development Group (BDG) on a monthly basis and Strategic Commercial Committee (SCC) on quarterly basis (+/-) - Monthly reporting on contract performance data to BDG and quarterly to SCC

- Named target markets, including areas outside of health commissioning, to enable better focus and prioritisation on our target routes to growth and diversification of income source - Active engagement with commissioners including regularly scheduled contract review meetings - Board approved Budget - Regular reforecasting of full year out-turn	- Contribution forecast report to BDG on a monthly basis and SCC on quarterly basis (+/-) - Management accounts reviewed monthly by EMT and Board
Gaps in controls/influences: - No current active plans for service reconfiguration - Limited ability to 'seed fund' new income generating service development opportunities - Lack of joined up data sets to allow objective analysis of underlying sustainability	Action plans in response to gaps identified: *(with lead and target date)* - Business Development team rebalancing focus to give increased priority to service development opportunities, and growth outside of health commissioned provision (ongoing RS) - Active engagement with a number of STP forums focused on integration and transformation across the patch (all EMT members - ongoing) - Trust-wide task and finish group to look at service configuration and sustainability (TN and RS – pilot in summer 2020, Trust-wide roll out from September 2020) - Development of Trust-wide long term strategic vision statement (RS -completion autumn 2020)

Strategic Aim: Services: Education
Corporate Objectives:
10. Continue to delivery high quality educational services adopting quality improvement processes across the Trust to ensure continuous improvement **DoE&T/DPGS**

RISK 11): **The risk that a failure to develop and modernise the Trust's educational offering has a negative impact on the sustainability of our provision**	
Risk Owner: Brian Rock	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 TARGET risk rating 3 x 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12 (current risk score unchanged)	
Rationale for current score: Progress is being made in the establishment of the Digital Academy following Board sign off. International development is being adversely impacted by COVID-19 though we continue to focus on communicating our offer and developing potential partnerships, including the delivery of an international conference. We expect a dip in activity and income through FY20/21 but believe this position will be mitigated following a resolution to the spread of coronavirus. Delivery of term 3 is now underway through remote provision on Zoom and while this should provide some impetus for innovation, staff fatigue might contribute the wish to return to pre-COVD-19 ways of teaching. The current focus on supporting core Trust activity in this period of uncertainty and reduced capacity will limit new course developments. In this period the adoption of remote delivery and technology will lead to a lasting change in people's willingness to access and preference for online delivery across our provision (long and short courses). There will also be an increase in our capability to deliver through remote means. The market will also become more crowded and competitive and therefore more sustainable development will require a longer period for more fundamental change. There is an opportunity to increase our reach beyond current geographical constraints.	
Controls/Influences *(what are we currently doing about this risk?)*: Clarity in the focus on the international strategy and plan. Project team established for Phase 2 of the DA. Successful procurement leading to the identification of preferred partner. Task & Finish group phase 2 has led to greater market insights for each portfolio and internal discussion with portfolio managers though the achievements are more incremental. Scoping of Phase 3 underway. Working group with internal and Essex representatives underway of scoping new long course development with agreed milestones including focus groups with students and employers.	Assurances received *(independent reports on processes; when; conclusions)*: Agreement on international strategy at ETC (July 2019) (+) International coordinator in role to support core team (April 2020) (+) Board sign-off on phase 2 of the DA (Sept 2019). (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
International plan delivery is slowed by current COVID-19 situation, Focus diverted and capacity reduced in the foreseeable future on new developments.	Reviewing current delivery plan for new modes of delivery including virtual international conference and other events. (DoE/DPGS & International Working Group, Sept 2020) Establishing Development Forum with Director of Strategy to engage across the organisations for new developments for educational delivery (DoE/DPGS & DoS, July 2020)

Strategic Aim: Finance and Governance
Corporate Objectives:

14. Meet the Trust's requirements with its national regulators. Implement the Action Plan from its 2018 CQC inspection including actions to strengthen integrated governance **CEO**
15. Develop 10-year plan for financial sustainability and meet Trust's budget and control total for 2019/20: **DepCEO**

RISK 12): **If the Trust fails to ~~meet its regulatory responsibilities to CQC and QAA there will be~~ respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation**	
Risk Owner: ~~Paul Jenkins~~ Medical Director	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8 (Current score unchanged)	TARGET risk rating 1 x 4 = 4
Rationale for current score: CQC Well Led Inspection expected shortly.	
Controls/Influences *(what are we currently doing about this risk?)*: Completed well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps Implementation of QAA review action plans and established plans from university partner institutional reviews (Essex and UEL) Annual student survey completed	Assurances received *(independent reports on processes; when; conclusions)*: Work streams reporting to the Board level Integrated Governance Committee to provide assurance of compliance and raise issues of risk to compliance with CQC (+) Formal CQC report – 'good overall' and 'outstanding' for the Effective KLOE. Requires improvement in gender services for Responsiveness KLOE because of waiting times (+) Excellent outcome from 2018 QAA monitoring visit (+) Positive university partner institutional reviews commending course provision and faculty expertise and commitment (+) Detailed action plan to address areas identified by CQC for improvement drawn up and approved by the EMT, the CQSGC/IGC and the CQRG. Progress monitored via EMT and CQSGC/IGC (+) Service Line self-assessments for CQC compliance (+/-) CQC Planning group monitoring implementation of actions (+) Service Manager and Board CQC seminars (+/-)
Gaps in controls/influences: Current service line assessment of CQC compliance required	Action plans in response to gaps identified: *(with lead and target date)* CQC action plan (DS/CCOO August 2020)

	Staff communications - 'values'(JR May 2020) Staff communications – updated CQC handbook (MS June 2020)

RISK 13): Failure to deliver the Trust financial plan will negatively impact on the delivery of our Control Total and quality of our services due to funding limitations, resulting in possible external sanctions **EMT recommendation to combine with risk 10b. Risk 13 CLOSED**	
Risk Owner: Terry Noys	Date reviewed: May 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	TARGET risk rating 2 x 5 = 10
Rationale for current score: Additional in-year costs have been incurred and in-year contribution from new business substantially below Budget. Contribution from TAP risk share assumed to be zero. A number of contract losses being incurred, with uncertainty over any related redundancy costs. Potentially significant, unbudgeted legal costs being incurred. Anticipated that staff costs will continue to run at below Budget levels. Potential for negative impact depending on outcome of Relocation	
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 (+ / -) In-year forecasts reviewed by EMT and Board (+ / -)
Gaps in controls/influences: Uncertainty over contribution from new business Uncertainty over staff spend	Action plans in response to gaps identified: *(with lead and target date)* Financial reforecast to be undertaken (TN: November); Review of historic accruals (UC: November) Additional income opportunities being sought (RSt)

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: May 2020

Report to	Date
Board of Directors	May 2020

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q4 quality metrics for the Trust. The Commentary section provides service updates on waiting times and 'DNAs' where these are available, given constraints on services dealing with the covid-19 pandemic. Updates are also included on the current position of Trust Quality Priorities and CQUINs. Please note the data in this report is Trust wide, with the exception of CQUINS that apply to London Contracting or NHSE contracts only.

The report includes the following **highlights and improvements**:

- Trust patient contacts increased by 140 over the quarter, with small increases in most services.
- In Q4 CYAF saw 90% of patients for their first appointment within the contracted waiting time. The Adolescent service remains below target but increased 10% compliance from 67% to 78%. Within this service the differential for those under 18 years was 53% and those over 18 years was within target of 85%. Referral to second appointments decreased across all services this quarter with the exception of Adult Complex Needs. TAP looks to have increasing waiting times for first appointment however, it is noted the data for the service in Q4 has been taken from two different sources owing to data migration.
- Overall Trust DNA compliance is 7.9% this quarter, with consistent performance of services below target, including both gender services. TAP and the Portman services are above 10%.
- Q4 saw the same number of complaints received as in Q3 at 30 with an improvement in average response days down to 18. Due to the current Covid-19 crisis nine complainants currently awaiting response have been advised of possible delays.
- Among our outcome measures, CORE improvement rates increased in Q4 to 100%. Time 1 Goal Based Measure completion rates further increased in Q4 from Q3, along with the Time 2 completion rate. Both remain under target but are improving. The QI project in Camden North and South continues to work on improving these.
- The CGAS completion rates have increased for Time 1 but decreased for Time 2.
- HR mandatory training compliance improved in Q4 to 85%.
- Commissioners have assessed CQUIN compliance for 2019/20 at 100%.
- Quality Priorities for 2019-20 show 1 fully met, 4 partly met and 1 not met

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

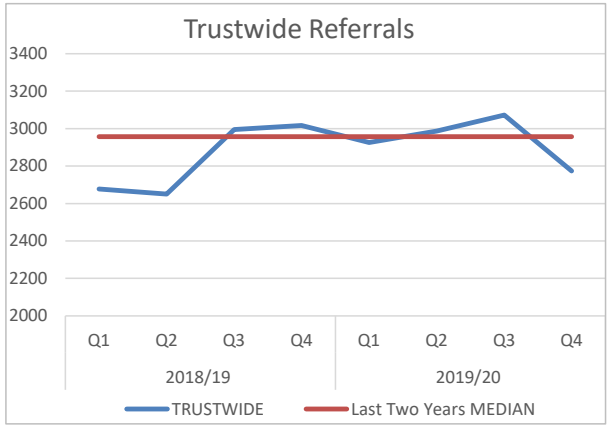
- The total number of Trust referrals received, with the exception of 'Other Camhs', has shown a decrease of nearly 298 referrals this quarter. Other Camhs saw an additional 37 referrals.
- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthly.
- GBM and CGAS collection rates under target, though there continue to be improvements compared to Q1 for all except CGAS Time 2 data.
- MHSDS collection rates are from January 2020 and show an ongoing small decrease in the three areas where we have been showing consistently poor data – ethnicity; employment status (adults) and accommodation status (adults). Compliance with the Ex-British Armed Forces indicator continue to improve. Actions completed during Q3 to improve compliance will show in the March NHS Digital report. The most recent DQMI is for December 2019 with compliance at 94.4% which is very good.
- Whilst completion rates of GBM and CGAS outcome measures are continuing to increase gradually the numbers remain low e.g. GBM T1 43% (up from 39%) equates to 72/166 due and for CGAS T1 67% (up from 58%) equates to 108/161. Changes to Carenotes logic to improve clinician access to measures in the Assist Panel have now been made. A QI project continues in the South Camden Team.

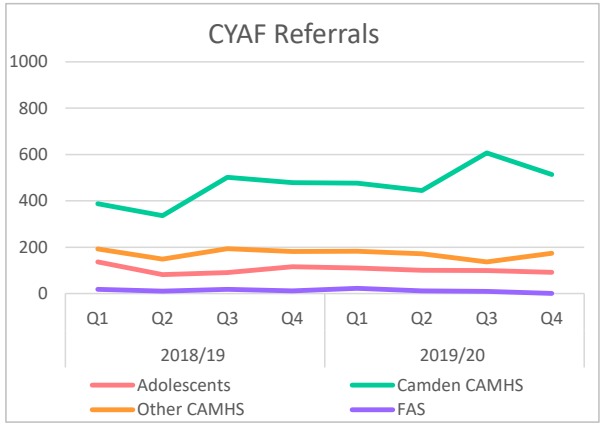
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.

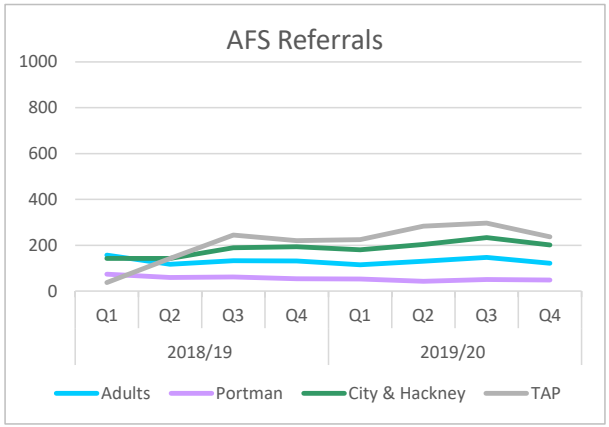
Trust strategic objectives supported by this paper
Finance and Governance

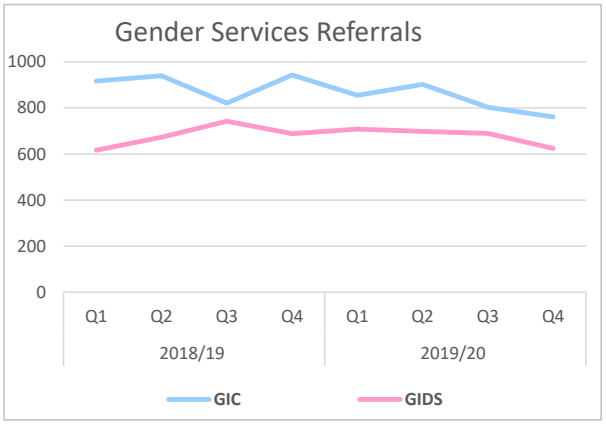
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q4 2019/20: Trust Reach – Access









Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
NB TAP information migrated to a newer version of EMIS during Q4. Report data extracted from two different sources.

Number of Referrals Received:

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

Trust-wide we saw drop in referral numbers between Q3 & 4. In Q4 the trust received 2774 which was 298 referrals lower than in Q3, when the trust received 3072.

Adolescent: in Q4 received 92 referrals, the average of referrals received during this financial year was 100 per quarter.

Camden CAMHS: in Q4 received 514 referrals, 66 fewer than in Q3. The average of referrals over the last 4 quarters was 510 and in the previous 4 quarters it was 425.

Other CAMHS: in Q4 received 174 referrals, an increase on the 137 referrals received in Q3. The average of referrals over the last 4 quarters was 166 and in the previous 4 quarters it was 179.

Family Assessment Service (FAS): the number of referrals dropped in Q4, with 1 referral compared to the 9 received in Q3 and the 11 referrals received in Q2.

Adults Complex needs: experienced a decrease in referrals, receiving 122 in Q4 compared to the 147 received in Q3. The average number of referrals received during this financial year was 128.

Portman: in Q4 experienced a lower number of referrals - 48. There was a quarterly average 49 of during this financial year.

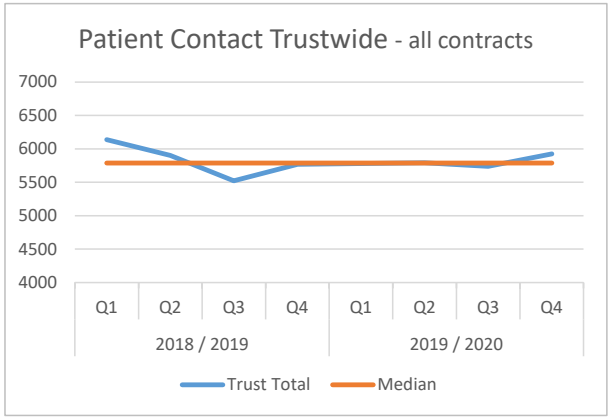
C&H PCPCS: had a decrease in Q4 32 fewer than in Q3.

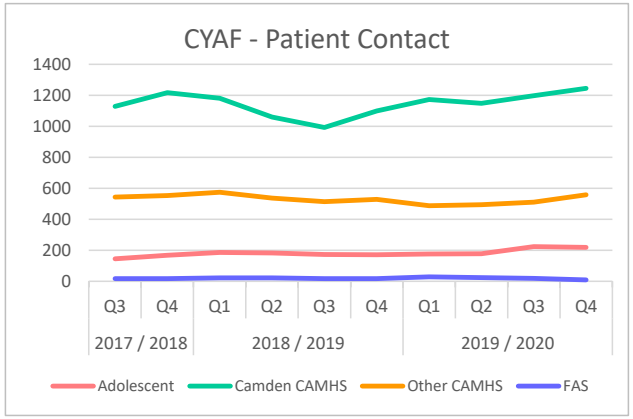
TAP: in Q4 experienced a decrease on the number of referrals with 237, compared to the 296 received in Q3.

