The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 30th July 2019

2.00pm–4.10pm
Lecture Theatre,
5th Floor
Tavistock Centre,

120 Belsize Lane,
London,
NW3 5BA

The Tavistock and Portman
NHS Foundation Trust

AGENDA Part 1

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 30th JULY 2019, 2.00pm – 4.15pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Deputy Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Deputy Chair		Verbal
1.3	Minutes of the meeting held on 28th May 2019	Deputy Chair		1
1.4	Action log and matters arising	Deputy Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Deputy Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Quality Dashboard (Q1)	Medical Director	2.30pm	3
2.4	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.40pm	4
3 Items for decision or approval				
3.1	Raising Concerns Review Report	Director of HR & Corporate Governance	2.45pm	5
4 Items for discussion				
4.1	WRES and RES Strategy Update	Director of HR & Corporate Governance	3.00pm	6
5 Items for information				
5.1	Board Assurance Framework	Chief Executive	3.15pm	7
5.2	Quality and Performance Reviews	Medical Director	3.20pm	8
5.3	Serious Incidents Quarterly Report (Q1)	Medical Director	3.25pm	9
5.4	Guardian of Safe Working Report (Q1)	Medical Director	3.30pm	10

		Presenter	Timing	Paper No
5.5	Responsible Officer's Revalidation Annual Report	Medical Director	3.35pm	11
5.6	Operational Risk Register	Associate Director of Quality & Governance	3.40pm	12
5.7	Complaints and Whistleblowing Register	Complaints Manager	3.45pm	13
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.50pm	14
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.55pm	15
6.3	Training and Education Committee	Committee Chair	4.00pm	16
6.4	Strategic and Commercial Committee	Committee Chair	4.05pm	Verbal
6.5	Clinical Quality, Safety and Governance Committee	Committee Chair	4.10pm	17
8 Any other business				
9 Date of Next Meeting				
	24th September 2019 – 1330 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			

The Tavistock and Portman NHS Foundation Trust

Board of Directors Meeting Minutes (Part 1)
28th May 2019, 1.30pm – 4.50pm

Present:			
Prof Paul Burstow Chair	Prof Dinesh Bhugra Vice Chair / Non-Executive Director	Mr David Holt Senior Independent Director / Non-Executive Director	Dr Deborah Colson Non-Executive Director
Mr Paul Jenkins Chief Executive	Mr Terry Noys Deputy Chief Executive / Finance Director	Mr Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Dr Sally Hodges Director of Children, Young Adults and Family Services
Dr Julian Stern Director of Adult and Forensic Services	Ms Louise Lyon Director of Quality and Patient Experience	Dr Chris Caldwell Director of Nursing	Dr Dinesh Sinha Medical Director
Attendees:			
Fiona Fernandes Business Manager Corporate Governance (notes)	Craig de Sousa Director of HR & Corporate Governance	Gill Rusbridger Freedom to Speak Up Guardian (Item 1.1)	Jessica Anglin d'Christian Governor
Julia Wall Governor			
Apologies:			
Helen Farrow Non-Executive Director			

Actions

AP	Item	Action to be taken	Resp	By
1	2.3.1	Minor amendments to the minutes	FF	Immed
2	3.2.10	Trust Professional Group Forum dates to be circulated to the board	DS	Immed
3	5.4.3	Work related stress and staff well-being results from Staff Survey	CdS/DB	Immed

1. Patient Experience Stories and Service Reports

1.1 Service Line Report – Freedom to Speak Up Guardian

1.1.1 Ms Rusbridger presented the report and highlighted:

- She has been in post for 4 years and that the role had been very well supported by the Trust, and has been working well.
- The role is voluntary and has to be neutral, independent, impartial and is a confidential service available to anyone in the Trust. It is not an easy role and there is a real need to respect and welcome concerns being raised by staff even if they want to remain anonymous, this should be accommodated.

- The thematic concerns raised have been around bullying, anxiety, not being listened to, and since the last report some of the concerns raised that have been are around patient safety within TAP and GIDS.

- It is commendable that staff do speak out however it is really important that if they speak out and raise issues that these are dealt without repercussions and that they feel valued. It is about finding a balance with this as it can be very uncomfortable for staff therefore making them very anxious and angry.

1.1.2 Responding to a question from Dr Colson, Ms Rusbridger explained that there is ongoing work being done training for middle management. Ms Rusbridger adding that she meets with Mr Jenkins and Mr de Sousa on a regular basis.

1.1.3 Responding to the query from Mr Holt, Ms Rusbridger stated that the main support for Freedom to Speak up Guardians is via the National Guardians office, however within the Trust there is also support for staff from other people like the Mental Health First Aiders and the Staff Consultation Line. It would be beneficial to strengthen the Freedom to Speak up Guardian role with a NED.

1.1.4 Dr Colson wanted to know how a NED could be more visible. Ms Rusbridger noted that Ms Farrow has been visiting the teams and services. It would be beneficial to make the Mental Health First Aiders more prominent as well.

1.1.5 Responding to Dr Sinha, Ms Rusbridger noted that the statistics are low compared to other smaller Trusts, however across the country the concerns raised are the same where staff feel that they are not being listened to or issues of bullying and harassment not being dealt with.

1.1.6 Reflecting on the question from Mr Holt, Mr Rusbridger commented that if there are recurring themes, these would be raised with Mr de Sousa and Mr Jenkins. It would also be raised at director level or with the Union representative.

1.1.7 Ms Rusbridger noted that it is very important that staff need to feel that they are being heard and responded to swiftly and that things are followed up either verbally or in writing as with complaints. Management also need to be respectful and open.

1.1.8 Mr Jenkins thanked Ms Rusbridger for her thoughtful analysis in her role. To ensure that staff feel listened to, posters will be put around.

1.1.9 The board of directors thanked Ms Rusbridger and noted the report.

2. Administrative Matters

2.1 Chair's Opening Remarks

2.1.1 Prof Burstow welcomed all of those in attendance.

2.1.2 Apologies were noted, as above.

2.2 Declarations of Interest

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

2.3 Minutes of the Previous Meeting

2.3.1 The minutes of the previous meeting were agreed as an accurate and true record, subject to minor amendments **AP1**.

2.4 Action Log and Matters Arising

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

2.4.2 There were no matters arising.

3. Operational Items

3.1 Chair and Non-Executive Reports

3.1.1 Dr Colson informed the board that on 15 May 2019 she had visited TAP and met with the user group and that there was a representative from MIND. The team were very welcoming and were interested in the role of the board and what it did.

3.1.2 The user group was very engaged and there was a strong sense of involvement, and their input was very useful. Ellie Cavalli will be producing a video for the board.

3.1.3 Dr Colson noted the board that the contract was due for review in March 2020 and that negotiations are key.

3.1.4 A discussion was held around DNAs as they were quite high. It was thought that this was potentially due to an error in EMIS where if there is no outcome inputted, then this converts to DNA. This is being looked into.

3.1.5 Prof Bhugra noted that he had attended a BAME network and it was informative. The BAME Champion Ms Henderson facilitates these meetings. There were interesting discussions about concerns and solutions and this will be raised at the EDI committee and will report back to the board.

3.1.6 Prof Burstow informed the board that he was concluding the NED appraisals and has had some very good meetings with colleagues.

3.1.7 The Board of Directors noted the report.

3.2 Chief Executive's Report

3.2.1 Mr Jenkins noted that this was Ms Lyon's last board meeting after a very long and distinguished career. He thanked Ms Lyon for her principled thoughtful contributions to the board that has spanned over 11 years.

3.2.2 Ms Lyon was key to the work with the CQC as well as championing equalities issues. Ms Lyon's passion and perseverance for LBGT and race equality is commendable. Mr Jenkins added that her presence will be missed at the board.

3.2.3 Prof Burstow wanted it noted and thanked Mr Lyon for being present at the meeting today following a family bereavement. Prof Burstow thanked Ms Lyon for the 11 years of service and reminisced about his application process for Trust Chair and the meeting he had with Ms Lyon and the insight she gave.

3.2.4 The Ms Lyon acknowledged the vote of thanks and mentioned that although she would be leaving her role, she will still be involved in the centenary celebrations as well as working on the consolidation of the Tavistock charities.

3.2.5 Mr Jenkins informed the board that following an email that he had sent to all staff, he wanted to confirm the senior management changes. Ms Hodges will be the Chief Clinical Operating Officer who will be supported by three Divisional Directors – Gender Services, Adult and Forensic Services and Children and Young Adults and Families. The Divisional Directors will report to the Board in their own rights.

3.2.6 Dr Sinha will take on a wider brief for quality working in conjunction with Ms Caldwell, who will also be responsibility for patient engagement and involvement.

3.2.7 Mr de Sousa will take over the executive lead for equalities and diversity as well as work on the race equality strategy.

3.2.8 Ms Surtees will attend the Board in her role as Director of Strategy.

3.2.9 Mr Jenkins informed the board that the first meeting of the Trust Professional Group Forum was held. This group was established to address how we can create a forum to challenge aspects of clinical work to allow learning from each other.

3.2.10 The meeting was well attended by clinicians from different parts of the Trust and was inspiring especially sharing of knowledge and having an understanding of each other's work. Dr Sinha will be arranging future dates. It would be beneficial to have NEDs and some of the board attending. Dr Sinha to provide the dates. **AP2**

3.2.11 Ms Yakeley and Mr Blumenthal presented an anti-social video which was very informative.

3.2.12 Ms Hodges commented that there was very good attendance and discussions and was pleased to see a mix from the Trust's non-patient facing roles.

3.2.13 Mr Jenkins informed the board that in April the Trustees from both charities met and agreed to recommend to their respective boards the merger of the two charities by creating a new entity. Work will commence on this and the aim is to align the launch of the new charity to mark the centenary of the Tavistock Clinic.

3.2.14 The board as Trustees of the Charitable Funds are being asked to accept and endorse the proposal formally. Mr Noys added that both charities have agreed to take this forward.

3.2.15 The board of directors noted the report and the recommendation for the merger of both charities was accepted.

3.3 Finance and Performance Report

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

- The income for the year was £56m and the Trust had achieved a year to date surplus of £2.7m PSF money and a control total of an additional £1.5m PSF money.

- Income for 2018/19 was £54m with a net surplus of £500k and £159k profit.

- The increase in income £3m is driven by GIDS, FCAMHS and Trailblazers.

- Expenditure increased by £3m based on pay reflecting agenda for change and the Trust breached the agency cap by 20% and NHSi are aware of this.

3.3.2 The board of directors noted the report.

3.4 Quality Dashboard (Q4)

3.4.1 Ms Lyon presented the quality dashboard report and particularly highlighted:

- Referral rates remain high in both GIDS and GIC and the increase in patients is linked to the increase in waiting times.
- Waiting times - work is being undertaken to bring the number down by getting better information from the referrers.
- Overview of the CQUINS although it is a good overall picture to year end, there are some disappointing areas (staff wellbeing).

3.4.2 Prof Burstow noted that he was struck by the wait times figures relating to adult complex needs and the Portman on page 52 and enquired when a breach is not a breach. Dr Stern inquired whether exceptions were accepted on the system and whether it started from the date the referral was received at the Portman.

3.4.3 Ms Lyon commented that the electronic referral system is being implemented to make referring easier. Discussions were had at CQSG and CQRG about this and this was work in progress to alleviate the issues.

3.4.4 In response to Prof Burstow's query about seeing more complexity in the patient seen and whether there was any sense in the data collected if a level of need changes over time. Dr Hodges responded that it was a high complex patient and that with Camden there is a bit more variation as they use the Thrive model. The cases that come to us are more complex. There is a measure called the current view that looks at the complexity and the long term plan is for early intervention.

3.4.5 Ms Lyon noted that we can look at more complexity as there is the data available and that there was retrospective data as well.

3.4.6 Dr Sinha suggested that it would be useful to share the outcome measures with other mental health trusts however we would need to increase the base rate.

3.4.7 Mr Jenkins noted that the current expectation of the commissioners is increasing and Dr Hodges added that the gold base measure were the most significant patient rating.

3.4.8 The board once again thanked Ms Lyon for her contributions and noted the report.

4. Items for Decision or Approval

4.1 NHS Improvement Licence Self Certification

4.1.1 Mr de Sousa noted that this was an annual declaration that the Trust have to make. This will be reported to the Governors and consulted with Mr Noys confirming that there is nothing adverse to declare. Once we have approval of the licence conditions it will then be published on the website.

4.1.2 The board of directors approved and noted the report.

5. Items for Discussion

5.1 Board Assurance Framework

5.1.1 Mr Jenkins presented the framework highlighting the following:

- Two risks rated 16 (4 & 12) these increased from 12. Risk 4 increased from 12 to 16 and risk 12 from 8 to 16. Both these ratings were more around treatment of the relocation expenditure of the auditors.
- Four risks rated 12 (2, 7, 9 & 10).
- Two risks had reduced in score (1 & 5) where risk 5 reduced from 12 to 8 and risk 1 reduced from 12 to 6.

5.1.2 Mr Jenkins noted that the board are asked to given a view that relocation was probable to the auditors and to agree the change of wording to 'probable'.

5.1.3 The board of directors noted the revised positions of risk 4 & 12 and the changes of the wording in the board assurance framework.

5.2 Serious Incidents – Quarterly Update

5.2.1 Dr Sinha presented the update report and highlighted:

- There were 26 clinical incidents logged.
- There were 4 deaths reported in the last three weeks and reported externally to STEIS. These cases are all subject to an internal concise report which allows the incident panel to determine the type of investigation to be undertaken.
- Looked at processes regarding deaths and serious incidents and the monthly incident panel that had been constituted has oversight of this.
- Incidents of patient aggression towards staff has increased and is being reported more frequently across trust services. Associate Medical Director has been asked to setup a group to look at the issues and make recommendations to ratify this and, to add to the guidance in already in place around managing difficult behaviours. Staff need to be trained in breakaway training and how to link the concerns as there is no security on site. A clearer plan will be brought to the next board.
- One inquest was held in relation to a death in 2016 and a specific panel looked at the Gloucester House incidents and will also focus on which incidents bring up risk for students and staff.
- IG incidents continue to occur predominately letters being sent to the wrong address. One incident in Q4 pertained to a patient file which was requested by the patient contained information relating to another patient. Recommendations are being made to have an IG incident category or a clinical incident with IG element on CareNotes.

- There was a non-formal complaint where a person's confidentiality was breached and this was reported to the ICO. ICO confirmed that this matter was deal with appropriately and no further action was taken by them.

In response to Prof Burstow's question, Dr Sinha responded that the increase in patient aggression could be the ebb and flow of clinical practice and it has exposed a gap in how we think about safety in the organisation. More work needs to be done in this area.

Prof Burstow suggested that this could be discussed as an item at the Board Seminar.

5.2.2 The board of directors noted the report.

5.3 Guardian of Safe Working – Quarterly Update

5.3.1 Dr Sinha presented the update report and highlighted:

- The number of incidents is increasing (breaches in the rota, fines being paid, claims being asked for and plans on the development of the junior doctors servicing the rotas).

- A meeting was held with the junior doctors and the vacancy factor is not as high as initially thought however it is still high.

- System level changes have been made.

- A nurse led service has commenced and she will be in contact with the trainers to support the junior doctors.

5.3.2 In response to a query from Dr Stern, Dr Sinha noted that although the vacancies are training post, they do have a clinical aspect to the role. Sheva Habel has taken up an additional role and there is no conflict of interest.

5.3.3

5.3.4 Responding to Ms Caldwell, Mr de Sousa commented that the contract for junior doctors changed two years ago to encourage them to do the right thing, and that there were rules/procedures that have been implemented.

5.3.5 The board of directors noted the report.

5.4 People Strategy Report

5.4.1 Mr de Sousa presented the report and highlighted:

- Mapping clinical roles – this is in the final phase of check pointing and all of the roles will be evaluated through the trust's job grading process.

- Staff Survey – supplement work is being done to get under the skin and to draw out proposals and recommendations. It highlighted that middle management will need further training and development and will be aimed at existing and new management.

- A new contract for occupational health and wellbeing services has been completed. The Trust has awarded a three year contract to Team Prevent Ltd who will take over from the current providers in September this year.

- HR continue to engage with the STP streamlining programme and has now aligned its mandatory and statutory training to the footprint framework.

- The workforce matrix shows signs of decrease in staff turnover and an increase in sickness absence. The sickness absence is related to small cases of long term sickness. Sickness absence reporting has improved.

- There is good compliance in statutory training and it was recently agreed at CQSG to remove the clinical training which as agreed with commissioners.

- Data is being migrated into the HR Learning solution.

5.4.2 Responding to Mr Holt's question about the initial actions on the staff survey 360 feedback, Mr de Sousa noted that this existed to clinical staff in the existing process and that we did not do developmental 360s. Middle management programme will need more work done.

5.4.3 Prof Bhugra enquired if in the staff survey whether there were any questions related to staff well-being which can be shared, as the rates of burnout were incredibly high. We need to support staff and be well placed to offer services. In response Mr de Sousa stated that the details were in the full report and that work related stress had increased. Mr de Sousa and Prof Bhugra to meet to discuss this. **AP3**

5.4.4 In response to Dr Colson's question, Mr de Sousa commented that the two red ratings under career pathways relate to a rotational program across the STP and we will be looking at internal career pathways in lieu of this. Regarding the red ratings on page 131, we are changing the approach of how to deliver the training and recording.

5.4.5 The board of directors noted the report.

5.5 Annual Operational Plan – Review of outcome 2018/19

5.5.1 Mr Noys presented the report and highlighted:

- It was a reasonable achievement for the year.

- Of the 19 actions 7 were fully met, 10 were partially met, 1 was not met and 1 was 'in train'.

Mr Holt commented that it was a fair summary of an ambitious organisation achieving a lot in the year. There is an honesty which underpins what has been done. Mr Holt congratulated colleagues as the trust is in a better positions and it is a positive story.

5.5.2 The board of directors noted the report.

6. Committee Reports

6.1 Audit Committee

6.1.1 Mr Holt reported that the agenda was mainly around the year end accounts. Internal audit have been very positive and moved up in the rating band. The quality is better than it has been in the past years.

6.1.2 The board of directors noted the report.

6.2 Equality, Diversity and Inclusion Committee

6.2.1 Prof Bhugra presented the report from the committee.

6.2.2 A vote of thanks was conveyed to Ms Lyon for her tremendous contribution made to the committee and the hard work that she has done.

6.2.3 Disability access survey has been completed and the BAME network came forward with solutions.

6.2.4 The board of directors noted the report.

6.3 Education and Training Committee

6.3.1 Mr Rock noted that there will be a Chinese delegation visiting on a four day programme.

6.3.2 The board of directors noted the report.

7. Any Other Business

7.1.1 There was no other business raised.

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	30th July 2019

Chief Executive's Report
Executive Summary
This report provides a summary of key issues affecting the Trust.
Recommendation to the [Board / Committee]
The board of directors is asked to note / discuss this report
Trust strategic objectives supported by this paper
All Trust strategic objectives

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Julian Stern

1.1 As previously announced, this will be Julian Stern's last Board as Director of Adult and Forensic Services. I would like to put on record my appreciation of Julian's role in leading these services and his contribution to both EMT and Board discussions.

While reducing his commitments, Julian will be continuing his clinical work. In addition, I am very pleased that he will be maintaining a leadership role in the Trust as Chair of both the Professional and Clinical Advisory Group (PCAG) and Scientific Meetings Committee.

2. Divisional Directors

2.1 Following the announcement of the new management structure for Clinical Services we have completed the recruitment to the three Divisional Director posts.

2.2 Following a robust external and internal process we have made the following appointments:

- AFS Tim Kent
- CYAF Rachel James
- Gender Ailsa Swarbrick

2.3 The new Divisional Directors will take up their posts over the next couple of months and, as agreed, will begin to attend meetings of the Board.

3. Violent incidents

3.1 The Trust's incident panel has become an important forum for gathering of various clinical governance activities such as reporting of and exploration of incidents. It has encouraged us to develop a culture of active learning through discussion of reviews, including concise reviews, mortality reports and SIRs and finally enabled the sharing and dissemination of learning. One of its activities has been to note and respond to any themes in emerging incidents.

3.2 A recent theme has been the emergence of a number of incidents that suggest a possible higher profile of risk in our clinical settings and an associated pattern of aggression. There were a number of incidents from the Portman Clinic,

incidents of threats and aggression from the Gloucester House and GIDS and others, which prompted this thematic exploration. In each case, the incident was discussed at the incident panel along with additional information being requested, if needed. This led to various actions, to immediately contain the heightened risk and its consequences on services, such as in the case of the Portman (including measures to improve environmental security) and a subgroup was set up to consider aggression within our clinical settings.

3.3 The findings and recommendations of the subgroup were discussed at the Incident panel and they were along three broad themes.

- Environmental Security
- Management of the incident of risk
- Post incident support

3.4 The Medical Director has undertaken to discuss the recommendations further in other forums before we agree any actions, as there are important decisions needed to respond to the possible changing picture of risk while maintaining the conditions for safe practice to allow our unique clinical interventions

4. STP

4.1 There are a number of current developments across the STP:

- We are starting work on producing the mental health chapter for the STP response to the Long-Term Plan. This will focus on how we deliver the key targets in plan while also giving some opportunity to reflect local priorities. The key issue will be transparency about funding.

- More widely work is progressing in developing a medium-term financial strategy for the STP which will support a return to financial balance. This will focus on a number of key priorities. I will provide a further briefing on the strategy in due course, including an analysis of the impact for the Trust.

- There has been progress towards moving towards the new integrated structures set out in the Long-term Plan. In particular we are now meeting with other organisations in Camden around the development of an Integrated Care Partnership for the borough.

5. BAME Network

5.1 On 9th July Paul Burstow and I attended the monthly meeting of the Trust's BAME Network, chaired by Irene Henderson, the Trust's Race Equality Champion.

5.2 The meeting was well attended and there was a constructive discussion of the progress made to date in progressing these issues as well as challenge on what we need to do to go further.

5.3 A short note is attached of the key issues which have been raised. These proposals are being considered by EMT and further report on action taken will be made at the September Board meeting.

6. Registration with the Officed for Students

6.1 At its July meeting, Education & Training Committee approved a recommendation to proceed with the application for direct registration with the Office for Students (OfS).

6.2 The OfS has been formed following the dissolution of the Higher Education Funding Council England (HEFCE). The strategic drivers are very clear for this, which include the retention of our Tier 4 licence needed to continue to recruit international students. We have the support from our main university partner, the University of Essex, and are in close discussion with them and with the OfS to understand the various options available to us. Our application will be submitted by 1 August and it is likely to take a period of months before we know the outcome. We are exploring the best options to mitigate any risks associated with the outcome of the application.

Paul Jenkins
Chief Executive
24th July 2019

Annex A

Meeting with BAME Network – 9th July

Introduction

1. Paul Burstow and I attended the BAME Network at its July meeting.

2. The meeting, chaired by Irene Henderson, our Race Diversity Champion, was well attended and there was a lively discussion.

3. There was a recognition from the group that the Trust is trying to address this agenda, but we acknowledged there was more we could do to demonstrate change.

4. A number of issues were raised which Paul and I agreed we would take back to EMT and the Board to see whether there was more we could do to address them.

Key issues

Communications

5. There was a discussion of what we could do to communicate more visibly that this was an organisation which welcomed staff from diverse backgrounds. There was a recognition that some of the Trust's external communications highlighted diversity but this more lacking in internal communications.

6. A number of ideas were suggested:

- Considering how we might use the video display in reception to communicate welcoming messages about diversity

- Using In Mind and other communication channels to cover stories about the experiences of BAME staff in the organisation including those who had bene more successful in rising to more senior positions.

Management Training

7. There was a recognition of the importance of strengthening management training in the Trust, with a particular focus on ~~new~~ managers, new to management roles. This was relevant to the diversity agenda but had wider

implications across the organisation. This is something we see as a priority and Craig de Sousa is researching options on how we might take this forward.

Mentoring and development opportunities

8. There was a discussion of the scope of extending opportunities for mentoring opportunities for BAME staff. As part of this there was a discussion of the benefits of introducing reverse mentoring with the aim of helping more senior staff be fully aware of the experience of BAME backgrounds.

9. There was also a call for looking at communication about courses and development opportunities and how opportunities might be better signposted by managers and the organisation to BAME staff.

Training and education

10. There was some recognition of the steps which had been taken to give focus to race equality within DET. There was a proposal to encourage a more systematic approach to getting portfolios and courses consider how issues of equality, including race became an integral part of their programmes rather than being perceived as an "add on" session to exiting programmes.

11. In addition, there was a view it would be helpful to target attention on those courses with the lowest participation students from a BAME background and that, using data, develop action plans on how this might be addressed.

Thinking Space

12. There was a request to continue and extend the programme of Thinking Space events with the scope to target a broader range of staff. Craig de Sousa already has this under review.

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: July 2019

Report to	Date
Board of Directors	July 2019

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for quarter 1 quality metrics for the Trust. The Commentary section provides service updates on waiting times and 'DNAs', and updates on the current position of Trust Quality Priorities and CQUINs. Please note the data in this report is for Trust wide, with the exception of CQUINS that apply to London Contracting or NHSE contracts only.

- The order of the report information has been amended to present details under the headings of: Access; Care; Outcomes and Well-led. The usual CQC KLOE headings have also been retained.

- A review of patients seen across the Trust shows that numbers have reduced compared to Q1 2018/19. The issue of reduced activity was discussed at EMT with input from our contracts team. Following this, the CCOO and other operational Directors are in the process of producing a plan for mitigation of the issues identified.