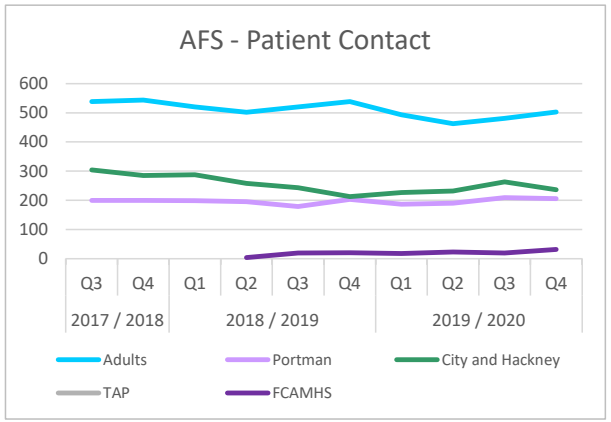
GIDS: in Q4 GIDS received 624 referrals, a decrease on Q3, when 690 referrals were received.

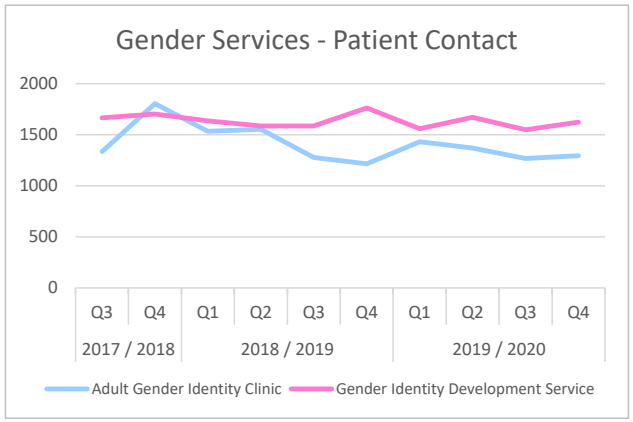
GIC: in Q4 received 761 referrals, a decrease on the 803 referrals received in Q3.

Q4 2019/20: Trust Reach – Access









Individual patients in contact with our services

We include all individual patients in all contracts who have had contact with our service, excluding EIS and Mosaic. They are reported only once per quarter. Data includes telephone contacts.

Trust-wide, we saw an increase in the individual number of patients seen comparing the last two quarters. In Q4 5926 patients were seen, and in Q3 5740. The average number of contacts over this financial year was 5809.

Adolescent: in Q4 saw 220 individual patients, a slight decrease from Q3 when saw 224. The average for this financial year was 199.

Camden CAMHS: in Q4 saw 1245 patients, 48 more than in Q3 – this is the highest number over the last two years.

Other CAMHS: in Q4 experienced a rise, seeing 559 patients – 48 higher than in Q3. The average this financial year was 513.

FAS: experienced a decrease in contacts, in Q4 they saw 9 patients and in Q3 20.

Adults Complex Needs: in Q4 saw 503 patients, a rise on Q3 data when 481 patients were seen. The average for this financial year was 485.

Portman: in Q4 had contact with 206 patients, slightly lower than in Q3 when they saw 209. The average for this financial year was 199.

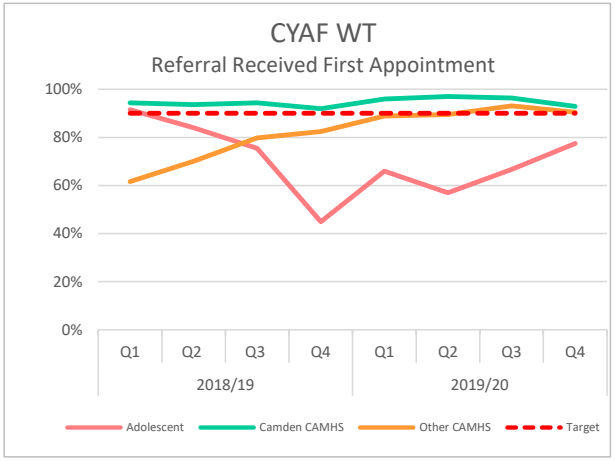
C&H PCPCS: in Q4 contacted 236 patients, a slight decrease from Q3 when saw 263. The average this financial year was 239.

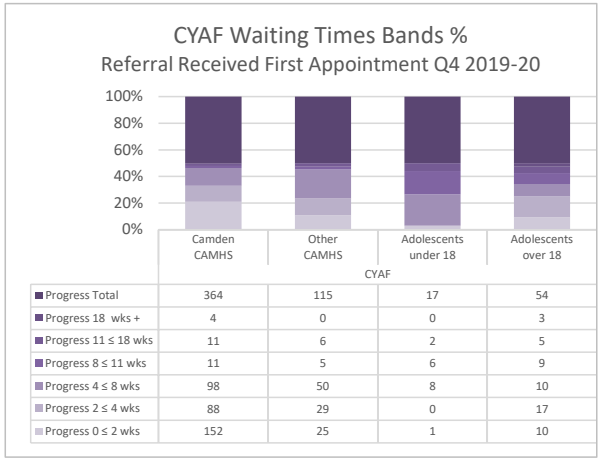
GIDS: in Q4 contacted 1622 patients, an increase on Q3 when saw 1549. The average for this financial year was 1599.

GIC: in Q4 contacted 1294 patients, an increase on Q3 when saw 1294. The average this financial year was 1340.

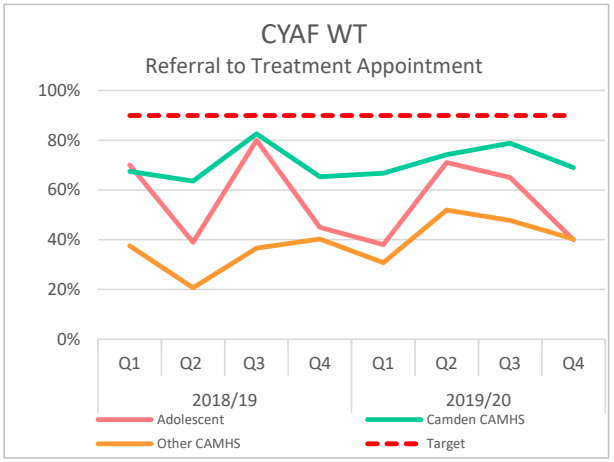
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
NB TAP information migrated to a newer version of EMIS during Q4. Report data extracted from two different sources.

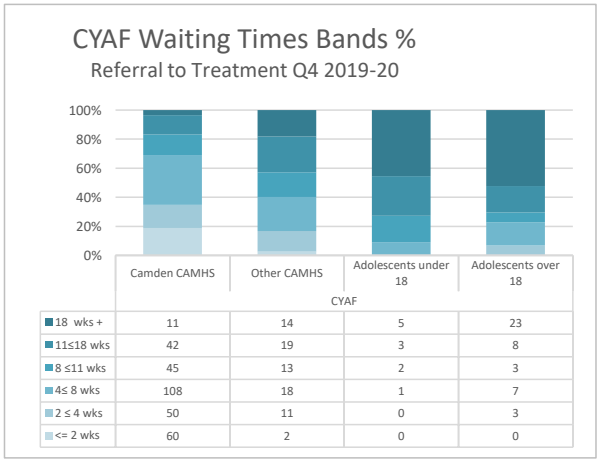
Q4 2019/20: Quality Responsive – Access





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
Progress Total	364	115	17	54
Progress 18 wks +	4	0	0	3
Progress 11 ≤ 18 wks	11	6	2	5
Progress 8 ≤ 11 wks	11	5	6	9
Progress 4 ≤ 8 wks	98	50	8	10
Progress 2 ≤ 4 wks	88	29	0	17
Progress 0 ≤ 2 wks	152	25	1	10





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	11	14	5	23
11≤18 wks	42	19	3	8
8 ≤11 wks	45	13	2	3
4≤ 8 wks	108	18	1	7
2 ≤ 4 wks	50	11	0	3
<= 2 wks	60	2	0	0

CYAF Waiting Times :

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

Referral to 1st appointment: In Q4 CYAF saw 90% of patients within the contractual waiting times.
Referral to 2nd appointment: In Q4 CYAF saw 60% of patients within the contractual waiting times.

Adolescent services
Referral to 1st appointment – in Q4 the whole service line saw 77% of patients within contractual hours, an improvement on the 67% in Q3.
- Adolescents under 18 - **53%**
- Adolescents over 18 - **85%**

Referral to 2nd appointment – – in Q4 the whole service line saw 40% of patients within contractual hours, compliance decreased compared to 65% in Q3.
- Adolescents under 18 - 9**%**
- Adolescents over 18 - **48%**

Camden CAMHS.
Referral to 1st appointment – has consistently done well since 2017/18 in Q4. The compliance rate is 93%, 3 percentage points lower than in Q3.
Referral to 2nd appointment – in Q4 69% of the patients had an appointment within 8 weeks, a lower compliance than in Q3, when 79% of patients were seen on time.

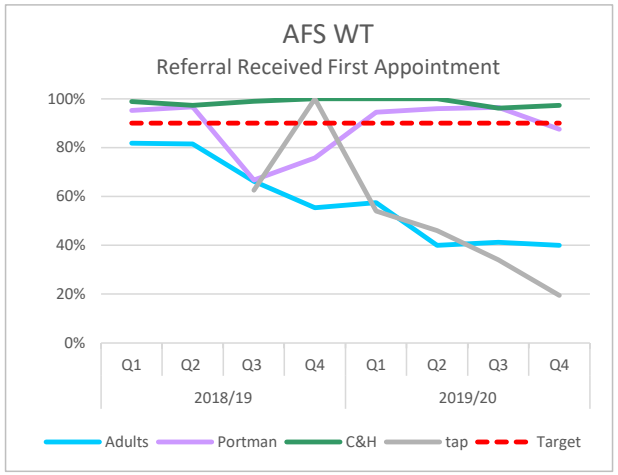
Other CAMHS
Referral to 1st appointment – In Q4 they achieved 90% - this is the second time they met the target since the end of 18/19.
Referral to 2nd appointment – in Q4 we noticed a decrease in patients seen on time with 40% compliance, compared to 48% in Q3.

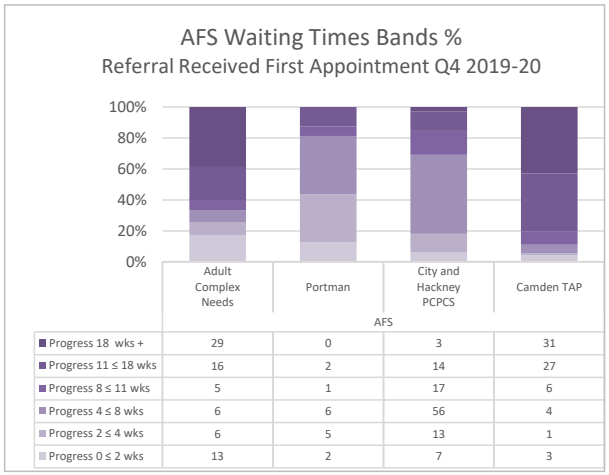
Family Assessment Service (FAS) is separate from the CCG and MHS contracts and the usual waiting time targets don't apply.

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

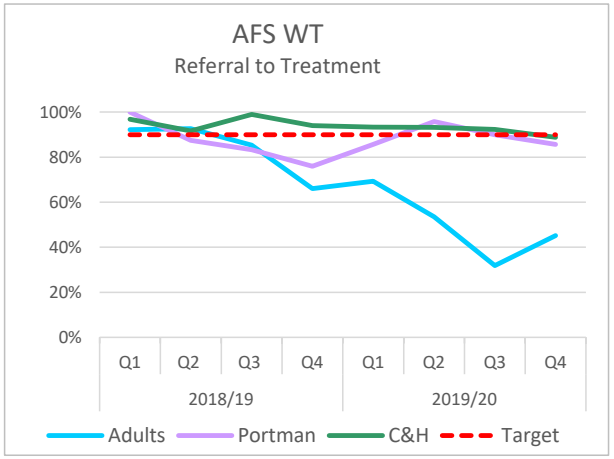
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
NB TAP information migrated to a newer version of EMIS during Q4. Report data extracted from two different sources.

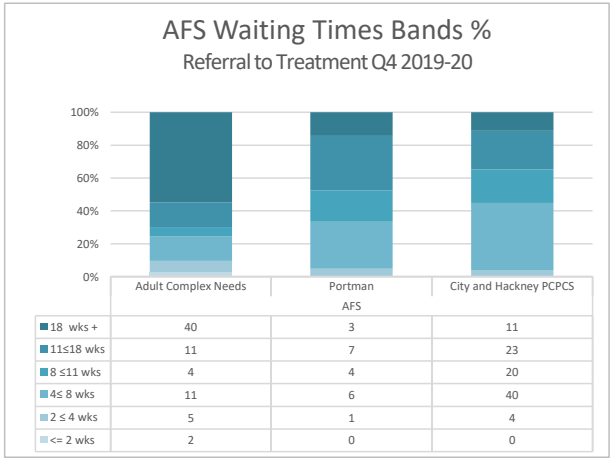
Q4 2019/20: Quality Responsive – Access





	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
Progress 18 wks +	29	0	3	31
Progress 11 ≤ 18 wks	16	2	14	27
Progress 8 ≤ 11 wks	5	1	17	6
Progress 4 ≤ 8 wks	6	6	56	4
Progress 2 ≤ 4 wks	6	5	13	1
Progress 0 ≤ 2 wks	13	2	7	3





	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	40	3	11
11≤18 wks	11	7	23
8 ≤11 wks	4	4	20
4≤ 8 wks	11	6	40
2 ≤ 4 wks	5	1	4
<= 2 wks	2	0	0

AFS Waiting Times :

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

Referral to 1st appointment: In Q2 AFS saw 60% of patients within the contractual waiting times. In Q3 this compliance was to 64%.
Referral to 2nd appointment: In Q2 AFS saw 72%. of patients within the contractual waiting times. In Q3 this compliance was to 69%.

Adult Complex Needs

Referral to 1st appointment –in Q4 they had 40% compliance, a slight decrease on Q3, when 41% compliance was achieved.
Referral to 2nd appointment – in Q4 they had 45% compliance, an increase on Q3, when they had 32% compliance.

Portman

Referral to 1st appointment – in Q4 they had 88% compliance, a decrease on Q3, when they had 96% compliance.
Referral to 2nd appointment – in Q4 they had 86% compliance, a decrease on Q3, when they had 90% compliance.

C&H PCPS

Referral to 1st appointment – in Q4 they had 97% compliance, an increase on Q3, when they had 96% compliance.
Referral to 2nd appointment – in Q4 they had 86% compliance, a decrease on Q3, when they had 92% compliance.

TAP

Please note that TAP information migrated to a newer version of EMIS during Q4. Report data was extracted from two different sources.
Referral to 1st appointment – in Q4 the percentage of patients seen on time lowered to 19%, in Q3 they had compliance of 34%.
Referral to 2nd appointment – this service does not report on second appointments as their system (EMIS) is not able to provide the data.

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

Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
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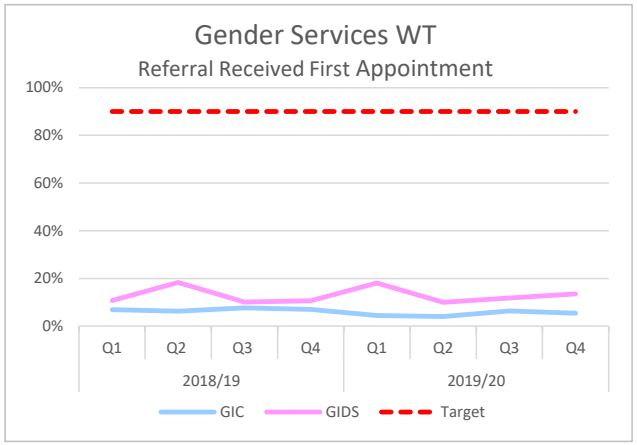
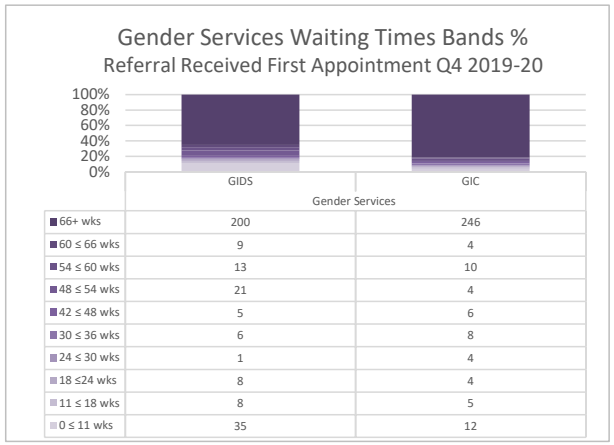
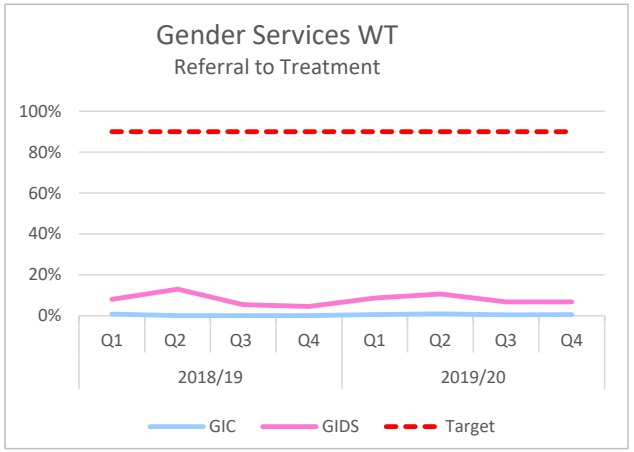
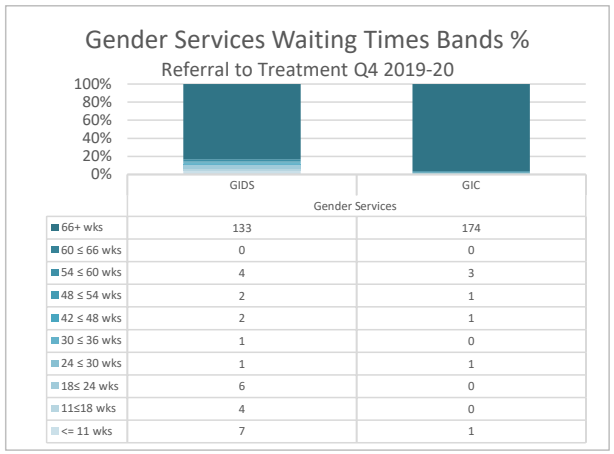
Q4 2019/20: Quality Responsive – Access





	GIDS	GIC
66+ wks	200	246
60 ≤ 66 wks	9	4
54 ≤ 60 wks	13	10
48 ≤ 54 wks	21	4
42 ≤ 48 wks	5	6
30 ≤ 36 wks	6	8
24 ≤ 30 wks	1	4
18 ≤24 wks	8	4
11 ≤ 18 wks	8	5
0 ≤ 11 wks	35	12





	GIDS	GIC
66+ wks	133	174
60 ≤ 66 wks	0	0
54 ≤ 60 wks	4	3
48 ≤ 54 wks	2	1
42 ≤ 48 wks	2	1
30 ≤ 36 wks	1	0
24 ≤ 30 wks	1	1
18≤ 24 wks	6	0
11≤18 wks	4	0
<= 11 wks	7	1

Gender Services Waiting Times:

Gender Services Directorate have had an unusually high number of referrals over the past few years and challenging demand nationwide, they have action plans in place and liaise closely with commissioners.

Referral to 1st appointment: Gender Services Directorate saw in Q4 10% of patients within the contractual waiting times.
Referral to 2nd appointment: Gender Services Directorate saw in Q4 3% of patients within the contractual waiting times.

GIDS: as a measure of awareness the GIDS website shares information about the WT issue; the current waiting time is advised on the website to young people and referrers and explains that they currently see young people who were referred 22-26 months ago.
Referral to 1st appointment – in Q4 achieved 14% compliance, a slight increase on 12% in Q3.
Referral to 2nd appointment – in Q3 achieved 7% compliance, the same as in Q3.

GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.
Referral to 1st appointment – in Q4 achieved 5% compliance, a slight decrease on Q3.
Referral to 2nd appointment – in Q4 achieved 0.54% compliance, a slight increase on 0.4% in Q3.

For further comments from service leads please see the commentary part of the report Page 24

Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
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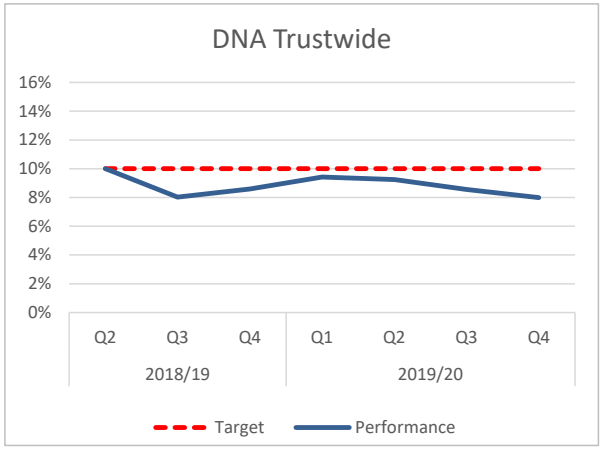
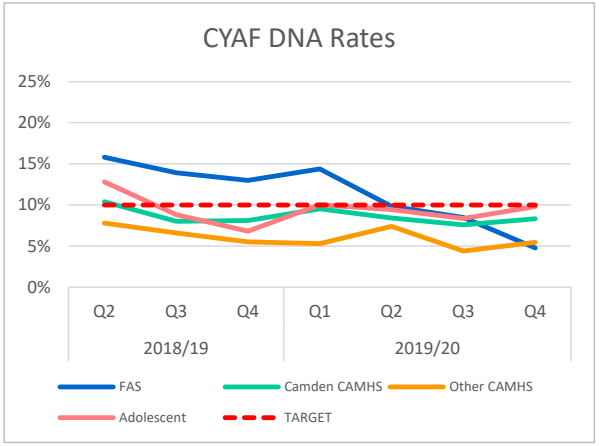
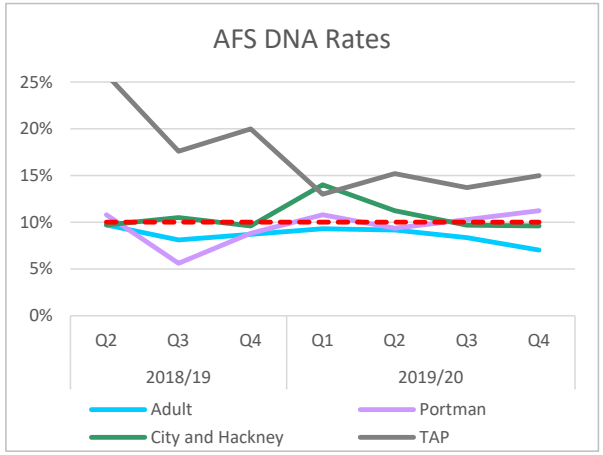
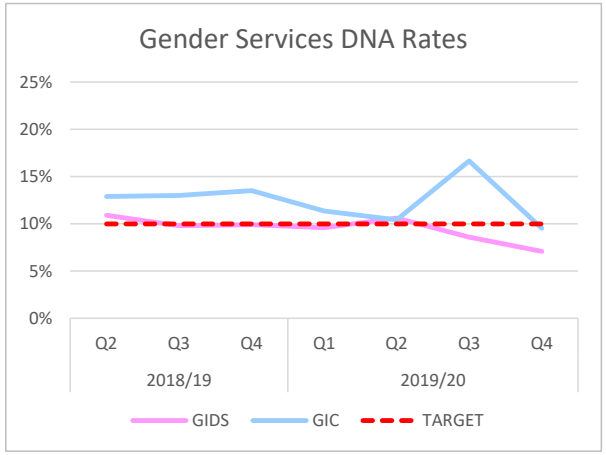
Q4 2019/20: Quality Effective – Access









Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.
NB TAP information migrated to a newer version of EMIS during Q4. Report data extracted from two different sources.

Did Not Attend (DNA)

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

Trust-wide, we saw an increase in compliance in DNAs. In Q4 7.9% of patients DNAed, a lower percentage than in Q3 when 8.55% of patients DNAed. The average DNA rate over this financial year was 8.80%.

Adolescents: had a DNA rate of 9.81% in Q4 – this is a higher rate compared to 8.35% in Q3. Target was met every quarter for the last financial year.

Camden CAMHS: in Q4 had a 8.33% DNA rate, slightly higher than in Q3, when the rate was 7.58%. Target was met every quarter for the last financial year.

Other CAMHS: in Q4 5.46% rate was achieved, slightly higher than in Q3, when 4.39% of patient DNAed. Target was met every quarter for the last financial year.

FAS: saw a significant improvement in DNA rates, achieving 4.76%, this is the lowest rate in Q4. This service line lowered the DNA rate for three consecutive quarters.

Adults Complex Needs: in Q4 7.01% of patients were DNAs, a lower percentage than in Q3, when 8.35% were DNAs.

Portman: saw an increase in DNAs in Q4, resulting in a 11.23% DNA rate, this is the second quarter they are just above the target. In Q3 had 10.28% DNA rate.

C&H PCPS: in Q4 9.59% of patients were DNAs, a slightly lower percentage than in Q3, when 9.69% were DNAs.

TAP: saw an increase in DNAs in Q4, resulting in a 15% DNA rate compared to a 13.70% rate in Q3.

GIC: in Q4 experienced an improvement in DNA rates, reaching a DNA rate of 9.52%. The target was meet this quarter.

GIDS: in Q4 we saw an decrease in DNAs, with a rate of 7.09%. This is the second quarter to see an improved performance in DNAs.

For further comments from service leads please see the commentary part of the report Page 25, 26 & 27

Q4 2019/20: Single Oversight Framework – Access

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers, with the indicators acting as a trigger to detect possible governance issues and identify potential support needs. The framework looks at five themes. MHSDS data is viewed alongside other quality of care information e.g. formal complaints, staff FFT, patient safety incidents (reported externally), and operational performance. The other four include Finance and use of resources (covered separately), Operational performance, Strategic change and Leadership and improvement capability (well-led)

Mental Health Service Data Set (MHSDS) and Data Quality Maturity Index (DQMI) Dataset Score
The DQMI was introduced into reporting in April 2018, with new data sets added in April 2019 and is in line with the Single Oversight Framework.

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

-The DQMI is published with a three-month delay and we have now received December's DQMI where we achieved 94%.

The Quality Assurance Department uses the Data Warehouse Information, which is used for internal reporting, to identify gaps in reporting. In order to improve on DQMI and MHSDS completion rate, the reports are discussed at the Quality Assurance Meeting (QAM) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved. The Quality Assurance Meeting (QAM) has been defining and implementing operational changes in all service lines to accommodate the new requirements: increased percentage expected for Ethnicity, Primary reason for Referral, Care Professional Service or Team Type Association and the Ex-British armed forces indicator. During Q4 the QA team developed an new tool to help team improve their data quality in basic patient details.

*The most recent published DQMI is for December 2020 and the compliance achieved is 94.4%. The actions completed during Q4 to improve compliance will show in March's NHS Digital

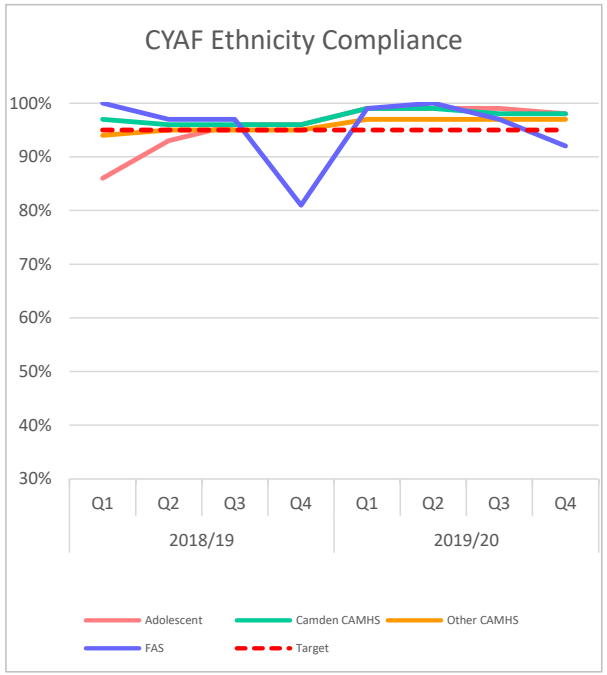
	Target	Month 7 October 2017/18	Month 10 January 2017/18	Month 1 April 2018/19	Month 4 July 2018/19	Month 7 October 2018/19	Month 10 January 2018/19	Month 1 April 2019/20	Month 4 July 2019/20	Month 7 October 2019/20	Month 10 January 2019/20
Valid NHS number	95%	99.10%	98.60%	98.60%	98.70%	98.90%	98.90%	99.00%	98.99%	98.95%	99.01%
Valid Postcode	95%	99.80%	99.70%	99.80%	99.80%	99.80%	99.80%	99.70%	100%	100%	99.71%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.50%	99.10%	99.00%	99.20%	99.00%	99.00%	99.20%	99.21%	99.15%	99.21%
Valid Organisation code GP Practice	95%	99.20%	98.20%	97.80%	98%	98.10%	98.20%	98.90%	98.88%	98.78%	98.46%
Valid Gender	95%	99.80%	99.80%	99.80%	99.70%	99.40%	99.40%	99.40%	99.44%	99.47%	99.41%
Ethnicity	85%	79.60%	78.40%	77.30%	76%	75.80%	76.10%	80.60%	81.88%	78.76%	77.79%
Employment Status (for adults)	85%	36.90%	43.40%	49.10%	50.50%	51.60%	54.00%	59.30%	59.79%	57.94%	56.67%
Accommodation status (for adults)	85%	36.60%	42.90%	48.50%	49.90%	51.00%	53.20%	58.30%	58.78%	56.90%	55.64%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%	*99%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%	*46%
DQMI -Data Quality Maturity Index	95%	The DQMI is not published in the same intervals. January's data has not been published yet. The most recent score is from Dec 2019 when we achieved 94.4%						89%	91%	94.1%	