- Some reporting issues were identified with the waiting time target for under 18 year olds from referral to 2nd appointment. This had previously been 18 weeks and had not been updated to 8 weeks. Information is provided in a table on page 3 and graphical information will be backdated for next quarter.

- Mental Health Service Data Set (MHSDS) data is presented on page 6 and shows an improvement in three areas where we have been showing consistently poor data – ethnicity; employment status (adults) and accommodation status (adults). These are included this year in a national CQUIN dataset.

- Goal Based Measure Outcome information has been updated to reflect changes in KPI parameters for 2019/20. An increased sample has led to greater visibility of OM compliance but has shown a drop in rates. See page 11.

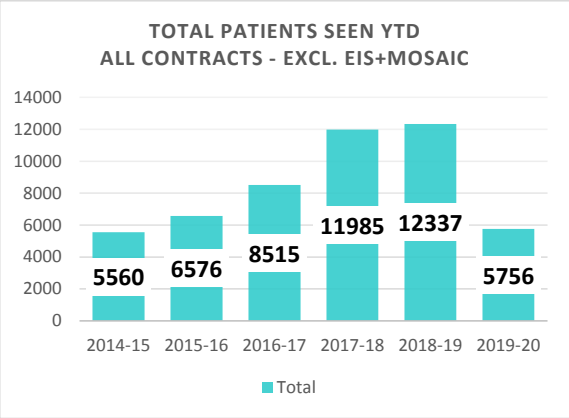
- An update of the Trust communications position specific to media particularly highlights the impact of the recent GIDS related coverage.

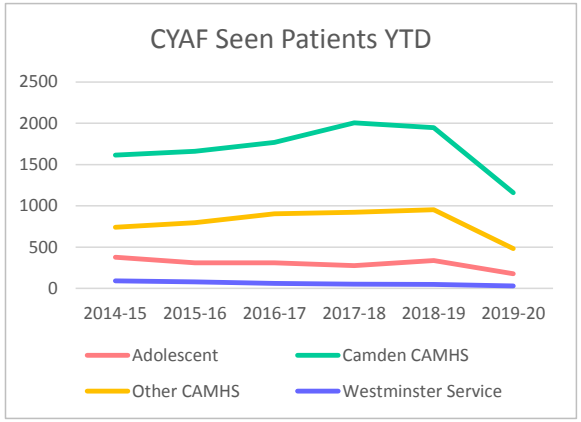
- The student survey opened 24th April 2019

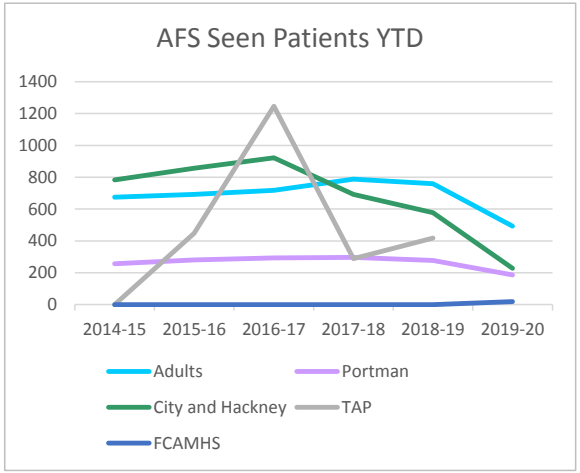
The Tavistock and Portman NHS Foundation Trust

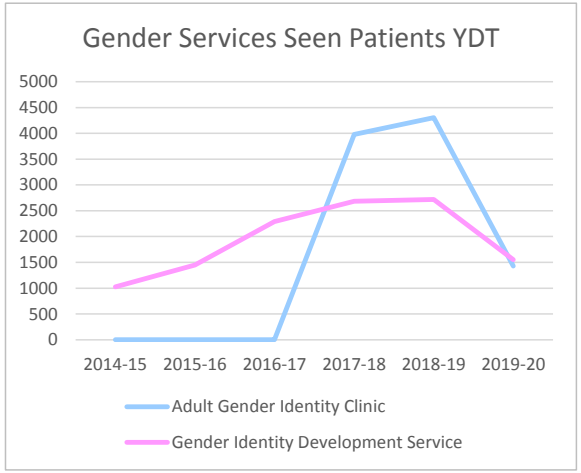
Recommendation to the Board of Directors	
The Board of Directors is asked to discuss the report.	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q1 2019/20: Trust Reach – Access









Data source: Data warehouse, informatics team 11/07/2019

Note: Telephone appointments are listed as an appointment where there is significant work done with the patient

Patients seen

The 'number of patients seen' has been historically represented in a 'year to date' format (YDT). In the run charts this makes the data look as if numbers of patients seen are plummeting, but this is only due to the fact that we reporting in one quarter. We are planning to change the format of this information for quarter 2, to show it quarterly for two years. This will make it easier to identify trends and changes as the year progresses.

The data we are able to compare is Q1 18/19 last year and this Q1 19/20 – we have identified a clear drop on number of patients seen – see breakdown below:

Adults Complex needs: comparing the last Q1 we have seen a drop in patients seen of 11%. Q1 18/19 had 555 seen patients and 19/20 had 493

Portman: comparing the last Q1 we have seen a drop in patients seen of 8%. Q1 18/19 had 204 seen patients and 19/20 had 187

C&H PCPS : again comparing the last Q1 we have seen a drop in patients seen of 11%. Q1 18/19 had 555 seen patients and 19/20 had 493

TAP: unfortunately we don't have information for 19/20 to be able to compare. We do know they saw 417 in Q1 19/10

Adolescent : comparing last year's Q1 and this year we have seen a drop of 13% on seen patients. Q1 18/19 had 202 seen patients and 19/20 had 176.

Camden CAMHS: we had a very slight reduction of 4% patients comparing both Q1s. Q1 18/19 had 1211 seen patients and 19/20 had 1159

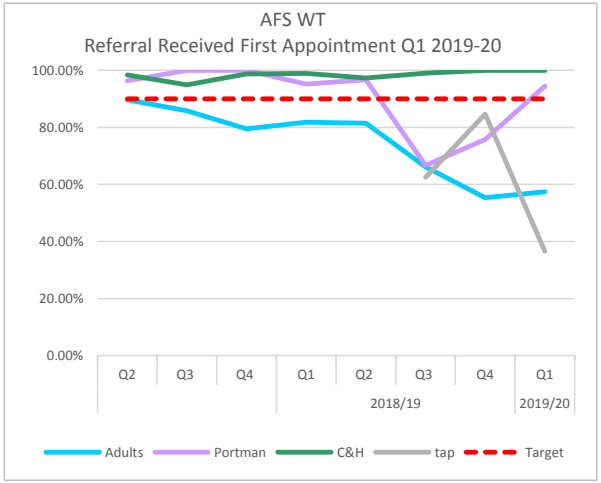
Other CAMHS: similarly we noticed another drop of 15% patients. Q1 18/19 had 567 seen patients and 19/20 had 482

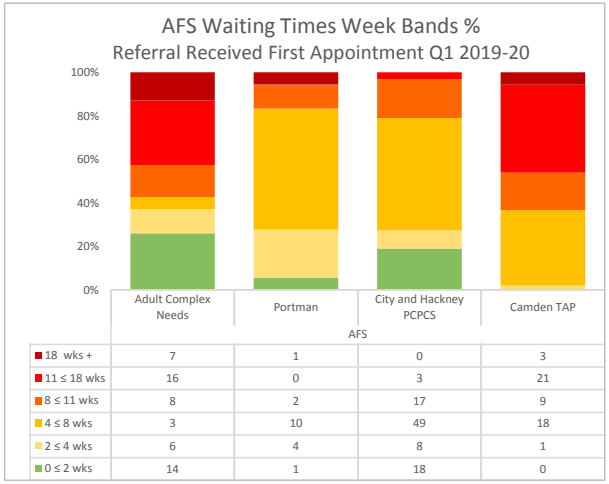
FAS (Westminster service) this team actually experienced a increase of 21% patients seen. Q1 18/19 had 24 seen patients and 19/20 had 29

GIDS: again comparing the last Q1 we have seen a drop in patients seen of 7%. Q1 18/19 had 1766 seen patients and 19/20 had 1554

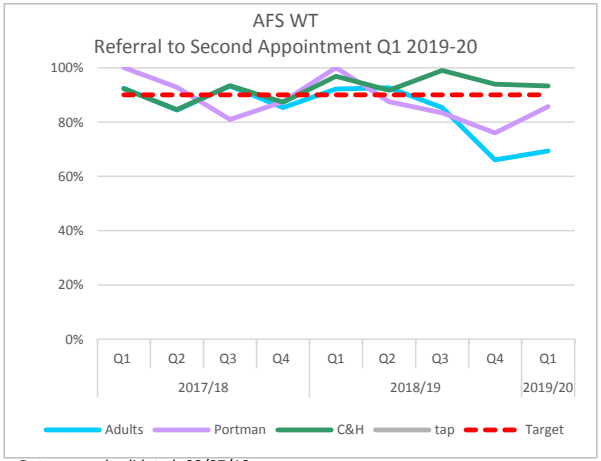
GIC: again comparing the last Q1 we have seen a drop in patients seen of 7%. Q1 18/19 had 1533 seen patients and 19/20 had 1554

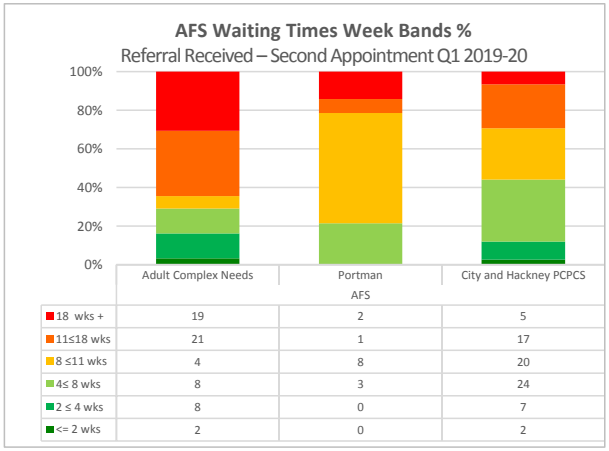
Q1 2019/20: Quality Responsive – Access





	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
18 wks +	7	1	0	3
11 ≤ 18 wks	16	0	3	21
8 ≤ 11 wks	8	2	17	9
4 ≤ 8 wks	3	10	49	18
2 ≤ 4 wks	6	4	8	1
0 ≤ 2 wks	14	1	18	0





	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	19	2	5
11≤18 wks	21	1	17
8 ≤11 wks	4	8	20
4≤ 8 wks	8	3	24
2 ≤ 4 wks	8	0	7
<= 2 wks	2	0	2

Data run and validated: 09/07/19
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

AFS Waiting Times : In Q4 2018/19 AFS saw 78.96% of patients within the contractual waiting times for first appointment. In Q1 this compliance has significantly decreased to 72% - due mainly to TAP. With regards to the waiting time from referral to second appointment: in Q4 AFS had 79% compliance and in Q1 we increased to 83%.

Adult Complex Needs

Referral to 1st appointment – in Q4 this service had an unusually low compliance of 55% but in Q1 they experienced a slight increase achieving 57%. AFS are experiencing staffing issues but they hope to continue with the increase into next quarter.

Referral to 2nd appointment - 66% of the patients had an second appointment within time. They also experienced a slight improvement on Q1 reaching 69% compliance.

Portman

Referral to 1st appointment – has consistently improved for three consecutive quarters, in Q4 they saw 76% of patients on time and in Q1 this figure increased again to 94% reaching the target.

Referral to 2nd appointment – in Q4 76% of the patients had an appointment on time, in Q1 this figure increased to 86% , unfortunately they did not reach the target but they are substantially closer.

C&H PCPS

Referral to 1st appointment – the target is been consistently met for the last two years. Both Q4 and Q1 had 100% compliance.

Referral to 2nd appointment – this parameter is also met consistently for the last year. Q4 had 94% and in Q1 they achieved 93% compliance.

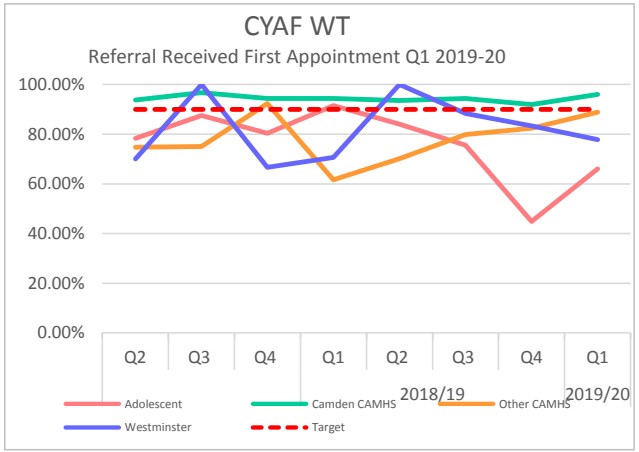
TAP

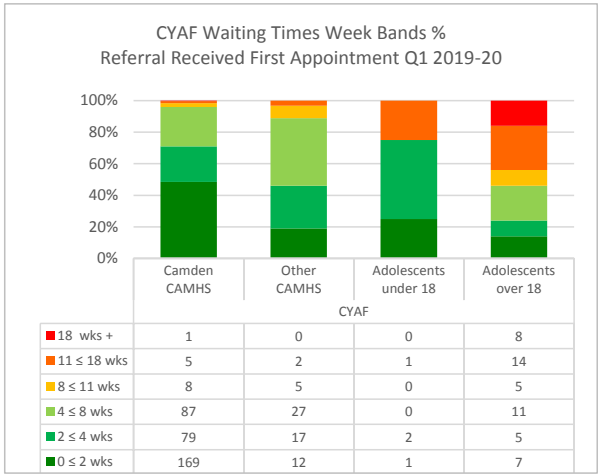
Referral to 1st appointment – they experienced a significant drop in performance likely to be due to staffing issues and availability of rooms in the GP surgeries.

Referral to 2nd appointment – this service does not report on second appointment as their system is not able to provide the data.

For further comments from service leads please see the commentary part of the report Page 17

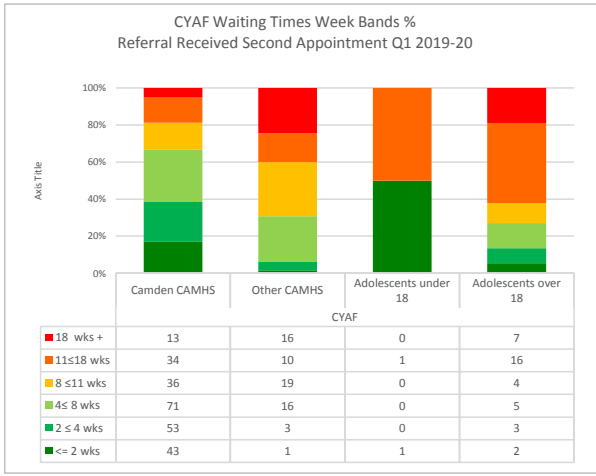
Q1 2019/20: Quality Responsive – Access





CYAF Waiting Times Week Bands %
Referral Received Second Appointment Q1 2019-20

Service Lines	<= 2 wks	2 ≤ 4 wks	4≤ 8 wks	8 ≤11 wks	11≤18 wks	18 wks +	Total	% compliance
Camden CAMHS	43	53	71	36	34	13	250	67%
Other CAMHS	1	3	16	19	10	16	65	31%
Adolescents under 18	1	0	0	0	1	0	2	50%
Adolescents over 18	2	3	5	4	16	7	37	38%



This quarter we learnt that the waiting times target for under 18 year olds was 8 weeks for referral to second appointment. We previously we had 18 weeks, Above you have the data for Q1 19/20. The graph will be backdated for the next quarter.

Data run and validated: 09/07/19
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

CYAF Waiting Times : In Q4 last financial year CYAF saw 75.6% of patients within the contractual waiting times for first appointment. In Q1 this compliance has significantly increased to 82%.

Adolescent services

Referral to 1st appointment – in Q4 this service had an unusually low compliance but in Q1 they experienced a significant increase in their performance. They still have a low compliance rate for Q1 at 66% which is due to a combination of increased referrals and a reduction in staff sessions.

Referral to 2nd appointment - 44% of the patients had an appointment within 8 weeks. Unfortunately we do not have Q4 data with the agreed timeframes.

Camden CAMHS.

Referral to 1st appointment – has consistently done well since 2017/18 in to 2018/19

Referral to 2nd appointment – 67% of the patients had an appointment within 8 weeks. Unfortunately we do not have Q4 data with the agreed timeframes.

Other CAMHS

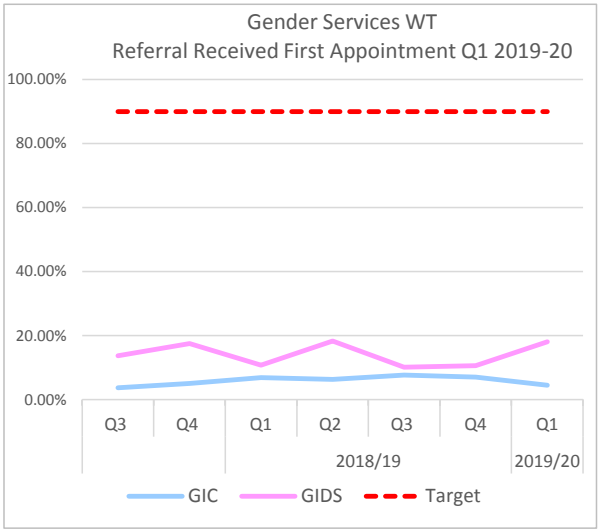
Referral to 1st appointment - had experienced a rise in compliance in Q4 with 82% of patients seen within expected times, and in Q1 achieved 89%. It is important to mention that their performance has improved consecutively since Q2 2018/19.

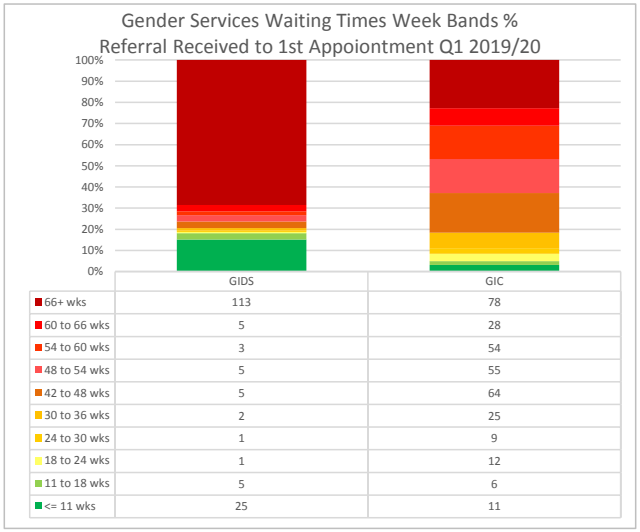
Referral to 2nd appointment - 31% of the patients had an appointment within 8 weeks. Unfortunately we do not have Q4 data with the agreed timeframes.

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

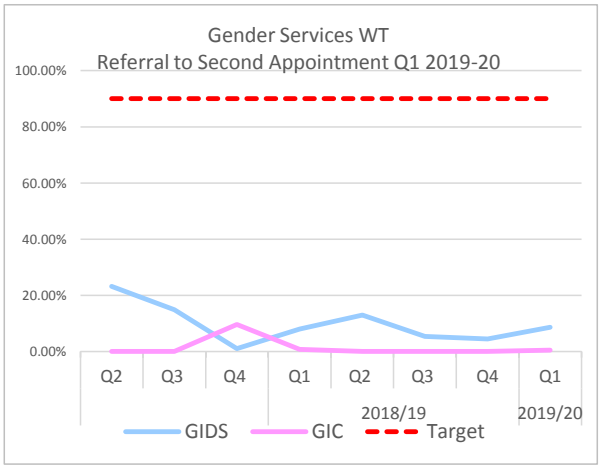
For further comments from service leads please see the commentary part of the report Page 19

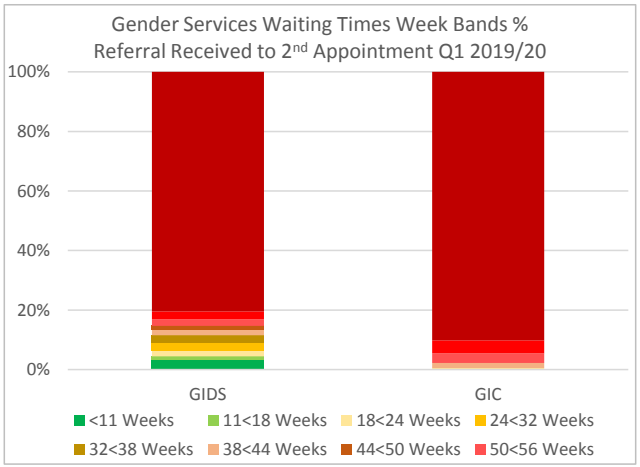
Q1 2019/20: Quality Responsive – Access





	GIDS	GIC
66+ wks	113	78
60 to 66 wks	5	28
54 to 60 wks	3	54
48 to 54 wks	5	55
42 to 48 wks	5	64
30 to 36 wks	2	25
24 to 30 wks	1	9
18 to 24 wks	1	12
11 to 18 wks	5	6
<= 11 wks	25	11





Data run and validated: 09/07/19
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Gender Services Waiting Times:

For first appointment in Q4 they achieved 8.81% compliance increasing to 11% in Q1. With regards to waiting times from referral to 2nd appointment: Q4 had 2.22% compliance and in Q1 we increased to 5%. Gender services have an unusual and challenging demand, they have action plans in place and liaise closely with commissioners.

GIDS

Referral to 1st appointment – Q4 compliance was 10.60% and Q1 achieved 18.7%. This increase could be linked to the implementation of a DNA and Cancellation policy update across the team.

Referral to 2nd appointment –in Q4 none of the patients had a second appointment within time. This was unchanged in Q1.

The Data Quality Team (DQT) will carry on meeting regularly with GIDS in order to support the review of waiting time issues amongst other KPIs.

GIC

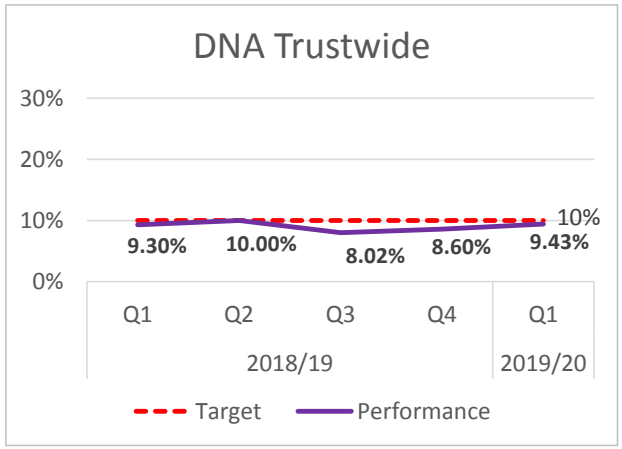
Referral to 1st appointment – Q4 compliance was 7.2% which dropped to 4.5% in Q1. The number of people on the waiting list is at an all time high and there are groups working on this issue nationally.

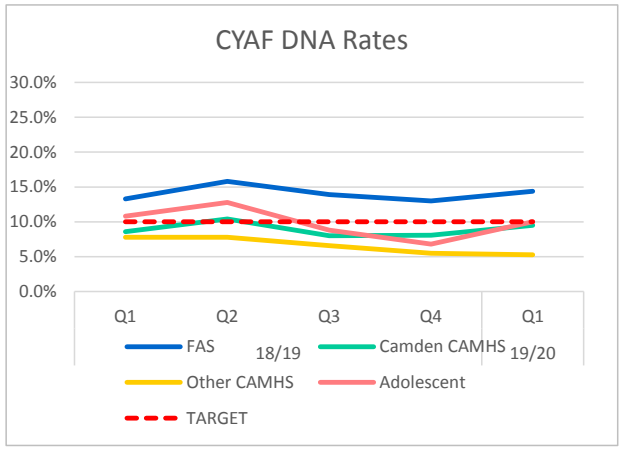
Referral to 2nd appointment –in Q4 4% of the patients had a second appointment within time increasing to 9% in Q1. GIC reported in Q4 they were working on a project to make the gap between appointments clinically safe. The increase in compliance is likely to be linked to this work.

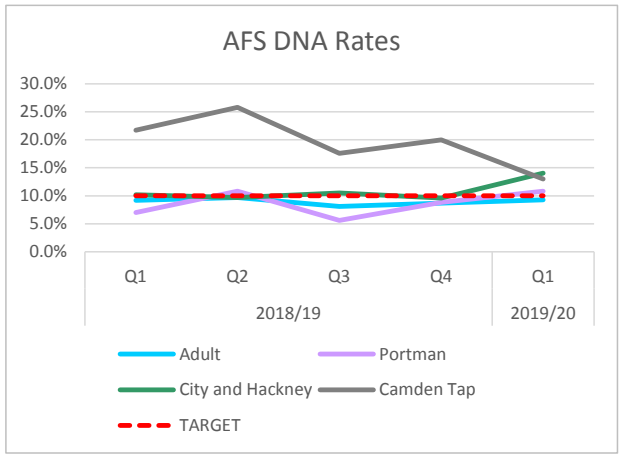
The Data Quality Team (DQT) will carry on meeting regularly with GIC in order to support the review of waiting time issues amongst other KPIs.