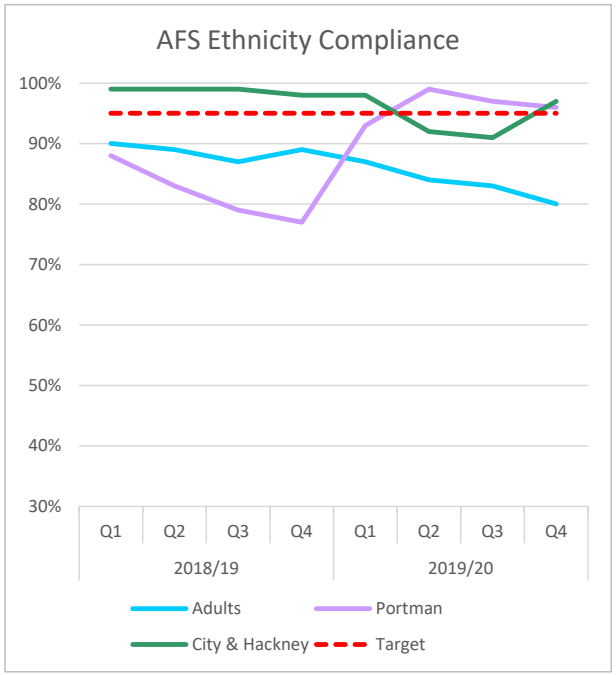
Data source: Data warehouse, informatics team 07/04/2020

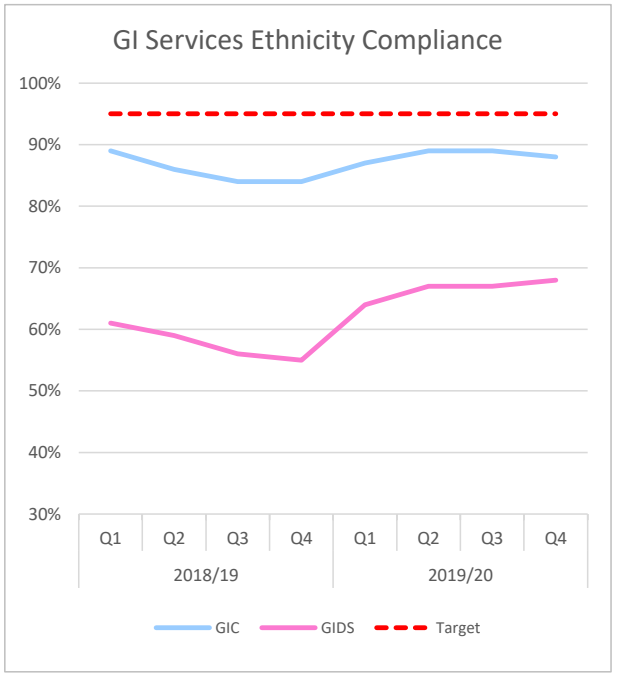
Q4 2019/20: Single Oversight Framework – Access

Ethnicity Rates

Ethnicity completion rates has been one of the most challenging MHSDS and DQMI data indicators as this financial year the target increased to 95%.
A major aspect in not reaching the target is the large number of patients open to teams who have not been seen.
Quality Assurance Team (QA team) continue to work with teams in the Quality Assurance Meeting, meeting regularly to improve this data further. Over the last few months the QA team has been working with informatics and admin leads developing a new report/tool to improve their data quality in basic patient details. This new report will allow teams to validate the current information held in CareNotes and to collect missing pieces of information in our system.





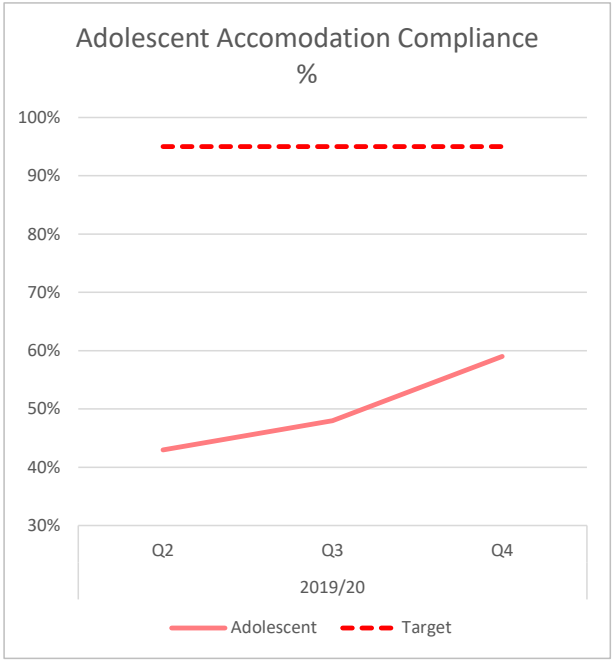


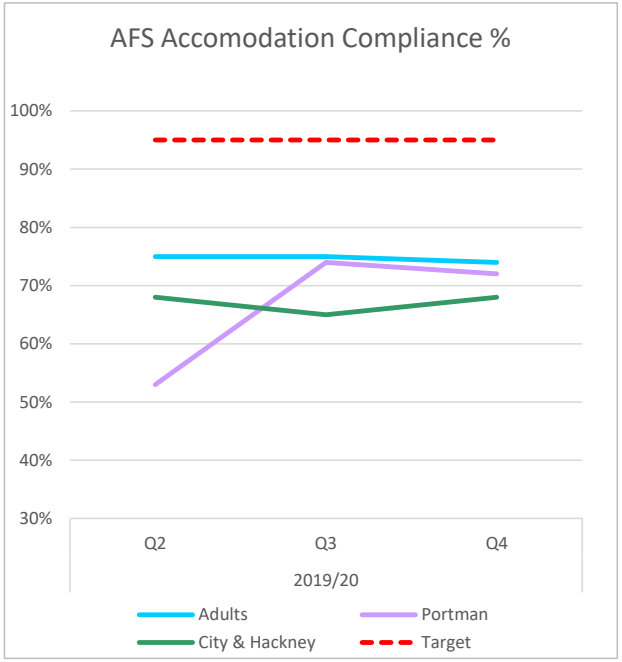
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.

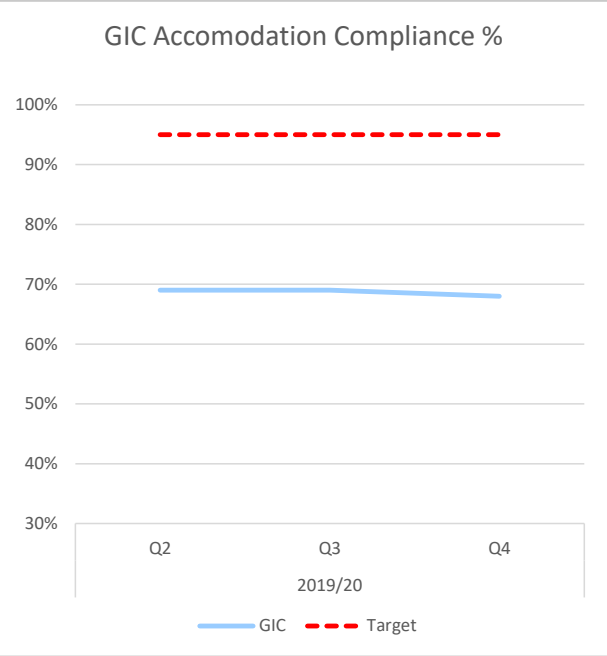
Q4 2019/20: Single Oversight Framework – Access

Accommodation Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Over the last few months the QA team has been working along with informatics and admin leads in developing a new report/tool to improve their data quality in basic patient details. This new report will allow teams to both validate the current information held in CareNotes and also collect missing pieces of information in our system i.e. Accommodation Rates.
Individual services are considering the best way to implement this tool within different teams





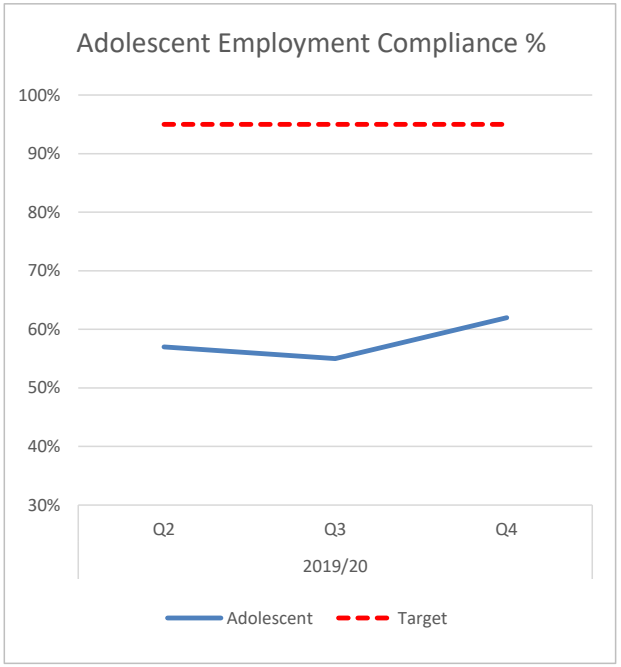


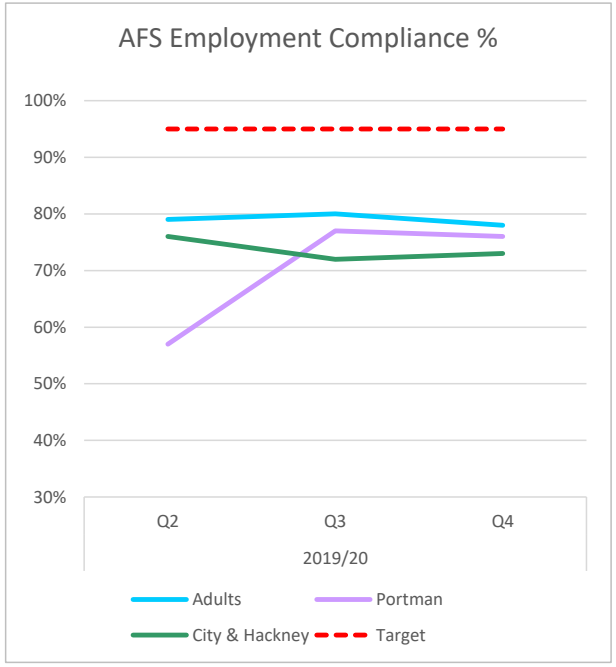
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.

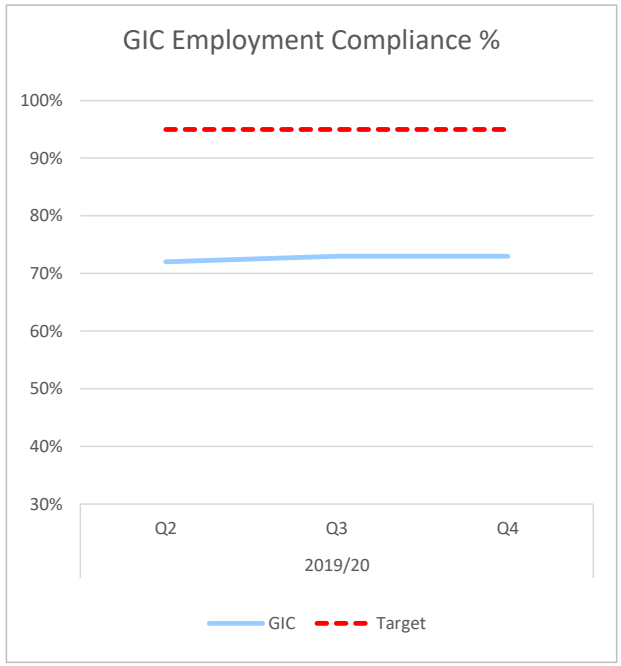
Q4 2019/20: Single Oversight Framework – Access

Employment Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Over the last few months the QA team has been working along with informatics and admin leads in developing a new report/tool to improve their data quality in basic patient details. This new report will allow teams to both validate the current information held in CareNotes and also collect missing pieces of information in our system i.e. Employment Rates.
Individual services would be able to develop the best way to implement this tool, adapting it to the nature of each teams.





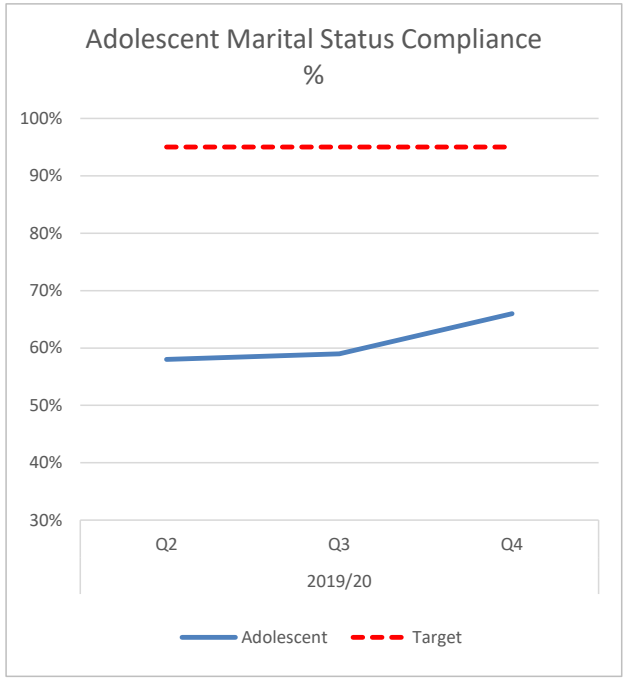


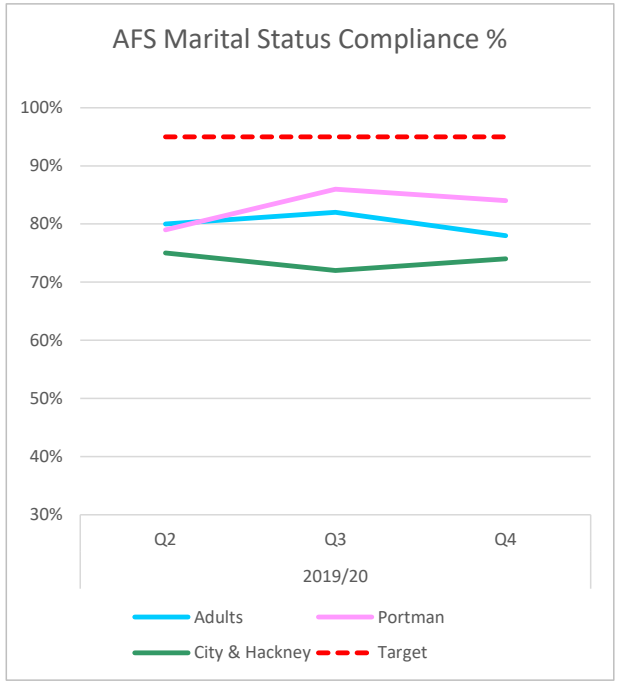
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.

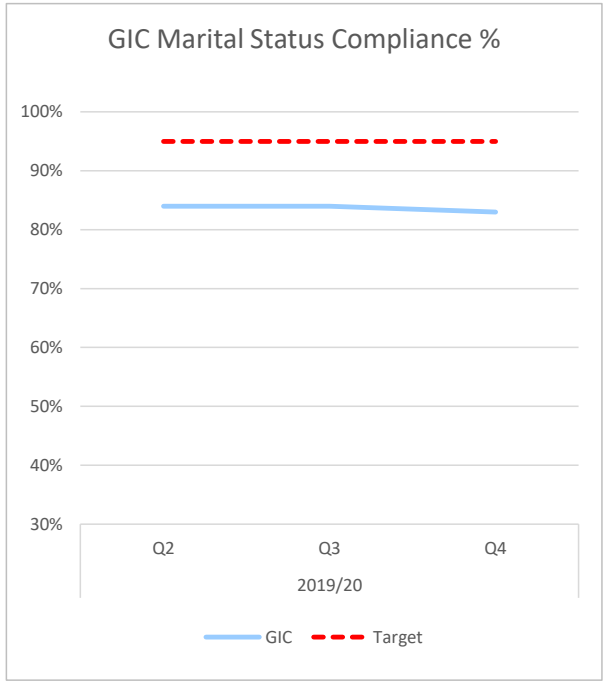
Q4 2019/20: Single Oversight Framework – Access

Marital Status Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Over the last few months the QA team has been working along with informatics and admin leads in developing a new report/tool to improve their data quality in basic patient details. This new report will allow teams to both validate the current information held in CareNotes and also collect missing pieces of information in our system i.e. Marital Status Rates.
Individual services are considering the best way to implement this tool within different teams

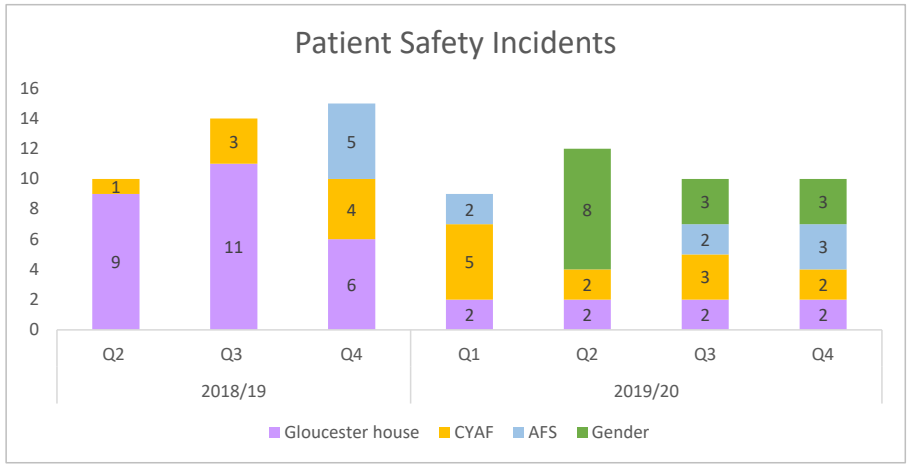


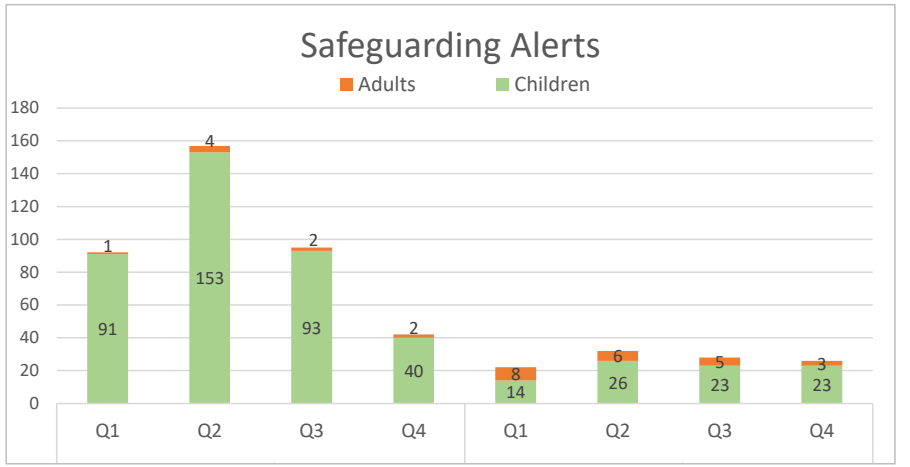




Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.

Q4 2019/20: Quality Safety – Care





NRLS reportable incidents include:
Gloucester House: 1 slip and trip, and 1 minor injury; **CYAF:** 2 patients in crisis , transferred to Home Care Team
AFS : 1 death at home - suspected suicide, 1 patient in crisis transferred and one patient who was very unwell and taken to RFH in an ambulance; Gender (GIC): 2 deaths from medical reasons , 1 attempted suicide . They had not been seen recently or were on the waiting list .
As always the above incidents are reported to the monthly Incident panel which is chaired by the Medical Director. Mortality reports are reviewed for the Adult and GIC deaths for the relevant services.

Data provided by *Health and Safety Manager 23/04/2020*

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

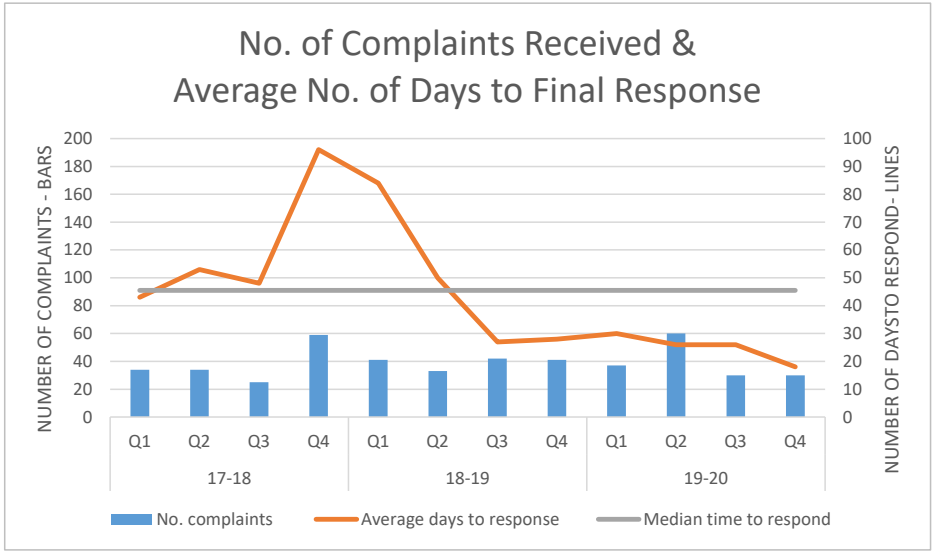
Data & commentary source: *Clinical Governance 08/04/2020*

Incidents Reported by Risk Level – Trust wide	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
1-4	81	119	88	100	65	69	60
5-8	42	35	22	28	28	38	30
9-12	7	3	9	3	13	11	18
15+	0	1	0	0	1	0	1
Total	130	158	119	131	107	118	109

This quarter has seen an increase in malicious emails, leaflets and Twitter for the GIDs service. They have been reminded to report all incidents and inform the Comms team who are overseeing these.

Data & commentary source: Health and Safety Manager 23/04/2020

Q4 2019/20: Quality Responsive – Care



During Q4 a total of 30 complaints were received. This is the same number of complaints as Q3. Of these complaints 21 have been responded to and 9 remain open. Of the complaints that have been responded to 7 have been upheld, 4 have been partially upheld and 10 have not been upheld.

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

Directorate	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
Adult and Forensic Services (A&F)	3	5	4	4	5	2	4
Children, Young Adult and Families (CYAF)	29	36	36	32	-	4	4
Gender Services	-	-	-	-	55	24	21
Corporate	1	1	2	1	-	-	1
No Directorate	-	-	-	-	-	-	-
Total	33	42	42	37	60	30	30

Total PALS enquiries Q4 01/01/2020 to 31/03/2020

Quarter	Total
2019/20 Q4	178
2019/20 Q3	212
2019/20 Q2	191
2019/20 Q1	190
2018/19 Q4	221
2018/19 Q3	175

Top PALS enquiries for Q4 2019/20:

- Communications
- Access to Treatment or Drugs

GIC & Adult Complex Needs continue to be the services receiving most enquiries.

Data & commentary source: Complaints Department 07/04/2020

Q4 2019/20: Quality Responsive – Care

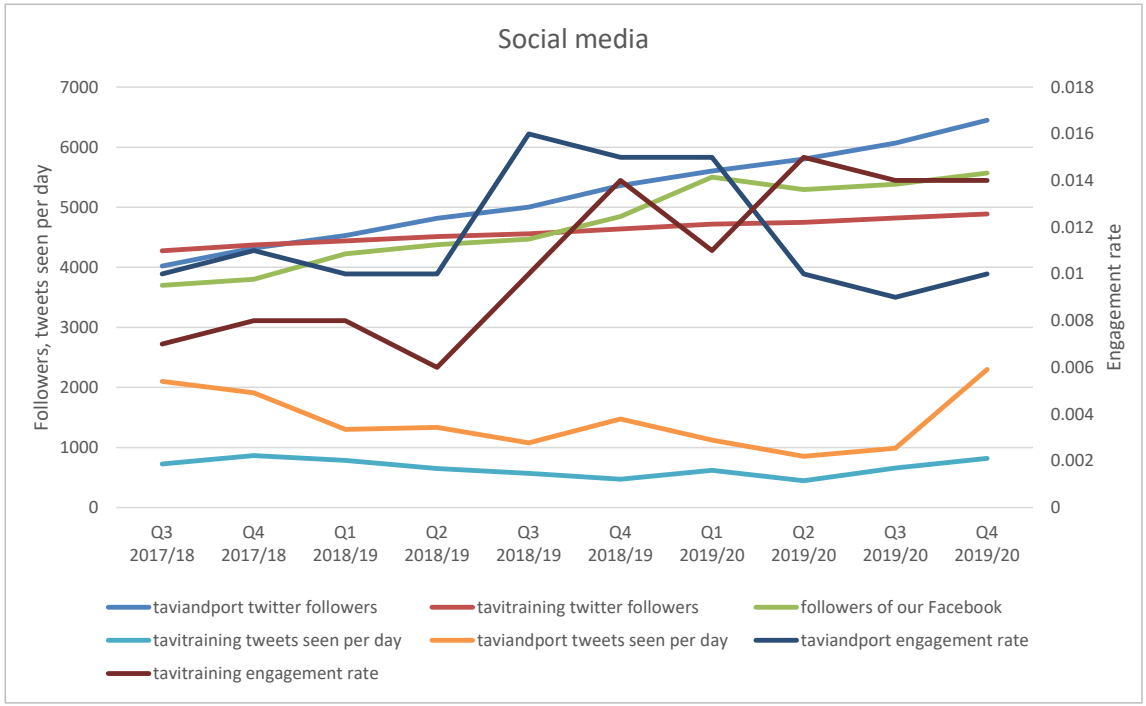
KPI London contracts			Q3 17/18			Q4 18/19			Q1 19/20			Q2 19/20			Q3 19/20			Q4 19/20		
Question number and description	Monitoring	Target	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%
Q4 from ESQ 'Views and worries were taken seriously'	Quarterly	n/a	127	121	**99%**	180	178	**99%**	140	139	**99%**	151	150	**99%**	113	113	**100%**	107	106	**99%**
Q6 from ESQ "The information I received about the Trust before I first attended was helpful."	Quarterly	75%	127	121	**95%**	180	178	**99%**	103	93	**90%**	124	114	**92%**	91	88	**97%**	84	81	**96%**
Q11 ESQ 'If a friend or family member needed this sort of help, I would suggest to them to come here'	Quarterly	80%	155	152	**98%**	168	164	**98%**	132	129	**98%**	144	143	**99%**	106	106	**100%**	103	103	**100%**
Q12 from ESQ "Options for my care were discussed with me"	Quarterly	n/a	124	121	**98%**	128	124	**97%**	91	87	**96%**	99	97	**98%**	72	70	**97%**	59	58	**98%**
Q13 from ESQ 'Involved in important decisions about my care'	Quarterly	n/a	168	164	**97%**	168	164	**97%**	93	89	**95.7%**	98	96	**98%**	72	70	**97%**	61	59	**97%**
Q15 from ESQ "Overall, the help I have received here is good"	Quarterly	92%	159	158	**99%**	169	166	**98%**	135	135	**100%**	147	146	**99%**	107	107	**100%**	105	105	**100%**

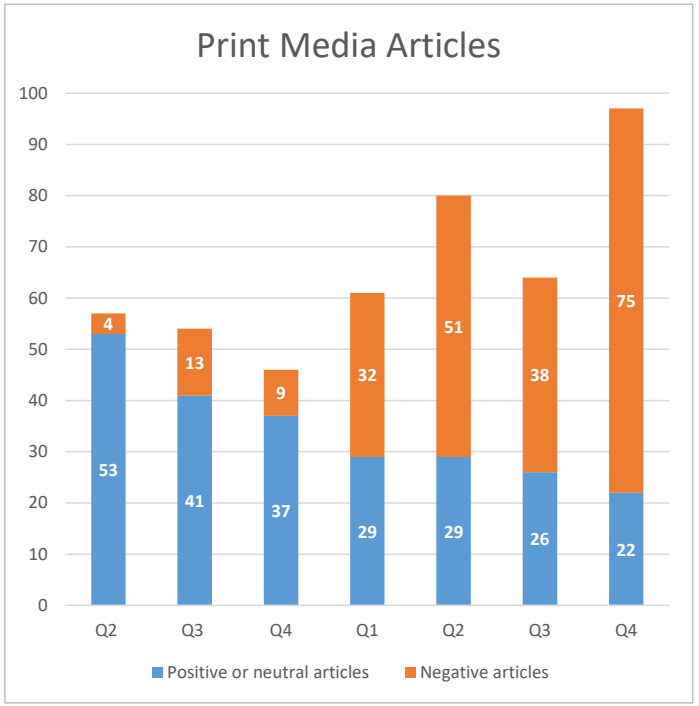
ESQ Rates

Traditionally the responses and feedback from our patients are very positive and we are very pleased with the comments and scores received. But we feel that the number of forms returned could be higher. The trust has piloted a new shorter form which aims to improve the collection rates and next month are implementing a new stage of the pilot project. Standardising ESQ Feedback is one of our current year Trust Quality Priorities.

Data source: SRRS (Internal Reporting System) Reported by the Quality Team 07/04/20

Q4 2019/20: Media – Care





This is a higher volume of overall coverage compared to Q3, a higher proportion of GIDS related coverage, and a decrease in sentiment: 23% positive or neutral coverage, compared to 40% positive or neutral in Q3, and 36% in Q2 of 19/20.