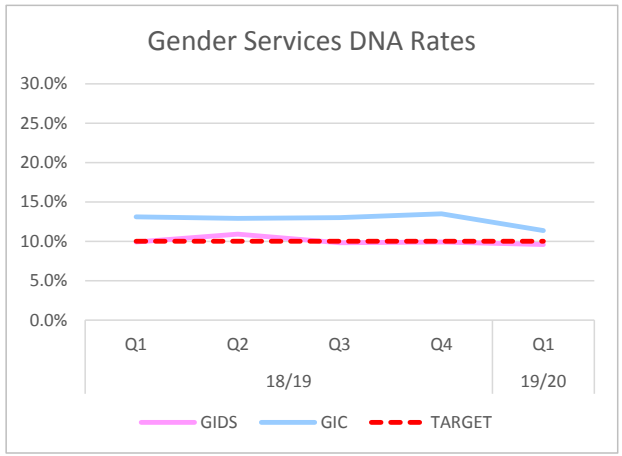
For further comments from service leads please see the commentary part of the report Page 19

Q1 2019/20: Quality Effective – Access









Data run and validated: 8th July 2019 : SRRS (Internal Reporting System) Reported by the Quality Team

The definition used for DNA figures is Numerator: Total DNA / Denominator: Total Appointments (Total Attended + Total DNA appointments

Did Not Attend (DNA)

DNA rates are expected to be no higher than 10%. The current rate is 9.43% which it is still within the target but close to our contractual target. This will be assessed in the next Clinical Data Quality Review Group (CDQRG).

Adults Complex Needs have maintained a good performance with 8.7% in Q4 and a slight increase to 9.3% in Q1.

Portman saw an increase from 8.8% in Q4 to 10.8 % in Q1.

C&H PCPS had an unusual rise of DNAs from 10% in Q4 to 14% in Q1. This was due to the implementation of groups for patients difficult to engage (chronic pain & many physical symptoms), C&H are liaising with facilitators.

TAP carried out a successful QI on DNAs and have managed to reduce the rates from 20% in Q4 to 13% in Q1. This is still above our target but significantly closer to it.

Adolescence had a DNA rate of 6.8% in Q4 and 10% in Q1.

Camden CAMHS Similarly in Q4 had a rate of 8.1% and in Q1 increased to 9.5% - but again it is still within the target.

Other CAMHS continue to consolidate a great rate sustained over the last year with 4.5% in Q4 had 4.5% and 5.3% in Q1.

FAS (Westminster) saw an increase from 13% in Q4 to 14.4% in Q1.

GIC saw a decrease from around 13% over the last two years to 11% in Q1. This is likely to be the result of the increase of SMS reminders consent collection.

GIDS also saw a decrease in DNAs possibly linked to a recent review of the department DNA policy from 9.9% in Q4 to 9.6% in Q1.

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

Q1 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) Data 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. This is a score collated from overall compliance against completeness of data items within the mental health dataset.

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

-DQMI – to be published 22 July 2019. this will inform the SOF.

The Data Quality Team uses the Data Warehouse Information, which is used for external reporting, to identify gaps in reporting. In order to improve on DQMI and MHSDS completion the Trust reports internally at the CDQRG meeting on a monthly basis to see where demographics of patients have been collected appropriately and where they need to be improved. The CDQRG 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. Then new indicators will be included on Q2 report as this data is not yet available for Q1. The CDQRG has been working on the dataset for 6 months and it has already seen some improvement on performance on the last reports. We are working towards 90% compliance before the end of the year, as this is a CQUIN for 2019/20.

	Target (%)	Month 1 2017/18 (%)	Month 4 2017/18 (%)	Month 7 2017/18 (%)	Month 10 2017/18 (%)	Month 1 2018/19 (%)	Month 4 July 2018/19 (%)	Month 7 October 2018/19 (%)	Month 10 January 2018/19 (%)	Month 1 April 2019/20 (%)
Valid NHS number	95%	**96.20%**	**96.20%**	**99.10%**	**98.60%**	**98.60%**	**98.70%**	**98.90%**	**98.90%**	**99.00%**
Valid Postcode	95%	**99.80%**	**99.80%**	**99.80%**	**99.70%**	**99.80%**	**99.80%**	**99.80%**	**99.80%**	**99.70%**
Valid Date of Birth	95%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Valid Organisation code of Commissioner	95%	**99.50%**	**99.50%**	**99.50%**	**99.10%**	**99.00%**	**99.20%**	**99.00%**	**99.00%**	**99.20%**
Valid Organisation code GP Practice	95%	**99.10%**	**99.20%**	**99.20%**	**98.20%**	**97.80%**	**98.00%**	**98.10%**	**98.20%**	**98.90%**
Valid Gender	95%	**99.80%**	**99.80%**	**99.80%**	**99.80%**	**99.80%**	**99.70%**	**99.40%**	**99.40%**	**99.40%**
Ethnicity	85%	**83%**	**83.10%**	**79.60%**	**78.40%**	**77.30%**	**76.00%**	**75.80%**	**76.10%**	**80.60%**
Employment Status (for adults)	85%	**26.30%**	**26.30%**	**36.90%**	**43.40%**	**49.10%**	**50.50%**	**51.60%**	**54.00%**	**59.30%**
Accommodation status (for adults)	85%	**26.10%**	**26.10%**	**36.60%**	**42.90%**	**48.50%**	**49.90%**	**51.00%**	**53.20%**	**58.30%**
ICD10 coding	85%	**NA**	**N/A**	**NA**	**NA**	**NA**	**NA**	**N/A**	**N/A**	**N/A**

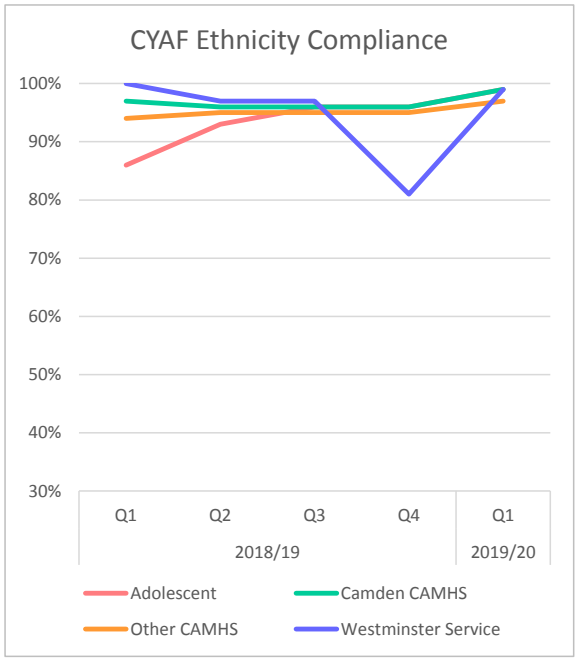
Data source: Data warehouse, informatics team.

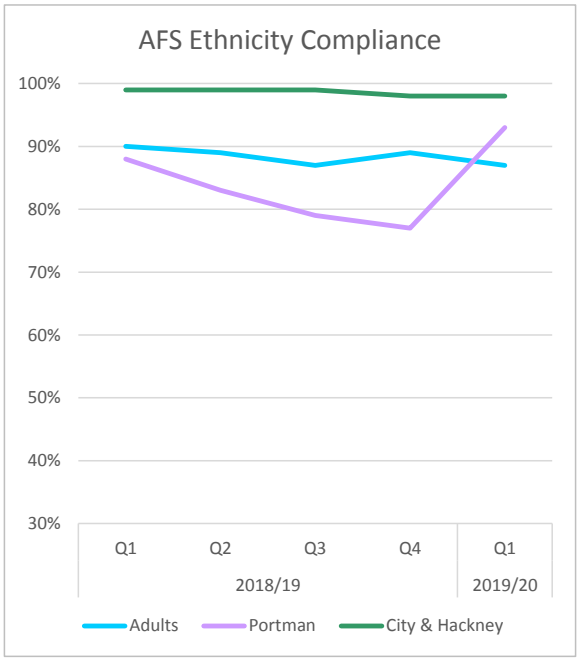
Q1 2019/20: Single Oversight Framework – Access

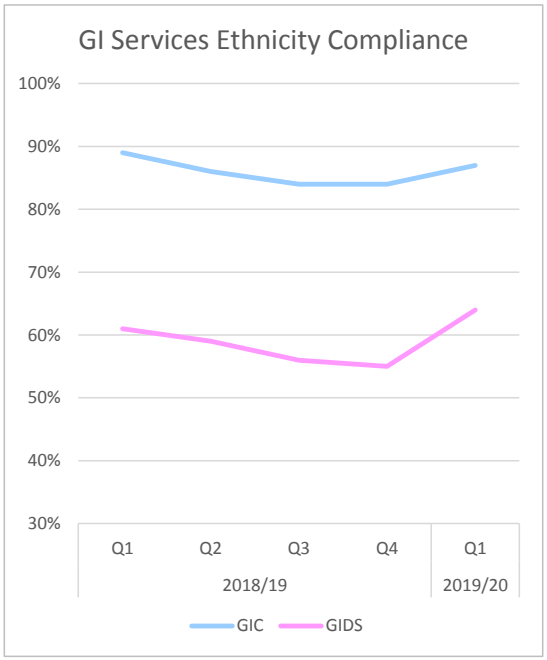
Ethnicity Rates

Ethnicity completion rates are one of the most challenging MHSDS data indicators, so we have been closely analysing this data. As you can see during Q1 we have increased the rates preparing our data for the target of 95% which is expected from Q2. The Data Quality Team continue to work with teams in the CDQRG meeting to improve this data further.

The team with the most noticeable improvement are: FAS (Westminster service) Portman and GIDS. The only service line with a slight decrease is Adults Complex Needs.

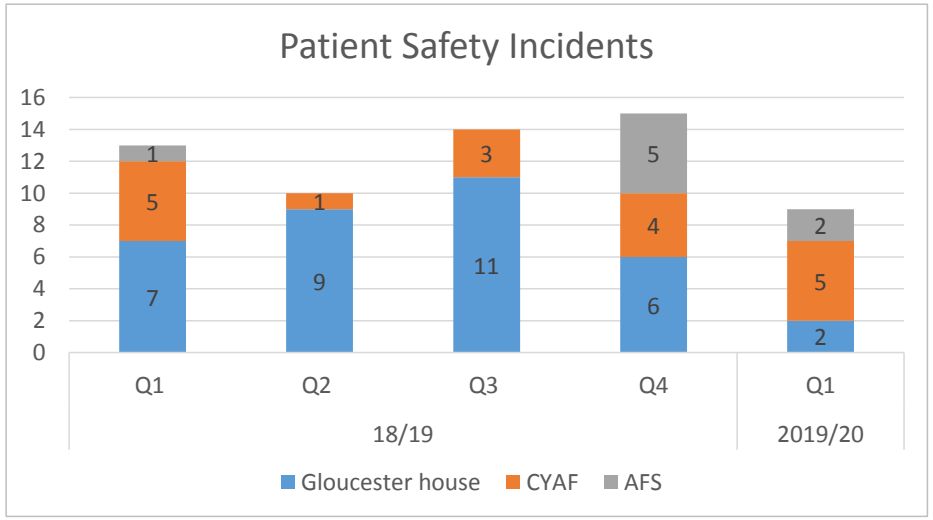






Data source: 8/07/19 SRRS (Internal Reporting System) Reported by the Quality Team

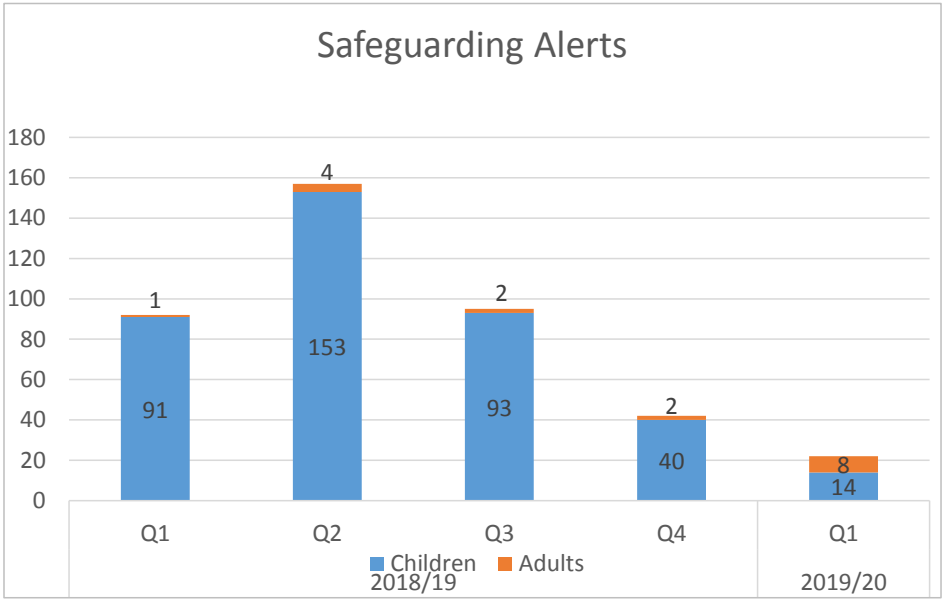
Q1 2019/20: Quality Safety – Care



Patient safety incidents are those reported externally to the National Reporting and Learning System (NRLS). The risk level of most incidents is very low.

Incidents Reported by Risk Level Trust wide	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1
1-4	75	81	119	82	101
5-8	20	42	35	22	28
9-12	6	7	3	10	3
15+	0	0	1	0	0
Total	101	130	158	115	132

Data source: Quality Portal – Incidents 08/07/2019



* Some cases have more than one type of concern and were counted as one for accurate reporting.
** There is a significant change in under 18 alerts in Q1 compared to previous quarters. Previously, when one would complete a new form, the form used to pull the data filled in the most recent form. The staff member would change only the parts of the form that needed changing. Recently we have changed the form so that this particular section of the form, recording an alert, would not pull over anymore and a clinician would only complete this section if they needed to record a concern/ alert. There is a possibility that previously the clinician would leave unchanged this section of the form rather than delete which would in turn affect our reporting values. Finally, since this is a changed form there is also a possibility that a clinician would not know where to record this information. Training and support is being offered to all who require it and this change has been communicated to staff.

Q1 2019/20: Quality Responsive – Care

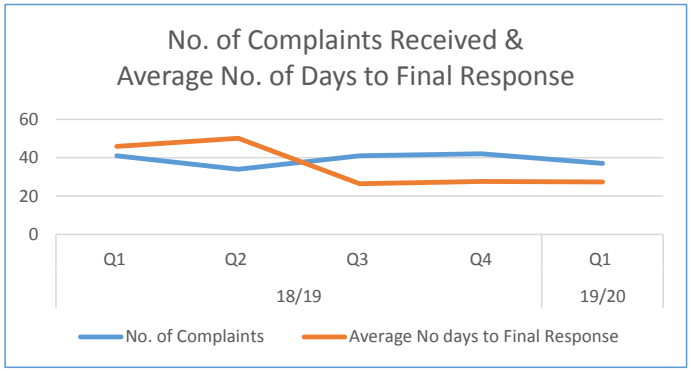
Total PALS enquiries 01/04/2019 to 30/06/2019

Quarter	Total
18/19 Q1	190
18/19 Q2	226
18/19 Q3	175
18/19 Q4	221
19/20 Q1	167

Top PALS enquiries for Q1 2019/20 remain unchanged

- Access to treatment
- Communications
- Appointments

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

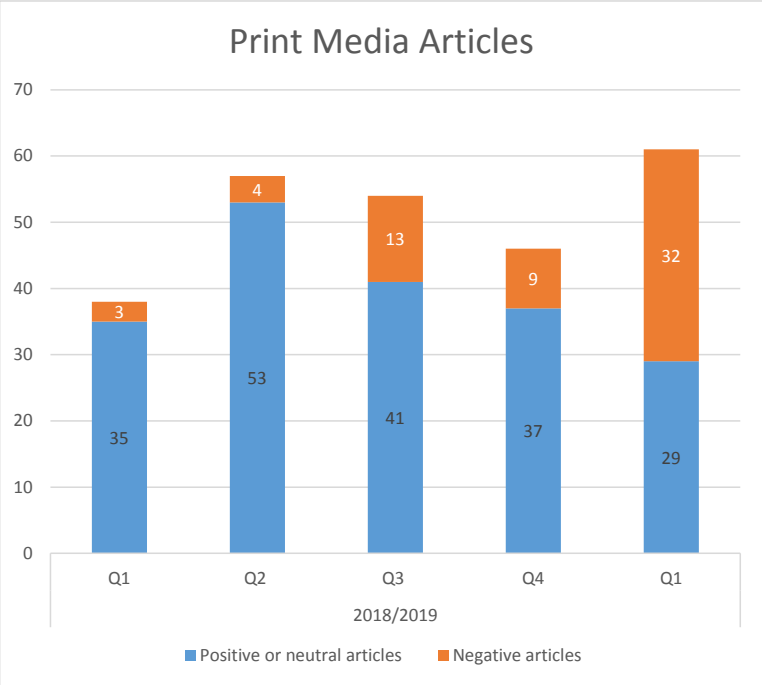


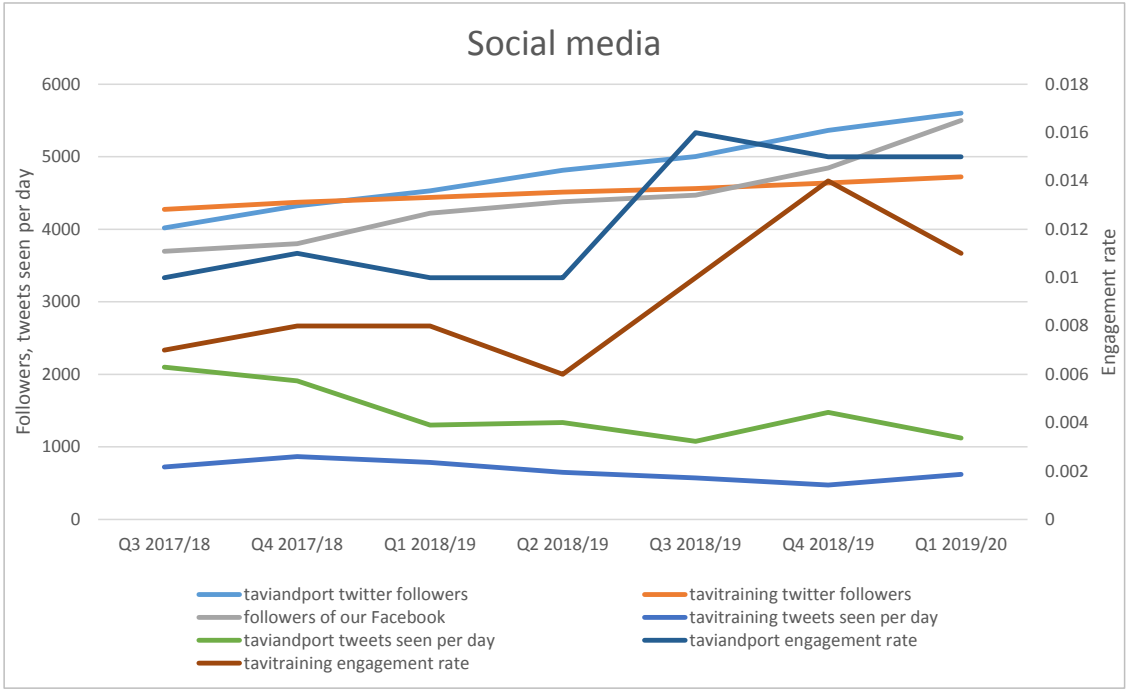
Directorate	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1
Adult and Forensic Services (A&F)	6	3	5	4	4
Children, Young Adult and Families (CYAF)	35	29	36	34	32
Corporate		1	1	2	1
No Directorate					
Total	41	33	42	40	37

Complaints Commentary: During quarter 1 a total 37 complaints were received, 32 from Children Young Adults and Families, 4 from Adult and Forensic and 1 from Corporate Services. This is a decrease of three complaints received compared to the previous quarter. The themes of complaints include: long waiting list to first appointment; use of a previous name in correspondence; confusion over appointments; ending of treatment; late cancellation of appointments; unsatisfactory clinical care and experience of clinical appointment which was distressing to the patient. In addition to formal complaints that require a full investigation and response from the Chief Executive we have also received several (approximately 8-10) informal complaints. These have been resolved to the satisfaction of the patient and subsequently they have not become formal complaints. All complaints which are upheld fully or in part have agreed action plans.

ESQ		2018/19				2019/20
Patient Satisfaction	Target	Q1	Q2	Q3	Q4	Q1
Q4 from ESQ - Quality Responsive Views and worries were taken seriously		99%	99%	99%	99%	99%
Q6 from ESQ - Quality Effective 'The information I received about the trust before I first attended was helpful'	75%	96%	94%	95%	88%	90%
Q11 from ESQ - Quality Effective 'If a friend or family member needed this sort of help, I would suggest to them to come here'	80%	98%	97%	98%	98%	98%
Q13 from ESQ - Quality Responsive Involved in important decisions about my care		97.00%	98.00%	97	97%	95%
Q15 from ESQ - Quality Effective 'The overall help I received here is good'	100%	99%	97%	99%	98%	100%

Q1 2019/20: Media – Care





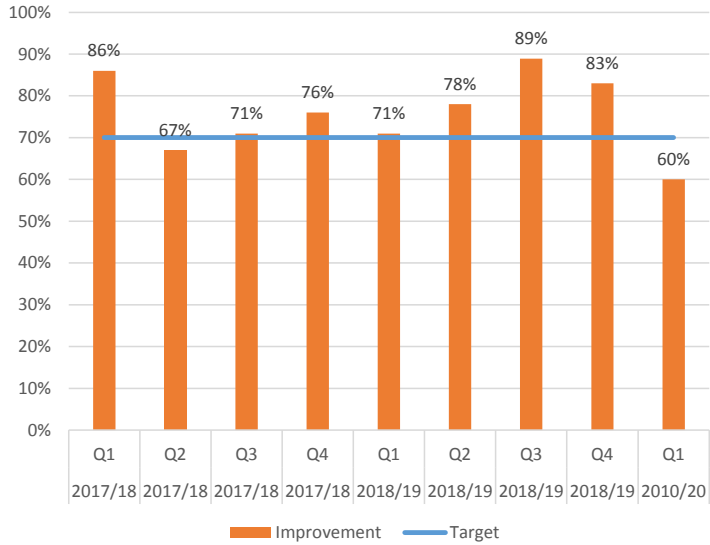
This is a higher volume of overall coverage compared to Q4, a much higher proportion of GIDS related coverage, and a significant decrease in sentiment: *52% positive or neutral coverage, compared to 89% positive or neutral in Q4 and 76% in Q3.*

Traffic to our website and number of visitors were both higher this year than last year.
Our social audiences are increasing in size. The amount of tweeting we are doing is lower due to the contested field of work and time pressures on the communications team.
About half of all website traffic goes to our course pages, half goes to the whole of the rest of the site combined. Stories around GIDs are our most popular news items.

Data source: Communications department

Q1 2019/20: Quality Effective – Outcomes

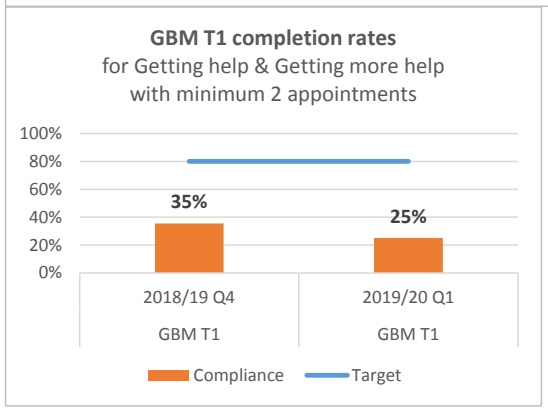
A F S

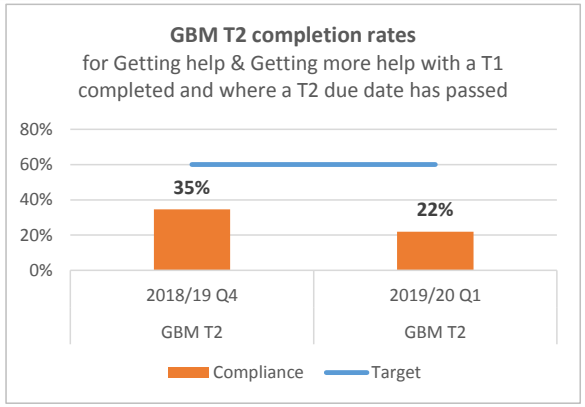


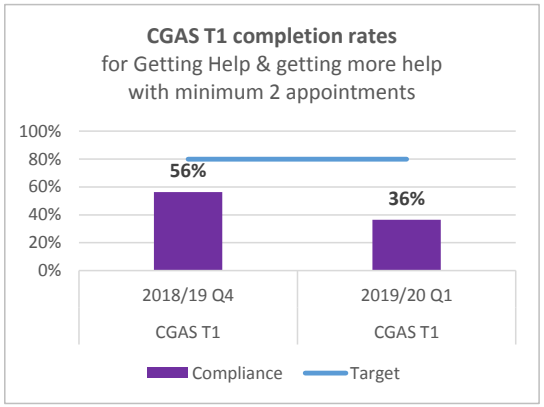
To calculate the CORE improvement rates we compare patients with a T1 (pre assessment) and a EOT (end of treatment). The number of cases within these parameters are very low. The DQT is liaising with the newly appointed Clinical Governance Lead for AFS to assess the situation and to develop a plan to monitor and improve both completion and improvement rates.
– In Q4 18/19 we had 6 CORE T1 and EOT to be able to compare improvement rates – out of those 6 patients 5 showed improvement.
–In Q1 19/20 we had 5 patients and out of those 3 had an improved score.
Services like Portman and Adults Complex Needs find difficult to complete and CORE EOT, due to the nature of their service.