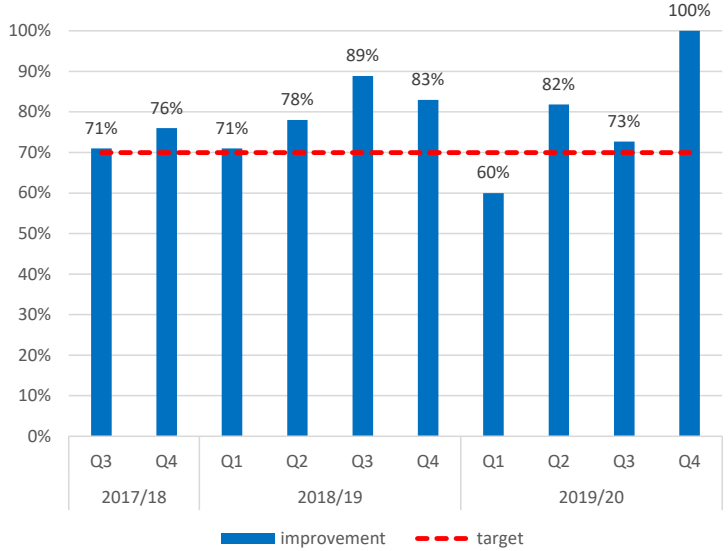
Gender versus non gender work:

- 17% of coverage related to non GIDS issues (14 items)
- 83% involved GIDS (83 items)

Data & commentary source: Communications Department 15/04/2020

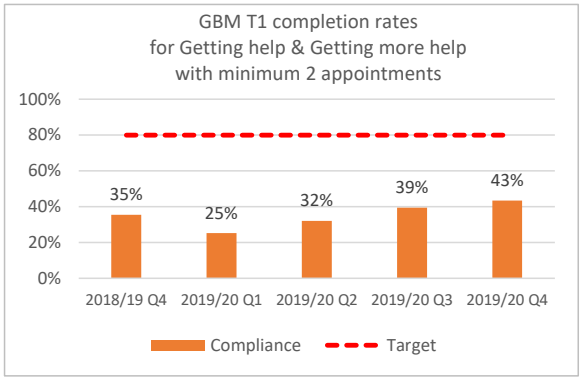
Q4 2019/20: Quality Effective – Outcome Measures

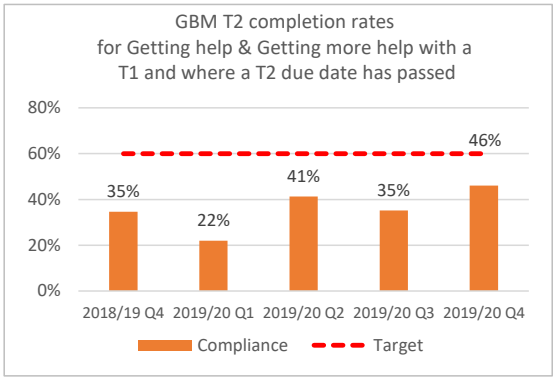
A F S and over 18 Adolescents

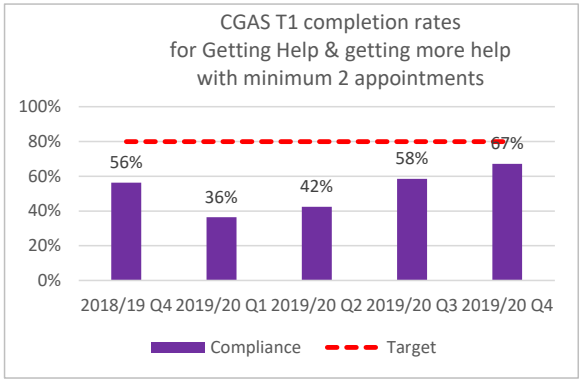


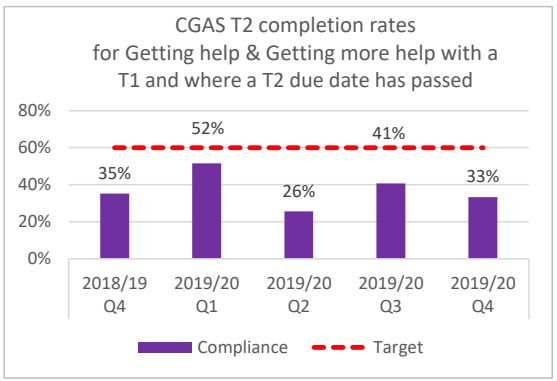
To calculate the CORE improvement rates **we compared patients with a Pre-Assessment and an End of Treatment score** (EOT) . The number of cases within these parameters is very low, but we are pleased to see an increase in the number of collected forms over the last two quarters. The End of Treatment form is challenging to complete for services like Portman and ACN as that session tends to be an upsetting event for the patient. The AFS Clinical Governance Group had a scheduled discussion to address completion rates and when CORE OM and EOT should be completed, unfortunately this has been delayed due to Covid-19 crisis.

C Y A F







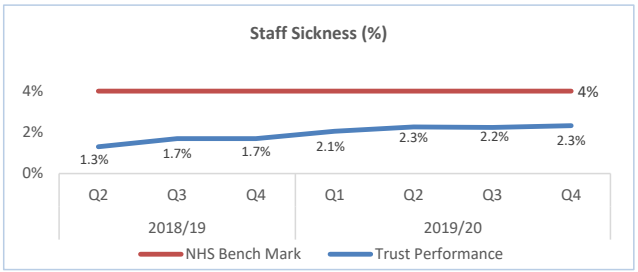


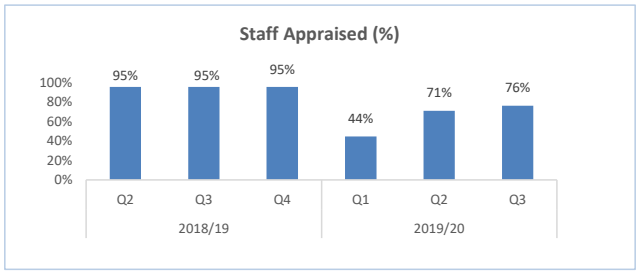
The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: GBM T1 has increased every quarter this financial year, reaching 43% compliance in Q4. GBM T2 has also increased in Q4 achieving 46%. QA team is working along with CYAF on improving the CareNotes interface and the logic in the Assist Panel.
-CGAS rates: CGAS T1 increased continuously, since Q1, reaching 67% compliance. CGAS T2 decreases in Q4 slightly.

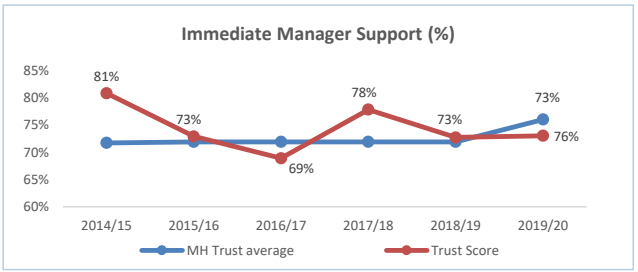
Data source: Q4 data as recorded on 07/04/2020 SRRS (Internal Reporting System) Reported by the Quality Team
Previous quarters' data as reported in relevant earlier reports.

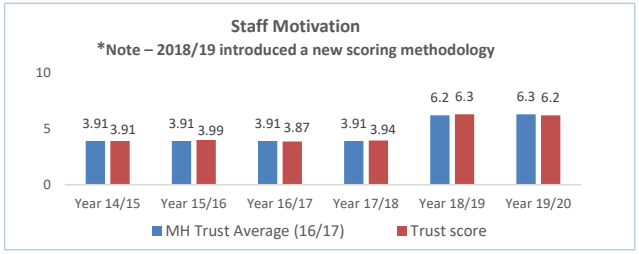
Q4 2019/20: Quality Well-Led

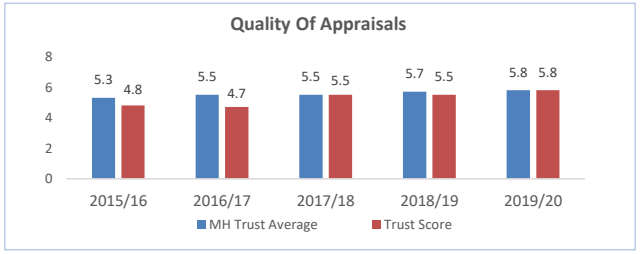
reporting on HR metrics to external bodies has currently been suspended across NCL

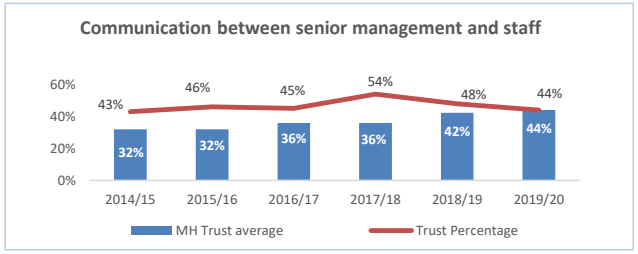


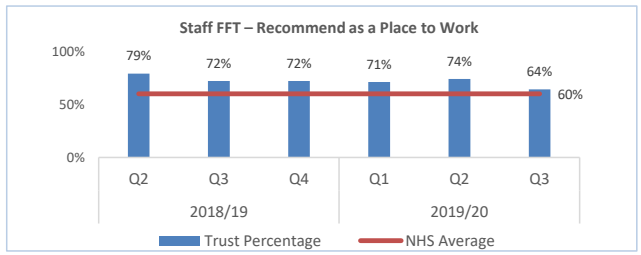


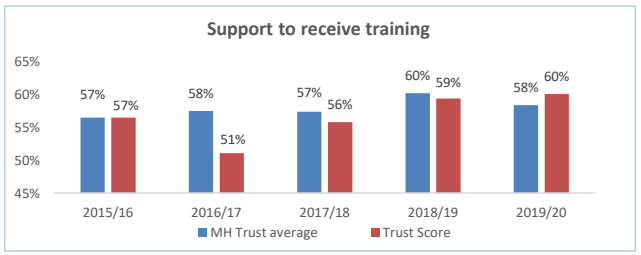


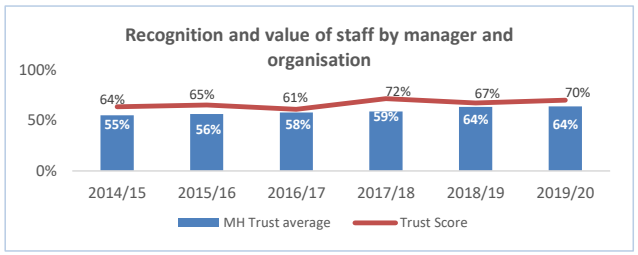


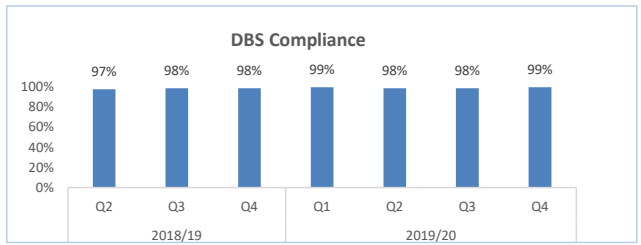


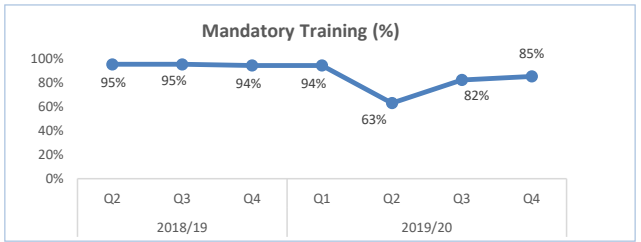








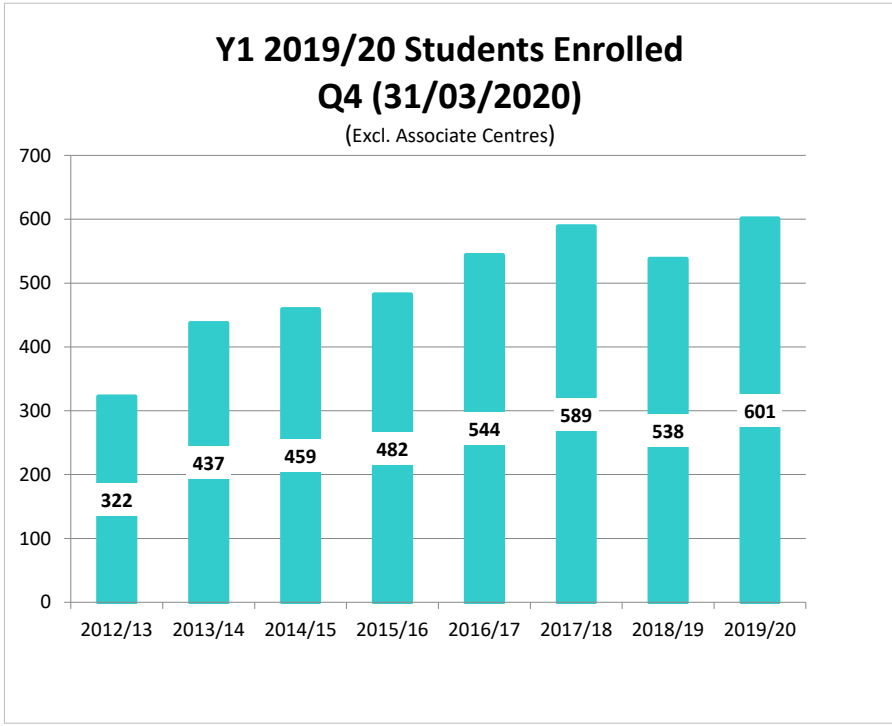




Mandatory training compliance has improved in Q4 with the level of compliance now reaching the internal reporting rating of amber as it is within an 80 – 85% range. Information from the annual national staff survey is included.

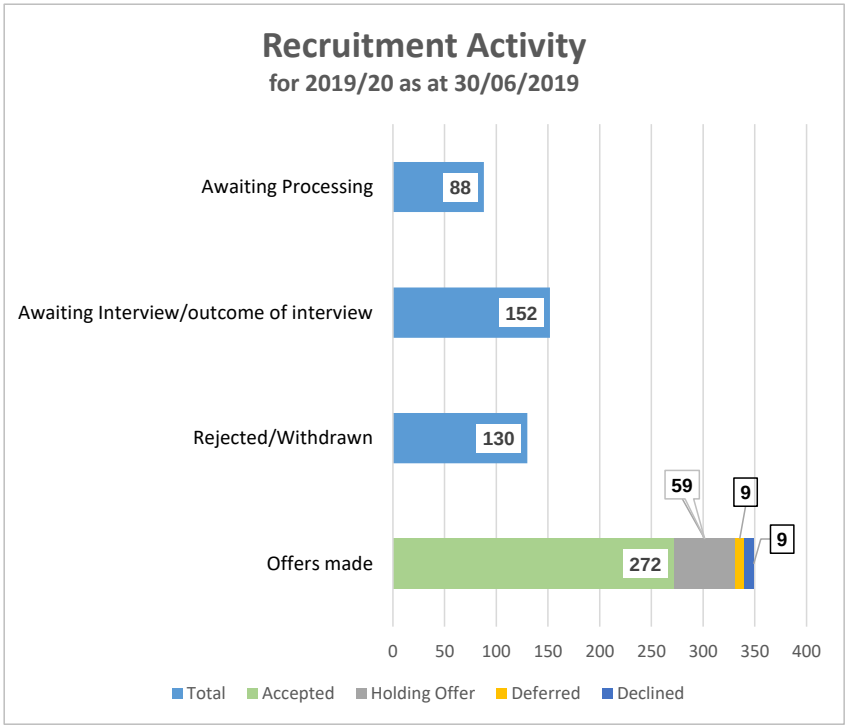
Data source: Human resources

Q4 2019/20: Directorate of Education and Training (DET) – Access



An increase in enrolled Y1 figures of 10% compared to 2018/19. The enrolled student number includes those who have reached both pre-enrolment (i.e. PE - fees paid and awaiting clearance of DBS checks) and full enrolment (C) stages, but excludes Associate Centres.

Data & commentary source: DET 15/04/2020



A slight increase (0.1%) as at snapshot date, compared to the total number of applications submitted for Academic Year 2018/19 was 701, which resulted in a final Y1 intake of 538. M6, M4 and M80 are now closed to application but other courses remain open and it is expected that the number of applications submitted will continue to increase prior to recruitment closing. The number of offers accepted, as at this point in the last academic year, was 235 and there have already been 272 accepted offers for 2019/20. **Note: The 'Offers made' block is cumulative; made up of the sub-set of offers accepted, holding, deferred and declined. The total is 349.**

Q4 2019/20: Directorate of Education and Training (DET) – Access

	Year	13-14 FY Actual	14-15 FY Actual	15/16 FY Actual	16/17 FY Actual	17/18 FY Actual	18/19 FY Actual	19/20 To Date	Comments
Course numbers	**CPD Portfolio**	45	58	70	94	93	100	84	
	Bespoke work	14	18	10	38	45	33	62	
	Visitors Programme / international					23	14	6	
	HEE additional in year funding						6	8	
Students	**Attendee/Student Nos**	2079	2738	2063	2279	2300	2193	3161	Student nos for 19-20 now includes full data for bespoke trainings (1323), not fully captured in previous years
								Identified Income to Date	
Income	**Income**	501,917	556,261	493,090	£692,710	£854,710	£1,271,641	£1,268,499	19-20 income includes £298,000 HEE funded perinatal activity; £76,466 HEE NW funded perinatal activity and £38K NCL funded perinatal activity
	Income growth on previous year	35%	16%	-11%	40%	23%	49%	0%	
	Contribution	160,769	158,104	123,616	£197,122	£527,123	£645,292	**£557,803**	Reporting from 2020/21 onwards (and retrospectively from 17/18) - the contribution will reflect contribution after the appropriate share of CEDU administration costs. Currently reflecting contribution based on income-direct costs only
						17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution			

Data source: DET 15/04/2020

Q4 2019/20: Directorate of Education and Training (DET) - Outcomes

The annual Student Survey (2019) commenced on 24th April and concluded on 30th June 2019. The results show a favourable outcome with an increase in all three focus areas in relation to our Student experiences. The Response rate was 65% compared to 59% in 2018. There is potentially a national postgraduate student survey, akin to the National Student Survey (NSS) being rolled out for all institutions registered with Office for Students (OfS), which is currently in consultation with providers.

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%	↑
2019	83.5%	92.0%	↑

Personal Development /Prepared: "As a result of the course 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%	↓
2019	*82.0%	90.0%	↑

Effectiveness ""Attending the course has improved my approach 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%	↓
2019	**83.0%	*97.0%	↑

Notes for 2019:

Benchmark data from National Student Survey (NSS) 2019

"Q27: Overall satisfaction"

Significant improvement against the Benchmark statistics for England and against previous year local result.

University Partner ratings:-
University of Essex 87.1%
University of East London 80.2%
(UEL Comparison for Registered Doctoral courses only)

Benchmark Question from NSS 2019

The question "As a result of the course I feel better prepared for my future career" was not used in the NSS 2019 Survey.

*The nearest comparable NSS 2019 question is:
"Q4: My course has challenged me to achieve my best work"

Better than the national benchmark but unable to do a direct comparison to the local student survey question.

University Partner ratings:-
University of Essex 81.15%
University of East London 80.75% (UEL Comparison for Registered Doctoral courses only)

Benchmark Question from NSS 2019

*The question was changed locally in the 2019 Survey from
"My course has provided me with opportunities to apply what I have learnt"
to
"Attending the course has improved my approach to my job"

**The Benchmark (National Student Survey, retained the original question: "Q7: My course has provided me with opportunities to apply what I have learnt".
Performance against the national Benchmark is significantly improved

University Partner ratings:-
University of Essex 79.55%
University of East London 80.34% (UEL Comparison for Registered Doctoral courses only)

Benchmark data is drawn from the OfS National Student Survey:
https://www.officeforstudents.org.uk/publications/national-student-survey-2019-publication-of-data/

Data & commentary source: DET 15/04/2020

Quarterly Quality Report Commentary Q4 2019/20

Introduction

As requested by the Board of Directors the following paper provides additional commentary and narrative from the Q3 Quarterly Quality Report, specifically commentaries form Service Leads on Waiting Times and DNAs which covers the reporting period and plans for the following quarter.

Quality Priorities and CQUINs are also covered, this year we are also providing a quarterly update for all CQUINS including commentary that is not due for the CCG.

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

The following metrics are summarised below:

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

Waiting Times feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q4	Objective / plan for next Quarter
Adolescent /AYAS	AYAS has seen 51 patients this quarter. The service continues to work hard ensuring that our new referrals are seen in a timely manner to assess their safety, suitability for a psychotherapy assessment and the level of support they are currently receiving in the community. This quarter we have managed to see 85% of over 18's for an initial appointment within 11 weeks. Unfortunately the number of under 18's seen within the allowed timeframe was around 50% due to an error in timeframes which has now been rectified. Patients being offered a second appointment is based on clinical risk and need.	In this very difficult time we will be concentrating on providing support and therapy to our therapy patients. We will be offering Pre assessment consultations and introductory meetings via Zoom to new referrals and will endeavour to do this within the required timeframes.
Camden CAMHS	We are pleased that we have maintained the waiting time target for 1st appointments. We note that the wait to second appt continues to improve	Monitor impact of Covid 19 pandemic on waiting times – we anticipate increases in staff absence over the coming weeks which may affect our ability to meet this target.
Other CAMHS	We are pleased that we have maintained the waiting time target for 1st appointments. Second appointment waiting times are possibly impacted in this service line due to waits for ASD assessments and this is something we will look into	Review wait to second appointments in all teams. Monitor impact of Covid 19 pandemic on waiting times – we anticipate increases in staff absence over the coming weeks which may affect our ability to meet this target.

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

Waiting Times feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q4	Objective / plan for next Quarter
Adult Complex Needs	We are pleased to note some improvement in Q4 vs Q3. The reporting reflects in part some of the issues around processes in how 1st and 2nd appointments are being offered and recorded on CareNotes.	With the appointment of a new Operations Manager and progress with SOP's, governance and a closer monitoring of capacity and demand we expect to have a clear picture of where the delays are and therefore a more targeted approach to understanding what needs attention. Part of that targeted approach is to review how we offer and record patient appointments on CareNotes as this will impact waiting time figures. We are also set to recruit to a 0.8wte post at the end of April , which will address a significant gap in staffing.
Portman:	As is visible from the graph, there was a small drop in compliance with waiting time targets for first and second appointments for Q4, as compared with full compliance for the previous 3 quarters. We have found two cases that exceeded the necessary waiting time for first appointments. Although these patients were offered their first appointment within the required timeframe, they both cancelled and so although the data suggests that they were breaches, they were both offered appointments within the required window.	We will aim to continue to perform well next quarter.
City and Hackney PCPCS	Commentary unavailable due to Covid 19	Commentary unavailable due to Covid 19
TAP	The TAP service has been through a period of unprecedented change whilst maintaining high standards of clinical care. The service has become further integrated with the Camden PCMH Network and in now subcontracted to Camden and Islington NHSFT. The service has had a significant cut to contract value of 30%, which added to a similar cut in 2018 leaves the staff team much depleted. At the same time referrals and systemic demand remain high but unsustainable, the graph clearly shows impact on waiting times in relation to capacity. We have recorded concerns about this situation on the operational risk register and expressed serious concern to CCG , GP colleagues and our PCMH partners.	In terms of assurances and actions to moderate risks to waiting times (and therefore patient safety) & staff wellbeing /morale we have agreed a new, capacity based contract with Camden and Islington that reflects a more realistic assessment of our provision and will need constant and careful monitoring to ensure that system wide changes do not lead to an increase rather than decrease in appropriate referrals into the service. We note at the time of writing that referrals continue to run well over the newly agreed figures. This may be a result of other local services limiting their intake, criteria or treatment offer to only Covid 19 related interventions. There are risks in this approach which may lead to GPs becoming more anxious and referring wherever they think they can get help. We have discussed the wider systemic implications on patient flow and safety with colleagues in the local Mental Health Partnership board and recommend that this board continue to develop plans for an 'alliance' type regular Mental Health / Psychological therapies group to convene so that the flow or appropriate referrals into respective services can be discussed, monitored and regulated more systemically. We remain concerned that there are few if any limits on referral into the wider PCMH service , either by diagnostic criteria or acuity, this is unsustainable. One helpful action would be to develop a separate SPE for secondary care such that the PCMH does not get (mis)used as the only gateway for the majority of MH services OR this service needs better resourcing.

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

Waiting Times feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q4	Objective / plan for next Quarter
GIC	Commentary unavailable due to Covid 19	Commentary unavailable due to Covid 19
GIDS	Commentary unavailable due to Covid 19	Commentary unavailable due to Covid 19

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

DNAs Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q4 2019-20	Objective / plan for next Quarter
Adolescent /AYAS	The DNA rate remains under 10%, there was a period before social distancing where a number of our patients were cancelling or not attending their appointments due to concerns around coronavirus transmission in the general community.	As we move to remote therapy interventions we will be assessing how best to support our patients in accessing their treatment and will be contacting people very actively if they are not picking up the phone or logging into Zoom appointments.
Camden CAMHS	Our DNA rate has now remained below target for two years. We are pleased that we have been able to maintain this and continue to monitor it	Maintain low DNA rate into the next year
Other CAMHS	Our DNA rate has now remained below target for two years. We are pleased that we have been able to maintain this and continue to monitor it	Maintain low DNA rate into the next year

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

DNAs feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q4 2019-20	Objective / plan for next Quarter
Adult Complex Needs	The DNA rates for complex needs are below 10% for Q4, however there is further improvement that can be made. We note the reduction in rates however it is not completely clear why this is the case but increased anxiety about the recent crisis situation may have had an impact alongside a departmental push to develop better and more frequent communication within teams about governance, patient comms and all important engagement with patients during a time of such high anxiety and poor mental health for many.	With the appointment of our Operations Manager, our aim is to continue low levels of DNA rates and develop a much stronger oversight and implementation of governance and operational strategies, and to signposts a more closely managed service. We also have a QI project aimed at helping clinicians understand the value of patient involvement and feedback – either via OM or involvement activities. Alongside these interventions we will be moving the adults complex needs waiting room closer to the clinical service treatment rooms and also closer to our own admin and data team. We hope this actions will provide a more contained experience whilst allowing us to communicate more directly with patients and collate data about their clinical experience, OMs, physical health and ESQs; all in one place. This plan should help improve the overall patient experience which we hope to have an additional impact on DNA. During the current crisis, patients have been given the option to have their appointments by telephone or Zoom, so that they have less difficulties in attending face to face appointments. This will be looked at as to whether this can be offered to certain patients, on a case by case basis beyond the current crisis. There is also the plan to investigate how appointments are offered to patients and recorded on CareNotes, so that appointments not taken up are appropriately outcomed.
Portman:	Our DNA rate over the year fluctuates around the 10% target. We are pleased with this data as our patient group are, often by definition, difficult to engage and keep in treatment.	To continue to monitor DNA rates on an on-going basis
City and Hackney PCPS	Commentary unavailable due to Covid 19	Commentary unavailable due to Covid 19
TAP	TAP completed a QI project earlier this year and it has successfully helped bring down the DNA rate from around 20% to an average of around 14% across the year with some quarterly fluctuations. Whilst not yet at a trust wide standard we think it better reflects the reality for our primary care patients situation i.e. that some are seeing a psychologist when they believe their problems to by mainly physical or socially determined. Our service user advisory groups remains and active force to support the clinical team in developing QI and other interventions with a view to optimising patient experience and involvement. Since TAP moved over from a TAP EMIS to a PCMH Emis owned by C&I we have not been able to send out text messages, we have contacted C&I to resolve this but it will have had some impact on attendance and DNA rates for TAP.	It is difficult to predict the next quarter during a period of unprecedented crisis with Covid 19 dominating NHS services. However, for many MH patients it is essential that we offer them 'business as usual' and maintain a reliable and predictable service. Having agreed a new contract with more realistic capacity targets and gone through a major staff consultation process with significant losses and re-organisation we will aim to consolidate the team's work around our current 'new' model of liaison, assessment and treatment starting to run on remote means with Zoom and /or telephone options. Some patients are choosing to delay or cancel consultations and treatments however we are working well to develop a confident and robust offer so that, in turn, patients feel we continue to be confident and proactive in reaching out to them. We hope these measures will maintain health but realistic DNA rates during the ongoing crisis.

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

DNAs Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q4 2019-20	Objective / plan for next Quarter
GIC	Commentary unavailable due to Covid 19	
GIDS	Commentary unavailable due to Covid 19	

3. Quality Priorities

3.1 Quality Priority 1: Improve identification and management of high risk patients

Quality Priority	1. Improve identification and management of high-risk patients	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust.	Risk assessment material is available for clinicians to access on the ESR. Reviewed and updated in Q4 Quarterly interactive assessment skills workshops open to all clinicians. Risk assessment and risk management are also considered where appropriate at the monthly incident panel and at the Trust wide Learning Lessons Forum held x5/year. Where there are risk concerns i.e risks to self, risk to others and risk from others discussions about individual cases take place in team meetings and in individual and peer supervisions. Care plans which are copied to GPs/referrers include information about risk assessment and risk management where indicated.	
Ensure all CYAF crisis plans have been regularly reviewed and updated. The frequency will need to be decided on a case by case basis but minimally once every 3 months.	Case note audits have been undertaken for CYAF and AFS and cover crisis plans. Actions have been followed up as a result of the audits. Audits are ongoing and included in the yearly audit programme for 2020/2021	
Continue to audit recording of clinical risk assessments and actions taken	Audits completed in AFS and CYAF including review of clinical risk assessments. These are ongoing and will be included in the yearly audit programme for 2020/2021	

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

Quality Priority	2. Experience of Service Questionnaire (ESQ) Review	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Further consultation with the Quality Advisory Group before completing and testing the new forms	*No Q4 updates required as workstream completed*	
Test streamlined forms in one service initially and review and evaluate effectiveness	*No Q4 updates required as workstream completed*	
Test streamlined forms in second service building on evaluation of first service	New ESQ form tested within second team, City and Hackney Primary Care Service. To be evaluated after enough responses return following Covid-19 reduced services	
Evaluate and review second test and adjust with a view to rollout across the directorates	Feedback from use within City & Hackney to be evaluated after enough responses return following Covid 19 reduced services	

3.3 **Quality Priority 3: Improve patient and carer involvement in care planning in CYAF teams**

Quality Priority	3. Improve patient and carer involvement in care planning in CYAF teams	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Improve quality of patient and / or carer involvement in the development of care plans	*As with Q3 unfortunately we have been unable to address this in Q4. This is something it is a challenge to measure in a meaningful way and there is a need for significant audit. We will link this with the service user involvement needed for outcome measures to address this issue.*	
Increase the quality of data recorded of care plans shared with patients and referrers	*We are yet to share the examples of good care plans and are working on this now. Data below indicates the number checked 'yes' to share has decreased in the past quarter which is likely to be due to reporting challenges and staff having less access to devices at the end of Q4.*	
Increase the percentage of care plans shared with patients and referrers	During Q4 **151** Assessment Summaries were completed *(**down** from 218 in Q3*). Of those **72 (48%)** Initial Care Plans were created/shared compared with *63% in Q3* During Q4 there were **237** Assessment Summary Reviews completed *(**down** from 333 in Q3*). Of those **49 (21%) Care** Plan Reviews were created/shared – compared with *31% in Q3* *In Q4 we changed the way in which we follow up on missing care plans with staff making this team based rather than central which we believe led to the improvement in those sent in Q3. For the final month of Q4 a number of staff have been unwell or unable to access a device as a result of the Covid 19 pandemic and this may have had some impact*	

3.4 **Quality Priority 4: Provide Effective Sleep Management Information**

Quality Priority	4. Provide Effective Sleep Management Information	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Establish an adolescent only group for patients experiencing sleep difficulties *(those aged 14 – 18)*	We were unable to run a group this quarter due to not having enough participants however a group was run last quarter.	
Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input	The sleep hygiene guidance has been developed however feedback has not been fully collated due to the restrictions around groups meeting because of COVID-19. We hope that this process will be completed when things return back to normal.	
Develop and disseminate information for clinicians on sleep in adolescence	This information is awaiting to be uploaded onto the intranet but again because of COVID, it has not been yet implemented.	
Share sleep information more widely with other external agencies	This information has not yet been shared due to COVID but it is hoped this will happen when things return back to normal.	