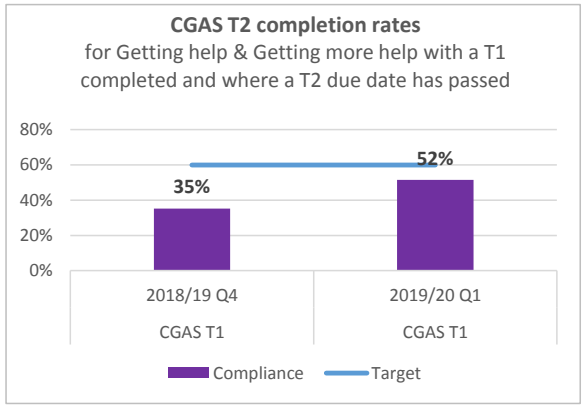
Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/07/19

C Y A F





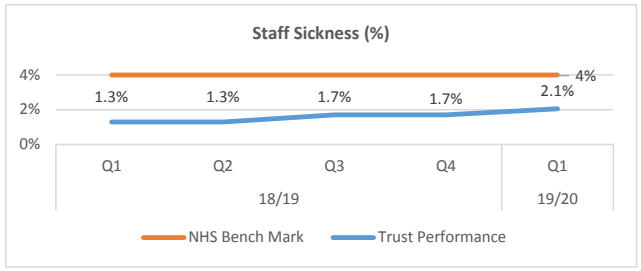


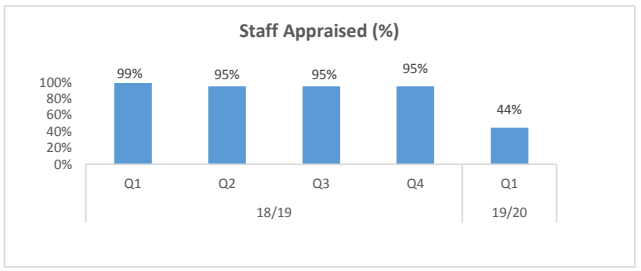


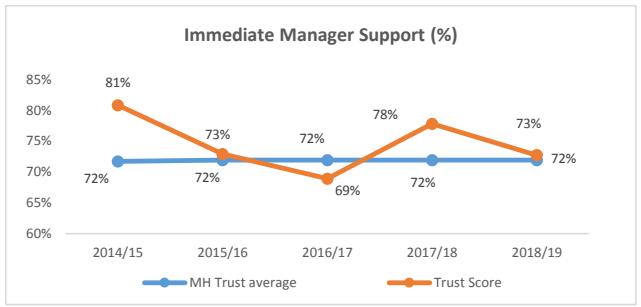
The KPI parameters changed for 2019-20. We are now including ALL patients who were seen two or more times, where previously we only included patients with a minimum of 6 appointments. We are now also including everyone with a due OM (Outcome Measure) rather than only patients open for 6 months or longer. By increasing the sample we are analysing a wider range of patients. Unfortunately the rates have dropped, but with greater visibility of our OM compliance we will be in a better place to improve performance. Please note data presented shows quarterly compliance rather than been presented YTD. *Only London Contracts in this figures.*

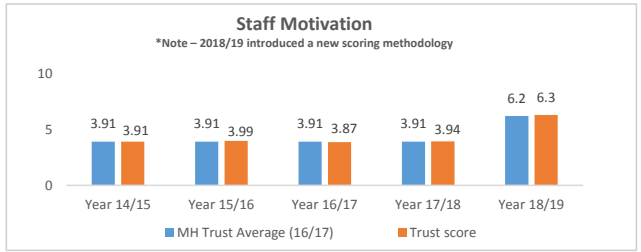
11

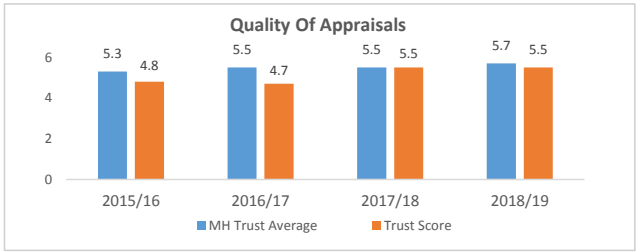
Q1 2019/20: Quality Well-Led

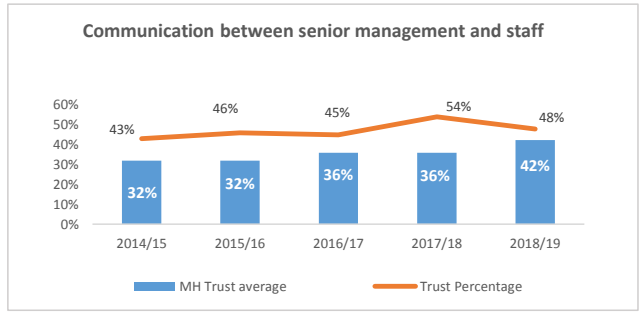


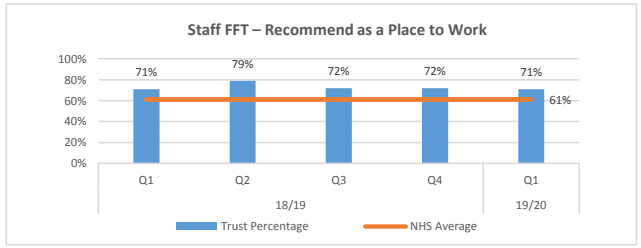


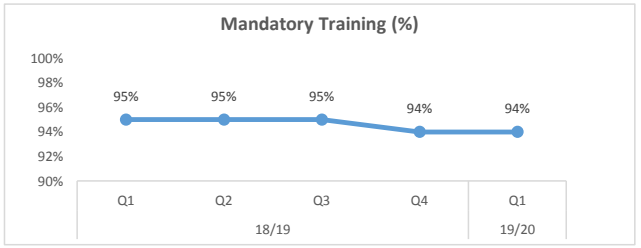


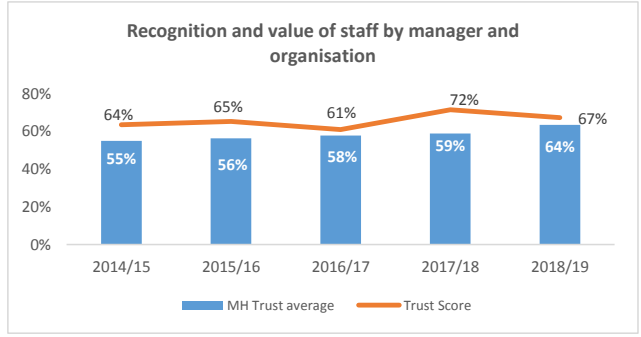


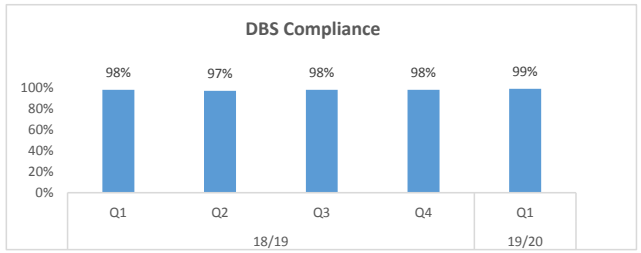


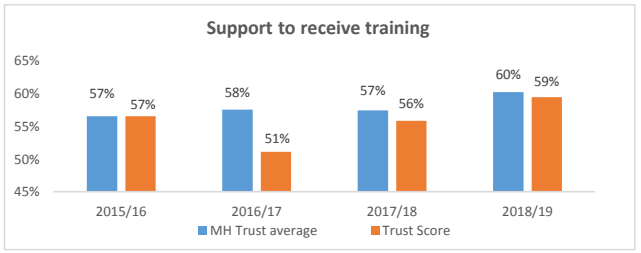






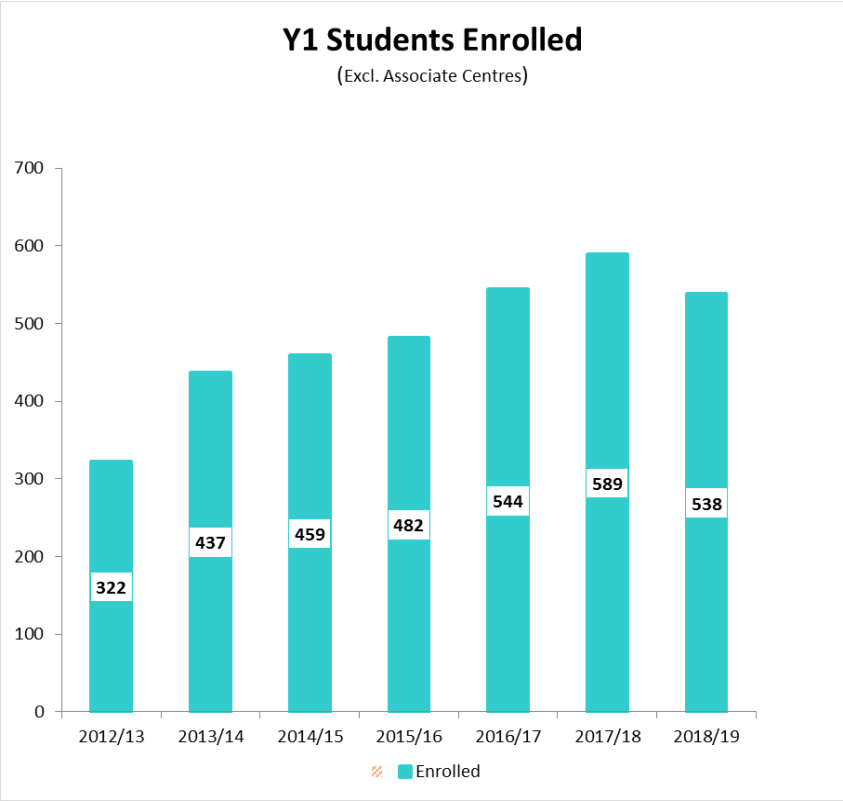




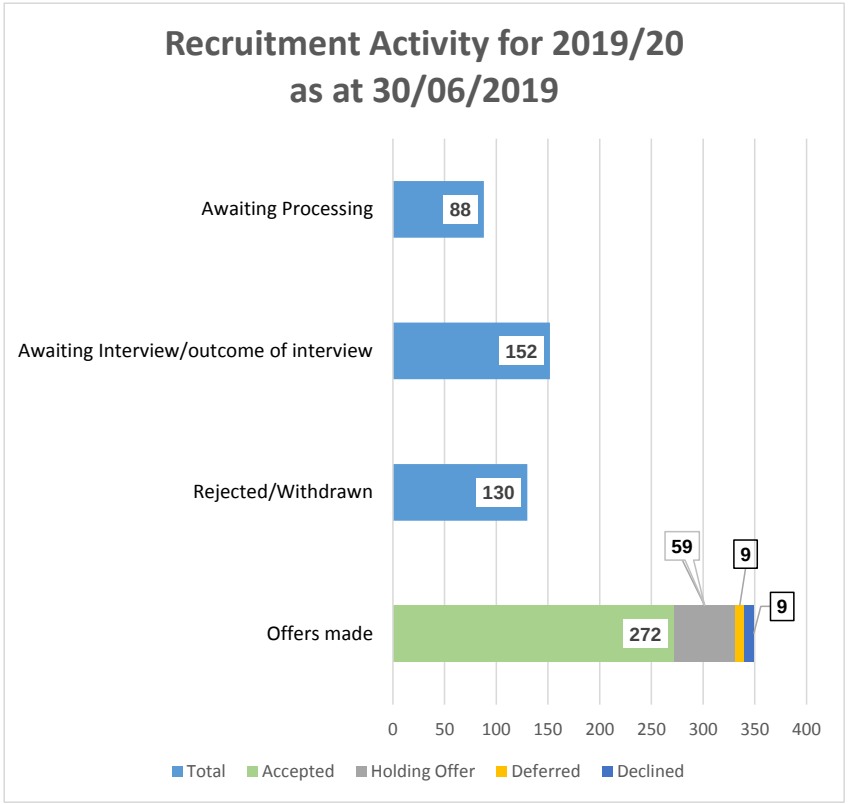


Data source: Human Resource Department 08/07/19

Q1 2019/20: Directorate of Education and Training (DET) – Access



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



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 accumulative; made up of the sub-set of offers accepted, holding, deferred and declined. The total is 349.**

Q1 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
Course numbers	**CPD Portfolio**	45	58	70	94	93	100	69
	Bespoke work	14	18	10	38	45	33	37
	Visitors Programme / international					23	14	5
	HEE additional in year funding						6	
Students	**Attendee/Student Nos**	2079	2738	2063	2279	2300	2193	919
								Identified Income to Date
Income	**Income**	501,917	556,261	493,090	£692,710	£854,710	£1,271,641	£713,394
	Income growth on previous year	35%	16%	-11%	40%	23%	49%	-44%
	Contribution	160,769	158,104	123,616	£197,122	£527,123	£645,292	

17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution

Activity and student numbers will continue to increase as new courses are scheduled and recruitment continues for all courses for AY 2019-20

Q1 2019/20: Directorate of Education and Training (DET) - Outcomes

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

Directorate of Education and Training (DET)

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

Student Experience and Outcomes

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

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

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

Notes for 2018:

Benchmark data from National Student Survey (2018)

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

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

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

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

Better than the national benchmark but a decline from last year

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

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

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

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

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

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

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

Quarterly Quality Report Commentary Q1 2019/20

Introduction

As requested by the Board of Directors the following paper provides a additional commentary and narrative from the Q1 Quarterly Quality Report. This report specifically covers those 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.

This part of the report contains some commentary one WT DNAs and updates on QP and CQUINS

The following metrics are summarised below:

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

Waiting Times feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q1	Objective / plan for next Quarter	Lead
Adult Complex Needs	Adult Complex continues to experience lack of clinical capacity. This is due to rotated ST4s (2) not having yet been replaced. Some long term sick leave, and maternity leaves have also had an impact.	We hope to have new ST4s by Autumn term. We are also in the throes of advertising new clinical sessions and we anticipate that this will have a positive impact in reducing the waiting times, although it may take time for new staff to get their bearings.	*Samia Anfu, Adult Department Manager*
Portman:	The waiting time data for Quarter 1 of 2019-20 shows that there has been an improvement in waiting times overall, as compared to the previous 2 quarters. We have adequate staff within the department to provide the first assessment consultation within the accepted timeline, and the work of the intake team, which allocates assessments to clinicians has meant that there has been close monitoring of any issues that arise between the point of acceptance of referral to allocation to the assessing clinician.	We will continue to ensure that the current system continues to function in a way that enables our current level of adherence to the required timeline to continue.	*Dr Andrew Williams, Consultant*
City and Hackney PCPS	PCPCS are pleased with our waiting times figures in Q4 and Q1. A majority of patients were seen within 8 weeks, and none waited longer than 18 weeks, meaning patients and referrers received support from the service in good time. Referral numbers increased from Q3 to Q4, and from Q4 to Q1, and staffing was reduced, so it is especially satisfying to see that the service was able to adapt to these changes adequately, without disruption to patients. Seeing patients within an appropriate timescale, particularly within a primary care setting, can reduce risk, mean less mental pressure on staff, and encourage GPs that they can expect their patients to be seen by the service quickly.	Continue the expedient processing of referrals, intake, and initial appointment booking. With new staff now in place, PCPCS hope to produce similar outcomes again.	*Chris Newlove Horton, Service Administration Manager*
TAP	TAP is in a new contract phase with the service sitting under a C&I contract for 19-20. The new contract does not disaggregate TAP data from the overall PCMH- Network so our data is effectively subsumed into a much larger patient group i.e. the TAP data is a relatively small cohort. The overall CCG contract has an aim of 3 weeks for patients to be seen for a 1st appointment and this remains unrealistic for most of our patients. This new expectation has focussed our minds on capturing the best possible data hence we are now seeking ways in which we can maximise our KPIs . One example is to make sure all clinicians record substantial phone conversations as a recorded intervention. We have just presented a plan to PCMH partners for a new QI project around waiting times reduction (e.g. texts rather than letters).	Having successfully completed a DNA QI project in June our governance and quality group are meeting again in July to instigate a waiting times QI project with the aim of improving our data for 1st contact within 3 weeks from referral. We have a number of clinical, operational & technical innovations to put into action.	*Tim Kent with help from Danae, Ellie, Gabriella and Sonia Cunha.*

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

Waiting Times feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q1	Objective / plan for next Quarter	Lead
Adolescent /AYAS	Waiting times within AYAS remain a high priority and a concern: We continue to feel the effects of a combination of increases in referrals to the service and a reduction in staff sessions, there will be no increase in staff sessions until the end of Q2. (Staff recruited to fill vacancies will start in mid-September). However there has been some improvement since Q4 due to the action plan of reducing the length of psychotherapy assessments which continues to be implemented and reviewed. It has not been possible for 100% of assessments over this period to be three sessions, additional action has been required.	Reduce psychotherapy assessment from 4 to 3 sessions where possible. -Self referring patients to be offered a psychiatric assessment on acceptance. -Referrals reviewed and psychiatric assessments offered to patients with specific vulnerabilities or social isolation.	*Dr Sheva Habel AYAS Service Manager*
Camden CAMHS	Regarding compliance with the First Appointment within 8 weeks of referral the service is performing well with 96% of patients receiving a first appointment during this time. The target is 90%. To achieve the desired 2 appointments within 4 weeks we are aiming to have the first appointment within 2 weeks. We are currently achieving this with 48% of our referrals.	As part of the 4WW programme we have invited the Intensive Support Team from NHSEI to review our service and systems to help us shorten out wait times further	*Andy Wiener, Service Lead*
Other CAMHS	The waiting times across the teams have improved over Q1. There have been some breaches as a result of complexity of referral, and needing to gain additional information prior to being in a position to offer an appointment, along with staff turnover in some teams reducing team capacity to offer appointments.	Liaise with localities to try to improve information provided at the point of referral. Review and improve CYAF referral form to support this process. Recruitment for vacant posts is underway to increase team capacity as appropriate.	*Rachel James, Service Lead*
FAS Westminster	Waiting times at FAS service are a complex picture and the variables are not all within our control: - Referrals of families can be forced to wait if the statutory social worker in the local, - the referrer might not supply all the required information to us at the point of referral - the referred cases are often in court proceedings and have hearings timetabled/listed which can be altered without our input or knowledge. These can impact on starting dates for assessments and lead to delays. The number of referrals can exceed our capacity and this can mean that cases have had to wait for clinicians to become available to carry out the work.	We are in constant on-going discussions with the commissioners and referring teams to devise solutions to these issues, including better referral gatekeeping by the service leads in the children's services.	*Steve Bambrough Clinical Services Director*

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

Waiting Times feedback and action plan from Service Leads – Gender Services			
Service line	Commentary Q1	Objective / plan for next Quarter	Lead
GIC	The waiting times for the Gender Clinics in the UK are at an all time high, and that includes the London clinic. We are working internally at the Trust Executive level to come up with ways to communicate with this population who are waiting. Externally, we are hoping that with the arrival of procurement, there may be a national approach to tackling the waiting times for these patients and review ways of working across the services to support patient demand and need.	The future plan for Quarter 2 is to work on the actions from the Task and Finish group around communication to external stakeholders. Further waiting list initiatives are being considered as we have officially reduced the number of first appointments we are offering in order to bring down the gap between appointments.	*Frances Endres, Service Manager*
GIDS	Numbers of patients who have hit the target waiting time have increased in quarter (from 10.8 to 18.3%) which may be due to the revision of DNA and cancellation policies which emphasises the prompt rebooking of non-attended appointments.	We will continue work on the DNA/cancellation policy and take measures to ensure it is used effectively i.e. audits, increased communication to the team.	*Kathleen Hughes, Service Manager*

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

DNAs feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q1 2019-20	Objective / plan for next Quarter	Lead
Adult Complex Needs	Whilst not happy about the DNA rate, we continue to work to try and get hcps to tighten up their response when patients appear to drop out of treatment (i.e. persistent absence); for HCPs to be quicker in this regard to discharge patients, rather than awaiting response from their supervisors – i.e. stricter adherence to Trust policy of maximum 3 consecutive DNAs.	This may require a clinical culture change, and is something that new head of service will grapple with.	*Samia Anfu, Adult Department manager*
Portman	The DNA rate has increased this quarter from 8.8% in Q3 to 10.8% in Q4. However, the fluctuations in DNA rates over the year may not be significant, and the average DNA rate for last year was 8.05% which is consistent with the trust average. In general, many of our patients have difficulties that interferes with their ability to engage in therapy, including lack of trust in others including professionals, feeling suicidal, and feeling too anxious to leave their home and fears of travelling on public transport.	As always we actively promote attendance through understanding of the difficulties in patient's attending, as well as phoning those who have given us permission to do so when they miss sessions.	*Jessica Yakeley, Associate Director for Portman Clinic*
City and Hackney PCPS	After looking at a breakdown of the DNA in Q1, we have realised that the majority of DNAs come from Group appointments. In Q1, PCPCS has launched an English speaking Medically Unexplained Symptom (MUS) group, alongside the Turkish speaking MUS group. Both of these groups target people with chronic pain and many physical symptoms who have a history of not being able to engage with services. PCPCS support GPs with difficult to engage patients, and as a result we feel the Q1 rate is reflective of that, as we continue with our attempts to engage these individuals in groups therapy. Nevertheless, following these results, we will have a discussion with the group facilitators to think around what can be done to increase engagement and avoid DNAs, particularly in the early stages of a group. We are satisfied with our DNA rates for assessments and individual treatments, which taken on their own fall below the Trust's 10% target.	PCPCS Clinical Operations Manager will meet with the group facilitators to think around what can be done to increase engagement and avoid DNAs in a group setting. As these new groups are now up and running, we hope Q2's DNA rate will be more in line with what we expect.	*Chris Newlove Horton, Service Administration Manager*
TAP	TAP carried out a QI project in order to look into DNA rates. We looked into the reliability of the data (An understanding amongst clinicians of what constitutes a DNA, An understanding amongst clinicians about trust policy re: cancellations/ DNAs, Having a process that ensures that all appointments are routinely outcome, Having a system that reliably reports on unattended appts). Some changes have been made as a result both on Emis automated outcomes and from the clinicians and admin team. These changes took effect in June which means that the improvement in DNA rates in this quarter is because of the changes.	Continue to monitor DNA rates and data validity and reliability.	*Danae Kokorikou, Assistant Psychologist*

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

DNAs Feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q1 2019-20	Objective / plan for next Quarter	Lead
Adolescent /AYAS	The DNA rate has increased since Q4 from a very low rate of 6.8 to 10%. The number of DNA's increased slightly in the first 2 months and were much higher in June. The most likely explanation to this was the discontinuation in mid-June of the text messaging service we had used to good effect to address DNA rates in AYAS and a lack of clarity prior to this whether the new system could meet the needs of the service. This resulted in clinician's being unsure as how best to communicate with patients and relying on the automated text messaging system and emails. It is also possible a proportion of the increase in DNA's could be understood by patients replying to the automated text or new text system to cancel appointments but this not being linked up to IT within the trust and so being lost in the system. It may also be due to the pressures on the age group of young people that we see facing public examinations over the summer months.	We are working with Admin to ensure that the text message service we use in AYAS meets the needs of the service and a change has been made to facilitate this. Clinicians will continue to work hard to engage individual patients who do not contact the service when they are unable to attend and review data to see if there is any improvements in upcoming months.	*Sheva Habel, Consultant Psychiatrist in AYA, CAMHS*
Camden CAMHS	DNA rates in Camden are consistently low reflecting the teams continued efforts to engage patients. The system for automated text reminders was implemented on Q1 which we hope will continue to support high rates of attendance	To monitor the automated text reminder stem	*Fiona Hartnett CYAF Service Manager*
Other CAMHS	The DNA rate has remained low in quarter 1, which reflects the hard work across the teams in ensuring the rate remains low.	Ongoing monitoring of automated text reminder system to ensure that DNA rates remain low	*Rachel James, Service Lead*
FAS Westminster	The patients assessed by the Family Assessment Service are typically referred by the Children Services and the vast majority of the work undertaken is instructed by the Court. There is an expected number of cases where the main factor accounting for the lack of engagement by the families relates to complex nature of their difficulties (complex mental health issues, trauma, substance misuse, domestic violence), the chronic nature of their involvement with Children Services and our service's significant impact on the decision making on placement for the children.	Over the last quarter, we have systematised our efforts to reduce the number of DNA by sending appointment letters to the patients, emailing Lead Solicitors and the Local Authorities' teams whilst continuing to work flexibly across different sites to maximise the engagement of patients.	*Alexandra Marinou, Family Health Worker*

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

DNAs Feedback and action plan from Service Leads – Gender Services			
Service line	Commentary Q1 2019-20	Objective / plan for next Quarter	Lead
GIC	The GIC has experienced a consistent 13% DNA rate for the last 2 years. This has now dropped to 11% which may be a result of collecting consent to SMS and the SMS reminders being sent out reaching the patients who started to share and consent to these new procedures one year ago.	The clinic is still on track to go live with the new appointments system in 2019-20 and it is anticipated that this will further reduce DNAs for the clinic.	Frances Endres, GIC Service Manager
GIDS	We are pleased that DNAs have dropped slightly, which we hope is due in part to a revised DNA policy and should continue. We are also pleased that cancellations by Trust have dropped, which is usually a reflection of sickness rates. We notice cancellations by clients have increased slightly, and this might be due to patients receiving clearer DNA and cancellation guidance.	We will continue to target an acknowledged higher rate of DNAs in first appointments in the service.	Kathleen Hughes, GIDS Service Manager

3. **Quality Priorities**

3.1 **Quality Priority 1**

Quality Priority	1. Improve identification and management of high-risk patients		
Named Lead	**Caroline McKenna**		
Key Workstreams	**Quarter 1 Narrative Updates**	**Supporting Docs**	**RAG Rating**
Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust.	A clinical risk assessment and risk management presentation covering core skills will be available for all clinicians via the Electronic Staff Record by end of July 2019. An additional presentation with more detailed information will also be available for those who wish to enhance their knowledge. Clinical Risk Assessment workshops will continue to run quarterly. This is face to face teaching and learning from clinical cases. In addition risk assessment/risk management is usually incorporated into the presentation and discussion at the quarterly learning lessons event (next one scheduled for 17 September 2019).		
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.	This area of clinical practice will need to be audited. This can be undertaken during Q2.		
Continue to audit recording of clinical risk assessments and actions taken	Audit of clinical risk has recently been completed and findings will be presented internally at Clinical Governance meetings and reported in September 2019 to the CQRG.		