3.5 **Quality Priority 5: Improved Waiting Time Experience within Adults Complex Needs Service from End of Assessment to First Treatment Appointment**

Quality Priority	5. Improving waiting time experience from end of assessment to first treatment session in Adult Complex Needs	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Reduce the number and % of patients dropping out between end of assessment and first treatment episode	The drop-out rate was assessed at end of Q2 and was lower than initially expected. Based on the low number and % of patients dropping out the focus for this target was amended to identify patients who started their therapy during Q3 and obtain feedback on their experience of being on the waiting list for treatment. These updates are covered in the targets below.	
Obtain feedback from service users on their experience of the gap period	Five out of the six participants reported feeling the wait between assessment and treatment was too long. This experience was further heightened by patients feeling the department had not done much to communicate with them. The one patient who did not report any major difficulty had less of a waiting time (5 months) compared to other patients. There was a shared understanding by many patients that resources are limited and therefore an expectation that they might be waiting some time but more could be done to communicate with patients about waiting lists and the therapy process.	
Review reasons for drop out and patient experience to improve the service for both patients and staff	As a result of the feedback the Complex Needs Service has implemented two phases of treatment as a trial for a group of patients for whom assessment has been recently completed. In the first phase we are offering intermittent treatment wherein patients are seen every 4 to 6 weeks. At the end of this phase the patients will be reviewed, with the majority likely to go onto phase 2 (longer treatment).	

3.6 **Quality Priority 6: Embedding Use of Meaningful Outcome Measures Within CYAF Teams**

Quality Priority	6. Embed meaningful use of outcome measures in services	
Key Workstreams	**Quarter 4 Narrative Updates**	RAG Rating
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.	**72** out of **166** due GBM T1's completed during Q4 - **43% compliance *Up*** *from 39% in Q3* *We are pleased that the rate has improved consistently over the year. This is particularly the case in Q4 where we have had to adapt to a new way of working in light of Covid 19. This has nearly doubled since Q1 however we are still considerably below the target. Changes to logic in Carenotes took considerably longer than we would have anticipated and there remain ongoing challenges in following up on missing outcomes due. Many have commented on the challenge of completing goals so early in an intervention with a patient and we are continuing to pursue a QI project to set some initial goals and then review these when it feels more appropriate to do so. Consideration will be given once this is completed to how learning is shared across teams.*	
	108 out of **161** due CGAS T1's completed during Q4 – **67% compliance - *Up*** *from 58% in Q3* *We are pleased that the rate has improved consistently over the year. This is particularly the case in Q4 where we have had to adapt to a new way of working in light of Covid 19. This has nearly doubled since Q1 however we are still considerably below the target. Changes to logic in Carenotes took considerably longer than we would have anticipated and there remain ongoing challenges in following up on missing outcomes due.*	
Obtain service user feedback on the use of outcome measures to feedback on progress.	*We have established a group across Camden to look at this. Initial meetings were cancelled as a result of Covid 19. We will reactivate this group and think about how we can facilitate these groups remotely at this time*	
60% patients with a second appointment 4 months prior Q1 or closed cases on CYP in the 'Getting help' and 'Getting more help' domains who have paired CGAS Time 1	**58** out of **126** due GBM T2's completed during Q4 – **46% compliance - up** *from 35% in Q3* *Again we are pleased that the completion rate for CGAS continues to improve though we have not achieved the target this is much better than in Q1.* *We will further investigate the reasons for this improvement and seek to share this more widely to further motivate staff to complete CGAS.*	
	36 out of **108** due CGAS T2's completed in Q4 – **33% compliance - *Down*** *from 41% in Q3* *Reminders staff to complete time 2 has been more challenging due to difficulties in the reporting feedback process.* *It is unclear why there only improvements with GBM and not with CGAS. We will undertake work in Q1 to look at why this may be the case and to improve meaningful feedback to staff to improve completion rates.*	
Develop a method of presenting outcome data in a form that can be easily shared with patients and carers to provide timely feedback on their progress and opportunities for review.	*We have established a group across Camden to look at this. Initial meetings were cancelled as a result of Covid 19. We will reactivate this group and think about how we can facilitate these groups remotely at this time*	

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	14th May 2020

Serious Incidents – Quarterly Report – Q4 2019-20

Executive Summary

This quarterly serious incident summary report for the Board covers Q4 2019-20. There were no non-clinical serious incidents identified in Q4.

There were 28 clinical incidents reported in Q4, none of which met the threshold for classification as a serious incident. However, there was one incident logged in Q3, December 2019, which was later identified in January 2020 as a serious incident and logged externally on StEIS and NRLS in Q4. This sad incident involved a patient from the Portman adult forensic service who died by jumping in front of train in November 2019 at Colchester train station.

Within the 28 reported clinical incidents there were an additional 5 patient deaths recorded during Q4; one patient from the Team Around the Practice service and the other four patients were from the adult gender services. Each of these sad events were investigated internally via concise reports which were reviewed at the monthly Incident Panels, chaired by the Medical Director. Due to the nature of the deaths, they were not escalated externally and did not reach the threshold for an external serious investigation.

There were also 2 attempted suicides which fortunately were not successful; one from our children's gender service and one from the adult gender service. These have also been reviewed at Incident Panel to ensure all involved elements of the incident have been interrogated for future learning.
All serious incident investigations, including non-clinical incidents and their action plans, are monitored via the monthly Incident Panel to identify any gaps for learning opportunities and to ensure completion and dissemination.

In December 2019 the Trust agreed with our commissioners to undertake a thematic case review of three of our previous serious incidents which were linked to gang related violence. It was envisaged this would be completed within four months, but due to the Covid-19 pandemic, this work has been delayed and the expected end date has now been extended to July 2020. The purpose of the thematic review is to establish whether there are service-related themes or wider issues or links recurring across the cluster of incidents or whether it is chance that this increase in incidents occurred.

Although the recent Covid-19 pandemic situation has proved very difficult to say the least, the Trust has maintained roll out of the Trust wide lessons learned events, with the last event held on 4th February 2020, and although virtual attendance has been more limited, it is felt essential that these events continue and are shared as widely across teams as possible, with all related information available via the intranet.

The new Adult Safeguarding & Prevent Lead, Paul Collin, was appointed on 25th March 2020 to this two session role. Level 3 adult safeguarding training has now begun across relevant services and will continue until compliance is reached for all relevant staff, which is monitored by HR.

The patient safety aspects of the 2018 CQC Inspection continue to be monitored by the Executive Management Team for all services and there is continued progress on the actions identified to ensure patient safety.

Recommendation to the Board	
The Board of Directors is asked to note this paper	
Trust strategic objectives supported by this paper	
Clinical Services	
Author	**Responsible Executive Director**
Clinical Governance and Quality Manager	Medical Director

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Trust Board	21st April 2020

Guardian of Safer Working Hours 2019-2020 Quarter 4

Executive Summary

The number of exception reports over this quarter is low. This is due to the build up to the social distancing interventions for COVID in March. I was due to step back from the role of GOSWH and the post was advertised in the trust but there were no applications. As such I am staying on in this role but will be looking to end this in due course.

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

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 Q4

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
January	5	2	3	0
February	6	2	2	2
March	0	0	0	0
Totals	11	4	5	2

If the NFA reports are removed there are is the same number of exception reports from Q2.

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 11
- There have been no formal requests for a work schedule review.

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies. There will be 2 vacancies coming up in the next recruitment.

2.4 Locum

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

	Number of shifts	Number Covered	Number Vacant	Clinicians
January	2	2	0	Sprs
February	0	0	0	
March	3	3	0	

2.5 Fines

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
Jan	11.5		£1,019.13	£382.18	£636.95
Feb	8.25	1	£825.89	£319.66	£506.23
March	0	0	0	0	0
Totals	20.75		£1845.02	£701.84	£1143.18

Fines accrued 2018-2019

	Total hours	Total fines	Total paid to trainees	Amount accrued
Totals	57.75	£6370.39	£2385.90	£3984.54

Fines accrued 2019 – 2020

Total	Total hours	Total fines	Total paid to trainees	Amount accrued
Q1	21	£2122.96	£766.09	£1326.85
Q2	14.5	£1991.99	£746.98	£1245.01
Q3	28	£4258.44	£1596.81	£2661.57
Q4	20.75	£1845.02	£701.84	£1143.18
Annual total	84.25	£10218.41	£3109.88	£6376.61

3. Junior Doctors Forum (JDF)

The junior doctors have discussed how they will be spending their fine amount. A disbursement for text books has been agreed and will be detailed in the next report once the fine has been released.

Fine Disbursement:

2018-2019	£3,984.54
2019 - 2020	£6,376.61
Total	£10.361.15
Fines agreed:	
books	£560.67
theatre	£388
refreshments	tbc
DBT	£5,000.00
Adult trainees book	tbc
Total	£5948.67
Amount remaining	£4412.48

4. Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC on 6th May 2020

5. Conclusions and Recommendations

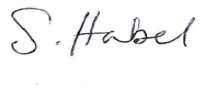
5.1. Members of the Board are asked to note the report

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.

5.3 The next period of time will be a challenge for the out of hours rota due to the required response to the COVID 19 pandemic.

5.4 I will be preparing the 2019 – 2020 annual report shortly.

5.5 I have not been able to step back from this role due to a lack of applications to the post when my tenure ended in February 2020. I am able to stay in role for the time being but this will need to be reviewed once the changes necessary to support the trainees during the pandemic have passed.



Dr Sheva Habel

Guardian of Safer Working Hours

The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 7th May 2020

Key items to note

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

Response to Covid-19

The committee noted the work and engagement of DET staff across teaching and professional services domains in collaborating to move in a short space of time to remote working and to continuing to plan and deliver the last term of this academic year. The committee particularly noted the work of three work streams set up and led by the DET Executive:

(1) Assessment and Progression: focusing on an immediate response for students due to submit assessments, the impact on individual students, and creating a framework for students to submit and progress in a timely manner.
(2) Student Support and Wellbeing: focused on concentrating support to students
(3) Delivery of Term 3: focused on moving term 3 of teaching to remote online delivery

Academic Year 2020-21

The committee noted the start of thinking around the tactical and strategic considerations for academic year 2020-21, and what learning could be taken from the immediate response.

Partnership with the University of Essex

The committee noted the positive response from the University of Essex to postponing renegotiation of the collaborative agreement and financial arrangements until the next calendar year, given the ongoing situation around the Covid-19 pandemic.

Book withdrawal and reinstatement

The committee noted the outcome of the investigation conducted by the Director of Education and Training/Dean of Postgraduate Studies into the purchase of the book *Inventing Transgender Children and Young People*, and the recommendation for developing an academic freedom policy and a procedure for the purchasing of new books to the library.

Long course development

The committee noted the outcome from a number of focus groups on long course development and discussed the two key emerging themes: links with potential employers and internships; and a definitive view on face-to-face provision over online delivery. The committee noted the view of changing the timeline and looking to a development for AY21-22.

Student Recruitment

The committee received an update on student recruitment, including around the creativity and adaptations by the recruitment team and course leads to continue to offer interviews and manage the pipeline. As at 23 April, we have around 6% less applications than at the same time last year, but weekly tracking suggests the gap is slowly closing. Accepted offers, however, are 19% ahead of where they were last time (69 v 58). There is also an increase in the number of new incomplete applications suggesting that considerably more people are starting to work on their applications.

Work is underway to explore scenarios and options for AY20/21 taking account of staff and student experience and related developments in the Higher Education sector.

Continuing Education and Development Unit (CEDU)
The committee noted that short course recruitment for the summer term 2019/20 suggests an impact as a result of Covid-19, but that this may also follow an increasing short course recruitment trend in which applicants wait until the last minute to commit to booking and making payment. The number of CPD enquiries has remained relatively stable, and further analysis of enquiry types is being undertaken to help understand trends and identify opportunities.

International Strategy
The committee noted the work being progressed in relation to a collaboration with a Chinese online platform, Wanwuyouyi, a platform which distributes psychology content to the greater China region. The committee noted that the International Working Group are scoping the possibility of delivering an international conference.

Tavistock Consulting
The committee noted the interesting developments of Tavistock Consulting's offer, particularly the shift online of the Executive Coaching Programme, Coaching Skills for Managers, and Advanced Coaching Practice. In addition, the Committee noted the work of Charlotte Williams, a TC consultant, in running online sessions to support other HE institutions.

Digital Academy
The committee noted progress of phase 2, including the discussions around branding and marketing.

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	02 July 2020

Report to	Date
Board of Directors	19 May 2020

Report on Audit Committee Meeting – 14 May 2020

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 14 May 2020.
These matters are provided for information and are the matters which the Audit Committee thought should be brought to the attention of the Board of Directors

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

HIGHLIGHTS OF A MEETING OF THE AUDIT COMMITTEE HELD ON 14 MAY 2020

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 14 May 2020.

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

2. HEAD OF INTERNAL AUDIT ("HoIA") OPINION

2.1 As previously indicated, the Committee heard that the Trust will receive an Amber / Green opinion from the HoIA. This is the second highest rating (out of the four available) and is line with that achieved in the previous two financial years. RSM have no clients within the NHS who receive the top rating.

2.2 In reaching the draft opinion, the HoIA indicated that the rating for the current year is not as strong as for the prior period, reflecting, in particular, a number of actions that have taken some time for the Trust to resolve and that 3 of the 7 audits carried out resulted in partial assurance opinions (Scheduling, Student Billing and Business Continuity and Disaster Recovery).

3. REPORT OF THE LOCAL COUNTER FRAUD SERVICE

3.1 The LCFS had recently run its annual awareness survey.

3.2 This was completed by 14% of Trust employees, which is considered high in the current environment (and above the 10% threshold which RSM consider to a reasonable response).

3.3 The survey showed excellent awareness of the LCF service and suggests that staff know how to report suspicions of fraud and are confident that he Trust would deal properly with such cases.

4. DEALING WITH COVID-19

4.1 The Audit Committee asked a number of questions relating to the pandemic. The Committee was pleased to hear that the Trust's local business continuity

plans ("BCPs")had worked well, as had the 'Gold Command' structure being utilised.

4.2 The Committee noted work, being led by the Medical Director, in terms of reviewing how local BCPs might be improved and what lessons the Trust could learn from the working arrangements enforced by the pandemic.

5. ANNUAL REPORT AND ACCOUNTS ("ARA")

5.1 The main part of the meeting dealt with the ARA.

5.2 Progress on this had been good with, to date, no significant audit issues.

5.3 In approving the ARA, the Board is required to approve the judgements made, underpinning the ARS, in a number of areas, most notably Relocation and the value of the Trust's key property assets.

5.4 A separate (Part 2) paper on these items has been prepared for the Board.

5.5 The Committee noted that there is no requirement, for 2019/20, for the Trust to publish quality indicators and that much of the information around performance is also not required.

5.6 In terms of the out-turn for the year, based on the draft ARA the Trust has slightly exceeded its Budget / Control Total, recording (subject to audit) a net surplus of £228k, versus a Control Total / Budget of a net surplus of £141k.

Terry Noys
Finance Director
13 May 2020

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 19th MAY 2020, 2.00pm – 3.30pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 28th April 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report and COVID-19 Briefing	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	Verbal
3 Items for noting				
3.1	Board Assurance Framework (BAF)	Chief Executive	2.35pm	3
3.2	Quality Dashboard (Q4)	Medical and Quality Director	2.45pm	4
3.3	Serious Incident Annual Report	Medical and Quality Director	3.05pm	5
3.4	Guardian of Safer Working	Medical and Quality Director	3.15pm	6
4 Board Committee Reports				
4.1	Education and Training Committee	Committee Chair	3.20pm	7

		Presenter	Timing	Paper No
4.2	Audit Committee	Committee Chair	3.25pm	8
5. Any other matters				
5.1	Any other business	All		
6 Date of Next Meeting				
	28th July 2020, 2.00pm – 4.00pm – Online / The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			