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		
Named Lead	Anthony Newell & Vicky Illingworth		
Key Workstreams	Quarter 1 Narrative Updates	Supporting Docs	RAG Rating
Further consultation with the Quality Advisory Group before completing and testing the new forms	The group including 3 patient representatives agreed design, layout, key questions and scoring system that was considered most user friendly and including a fairly weighted likert scale tick box, and non bias questions.		
Test streamlined forms in one service initially and review and evaluate effectiveness	The (isolated) test will begin in Mosaic service in Q2. This service does not report to Camden so will not affect Tavistock data.		

3.3 **Quality Priority 3**

Quality Priority	3. Improve patient and carer involvement in care planning in CYAF teams		
Named Lead	**Rachel James**		
Key Workstreams	**Quarter 1 Narrative Updates**	**Supporting Docs**	**RAG Rating**
Improve quality of patient and / or carer involvement in the development of care plans	We are waiting for data indicating the level of involvement. Informatics have been working to create a new report in Q1 and during Q2 we will review the report and data for reliability and refinement.		
Increase the quality of data recorded of care plans shared with patients and referrers	A reporting schedule is in place to highlight where care plans have not been completed. We are aware that there are differences in the review and process of this information. We have amended the field on Carenotes to reduce misinterpretation and inaccuracies in data recording. This has been changed from "Has a copy of the Treatment/care plan been sent to the GP?" to say "Admin to generate care plan and send to GP" and "Admin to generate care plan and send to patient". At present this is not a mandatory field but in Q2 we will audit completion rates to review.		
Increase the percentage of care plans shared with patients and referrers	We are waiting for data indicating the level of involvement. Informatics have been working to create a new report in Q1 and during Q2 we will review the reporting and data for reliability and refinement.		

3.4 **Quality Priority 4**

Quality Priority	4. Provide Effective Sleep Management Information		
Named Lead	**Rhia Gohel**		
Key Workstreams	**Quarter 1 Narrative Updates**	**Supporting Docs**	**RAG Rating**
Establish an adolescent only group for patients experiencing sleep difficulties *(those aged 14 – 18)*	An adolescent only group has been established and the first group is due to run July – August 2019	n/a	
Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input	Sleep hygiene information is currently being written, with a view to getting it sent to our PPI group for feedback in Q3	n/a	
Develop and disseminate information for clinicians on sleep in adolescence	Progress on this has been made – a clinician's guide has been briefly drafted, but will be completed by Q4	n/a	
Share sleep information more widely with other external agencies	Once completed, our sleep booklets will be widely shared with local GP practices as well as other local NHS Trusts and community hubs for them to display.	n/a	

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		
Named Lead	**Hiroshi Amino**		
Key Workstreams	**Quarter 1 Narrative Updates**	**Supporting Docs**	**RAG Rating**
Reduce the number and % of patients dropping out between end of assessment and first treatment episode	First of all we need to gather information about the actual number of patients who have dropped out at the point of starting therapy and whether there is any clear link with the length of the waiting time. We have begun gathering information about those patients who have been invited for the preliminary interview for regular therapy such as individual therapy of once weekly, twice weekly and thrice weekly and group therapy between April and June 2019.		
Obtain feedback from service users on their experience of the gap period	We have not yet obtained any feedback from patients who have not started regular therapy.		
Review reasons for drop out and patient experience to improve the service for both patients and staff	We are gathering the information for the first three months because the number of patients who have been taken on for regular therapy is small for each month. We need to have more data to form relevant understanding whereby we can develop strategy to improve the service.		

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		
Named Lead	**Andy Wiener and Vikki Lee**		
Key Workstreams	**Quarter 1 Narrative Updates**	**Supporting Docs**	**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.	GBM T1 Update: During this quarter the focus has been on developing reports that can be used to monitor the number of GBM completed. Run charts are now being run which show week to week the compliance with the target. However, there have been difficulties getting the logic of the assist panel to work as clinicians would wish, so a hold has been put on the QI project in South Camden until the logic for the assist panel has been sorted out. There is a meeting on the 16th of July to resolve this issue. CGAS T1 Update: During this quarter the focus has been on developing reports that can be used to monitor the number of CGAS completed. Run charts are now being run which show week to week the compliance with the target. However there have been difficulties getting the logic of the assist panel to work as clinicians would wish, so a hold has been put on the QI project in South Camden until the logic for the assist panel has been sorted out. There is a meeting on the 16th of July to resolve this issue.		
Obtain service user feedback on the use of outcome measures to feedback on progress.	As yet service user groups have not been set up, the plan is to set up a service user focus group in September 2019		
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	GBM T2 Update: During this quarter the focus has been on developing reports that can be used to monitor the number of GBM completed. Run charts are now being run which show week to week the compliance with the T2 target. However there have been difficulties getting the logic of the assist panel to work as clinicians would wish, so a hold has been put on the QI project in South Camden until the logic for the assist panel has been sorted out. There is a meeting on the 16th of July to resolve this issue. CGAS T2 Update: CGAS T1 Update During this quarter the focus has been on developing reports that can be used to monitor the number of CGAS completed. Run charts are now being run which show week to week the compliance with the T2 target. However there have been difficulties getting the logic of the assist panel to work as clinicians would wish, so a hold has been put on the QI project in South Camden until the logic for the assist panel has been sorted out. There is a meeting on the 16th of July to resolve this issue.		
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.	The informatics department have developed a "chart" tab on Carenotes which can be shown to young people on screen. There need to be some tweeks, (making sure that the charts upload immediately and that the RCADS sores get displayed in a rational way) We also need to get a process around getting feedback from young people about what they think of the charts. These issues will be discussed in the meeting on the 16th of July.		

4.1 CQUINS

Quarter 1 Targets	Flu Vaccinations Quarterly Performance	Supporting Docs	RAG Rating
Achieve an 80% uptake of Flu Vaccinations by frontline clinical staff *(between 1st September 2019 and February 28th 2020)*	Planning for September is ongoing		

Quarter 1 Targets	MHSDS Data Quality Maturity Index Quarterly Performance	Supporting Docs	RAG Rating
No Specific Q1 Targets, so request is for an update on associated work streams - with an eye on achieving 95% DQMI scores by Q2	▪ Preliminary preparations for this CQUIN have involved setting up a designated Action Plan on the Trust's Quality Portal to allow for clearly defined workstreams with named leads and associated deadlines for each ▪ MHSDS is currently being shared with teams on a monthly basis at the Trust's monthly Clinical Data Quality Reference Group (CDQRG) meetings. This allows each service to remain sighted on their own data recording performance levels, and will identify specific areas where improvements are required ▪ Following on from the CDQRG meetings, service-level data is shared with admin leads within each service flagging up any missing MHSDS data that needs to be populated ASAP ▪ Although the Maturity Index score is not yet an active measure for the service during 2019/20 Q1, the above workstreams will help to ensure that teams are familiar with the concept of the MHSDS Maturity Index. This, alongside the preparatory work listed above, will hopefully put us in a good position to achieve targets associated with coming quarters		

Quarter 1 Targets	MHSDS SNOMED Codes Quarterly Performance	Supporting Docs	RAG Rating
No Specific Q1 Targets, so request is for an update on associated work streams - with an eye on achieving 70% intervention target by Q3	(1) Defined the cohort to be: Second Attended Appointment within the period. (2) Within the cohort, I have taken all the attended/carer attended appointments where appointment date is between referral date and period end date. (3) All Contract / CCGs were considered. (4) For the period APR2019-JUN2019, there were around 981 cases in the cohort, among which 737 cases had SNOMED code present – which makes the current intervention measurement more than 70%		

4.2 CQUINS

Quarter 1 Targets	Anxiety Disorders & RCADS (Local CQUIN) Quarterly Performance	Supporting Docs	RAG Rating
Agree a list of Anxiety Disorders	Following discussion between clinical colleague it has been agreed to use the following categories Social Phobia Panic Separation Anxiety Generalised Anxiety Obsessive Compulsive		
Confirm use of 'Current View' and RCADS with clinicians	On reviewing the plan with the clinical colleagues we have concluded that the most reliable way of establishing if a child or young person has an anxiety problem is to do the RCADS on all cases children or young people 8 or over 8 years old in the Help or More Help Domains, and to use a score of "likely" as the indicator of an anxiety problem. Therefore although the Current View form will be completed routinely it will not be used to decide if someone has an anxiety problem.		
Amend RCADS form link to be available for all CAMHS services	The proposal for change has been agreed by the CYAF senior team and discussions have begun with the informatics team to decide how to change the logic in CareNotes to make RCADS easily available for all teams using the OM assist panel		

Quarter 1 Targets	GIDS Telemedicine / Virtual Patient Sessions Quarterly Performance	Supporting Docs	RAG Rating
No Specific Q1 Targets, so request is for an update on associated work streams – with an eye on ensuring achievement of Q2 targets *(listed on following page)*	The Trust's Information Management and Technology Steering Group approved and formalised the support of colleagues in central departments for this Telemedicine project in mid May. That same month, a meeting was held in Leeds with the clinical lead of Telemedicine there to consider the testing of the new system to ensure its usability on site and some of the practicalities involved in identifying young people and families to be considered for treatment appointments delivered with Telemedicine. The use of Telemedicine in the context of network meetings with fellow professionals in CAMHS and schools was also discussed.		

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board	30 July 2019

Finance and Performance Report

Executive Summary

The YTD report for June is attached

Recommendation to the Board

Board is asked to note the report

Trust strategic objectives supported by this paper

Services / Growth and Development / Finance and Governance

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

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 3 **Jun-19**

Summary I&E

Balance Sheet

Funds flow

Capital Expenditure

Period 3
30 June 2019

	2018/19 Actual **YTD** £'000	2019/20 Actual **YTD** £'000	2019/20 Budget **YTD** £'000	Variance Actual v Budget £'000	**Variance Actual v Budget %**
Income	12,816	**13,669**	13,802	(133)	**(1)%**
Staff costs	(9,190)	**(10,325)**	(10,840)	514	**5%**
Non-staff costs	(2,777)	**(3,096)**	(3,128)	32	**(1)%**
Operational costs	(11,967)	**(13,421)**	(13,968)	546	**4%**
EBITDA	848	**247**	(166)	**413**	**-249%**
- Margin	7%	**2%**	-1%		
Interest receivable	4	**14**	9	**5**	**51%**
Interest payable	(7)	(13)	(13)	**(0)**	
Depreciation / amortisation	(298)	**(401)**	(401)	**(0)**	**0%**
Public Dividend Capital	(163)	**(163)**	(163)	**0**	**0%**
Restructuring costs	0	**0**	0	**0**	
	0				
Net surplus	386	**(315)**	(732)	**418**	**-57%**
- Margin	3%	**(2)%**	(5)%		

FINANCE AND PERFORMANCE REPO BALANCE SHEET

Period 3

30 June 2019

	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	155									
Land and buildings	19,771									
IT equipment	3,479									
Other	0									
Property, Plant & Equipment	23,249	0	0	0	0	0	0	0	0	0
Total non-current assets	23,405	0	0	0	0	0	0	0	0	0
Trade and other receivables	3,291									
Accrued Income and prepayments	6,336									
Cash / equivalents	7,426									
Total current assets	17,053	0	0	0	0	0	0	0	0	0
Trade and other payables	(2,552)									
Accruals	(4,216)									
Deferred income	(2,890)									
Provisions	(120)									
Total current liabilities	(9,778)	0	0	0	0	0	0	0	0	0
Total assets less current liabilities	30,680	0	0	0	0	0	0	0	0	0
Non-current provisions	(248)									
Long term loans	(4,000)									
Total assets employed	26,432	0	0	0	0	0	0	0	0	0
Public dividend capital	3,474									
Revaluation reserve	12,621									
I&E reserve	10,338									
Total taxpayers equity	26,433	0	0	0	0	0	0	0	0	0
Cash Analysis										
Non-ITFF balance	3,426	0	0	0	0	0	0	0	0	0
ITFF balance	4,000	0	0	0	0	0	0	0	0	0
Total cash	7,426	0	0	0	0	0	0	0	0	0

MONTHLY FINANCE AND PERFORMANCE I FUNDS FLOW
Period 3
30 June 2019

	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	YTD Act £'000
Net Surplus	(315)				(315)
Depreciation / amortisation	401				401
PDC dividend paid	163				163
Restructuring costs					0
(Increase) / Decrease in receivables					0
Increase / (Decrease) in liabilities	(1,106)				(1,106)
Increase / (Decrease) in provisions					0
Net Interest paid	(1)				(1)
Net operating cash flow	(859)	0	0	0	(859)
Interest received					0
Interest paid					0
PDC dividend paid					0
Restructuring costs					0
Cash flow available for investment	(859)	0	0	0	(859)
Purchase of intangible assets	0				0
Purchase of property, plant & equipment	(284)				(284)
Net cash flow before financing	(1,143)	0	0	0	(1,143)
Drawdown of debt facilities	0				0
Repayment of debt facilities	0				0
Net increase / (decrease) in cash	**(1,143)**	**0**	**0**	**0**	**(1,143)**
Opening Cash	8,569		0	0	8,569
Closing cash	**7,426**	**0**	**0**	**0**	**7,426**

Capital Expenditure
Period 3
30 June 2019

REPORTING MONTH	PRIOR	2019/20					
Jun-19	TOTAL	ANNUAL			Y.T.D		
3	£000 Actual	£000 FC	£000 Budget	£000 Delta	£000 Actual	£000 Budget	£000 Delta
PROJECT							
SITS Phase 2	354	**0**	**-**	**0**	**0**	**-**	**0**
Microsoft Office 365 E-Mail Migration	16	**-**	**-**	**-**	**-**	**-**	**-**
Robotic Process Automation - Scheduling	-	**-**	**-**	**-**	**-**	**-**	**-**
Endpoint Replacement 2019/20	-	**61**	**259**	**(199)**	**61**	**21**	**39**
Endpoint Procure/Config/Compliance/Monitor	11	**-**	**167**	**(167)**	**-**	**64**	**(64)**
Patient-Level Individual Costing System (PLICS)	0	**-**	**-**	**-**	**-**	**-**	**-**
e-Referrals System Implementation	16	**-**	**54**	**(54)**	**-**	**34**	**(34)**
Programme & PMO Development	12	**-**	**-**	**-**	**-**	**-**	**-**
Tavistock Centre Data Centres Power Provision	-	**-**	**65**	**(65)**	**-**	**-**	**-**
IMT Service Improvement	41	**27**	**30**	**(3)**	**27**	**30**	**(3)**
SMS Appointment Reminders	24	**-**	**-**	**-**	**-**	**-**	**-**
Digital Dictation, Transcription, & Hybrid Mail	0	**-**	**-**	**-**	**-**	**-**	**-**
Cyber Essentials	-	**-**	**16**	**(16)**	**-**	**16**	**(16)**
Data Warehouse Optimisation & Dashboards	7	**-**	**-**	**-**	**-**	**-**	**-**
Care Notes Renewal	101	**(14)**	**-**	**(14)**	**(14)**	**-**	**(14)**
Health Information Exchange	5	**-**	**15**	**(15)**	**-**	**-**	**-**
MyTap Annual Upgrade 2019/20	-	**21**	**41**	**(20)**	**21**	**20**	**1**
Health & Social Care Network	12	**-**	**33**	**(33)**	**-**	**-**	**-**
DET Record Management System	14	**(2)**	**-**	**(2)**	**(2)**	**-**	**(2)**
Scheduling & Robotic Process Automation	626	**53**	**404**	**(351)**	**53**	**58**	**(5)**
Data Warehouse & Dashboard	(92)	**-**	**-**	**-**	**-**	**-**	**-**
		(10)	**-**	**(10)**	**(10)**	**-**	**(10)**
IT	**1,148**	**135**	**1,085**	**(950)**	**135**	**244**	**(108)**
Ventilation		**-**	**59**	**(59)**	**-**	**30**	**(30)**
Security		**-**	**-**	**-**	**-**	**-**	**-**
Safety		**-**	**31**	**(31)**	**-**	**31**	**(31)**
Pumps		**-**	**29**	**(29)**	**-**	**21**	**(21)**
Water	7	**-**	**68**	**(68)**	**-**	**14**	**(14)**
Electrics		**-**	**66**	**(66)**	**-**	**13**	**(13)**
PC Compliance		**-**	**9**	**(9)**	**-**	**9**	**(9)**
TC Compliance		**-**	**54**	**(54)**	**-**	**54**	**(54)**
Access		**-**	**-**	**-**	**-**	**-**	**-**
Agile Working		**-**	**33**	**(33)**	**-**	**33**	**(33)**
Miscellaneous / Contingency		**-**	**-**	**-**	**-**	**-**	**-**
LH - 67 Belsize Lane		**15**	**18**	**(3)**	**15**	**18**	**(3)**
Clapham Junction Re-fit		**25**	**28**	**(3)**	**25**	**28**	**(3)**
		-	**-**	**-**	**-**	**-**	**-**
ESTATES	**7**	**40**	**396**	**(355)**	**40**	**250**	**(210)**
Digital Academy	2	**-**	**505**	**(505)**	**-**	**-**	**-**
FNP Database		**-**	**642**	**(642)**	**-**	**47**	**(47)**
FNP Database - Funding		**-**	**(642)**	**642**	**-**	**(47)**	**47**
		(10)	**-**	**(10)**	**(10)**	**-**	**(10)**
OTHER	**2**	**(10)**	**505**	**(515)**	**(10)**	**-**	**(10)**
RELOCATION	**1,445**	**119**	**1,322**	**(1,203)**	**119**	**140**	**(21)**
TOTAL	**2,601**	**284**	**3,307**	**(3,023)**	**284**	**634**	**(350)**

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	30 July 2019

Raising Concerns Review Report

Executive Summary

On 10 March 2019 the Director of Human Resources and Corporate Governance was commissioned by the Board of Directors to undertake a review of the Trust's processes, procedures, policies and practises around raising and handling concerns.

The review process has assessed the Trust's policies, procedures and processes for raising and managing concerns. As a result the report makes eight recommendations for the Board to consider.

Recommendation to the Board

Members of the Board of Directors are asked to note and consider the recommendations proposed as part of this review.

Trust strategic objectives supported by this paper

People
Finance and Governance

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

The Tavistock and Portman
NHS Foundation Trust

Raising Concerns Review Report

Produced by
Craig de Sousa
Director of Human Resources and
Corporate Governance

Contents

Part 1 – Introduction and Methodology

1. I am Craig de Sousa and I am employed by the Tavistock and Portman NHS Foundation Trust ('the Trust') as the organisation's director of human resources and corporate governance. I have been employed by the Trust since 15 February 2016 and I have held my current position since then. Prior to my employment at the Trust I have worked for 18 years in various operational and senior leadership human resources roles across the health service. I hold a BA (Hons) in human resource management; I am a chartered fellow of the chartered institute of personnel and development; and, I hold an MSc in healthcare leadership.

2. On 10 March 2019 I was commissioned by the Board of Directors to undertake a review of the Trust's processes, procedures, policies and practises around raising and handling concerns.

3. I conducted a fact finding process and interviewed a number of officers of the Trust, conducted an all staff survey, arranged for two externally facilitated open forum sessions, collected documentary evidence and any other information that I believe is relevant. This report summarises my findings against each the areas I was asked to explore by the Board and, where appropriate, makes recommendations.

4. In the course of my review I have conducted interviews with the following witnesses:

Name	**Job Title**	**Interview Date**
Brian Rock	Director of education and training / dean of postgraduate studies	18 April 2019
Terry Noys	Deputy chief executive and finance director	25 April 2019
Sally Hodges	Director of children, young adults and family services	26 April 2019
Gill Rusbridger	Freedom to speak up guardian	29 April 2019
Julian Stern	Director of adult and forensic services	02 May 2019
Angela Haselton	Staff side chair	02 May 2019

5. All interviewees were provided with information at the outset of their interviews in relation to their role in the review, the way in which the information they provided would be recorded, stored and used.

6. Trust staff were also invited to contribute to the review. To do this an all staff survey was launched and two open forum sessions were scheduled and facilitated by Ruth Ball, an independent organisational development consultant. During the review period there was also a chief executive's session which took place on 25 April 2019.

7. I have obtained a number of documents in the course of my review which are relevant to the report. These are provided in Appendices A - D. I make specific reference to documents in this report where I consider it helpful to do so.

8. Where I make findings of fact and draw conclusions within this report, I do so based on the interviews that I have conducted and the information available to me to the best of my knowledge and belief. Where I have encountered conflicting information, I have sought to make findings based on the balance of probabilities.

Part 2 – Policies and Procedures

9. The review was conducted outside of the Trust's procedures. However, I have given due regard the following policies and procedures.

    a. Raising concerns at work (whistleblowing) procedure.

    b. Grievance procedure

    c. Bullying and harassment procedure

    d. Anti-fraud and bribery procedure

10. Copies of the policies and procedures can be found in appendices A - D.

Part 3 – Information Gathering

Director interviews

11. I met with four of the Trust's executive directors and undertook interviews with a set of structured questions against each of the points within the terms of reference. Summary notes were taken during each meeting.

12. From the meetings with the executive directors it was very clear that all of them had a very good awareness and understanding of the procedures which exist within the organisation for handling concerns. Each were able to name the procedures but all confirmed that if an issue arose that they would need to re-read the documents to refresh their memory of the exact steps that need to be followed.

13. During the interviews each of the directors were able to describe what their role is, as an executive director, for handling concerns. That said, there were two directors who explained that they would need further guidance and support to identify when it would be right for them to commission an investigation in line with the raising concerns (whistleblowing) procedure.

14. Through the interviews is became very clear that each of the directors understood the board of directors role in overseeing formal concern reviews. What they were more unclear about was a) the actual role of the council of governors; and, b) the council's role is in relation to concern reviews.

Freedom to speak up guardian interview

15. The freedom to speak up guardian was met with and like the directors I asked the similar questions as the directors.

16. The guardian has been in post since October 2015 and has clearly done a lot of work to develop and embed the role in the organisation.

17. It was noted that the individual has attended a number of training sessions, participates on a peer network in the London region and has liaised with the national guardian's office.

18. The guardian explained to me that staff have been approaching her over the last three years and there has been consistent themes of concerns being reported. These include bullying and a small number of patient safety concerns.

19. The individual is an experienced clinician and was able to describe all of the routes for raising concerns and has a clear understanding of the board and council of governor's roles in handling concerns. She also explained to me that she had easy access to the chief executive to raise concerns which required immediate attention.

20. I was pleased to learn that when concerns arise that she is also able to freely and confidently raise issues with specific executive directors to make them aware and able to take action.

Chair of staff side interview

21. The chair of staff side contributed to the review and was, like others, very thoughtful in her account of what exists, works well, needs improvement and the organisation's processes for managing concerns.

22. The individual was able to describe in a lot of detail the organisation's processes, policies and systems for raising concerns and also the roles that exist to support staff.

23. Reflecting on her experiences of formal processes, she particularly noted that investigative meetings, within employee relations processes, have become a lot more robust with a lot of thought and planning being made in to questions and exploring issues.

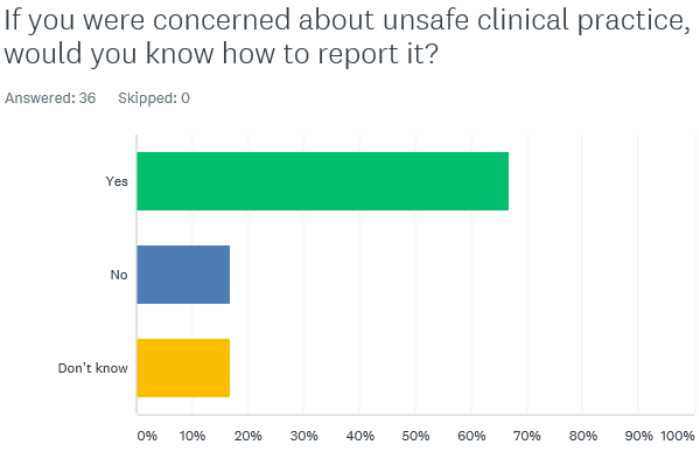
24. Reflecting on the processes, it was noted that there is variable approaches across different managers within the organisation as to how they approach concern issues. She particularly emphasised that we operate in a clinically led organisation and with that many of our managers have progressed in to leadership roles but there has not been appropriate management development behind them.

25. It was pleasing to hear that the chair of staff side has access to key senior people, including the chief executive, and feels confident about sharing issues that arise.

All staff survey

26. The all staff survey ran between the period 29 April 2019 – 17 May 2019. The survey was constructed using questions which feature in the NHS staff survey and some supplementary multiple choice and free text based questions.

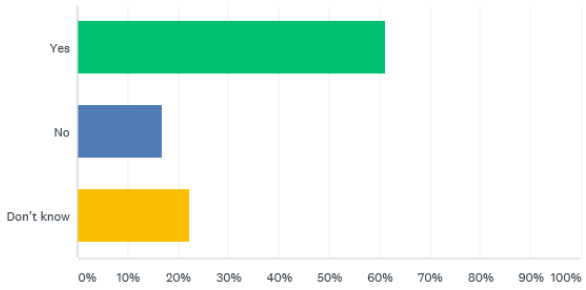
27. The following tables summarise the findings from the survey.



ANSWER CHOICES	RESPONSES
Yes	66.67%
No	16.67%
Don't know	16.67%

If you were concerned about any other practice, would you know how to report it?

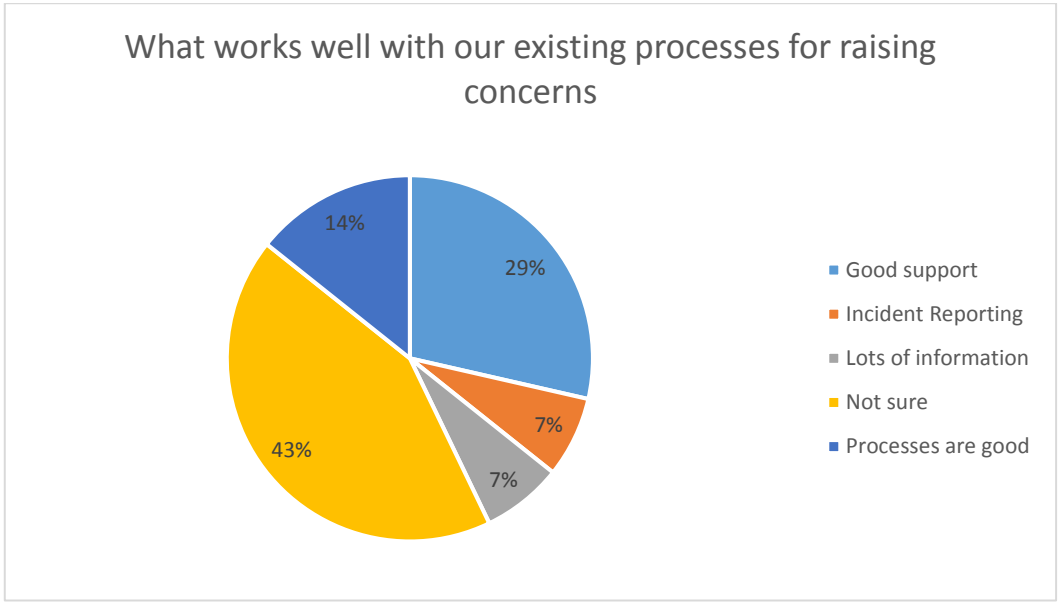
Answered: 36 Skipped: 0

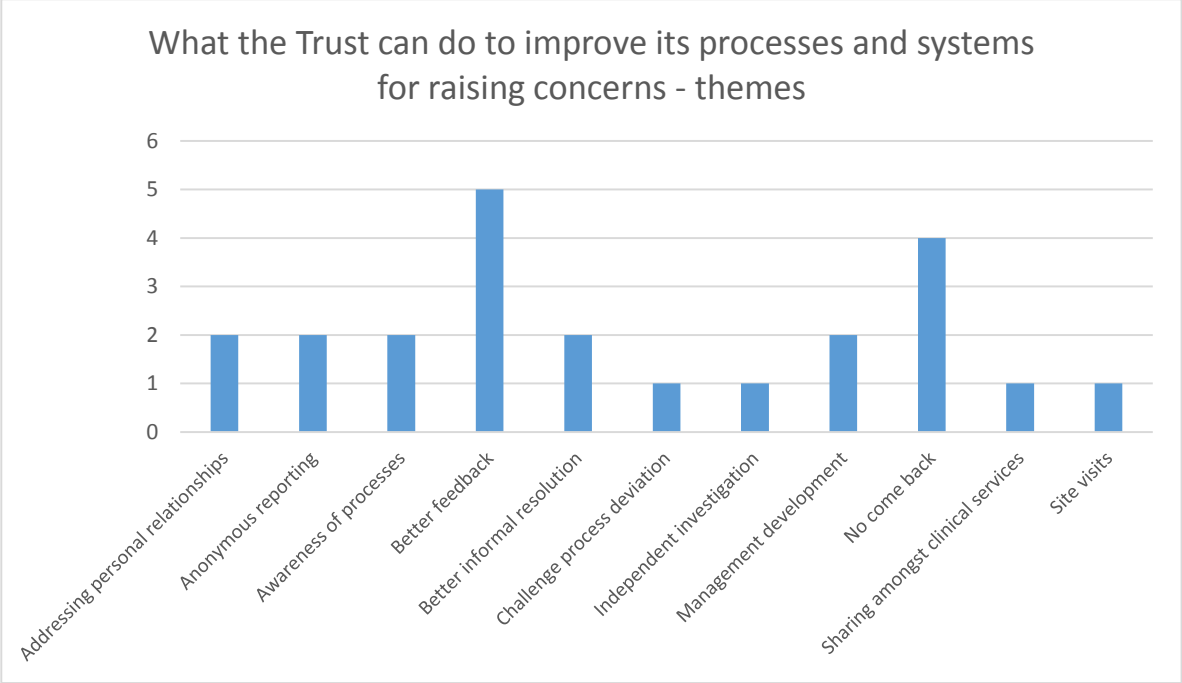


ANSWER CHOICES	RESPONSES
Yes	61.11%
No	16.67%
Don't know	22.22%

To what extent would do you agree with the following statements.

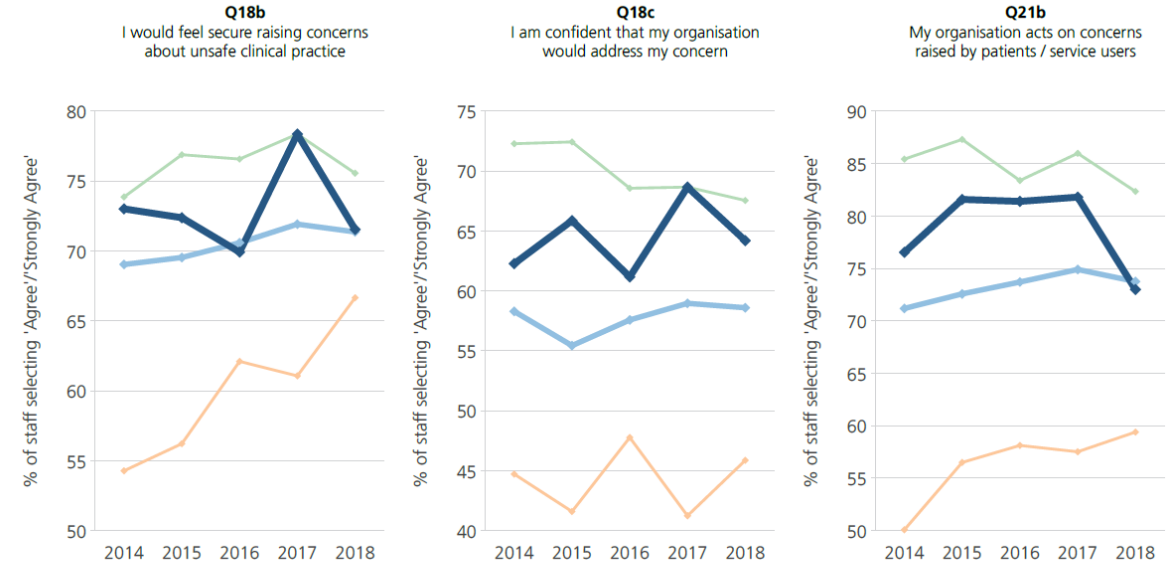
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Weighted Average
I would feel secure raising concerns about unsafe clinical practice.	8.33%	16.67%	25.00%	33.33%	16.67%	3.33
I would feel secure raising concerns about any other practice.	8.33%	33.33%	11.11%	33.33%	13.89%	3.11
I am confident that the organisation would address my concern	8.33%	27.78%	27.78	25.00%	11.11%	3.03





Data from the NHS staff survey

The all staff survey received a small response, in comparison to the NHS staff survey which saw a 60% participation rate. Below is the information specifically related to the confidence of staff about reporting concerns.



	2014	2015	2016	2017	2018
Best	73.9%	76.9%	76.6%	78.4%	75.6%
Your org	73.0%	72.4%	69.9%	78.4%	71.5%
Average	69.0%	69.5%	70.6%	71.9%	71.4%
Worst	54.3%	56.2%	62.1%	61.1%	66.7%

	2014	2015	2016	2017	2018
Best	72.3%	72.4%	68.6%	68.7%	67.6%
Your org	62.3%	65.9%	61.2%	68.7%	64.2%
Average	58.3%	55.4%	57.6%	59.0%	58.6%
Worst	44.7%	41.6%	47.8%	41.2%	45.9%

	2014	2015	2016	2017	2018
Best	85.4%	87.3%	83.4%	86.0%	82.3%
Your org	76.5%	81.6%	81.4%	81.8%	73.0%
Average	71.2%	72.6%	73.7%	74.9%	73.8%
Worst	50.1%	56.5%	58.1%	57.5%	59.4%

Open forum sessions

28. Two open forum sessions were set up and took place on the following dates: [add]. During these meetings the participants were asked to contribute to a discussions. The external facilitator particular noted that:

"I was impressed by how much is already in place when I was talking to the folk who came to the second open forum."

29. The following bullets outline a summary of the information gathered during the sessions.

- *When a concern is raised with the appropriate manager, would like an acknowledgment of the concern, something to say 'this will be addressed within an appropriate timescale' and a further response within a period of time to say 'this is still being looked to' and any updates on progress.*
- *Would like to be given a clear idea of how long it is likely to be before we receive a response.*
- *Recommend that if concerns are raised about a person/procedure/patient in an exit interview, that these are then discussed or raised with an appropriate manager.*
- *Recommend having a clear process which says, 'if there's an issue and you need to talk to your manager, there will be some resolution and you will be kept informed'. Have a proper process to follow at each stage of escalation.*
- *Would like the stressful and critical nature of front-line work to be recognised and acknowledged.*
- *Suggestion to have some kind of mixed group meetings. Chief executive briefings are generally attended by managers and senior clinical staff. Need to find a way to encourage more staff to attend these meetings and allow them to attend by providing cover etc.*
- *When concerns are raised at CEO briefings, would like to be given some indication of how they are being handled and within what timeframe. Perception that complaints such as racial abuse / bullying from patients have been unresolved has led to dis-engaged staff. Recommend more transparency and publicity of the complaints process and agreed protocol.*
- *Aware that there are policies and procedures (Mental Health First Aiders, Speak Up Guardian etc) but there is a perception that people aren't following them. Recommend more visibility of the policies, more publicity and understanding of the process and a way of ensuring managers follow the agreed processes, much like you would with a customer complaint.*
- *Recommend having more security in the building to prevent dangerous situations with patients. Includes putting up signage around what is expected of everyone (staff and patients) when they are in the trust building.*
- *Recommend putting up signage of Trust Values to remind staff to treat each other with respect and courtesy.*
- *Recommend having more of an 'adult to adult' attitude as opposed to a paternalistic attitude as trying to keep staff safe has led to them feeling excluded. Something about staff seeing that leadership is listening. Suggest having a board up saying 'you said… we're doing'. Could also do something similar with staff survey results.*

- *Suggested having a way in which concerns/issues can be raised at Council of Governors and Board level meetings, and for staff to feel comfortable doing so. Recommended having a way to make suggestions anonymously.*

- *Suggested having an anonymous questionnaire for new starters, in order to measure impressions of the trust, to be filled out every 3 months in the first year. To give new staff the ability to share what they feel is good about working in the trust and what could be improved / if there are any issues or concerns. Could include the option to share your name if wanted.*

Part 4 – Findings in Relation to the Terms of Reference

A	What are the existing arrangements for raising concerns which should include a description of these, their strengths and where they might be improved.

30. Throughout the course of my review I have identified procedures which exist for raising concerns within our organisation, these are provided in appendices A - D.

31. Having reviewed the procedures they are all functional and detail the correct steps. When I reviewed the raising concerns (whistleblowing procedure) it was noted that it aligns to the national model policy provided by NHS Improvement. However, there is a deficit within it. The current procedure sets out timescales for responding to concerns which are relatively short and do not take in to account where complex cases may arise. The national policy is less prescriptive in this regard and simply states that issues should be investigated without unnecessary delay and that they should be dealt with using an appropriate timetable.

32. In addition to the written procedures, the following individuals all play either a role in listening to, responding to or investigating and acting on concerns.

    - Line managers
    - Heads of discipline
    - Directors
    - Human resources staff
    - Trade union stewards
    - The freedom to speak up guardian
    - Mental health first aiders
    - Our employee assistance programme telephone line, provided by CareFirst
    - The counter fraud service
    - The chief executive
    - A named non-executive directors.

33. Of those listed above their roles are very clear with the exception of two. The heads of discipline play an important role in the professional development of their workforce but there can be tension between these roles and the service lines. Because of a lack of role clarity there have been examples where concerns have been handled by this role and not connected back to the service line.

34. The named non-executive director role, of all of my interviews not one of the participants identified this as a route for staff to raise concerns. The freedom to speak up guardian reflected back to me that staff should be able to raise concerns to the non-executive directors but gaining access or contact with them is unclear.

Conclusions

35. Having explored this area in a lot of detail, I have come to the conclusion that the Trust has a number of good processes and systems but there is scope for improvement in some of these areas. It is very clear the organisation does not lack in people to approach when a concern arises, however, clarifying some roles would be beneficial.

36. In my final recommendations I will set out suggested actions which propose an update to the raising concerns (whistleblowing) procedure, a change in the time commitment to the freedom to speak up guardian role, clarifying the role of the head of discipline, and actions to improve the access to the named non-executive director.

B	The understanding amongst the Board of Directors and Executive Directors about their roles in managing / seeking assurance on these matters.

37. Having interviewed directors who have the largest remit in terms of workforce and service delivery, it was very clear that each of them have a very clear understanding of their own role and the way in which they would handle a concern.

38. As noted in my findings, earlier, I have identified a small number of individuals who felt they would not always necessarily know about what is the line that has to be crossed when matters should stop being handled informally and a more formal process commissioned.

39. It was heartening to know that the directors have good relationships with one another and that if they were ever in doubt they would consult with colleagues to shape their thinking about the best approach to take.

40. Through the process I did also detect that there was an awareness of the different roles between the board of directors and the council of governors, but people felt they needed to seek assurance from me that their interpretation was correct.

Conclusions

41. The directors are all well established in their positions and could articulate well the routes for raising concerns and a summary of the process they would need to follow.

42. Having identified some gaps in understanding about when a formal process needs to start and the differing roles between the board and the council, I will make recommendations later in this report to address to try and address these issues.

C	The understanding of staff, more widely, on the processes of raising concerns. This should include exploring barriers that may or may not exist.

43. The survey and the open forum sessions were revealing in that many of the staff are aware of the processes for raising concerns. The results have showed that there is a greater tendency to raise issues with line managers in first instance but there is also knowledge of other routes to do so, if staff feel this is appropriate.

44. What is very clear from the results of the surveys is that there appears to be awareness about our processes but the confidence to be able to use them seems somewhat lower than where it ought to be.

45. Having analysed the information very carefully there are three prominent themes which act as barriers around raising concerns, these include:

    - Staff feeling safe to raise a concern and know that there will be no come back from doing so.

    - That a barrier to raising concerns is the lack of feedback when one is raised.

    - The capability of our line managers varies and development of this staff group would be beneficial, specifically about what best to do when an issue arises.

46. What is very clear when balancing this information against the data from the NHS staff survey, there has been a diminishment of confidence amongst our staff about the processes for raising and handling concerns, specifically relating to clinical issues.

Conclusions

47. Having done some extensive work with staff across the organisation there is a good understanding of our processes and support. That said, there are issues around staff feeling confident and safe to raise issues. There was a marked improvement in this area in the 2017 staff survey but that result trend as quite drastically diminished in 2018.

48. I will make a number of recommendations based on this area of the terms of reference which focuses on how we improve the culture of raising concerns and increase management capability to be able to handle them fairly and objectively.

D	An assessment of any areas where the process for raising concerns have not worked effectively and the learning which should be taken from these cases.

49. This review process was commissioned following the concerns raised about the gender identity development service (GIDS) and as a result of this many people reflected their experience of this process.

50. The GIDS review process was an example where the management of the concerns process had deviated and the causal reasons for this were the result of a number of factors.

    a. The first was the concerns were raised in 2017 with a small number of senior staff and no process of formal investigation was started.

    b. The executive management team were made aware of increased turnover in the clinical services in December 2017

    c. An analysis of the data by service line was considered in January 2018 which identified turnover was higher in the Camden CAMHS service and GIDS. However, the rate was not disproportionate to other mental health services when compared to the data available on NHS Digital's workforce statistics. The reasons recorded for leaving did not identify anything other than voluntary turnover.

    d. By mid-2018, the individual who identified the concern initially had not received feedback and made the decision highlight the issue to the council of governors, as they held an elected seat on this body, in July 2018. It was at this point the

Trust ought to have commissioned a review rather than wait for a paper to be produced after the summer.

51. Through the process there were no other examples shared about where our processes for raising concerns had not worked effectively. What people did acknowledge through the process is that there appears to be a lack of joining back the circle, in other words closure and feedback appears to not happen as well as it ought to.

Conclusions

52. Having reviewed the information very carefully, the learning which the Trust should takes is that there needs to be a greater degree of formality introduced the moment a serious concern becomes apparent. This means that senior staff need to swiftly investigate issues and then ensure that there is appropriately timed updates to those that raised the issues initially until their conclusion.

53. In making the above conclusion it is important that there is clarity across the organisation that if a concern relates to a specific person it may not always be possible to share exactly what has happened as a result. The reason for this is the employment relationship is an important one and an employer has a duty to preserve confidentiality.

54. A piece of learning that has emerged is that there is a lack of clarity about the differing roles of the board of directors and the council of governors. Having reviewed the Trust's constitution and the Monitor code of governance, the below summarises their functions:

    - *The board of directors is a unitary board made up non-executive and executive appointments, its role is to ensure the safe, quality assured and financially managed delivery of health and care services. It is wholly responsible for the operation of the Foundation Trust.*

    - *The council of governors is an elected body from constituents who form the membership of the organisation. Its role is to hold the board of directors, individually or collectively, to account for the operation of the foundation trust. It is not responsible for directly involving itself in operational matters. The council does hold some decision making powers which relate to the appointment of the Trust chair, non-executive directors and the external auditor. It is also responsible for the approval of significant transactions, acquisitions and mergers.*

55. Later within this report, I will make a number of recommendations to respond to these points of learning.

E	What can be learnt from best practice in other NHS organisations.

56. Throughout my interviews with senior staff and the data gathered from other sources it is right to say that the Trust has taken a thorough approach in identifying routes where people can take their concerns.

57. I have identified through the course of my review a number of good practice examples which the Trust has not adopted. These include:

    a. Some NHS organisations have adopted a freedom to speak up guardian role who acts in the capacity as a Trust wide champion. To support those individuals in

their roles, speak up champions have also been recruited to give a wider spread of people, at varying seniorities, who can be approached if there is a concern.

b. There are examples of organisations that have outsourced some aspects of their speaking up processes to external companies which provide confidential telephone lines and web platforms to report issues.

c. I identified a small number of organisations which have developed in house anonymous reporting tools through their intranet.

Conclusions

58. The organisation has a very large number of people who support staff to raise concerns, of the examples of processes we do not benefit from there are some which the organisation ought to consider adopting which I will described later in the report.

59. I have reflected very carefully about outsourced services, however, having spoken to peer HR directors across the London mental health sector I understand that they are very expensive and cost prohibitive. As a result this will not feature in my recommendations.

Part 5 – Final Conclusions and Recommendations

60. As a result of this review I have concluded overall the organisations processes for raising concerns are well established and there a many routes by which staff can speak with an individual when there may be issues. I have also identified some areas where our processes, procedures and systems could be improved. I now set out a number of recommendations for the board of directors to consider:

    a. The freedom to speak up guardian is well regarded and well established. Reflecting on the time commitment of the role and learning from other organisations it is recommended that the position is converted from being paid a responsibility allowance to a one session (3¾ hours) a week, worked flexible, post graded at Band 8c.

    b. To support the guardian, it is recommended that the Trust considers whether it wishes to create non-remunerated champion roles to give a mix of individuals that staff can raise concerns to.

    c. The raising concerns (whistleblowing) procedure should be reviewed and updated to closer reflect the national model procedure.

    d. That a short and succinct document is developed outlining the responsibilities of the board of directors and the council of governors. This should be principally used for executive directors but should be available to all staff.

    e. A piece of work was undertaken by the previous CAMHS director which outlined the differences between service directors and heads of discipline. This should be revisited, refreshed and published to ensure there is clarity about each of the roles' remits.

    f. The Trust should consider how it improves access to the non-executive director link for concerns, without breaching the individual's confidentiality. This may be through a dedicated Trust email box or a form on the intranet that, once completed, sends an email out to the individual's non-Trust email account.

    g. The Trust should consider if it wishes to develop anonymous concern reporting processes and if so those that are appropriate.

    h. A management development programme should be developed and rolled out to all line managers covering a range of subject areas (employee management, concerns, finance, governance etc…). This process should also include the development of a managers' induction process.

61. I would like to take this opportunity to thank every individual that has contributed to this review.

Craig de Sousa
Director of Human Resources and
Corporate Governance

24 June 2019

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	30 July 2019

Race Equality Strategy Update

Executive Summary

In January 2019, the Trust board approved an action plan covering a number of activities for the year building on work from previous years.

Overall there is a lot of activity taking place to deliver the actions committed to in the race equality strategy.

Ongoing progress of this work is being monitored by the equality, diversity and inclusion committee and ongoing feedback is being received from the BAME network.

Recommendation to the Board

The Board of Directors is asked to note and discuss this paper.

Trust strategic objectives supported by this paper

People

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

Race Equality Strategy

1. Introduction

The Trust's race equality strategy was launched in October 2017 and is aimed at improving the employment experience of black, asian and minority ethnic (BAME) staff.

In January 2019, the Trust board approved an action plan covering a number of activities for the year building on work from previous years. This paper provides an update on progress being made against our planned activities.

2. Progress against the action plan

Overall there is a lot of activity taking place to deliver the actions committed to in the race equality strategy.

Progress is being monitored on an ongoing basis through the equality, diversity and inclusion committee. We are also continuing to receive helpful and constructive feedback from the BAME network which continues to inform the approach we need to reflect on what more we need to do.

The table below provides the actions that we committed to and provides and update on progress that is being made.

Action	Detail	Responsible	Timescale	Update
Influence the wider system to increase access for underrepresented groups	Engage the directorate of education and training and national training and education providers in a dialogue and co-creation of meaningful actions which will increase access to: • Clinical psychology • Psychotherapy • Specialist mental health nursing	Director of HR & Corporate Governance	April 2019 – March 2020	Limited action has taken place against this action as a result of the director of quality and patient experience stepping down. A meeting will be scheduled in September 2019 with the Clinical Chief Operating Officer and the Director of Education and Training to agree a plan about how best to engage with wider stakeholders.
	Using funds allocated by the Tavistock Clinic Foundation, develop and implement a bursary scheme to support individuals to gain access to Tavistock and Portman professional qualifying programmes.	Director of Education and Training / Dean of Postgraduate Studies	September 2019	A bursary scheme has been developed for child and adolescent psychotherapy trainees which will launch in the coming academic year. The Tavistock Clinic Foundation has awarded a grant to DET to develop a wider scheme.
Increase the capability and confidence of senior leaders, across the organisation, to engage in conversations about race, culture and difference.	Reflecting the importance placed on the strategy, in the 2019 appraisal round all staff will be required to have at least one objective agreed on how they will implement the race equality strategy.	Director of HR & Corporate Governance – for guidance All Trust managers to implement	February 2019 – July 2019	The 2019 appraisal round has opened and this action has been incorporated in to the guidance and requirements. The outputs of the appraisal round will be audited in October 2019 to assess compliance with this requirement.
	Evaluate the impact of the race Thinking Spaces which took place in 2018. Commission and roll out, further, Thinking Space events to continue the dialogue about the challenges of achieving race equality, in all areas of the Trust's activity, including training.	Director of HR & Corporate Governance	June 2019	An evaluation has been completed and feedback evidences that the Trust should commission further Thinking Space events. Plan will be made from September 2019 about how best to roll out further sessions.
	Roll out, Trust wide, the cultural intelligence master class programme and evaluate its impact one year following delivery.	Director of HR & Corporate Governance	April 2019 – March 2020	As a result of the NHS staff survey results a management development programme is being commissioned for middle managers across the organisation. Cultural intelligence has been included in the specification.

Action	Detail	Responsible	Timescale	Update
	Develop and publish a statement for all Trust adverts about the organisation's commitment to attracting candidates from underrepresented backgrounds.	Director of HR & Corporate Governance	April 2019	A revised statement has been published on the Trust's electronic recruitment solution.
	Develop a handbook for managers and staff detailing how recruitment works in practice. This will detail the requirement that all selection process should comprise of a diverse panel.	Director of HR & Corporate Governance	May 2019	A handbook has been fully developed and will be launched formally across the Trust from September 2019.
	Undertake an audit of recruitment processes to assess compliance and adherence to the set out processes. This will include: • Reviewing outcomes • Monitoring compliance with BAME representatives being part of panels.	Director of HR & Corporate Governance	October 2019	Scoping of this audit is underway and activity will commence in October with results from the activity being reported to the EDI committee.
	Audit the progression of BAME students from the point of application to final outcome.	Director of Education and Training / Dean of Postgraduate Studies	October 2019	Scoping of this audit is underway and activity will commence in October with results from the activity being reported to the EDI committee.
	Roll out further events for the student body focused on equality, diversity and inclusion.	Director of Education and Training / Dean of Postgraduate Studies	Ongoing	Work on this area is ongoing.
Review and implement ways of integrating discussion on health inequalities and access issues within clinical and training team meetings.	Clarify and review the role of equality champions within each directorate.	Clinical Chief Operating Officer and Director of Education and Training / Dean of Postgraduate Studies.	October 2019	Since April 2019 a review has been undertaken of all of the diversity and inclusion roles which exist across the organisation. The Trust wide champions' and the DET roles are clear and documented in an appropriate specification. More work, however, is required to define the clinical services roles which will be completed by October 2019.

Action	Detail	Responsible	Timescale	Update
	Agree a methodology or consistent approach for equality focused discussions to happen at clinical team meetings. Informed by data.	Clinical Chief Operating Officer		
	Develop a programme of work to increase compliance with protected characteristic data capture and recording on CareNotes.	Clinical Chief Operating Officer	June 2019	The Trust's mental health service data set (MHSDS) has shown indicators of improving
	Scope and implement a cultural consultation service to allow clinical and training staff a support channel for handling issues and challenges around race and other related social factors.	Director of HR & Corporate Governance and Clinical Chief Operating Officer	**Original:** June 2019 **Revised:** March 2020	This action was previously owned by the Director of Quality and Patient Experience. Having reflected on the work undertaken to date, it is proposed that this work activity is reviewed and a revised completion date of March 2020 is agreed.

3. The workforce race equality standard

As we head in to the summer, NHS England will shortly provide the Trust with the data capture template for the workforce race equality standard. Ahead of the template arriving we have undertaken some analysis of what messages to expect. These include:

- Our non-clinical workforce continues to become more diverse, however, our clinical workforce statistics indicate that there has been little change in this area.

- Our board diversity statistics will show positive change, but there is still more work to do in this area.

- The experience of black, asian and minority ethnic staff is still divergent compared to white staff.

Prior to consideration at the September board of directors, the statistics will be scrutinised in more depth by the EDI committee.

4. Conclusions and recommendations

The board of directors are asked to:

a. Note the updates provided within this paper;

b. Reflect and discuss about progress being made; and

c. Discuss what more the Trust might do to further build on the work achieved to date.

Craig de Sousa
Director of Human Resources and Corporate Governance
Executive Lead for Equality, Diversity and Inclusion

July 2019

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	July 2019

Board Assurance Framework

Executive Summary

The following Assurance Framework (BAF) identifies key risks to achieving the Trust's strategic objectives for 2019/20. It is the first BAF for the current year.

Many of the risks are similar to those on the BAF for 2018/19 but with updated wording and assessment. Risks 9 and 10 are new, relating to gender services and the Trust capacity to deliver the External Affairs Strategy

There are three risks rated 16 – 20 and three rated 12. See page 3 for summary.

It is planned for the BAF to be taken from the new electronic risk register module for the November Board. The risk register module is currently being tested.

Recommendation to the Board

The board is 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 is currently being tested. It is still proposed the new look BAF will be available for the November Board.

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 are three red rated risks: Risks 5, 9 and 13.

- Risk 5: Risk of failure to deliver affordable and appropriate Estates solutions
- Risk 9: Inadequate staff capacity and morale leading to possible failure to deliver the GIDS action plan
- Risk 13: Failure to deliver the Trust financial plan

3.2. There are four risks rated 12: Risks 2, 3, 8 and 11.

- Risk 2: The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience
- Risk 3: Pressures on leadership impacting negatively on staff morale and engagement to deliver strategic objectives
- Risk 8: Wider financial pressure in NCL with negative consequences for delivering the mental health programme in STP and Trust
- Risk 11:Failure to develop and modernise the Trust's education offering negatively impacts on the sustainability of our provision

3. 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

4. CONCLUSION

4.6. The Board is invited to approve the Risk Appetite, which is unchanged from 2018/19, and the Board Assurance Framework which has been updated with risks to the 2019/20 strategic objectives; and to comment whether, with the action plans as set out, the risks are tolerated.

JULY 2019 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, 10	1, 12	
	Could occur	3		6		3, 8, 11	5, 13
	Likely to occur	4		7	2	9	
	Almost certain to occur	5					

Board Assurance Framework 2019/20 – Summary

					Current Risk Score				
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 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)				**Green (1x4)**
2	The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience	CEO	People	2	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)				**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	DoN	People	4	6 (2x3)				**Green (1x3)**

	Risk	Owner	Strategic Aim	Corporate Objective	Current Risk Score July 2019	Nov 2019	Mar 2020	May 2020	Target Risk L = likelihood C= consequence Risk = L x C
	viability of 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 automony	DoF	People	5	15 (3x5)				Amber (2x5)
6	The risk that insufficient staff capacity /engagement with the quality agenda has a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care	CCOO	Services: Clinical	6	6 (3x2)				Green (2x2)
7	The risk that our data systems do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance,	CCOO	Services: Clinical	6	8 (4x2)				Green (2x2)

					Current Risk Score				
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L = likelihood C= consequence Risk = L x C
	commissioner scrutiny and poor CQC ratings.								
8	The risk that wider financial pressures in North Central London with 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)				**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)				**Amber (3x3)**
10	The risk that the Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability	DoS	Growth and Developme nt	11	6 (2x3)				**Yellow (2x3)**
11	The risk that a failure to develop and modernise the Trusts Educational	DoET/ DeanPGS	Services: Education	12	12 (3x4)				**Amber (3x3)**

					Current Risk Score				
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L = likelihood C= consequence Risk = L x C
	offering has a negative impact on the sustainability of our provision								
12	If the Trust fails to meet its regulatory responsibilities to CQC and QAA there will be negative consequences for our reputation and the quality of patient and student experience	CEO	Finance and Governance	14	8 (2x4)				**Green (1x4)**
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)				**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>Risk Owner: Craig de Sousa</td><td>Date reviewed July 2019</td></tr>
<tr><td colspan="2">INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 TARGET risk rating 1 x 4 = 4
CURRENT risk rating: Likelihood 2 x Consequence 4 = 8</td></tr>
<tr><td colspan="2">Rationale for current score:
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>Controls/Influences (what are we currently doing about this risk?):
Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee

Race Equality Champion appointed and BAME network established: regular communication between the Champion and the Director of HR and</td><td>Assurances received (independent reports on processes; when; conclusions):

Workforce Race Equality Standard annual report (+/-)
Staff survey (+ / -)
November CQC report confirmed that staff remain unconfident about progress (-) Revised action developed</td></tr>
</table>

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.	in consultation with BAME network, approved by the Board March 2019 (+)
Gaps in controls/influences: Further training for managers who have attended Thinking Space events to ensure clarity about action necessary to implement the strategy at local level	Action plans in response to gaps identified: *(with lead and target date)* Develop training plan for managers, (DoHRCG, Oct. 2019) Using funds allocated by the Tavistock Clinic Foundation, develop and implement a bursary scheme to support individuals to gain access to Trust professional qualifying programmes (DoHRCG, Sept 2019) Increase capability and confidence of senior leaders, across the organisation, to engage in conversations about race, culture and difference (DoHRCG, March 2020) Review and implement ways of integrating discussion on health inequalities and access issues within clinical and training team meetings (CCOO, Oct 2019)

<table>
<tr><td colspan="2">RISK 2): The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience</td></tr>
<tr><td><u>Risk Owner</u>: Paul Jenkins</td><td>Date reviewed July 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 4 x Consequence 3 = 12 <u>TARGET risk rating</u> 2 x 3 = 6
<u>CURRENT risk rating:</u> Likelihood 4 x Consequence 3 = 12</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
Recognition of pressure of workload across all parts of the organisation combined with negative impact of external media attention around gender work.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
CEO question time and other engagement events with staff
Trust interprofessional 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</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):

Staff survey (+/-)
Staff feedback (formal and informal) (+/-)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Strengthen staff engagement
More formal strategy for addressing staff morale and wellbeing</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Staff engagement events (ongoing CEO)
Pilot stress and resilience framework (31/12/ 2019 CCOO)
Refresh people strategy (31/3/2020 DoHRG)</td></tr>
</table>

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.**	
Risk Owner Craig de Sousa	Date reviewed: July 2019
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 2018 (+ /–) Quarterly Friends and Family Test Results (+) Quarterly HR & OD Assurance Reports (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
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	OD and People Strategy delivery plan (DoHRCG Mar2020) Staff survey action plans review (DoHRCG Sep 2019) Select 2 teams to undertake Stress and Resilience Framework (with facilitation) (HoHRCG Mar 2020) Staff Education Programme (HoHRCG Mar 2020) New OD and People Strategy 2020 – 2023 (HoHRCG Mar 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: July 2019
INITIAL risk rating (at identification): Likelihood 2 x Consequence 3 = 6 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE' reduced from risk level 12 to 6 due to the increased positive profile of the NWSDU and engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity	
Controls/Influences *(what are we currently doing about this risk?)*: NWSDU and NMHWDC Communications strategies and Plans in place NWSDU/ IJT /CC Objectives: One conference delivered in April 2019, Planned conference for March 2020 Attendance as external speakers at relevant Conferences (IJT & CC x1 Nov 19) IJTx3: May 19, Sept 19, Dec 19) IJT attendance at Pan ALB Health & Wellbeing Group CC attendance at LWAB CC MH Workforce lead for NCL STP CC role in HEE Capital Nurse programme IJT Engagement in Pearson 'Learner MH & Wellbeing' HEE Workstream	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) 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. (IJT July 19) Agreement and ongoing work for development of shared communications strategy with HEE Mental Health Programme Board (IJT July 19) Ongoing work with Pearson Commission Group and Pan ALB H&WB group (IJT July19)

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: July 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 3 x Consequence 5 = 15	TARGET risk rating 2 x 5 = 10
Rationale for current score: 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	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)* Exchange of contracts with vendor re relocation site (IG 31 July 2019) Acquisition of lease on new property (Finchley Road) (IG 31 July 2019) Remodelling of space at Tavistock Centre (IG 31 Dec 2019)

Strategic Aim: Services: Clinical

Corporate Objectives:

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

RISK 6): The risk that insufficient staff capacity /engagement with the quality agenda has a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care	
Risk Owner: Sally Hodges	Date reviewed: **July 2019**
INITIAL risk rating (at identification): Likelihood 3 x Consequence 2 = 6 CURRENT risk rating: Likelihood 3 x Consequence 2 = 6	TARGET risk rating 2 x 2 = 4
Rationale for current score: staff report capacity issues. Staff survey results reflect this also	
Controls/Influences *(what are we currently doing about this risk?)*: New divisional director structure to ensure engagement	Assurances received *(independent reports on processes; when; conclusions)*: Directors appointed July 2019
Gaps in controls/influences: Work on structure and engagement required	Action plans in response to gaps identified: *(with lead and target date)* Work on structure and engagement, led by CCOO, new structure to be in place by October 2019, embedded by April 2020

<table>
<tr><td colspan="2">RISK 7): The risk that our data systems 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.</td></tr>
<tr><td><u>Risk</u> Owner: Sally Hodges</td><td>Date reviewed: July 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 4 x Consequence 2 = 8 <u>TARGET risk rating</u> 2 x 2 = 4
<u>CURRENT risk rating:</u> Likelihood 4 x Consequence 2 = 8</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
Data reports from different sources e.g. team reports and contract still not consistent. Staff concerned that data does not reflect their experience</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
Group overseeing data process set up</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
Minutes of working group
Data strategy in place</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Improvements required in all areas in relation to data including: data systems (IT); operational data entry; and data analysis</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Work on data to continue (DWL with data strategy fully implemented by April 2020)</td></tr>
</table>

<table>
<tr><td colspan="2">RISK 8): The risk that wider financial pressures in North Central London with negative consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives</td></tr>
<tr><td><u>Risk Owner</u>: Paul Jenkins</td><td>Date reviewed: July 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 3 x Consequence 4 = 12 <u>TARGET risk rating</u> 3 x 3 = 9
<u>CURRENT risk rating:</u> Likelihood 3 x Consequence 4 = 12</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
Wider financial pressure across the STP</td></tr>
<tr><td><u>Controls/Influences</u> (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</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
Agreement by Regulators of Medium-Term Financial Plan (+/-)
STP plan for mental health (+)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Decisions of the regulators
Wider financial position across the STP</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Involvement in development of medium-term financial plan (JR/TN Sep 2019)
Refreshed STP plan for mental health with agreement over use of ring-fenced investment for mental health Ist draft (PJ Oct 2019)
Further refresh of priorities in line with NHS Long Term Plan (PJ Oct 2019)
Action plans on local commissioning of Tier 4 (SH, business case implementation from 30/9/2019)</td></tr>
</table>

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 Owner: Sally Hodges	Date reviewed: **July 2019**
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: Staff morale low in service because of frequent external criticism. Many staff have left leaving significant vacancies. Staff under-performing owing to need to focus on external environment	
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 to the monthly Gender Task and Finish group (+)
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)

Strategic Aim: Growth and Development

Corporate Objectives:

10. Progress the Trust's longer-term priorities for new service development and meet the target for new growth in 2019/20 **DoS**
11. 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**
12. 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 10): The risk that the Trust does not have skill sets or capacity to deliver new business development opportunities with negative consequences for future income growth and sustainability	
Risk Owner: Rachel Surtees	Date reviewed: **July 2019**
INITIAL risk rating (at identification): Likelihood 2 x Consequence 3 = 6 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6	TARGET risk rating 2 x 3 = 6
Rationale for current score: Current controls and assurances adequate	
Controls/Influences *(what are we currently doing about this risk?)*: - Active management of pipeline to have even spread of prospects across the three directorates and at different stages of development (prospect development; proposal writing; in implementation). - Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG). - Named target market areas to enable better focus and prioritisation on our target routes to growth	Assurances received *(independent reports on processes; when; conclusions)*: Pipeline report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Contribution forecast report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-)

- Established Business Development Operational Group, reporting to BDG, to ensure better oversight of corporate service input to the new business pipeline and identify areas of capacity constraint	Regular Business Development representation at CYAF; AFS & DET Executive Management Team meetings (+/-)
Gaps in controls/influences: No gaps	Action plans in response to gaps identified: *(with lead and target date)*

Strategic Aim: Services: Education

Corporate Objectives:

13. 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: **July 2019**
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	TARGET risk rating 3 x 3 = 9
Rationale for current score: Without a significant increase in the level of resourcing any growth will be incremental. Two key developments for growth – in respect of our international provision and the Digital Academy – are in the early stages of development. Whilst much work has been undertaken on the feasibility of establishing a Digital Academy, the Board has yet to sign off on the FBC. Whilst this project carries a high degree of risk with it, this is in line with the Trust's risk appetite for new business developments. Whilst we also continue to address the delivery of our mainstream provision, progress is slow. Some developments in our long courses is underway with our University Partner though this is not likely to be ready until AY20/21.	
Controls/Influences *(what are we currently doing about this risk?)*: Clarity in the focus on the international strategy and plan. Well established project team focussed on developing feasibility of the DA through desk research and external market assessment. Successful procurement leading to the identification of preferred partner. Working with input from partner to establish commercial model and delivery plan for phase 1.	Assurances received *(independent reports on processes; when; conclusions)*: Agreement on international strategy at ETC (July 2019). Board sign-off on phase 1 and 1b DA project (Oct 2018 & May 2019).

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. Working group with internal and Essex representatives underway of scoping new long course development.	
Gaps in controls/influences: International plan being delivered to within BAU due to other competing priorities including OfS registration Board sign-off of DA	Action plans in response to gaps identified: *(with lead and target date)* Preparation of DA FBC for Sept Board 2019 (AD, Delivery & Development (DET) – Sept 2019. Continued focus to deliver in-year income targets to meet budget requirements for international provision (Director of Education & Training / Dean – March 20. Review of T&F phase 2 and consideration of next steps (DoET /DoF – October 2019)

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 a negative consequences for our reputation and the quality of patient and student experience leading to CQC and QAA formal action	
Risk Owner: Paul Jenkins	Date reviewed: **July 2019**
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8	TARGET risk rating 1 x 4 = 4
Rationale for current score: CQC report positive but with some actions which are being addressed.	
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 Clinical Quality Safety and Governance Committee 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 CQC, the CQSGC and the CQRG. Progress monitored via EMT and CQSGC (+)
Gaps in controls/influences: Current service line assessment of CQC compliance required	Action plans in response to gaps identified: *(with lead and target date)* Service Line self assessments for CQC compliance (August 2019)

<table>
<tr><td colspan="2">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</td></tr>
<tr><td><u>Risk Owner</u>: Terry Noys</td><td>Date reviewed: July 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 3 x Consequence 5 = 15 <u>TARGET risk rating</u> 2 x 5 = 10
<u>CURRENT risk rating:</u> Likelihood 3 x Consequence 5 = 15</td></tr>
<tr><td colspan="2"><u>Rationale for current score:</u>
Early in the financial year to be clear on outcome. Additional costs have been incurred but contribution from new business remains uncertain.
Potential for negative impact depending on outcome of Relocation</td></tr>
<tr><td><u>Controls/Influences</u> (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</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
Management accounts reviewed monthly by EMT and Board (+ / -)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Uncertainty over contribution from new business</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Financial reforecast to be undertaken (TN: October)
Additional income opportunities being sought (RSt)</td></tr>
</table>

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	30/07/2019

Quality and Performance Review

Executive Summary

This report provides a summary of the work being undertaken at the Quality Review Meetings.

Recommendation to the [Board / Committee]

The board is asked to note and discuss this report

Trust strategic objectives supported by this paper

All trust strategic objectives

Author	Responsible Executive Director
Dr Dinesh Sinha, Medical Director & Responsible Officer	Dr Dinesh Sinha, Medical Director & Responsible Officer

Quality Review Meetings (QRM)

We have committed to a review of governance processes at various levels in the trust to accompany the strengthening of our structures at corporate level. One of our 'should do' actions from the CQC's inspection in 2018 was for the trust to review how we hold service lines to account and to ensure this happens in a consistent and robust manner. In direct consequence, we undertook to set up the quality review meetings, which aim to further strengthen the recent structural improvements made within Trust Services.

Hence the new divisional structure of the trust has been accompanied by the setting up of a quality review meeting on a quarterly basis with each division. The first set of these meetings has now been completed and the agenda has followed various suggestions and examples from other NHS Foundation Trusts. These meetings are attended by Paul Jenkins CEO, Dinesh Sinha Medical Director & Director of Quality and Sally Hodges CCOO. The aim of these meetings is to provide a supportive frame for a prospective conversation about various items on the agenda, included in appendix 1.

The feedback has been that these meetings have been helpful, in increasing the visibility of risks and opportunities in the coming quarter but also getting a sense of the support required by the divisions and the new divisional directors for the delivery of key performance indicators, quality improvement, change and patient experience.

Our aim is to continue these meetings and refine the agenda, as applied to each division with a common structure and in this way provide better support for our services in their continuing improvement.

The Tavistock and Portman NHS Foundation Trust

Appendix 1

Quality Review Meeting

May 13th 2019, 14.00 Venue Small Meeting

AGENDA

Item	Subject	Task	By
1.	Welcome and apologies		
2.	Setting the Framework		
3.	Safety, Serious Incidents & Risk Issues		
4.	Quality Improvements/Transformation		
5.	Delivery on Key Performance Indicators (KPI) Waiting times Workforce issues inc training and development Leadership Commissioning Data Set		
6.	Risks and Opportunities for 2019/20		
7.	Good News & Patient Feedback		
8.	Regulatory & Compliance Update		
9.	AOB		
	Date of next meeting:		

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	10th July 2019

Serious Incidents – Quarterly Report – Q1 2019/20

Executive Summary

This quarterly serious incident summary report for the Board covers Q1 2019-20. There were 22 clinical incidents logged on the quality portal during Q1 2019-20 and 4 of these incidents were classified as serious incidents, which sadly were 4 patient deaths.

One patient death, took place in January 2019 (Q4), within the adult Gender Identity Clinic service, but the service were only notified of the death in Q1. The patient's sister contacted the service to inform them that her sister, aged 47, had died at their home by falling down the stairs. The patient's sister also confirmed that she herself was not seeking any support from the service in relation to her sibling's death. This death was externally reported on StEIS and an internal concise review was requested from the service. The service submitted the concise review to the May incident panel considered the internal concise report from the service and agreed that there was no further action to be taken and it was agreed to request a de-escalation on StEIS.

There was a further patient death reported to the adult Gender Identity Clinic in Q1, which occurred in April 2019. The patient's mother notified the service of her child's death by suicide and this death was externally reported on StEIS. The service completed an internal concise review which was considered at the April Incident panel and it was agreed a full RCA investigation was required, which will be formally submitted to commissioners and relevant stakeholders in July 2019.

There were also 2 reported deaths within the AFS, Complex Needs services. The first was reported on 8th April when the department received an email notifying them of the patient death as a suspected suicide. This death was externally reported on StEIS and an internal concise review was completed by the service. This incident was reviewed at the April Incident Panel and it was agreed a full RCA investigation was required, which will also be formally submitted to commissioners and relevant stakeholders in July 2019.

The AFS Complex Needs service was also notified of a further patient death in Q1 in that the patient's friend contacted the department to notify them that she had found the patient dec at home a few days previously, in May 2019. This death has also been externally logged on and a full RCA investigation has been initiated, which is due for formal submission in Augus 2019.

Recommendation to the Board

The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper

Clinical Services	
Author	**Responsible Executive Director**
Clinical Governance and Quality Manager	Medical Director

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	30-07-19

Guardian of Safer Working Hours 2019-2020 Quarter 1

Executive Summary

The Q1 report indicates that overall the trainees are working within safe parameters. There continues to be working outside of prospective hours whilst on call, particularly on the weekends and the trainees are considering requesting a form work schedule review for the out of hours work they undertake. This will most likely be requested after the summer holidays.

Recommendation to the [Board / Council]

Members of [forum] 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 Q1 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 Q1

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
April	9	6	3	0
May	6	3	3	0
June	10	5	2	3
Totals	25	14	8	3 (12%)

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 10.
- There have been no formal requests for a work schedule review however it is likely that the CAP Trainees will request one once they have informally monitored their out of hours work.

2.3 Vacancies

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

There will be 2 vacancies on the Adult Medical Psychotherapy Higher Training scheme in the summer for dual training which have been recruited to. This round of training did not recruit to all single training numbers (2) which will be recruited to in February 2020.

2.4 Locum

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

	Number of shifts	Number Covered	Number Vacant	Clinicians
April	2	2	0	Sprs
May	2	2	0	
June	3	3	0	

2.5 Fines

	Extra hours worked Normal	Enhanced	Total fine	Amount paid to trainees	Fine Remaining
April	7	0.5	681.05	225.38	425.65
May	2	7.5	1087.43	407.79	679.64
June	4	0	354.48	132.92	221.56
Totals			2122.96	766.09	1326.85

Fines accrued 2018-2019

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

3. Junior Doctors Forum (JDF)

The CAP trainee reps have provided trainees with an updated flow charts to support exception reporting

In the JDF CAP trainees fed back they have met with Adult psychotherapy trainees to discuss disbursement of fees.

We thought about impact of requesting a work schedule review, what this might entail, whom should be approached in relation to this and appropriate timings to truly capture the work that Trainees undertake out of hours.

The renegotiated contract was discussed briefly on 1st July 2019

4. Local Negotiating Committee (LNC)

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

5. Conclusions and Recommendations

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

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

S. Habel

Dr Sheva Habel

Guardian of Safer Working Hours

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	30th July 2019

Designated Body Annual Board Report

Executive Summary

The report provides a summary of the work undertaken.

Recommendation to the [Board of Directors]

The board of directors is asked to note / discuss this report

Trust strategic objectives supported by this paper

All trust strategic objectives

Author	Responsible Executive Director
Medical Director/Responsible Officer	Medical Director

Designated Body Annual Board Report

Section 1 – General:

The board of Tavistock and Portman Foundation NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 4th June 2019

Action from last year:

Comments: The Responsible Officer (RO) Dr Dinesh Sinha and Appraisal Lead (AL) Dr Caroline McKenna email regular updates on revalidation to all doctors in the Trust. All medical staff in the Trust have been informed that revalidation requires them to have an annual full appraisal, which has to be recorded on the electronic system of SARD (Strengthened Appraisal and Revalidation Database). The Trust cannot allow medical staff who are not revalidated to continue to work with patients and failure to have up to date appraisals, properly recorded, can impede progression and revalidation.

There has been a continual investment and improvement in resources for revalidation over the past year. We have had an appraiser training session for a group of appraisers were trained by an external trainer. This has helped develop capacity to continue refresher appraiser sessions within the trust and training for new appraisers. There is a refresher session planned on the 30th of September, which will be the first of a series.

The various appraiser meetings have been used to assess the continued improvements in appraisal processes and revalidation. There was a significant review of the appraisal portfolio and overall requirements for revalidation. This was accompanied by engagement with appraisers and Consultants through the MSC and the appraisers group. Consequently, an instruction was sent to all consultant colleagues to ensure various improvements in the way they collected information for the multi-source feedback (MSF), including the use of a standardised form, which is now based within SARD.

Action for next year: We will continue to improve our processes

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: New RO was appointed in Aug 2018 Comments: Dr Dinesh Sinha, Medical Director Action for next year:

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Comments: Yes, we currently have sufficient funds, capacity and other resources for the RO to carry out his role. Action for next year: We will continue to review our processes and resources.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: A new Revalidation Manager (RM) was appointed earlier this year Comments: The RM keep an ongoing review of our independent doctors with a prescribed connection. More recently, we have conducted a further review of the basis of the prescribed connection to the designated body for independent doctors and followed input and advice from Higher London responsible officer and the GMC employment liaison advisor (ELA). Following review, several individuals within our independent list will be asked to move their responsible officer and designated body to an independent body. At the same time, we will continue to add some individuals who have a basis for prescribed connection to our independents list. Action for next year: We will continue to improve our processes

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: n/a Comments: Yes, the Trust has an Appraisal and Revalidation Procedure Action for next year: Our Medical Appraisal and Revalidation Procedure is currently being reviewed by the AL for renewal.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: n/a Comments: Our appraisal and revalidation processes are discussed with the GMC and ELA, and any changes with the HLRO on an ongoing basis. Action for next year: We will continue to improve our processes

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: n/a Comments: Yes, we support our locums and short term placement doctors, as appropriate Action for next year: we will continue our efforts to support this group of doctors.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: n/a Comments: The expectation of an annual appraisal and its practice are understood and operational. At the same time, we have agreed with the GMC ELA and HLRO to shift appraisal dates closer to revalidation dates, as appropriate. The RO maintains regular contact with the Trust GMC employment liaison advisor and in these we discuss continuing improvements, including the setting up of a Responsible Officer Advisory Group (ROAG), which is attended by the appraisal lead Dr Caroline McKenna, Medical HR Umran Murad and Revalidation Manager Lorna Campbell. Action for next year: We will continue to improve our processes

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a Comments: Any delays in appraisal or issues with appraisal are discussed with the RO and in our Responsible Officer Advisory Group (ROAG), which was set up by the RO. Action for next year: We will continue to improve our processes

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: n/a Comments: Yes, the Trust has a Medical Appraisal and Revalidation Procedure Action for next year: The Medical Appraisal and Revalidation Procedure is currently being reviewed by the AL for renewal.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N/a Comments: We have an ongoing plan for refresher training our group of appraisers and to train new appraisers. Action for next year: We will continue development of this important workforce for revalidation

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: n/a Comments: The Trust has regular appraisers meetings, which enable improvements in training and development. The RO, RM and AL attend networking and external development events. Action for next year: We will continue development of this important workforce for revalidation

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: n/a Comments: RO has set up a Responsible Officer Advisory Group (ROAG), and provides an annual report to the Board regarding systems in place for appraisals and revalidation. Action for next year: We will be doing a pilot for including lay members in the ROAG

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: all recommendations were timely Comments: The RO provides recommendation using GMC Connect Action for next year: We will continue to review our processes

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: n/a Comments: Yes, the appraiser, appraisal lead and RO attempt to have early discussions about any emerging issues and these issues are noted at ROAG. All doctors are advised of any deferrals and steps required to reach revalidation. Action for next year: We will continue to improve our processes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: n/a Comments: The Trust has had significant improvements in its clinical governance structures and supports for all staff, including doctors. This includes the new incident panel and improvements in conduct of incident reviews. There has also been a significant change in learning through a new format for learning lessons and the launch of the Tavistock Inter Professional Event. Action for next year: We will continue to improve our processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: n/a Comments: Doctors are supported in collecting and highlighting relevant information for their appraisals and revalidation. Action for next year: We will continue to improve our processes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: n/a Comments: We have a Raising Concerns & Whistleblowing Policy. The RO and HR will always actively seek advice from GMC ELA, NCAS and others regarding possible investigations or interventions for any concerns. Action for next year: We will continue to improve our processes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: n/a Comments: We have not had any significant number of concerns about doctors. However, if this were to change then we would report numbers with analysis to the Board. Action for next year: We will continue to review our processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: n/a Comments: RO has ongoing contact with senior colleagues in various other organisations Action for next year: we will work towards substantiating a procedure for transferring information as appropriate

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: n/a Comments: Our Raising Concerns & Whistleblowing Policy contains a detailed description of safeguards for all staff and processes for responding to concerns with links to other policies. The Trust has recently undertaken a raising concerns review and actions from this will add safeguards. Action for next year: We will continue to improve our processes

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: n/a

requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: Yes. We have identified a need for strengthening of our processes for honorary staff.

Action for next year: All staff records are being moved to ESR to ensure appropriate governance.

Section 6 – Summary of comments, and overall conclusion

- **The General Medical Council (GMC) continues to support the Trust in its role. This report outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.**
- **Doctors require revalidation or renewal of their licence to practice once every five years. They need to maintain a prescribed connection with the designated body and revalidation recommendations are made by the Responsible Officer.**
- **The RO for our medical trainees the Postgraduate Dean for Health Education North Central and East London, Dr Tim Swanwick.**
- **None of the doctors for whom the Tavistock and Portman NHS FT is the designated body is currently subject to any GMC fitness to practice procedures or any imposed conditions or undertakings.**

Overall conclusions:

The Trust has a committed workforce of Medical staff. The RO and colleagues continue to improve processes for appraisal and revalidation.

Additionally, development for the work stream was promoted through a Consultant away day held in July 2019, which received very positive feedback. It was a unique opportunity for Consultants to come together and discuss the challenges faced with in their individual roles and services and also their contributions to the agenda of the trust.

We intend through the next year to continue to engage stakeholders internally and externally, while continually improving the processes and experience of appraisal and revalidation.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	30 July 2019

Operational Risk Register

Executive Summary

Operational risks graded 15+ and new risks are brought to the attention of the Board. There have been no other risks which specifically increased this quarter. All changes are highlighted in Red. There are currently 88 risks on the Operational Risk Register. The following report includes information on twelve of them:

- FNP Risk 113 is risk level 20 and relates to the procurement of a new information system for the national unit.

- Two Estates and Facilities risks have current scores which reduced from 15 to 6 and 20 to 12 owing to action plans being implemented. These relate to Risk 74: hard services provision, and Risk 91: scale & complexity of backlog (strategic).

- Cyber Essentials: Risk 117. The Trust is working towards completing accreditation in 2019/20.

- Three new risks have been added to the Operational Risk Register having been identified by the Electronic Referral System (eRS) project board as operational risks.

- One new risk (Risk 124) concerns the risk of 'violence and aggression' by patients to staff and /or other patients.

- Two new risks for GIC have been added (Risks 125 and 126) relating to accommodation and recruitment.

- Two new risks for GIDs have been added (Risks 127 and 128) relating to staffing, and waiting times.

Risks 9+ continue to be reviewed via the relevant governance work streams on a quarterly basis: Patient Safety and Clinical Risk; Corporate Governance and Risk; Information Governance and reported to the Clinical Quality Safety and Governance Committee. The Operational Risk Register was reviewed by the

Executive Management Team on Tuesday 23rd July 2019.

Recommendation to the Board	
The Board of Directors is asked to note the new risks, updates and actions	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Associate Director of Quality and Governance	Deputy Chief Executive / Director of Finance

The Tavistock and Portman NHS Foundation Trust

	Risk raised by whom?	Date raised		Scope of risk	Current Status	Risk Category	Risk Summary	Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	Risk Description Detail: Event (what then is the possible resulting event?)	Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps (what is the gap between initial and target risk rating? What other controls are needed|?)	L	C	Current Risk	Action Plan (Ensure date and action owner are identified)	Actions update (updated along with the current risk position)	Operational Lead	Operational monitoring group	Review Cycle	Last reviewed	Next review	Governance and reporting group	L	C	Target Risk
74	Estates and Facilities	13/04/2018	HoEFM		Open	Delivery	Hard services provision	If very limited levels of appropriately qualified staff for hard services continues within the Trust	The E&F department may not be able to provide a prompt response to hard facilities management (FM) incidents or requests	Reactive & planned maintenance may be delayed leading to a perceived reduction in quality	5	3	15	Interim arrangement in place. Works that were being undertaken by local staff that they were not qualified to perform have been stopped. Reports completed and appointments made.	3 month contract let to Target Building Solutions to maintain compliance. NHS Framework procurement in place to go live Jan 2019 Alcumus compliance report and M&E report completed. Authorising engineers appointed. Contracts in place for permanent third party provision of hard services. Compliance remediation programme in progress		2	3	6		Risk score reduced from 5x3 = 15 to current 2x3=6	Ian Garlington	Estates and Facilities Risk Action Group	Quarterly	22/07/2019	22/10/2019	Estates and Facilities Workstream	2	3	6

91	Estates and Facilities	13/04/2018	DoEFC		Open	Financial	Scale & complexity of Backlog (Strategic)	The elevated and increasing level of backlog maintenance	The Trust will not be able to address effectively as a series of separated capital "minor backlog" projects	Resulting in a increased cost and delay to delivery of the remediation in amongst the broader future Estate Strategy and increasing cost to remedy the backlog over time.	4	5	20	Full understanding of the detail of backlog including interdependencies commissioned. Fabric and M&E surveys completed New 2019/20 capital plan started	Bid for financial support issued to NCL STP Fabric and M&E survey reports 2018/19 remedial works all done		3	4	**12**	Complete Capital Plan 2019/20	Updated	Ian Garlington	Estates and Facilities Risk Action Group	Quarterly	22/07/2019	22/10/2019	Estates and Facilities Workstream	2	3	6

113	FNP	26/10/2018	DoIT	CYAF, FNP National Unit, FNP teams	Open	Financial, Delivery	If a new information system is not procured in a timely manner costs will substantially increase and the NU will be unable to meet business development and improvement ambitions, or contract requirements .	A new information system is not procured in time and the current contract renews for another year or not at all, as NS Digital are unwilling to continue supporting the current infrastructure	Substantial increased costs incurred through inaction	inability to meet NU business development and improvement ambitions, failure to meet terms of PHE contract, and violation (non-compliance) of the FNP license	4	5	20	Dedicated project to oversee the procurement and implementation of a new information system. Procurement to be led by Tavi in partnership from PHE colleagues; Discussions held with current system supplier regards contingency options beyond 31.3.20.	Commissioned an interim reactive maintenance service ; Identified preferred supplier and in negotions reagrds costs; Governance group established with representation from NU/Tavi/PHE .	Despite control measures being agreed, progress to implement is slow, thereby increasing the risk and likely consequences . Further controls include contingency planning for failure to implement new system and effective procurement and technical support to implement new system by 31.3.20; Liaison with Scottish collegues to identify enablers in developing new system including GDPR elements; Agreement of a shared risk position between Tavi SMT SRO and PHE to minimise risks in procurement and development and robust handover .	4	5	20	Liaison with Scottish colleagues to identify enablers in developing new system including GDPR elements; Agreement of a shared risk position between Tavi SMT SRO and PHE to minimise risks related to transition in procurement , development and implementation of new systrem. (Alex Stephenson (ASt) and Project Board/ Governance Group by September 2019. PHE IT and IG to be invited to attend the project board. (ASt, July 2019) Written risk statement (Oct 2019)	Conversations about shared risk position are taking place with PHE. Representatives from PHE procurement and data teams have been invited to be part of the project board.	Ailsa Swarbrick	EMT	Monthly	24/07/2019	31 August 2019	CGR workstream	3	2	6

117	IM&T	26/02/2019	SIRO	Trustwide	Open	Financial, Reputation, Compliance / Regulation	Absence of Cyber Essentials accreditation leads to increased liklihood and consequence of other IG related incidents	Absence of Cyberessentials accreditation and associated good practices in the Trust	Should IG incidents occur in the Trust When Trust is bidding for new business	Greater chance of increased frequency and impact for incidents. Financial impact of lost bid opportunities	2	4	8	Alternate controls, such as DSPT submission with complete compliance shown, for provision under contract bidding	New accreditation - existing IG workstream minutes	CyberEssentials Accreditation	2	4	**8**	Complete CyberEssentials accreditation in 2019/20 year		Ndumbe Shu	IM&T Risk Action Group	Quarterly	22/07/2019	1 October 2019	IG Workstream	1	3	3
121	E-referrals Project board	13/05/2019	Director of AFS	Trustwide	Open	Service delivery, Reputation	Implementation of new electronic referral system leading to increased GP referrals	If the implementation of the new electronic referral system leads to more referrals from GPs	then services may be unable to meet demand	increasing the pressure on staff to manage the flow of referrals, longer waiting times of patients, potential damage to relationships with commissioners, staff stress and patient dissatisfaction	2	3	6	careful implementation of the tool phased across services, reviewing progress and impact	Pilot in city and Hackney was successful and did not lead to an increase in referrals	Pilot conducted in one team working in one borough. Yet to see impact on those with higher referral numbers and/or those working in a nationwide capacity.	2	3	6	Continued review of roll out at e-referrals project board 9FH / JS) Continue to monitor impact on referral numbers and review as necessary (FH/JS)		Fiona Hartnett	E-Referrals project board	quarterly review	16/05/2019	1 August 2019		1	2	2

122	E-referrals Project board	13/05/2019	Director of AFS	Trustwide	Open	Service delivery, Reputation	Implementation of new electronic referral system leading to increased waiting times for patients to be seen	If we don't manage GP risks submitted via ERS in a timely way because of the Intake team needing to review yet another system	then there may be an increase in variable waiting times for these patients compared to referrals received by other methods	resulting in poor patient satisfaction and increased workload for intake admin teams in checking and updating another system	2	3	6	careful implementation of the tool phased across services giving opportunity to test impact and implement controls	Pilot in city and Hackney was successful and di not lead to an increase in referrals		2	3	6	Continued review of roll out at e-referrals project board 9FH / JS) Ensure sufficient training is provided to staff before roll out (July 2019 FH//JS) Continue to monitor impact onstaff and review as necessary (FH/JS)		Fiona Hartnett	E-Referrals project board	quarterly review	16/05/2019	1 August 2019		1	2	2

123	E-referrals Project board	17/05/2019	Director AFS	Clinical Services	Open	Reputation	Patients receive incorrect information about dummy appointments causing unnecessary anxiety	If we don't manage GP communications about the dummy appointments	They may ignore alerts and warning and patients could receive incorrect appointment information	resulting in unnecessary anxiety and impacting on Trust reputation	3	4	12	Project Board and phased implementation The system is set up to support external communications about dummy information. The dummy appointment is 1 minute long, out of hours and set very far in the future. Appointment type changed to 'telephone appointment' which removed the trust address from the letter eRS system alert created to advise GPs these are dummy apointments and they should not give patients any correspondence. Free text working section amended to explain this is not an actual appointment Risk raised with eRS SRO at NHS digital	Project Board minutes, issues and risk log Communications with staff about dummy information - workshops completed	No gaps	2	3	**6**	Continue to closely monitor services to confirm if any occurrences happen		Linda Williamson	E-Referrals project board	quarterly review	22/07/2019	1 October 2019		2	3	6

124	Clinical Governance	23/07/2019	MD and CCOO	Clinical services	Open	Delivery, Safety	Risk and Violence	If the changing picture of risk and increased incidents of violence are not managed	threats or actual aggression from patients and their carers may increase	risking the safety of patients and staff being compromised due to becoming victims of aggression and violence	4	3	12	The incidents were addressed and reports raised and discussed at the incident panel. A review of the Trust's response to violence has taken place.	Continuing updates to CEO, operational directors, EMT and Board on the work to contain aggression within clinical settings	Consensus of actions to be agreed and implemented	2	3	6	Various recommendations are now being discussed, with plans to build a consensus on actions (DATE/CMc)		Dr Caroline McKenna	Clinical Governance	Quarterly	23/07/2019	23 October 2019	PSCR	1	3	3
125	GIC	24/07/2019	Director of E&F	GIC service	Open	Quality of care, Reputation	GIC staff accommodation	If we have no place for new members of staff to work and sit	we will lose the clinicians who have been recruited and will not be able to see the patients we are contracted to see by NHSE	resulting in loss of clinical staff, under performance and further delays in patient care	4	4	16	We have not expanded the clinic as we would have liked due to lack of space.	Low numbers of patient seen reported to NHSE. They have uplifted our budget but are unhappy with the low performance.	We not must expand due to under performance, however, need space to expand into. Action plan required	4	4	16	Meeting with Risk Owner 25/7/2019 to identify relocation action plan		Frances Endres	GIC Executive	Monthly	24/07/2019	24 August 2019	Estates and Facilities Workstream	2	2	4

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The Tavistock and Portman
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126	GIC	24/07/2019	GIC Service Manager and Clinical Director	GIC service	Open	Financial, Reputation, Quality of care, Delivery	GIC staff recruitment	If we are unable to recruit appropriate staff, we risk underperforming, and not future-proofing our services.	then there will be no future gender clinicians to carry the work forward.	resulting in unsupported patients, lack of succession planning and inability to grow the service to support demand	3	3	9	We have been fortunate to have known of people who were interested in our vacancies and were involved in the field already. This number, however is not a large number of gender specialists so we are keen to train new staff.	We have been able to recruit to all vacancies so far. There is a new course starting with the Royal College of Physicians which is being run by Dr. Leighton Seal from our staff which will train clinicians in this area before seeking placements in GICs	The rebanding of posts in order to advertise lower banded medical staff. Filling vacant medical sessions to increase medical experience in GIC	3	3	**9**	Offer vacant medical sessions to staff grade doctors ensuring that there is a broader range of individuals who are able to apply. (Sept 2019 FE, JB) Advertise future medical roles as specialist doctor posts to broaden disciplines able to apply for roles (Sept 2019, FE, JB)		Frances Endres	GIC Executive	Quarterly	24/07/2019	24 October 2019	PSCR	2	2	4

127	GIDs	Gender Divisional Director	GID Service, Communications staff, senior management	Open	**Delivery**, financial, Quality of care, Safety, Reputation, Compliance	GIDS staffing	If internal and external scrutiny GIDS continue to escalate and involve Trust staff	Some staff may feel the work becomes too stressful, worry about being personally attacked, or find that the trust with colleagues has broken down and as a result leave the service.	Resulting in a negative impact on service delivery and a further growth to waiting list.	5	4	**20**	Support from Director and Executive leads with the GIDS team, at meetings and more widely across the Trust; Consultation support service; Staff satisfaction survey review; Proactive communications team; Gender Task and Finish Group	Staff satisfaction survey; exit interview information; GIDS information statements on Trust website in response to criticisms; Proactive communications activity aimed at both patients and the general public	Strategy around new staff, Strategy around new staff, Further detailed analysis of Exit interviews, Build on positive staff survey results and ESQ	5	4	**20**	Strategy for supporting staff (30/9/2019 KH) Comms exercise (6/9/2019 LT) Analysis of Exit interviews (ongoing) Agree actions to progress from the positive survey results (30/9/2019 KH/PC)		Polly Carmichael	GIDs Executive	Monthly	25/07/2019	25 August 2019	PSCR	3	4	12

128	GIDS	25/07/2019	Gender Divisional Director	GID Service	Open	**Safety**, delivery, financial, Quality of care, Reputation, Compliance	GIDS waiting times	If referrals continue to increase and activity stays at current rate, waiting times will continue to increase.	There may be a possible increased chance of a serious incident for a YP on the waiting list, and increased anxiety and stress for those patients waiting. There is a risk that many YP will never access GIDS, and be referred to GIC without prior psychosocial assessment	The service could be decommissioned by NHSE. Clinical risks will need to be managed as they arise – likely taking more clinical time, again increasing wait time through time required per patient. More time will need to be spent managing reputation of service via media requests and stakeholder engagement. Burden on primary care increases.	4	5	20	Recent increases in the staff base to increase resources taking cases from the waiting list. DNA and cancellation policy revised so that people not engaging with service can be discharged. Caseload and activity monitoring on staff has increased, with clearer guidance on how many new patients should be seen per staff member per month. Waiting list initiatives: - Moving YP approaching adult age to appropriate waiting list or discharging via clinical phone call. - Calling YP to gather more information at referral point to reduce burden on assessment phase. - Liaising with referrer in consultation style to effectively manage concerns locally. - Liaising with local CAMHS services to better educate primary care on effective	Waiting list reports showing continued increases (-) High numbers of staff leaving counterbalances work undertaken to expand staff base. (-) New staff take time to effectively train. (-) GIDS action plan (+)	More evidence in terms of what most effective actions can be taken on waiting list to inform focussed prioritisation of initiatives.	4	5	**20**	Identify guidance/ criteria on which YPs service is most appropriate for. (Sept 2019 PC) Undertake regular audits to understand factors impacting on the waiting times (Sept 2019 and then ongoing, KH) Explore communications with patients to improve awareness of waiting times (Sept 2019 KH/PC)		Polly Carmichael	GIDs Executive	Monthly	25/07/2019	25 August 2019	PSCR		2	5	10

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	30th July 2019

Annual Complaints Report 2018-19: Patient Services

Executive Summary

Complaints have remained at a similar level over the past year compared to 2017-18. At the beginning of 2018 there was an increase in complaints in GIC which was partly due to the reorganisation of the administration structure at the clinic. This unfortunately coincided with staff sickness and annual leave which meant that the response times for many of the complaints were much longer than the Trust's time frame of 25 working days.

The new post within the Gender Identity Clinic to assist with Complaints, PALS and PPI has had a positive impact on complaint handling within the Gender Identity Clinic. Some issues are resolved before they become complaints, when a complaint is received Complainants are contacted within a few days to resolve any immediate issues.

Complaint numbers within CYAF (excluding GIC) have remained at approximately the same level, there has been an increase in complaints to AFS.

Recommendation the [Board / Committee]

The Board is asked to approve this report

Trust strategic objectives supported by this paper

Improve the effectiveness and quality of patient experience.
Continue to meet regulatory standards with CQC.

Author	Responsible Executive Director
Amanda Hawke, Complaints Manager	Paul Jenkins, Chief Executive

The Tavistock and Portman
NHS Foundation Trust

Annual Complaints Report

1. Introduction

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. The majority of our complaints continue to be received within the Gender Identity Clinic. The themes relate to waiting times and communications with a smaller number relating to aspects of clinical decision making, access to therapy, disagreement with clinical reports and information governance incidents. This report summarises the complaints received in the year, and the lessons learned from this important form of patient feedback.

This complaint report covers formal complaints received by clinical and corporate services. All complaints relating to Education and Training are logged and responded to by the Dean.

2. Analysis

A total of 156 complaints were received for the year, 152 of these relate to our clinical services and 4 complaints relate to corporate services.

18 complaints were received in the Adult and Forensic Directorate,
134 were received in the Children, Young Adults and Families Directorate (101 of these relate the Gender Identity Clinic)
4 were received in the Corporate Directorate.

Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant.

During 2018/19 two complaints were investigated by the Parliamentary and Health Service Ombudsman, one was not upheld and one was partially upheld. An apology was sent to the complainant as directed by the Ombudsman. During the year there have been two further preliminary enquiries from the Ombudsman and information has been supplied as requested.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, to ensure that improvements to our services are made we have instigated a more robust system of actions plans following upheld complaints.

Complaints presentations are given at Induction Days and INSET days to ensure that staff are aware of the complaints procedure and how to advise patients who wish to make a complaint. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

As reported last year we now use the Quality Portal to manage all complaints received in the Trust. This is working well for complaints management and work is continuing on managing action plans that arise from upheld complaints. Patients are able to submit a complaint on-line via our website alternatively they can be submitted by email or letter and these are then uploaded onto the Quality Portal by the Complaints Manager.

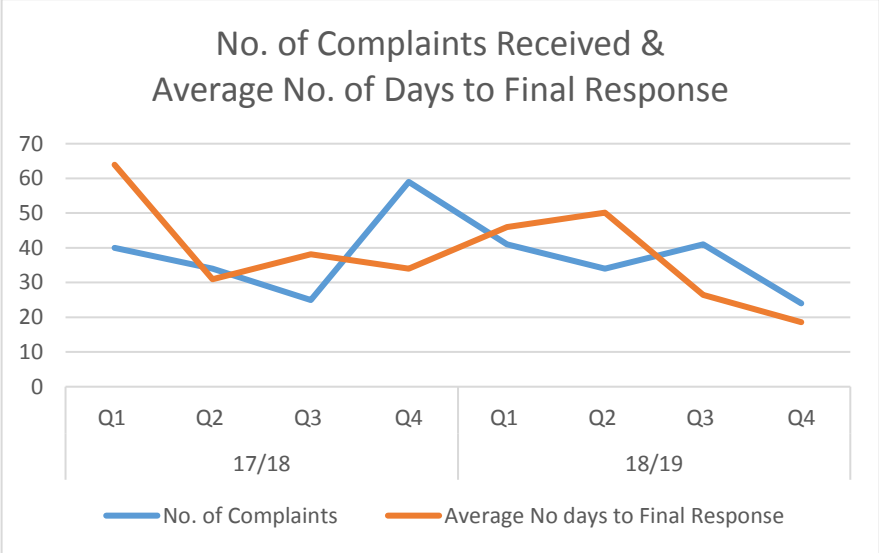
3. Formal complaints received

The chart below shows the numbers of formal complaints over the past 6 years.

Year	2014-15	2015-16	2015-16	2016-17	2017-18	2018/19
No of formal complaints	12	14	27	39	154	156

4. Time to respond to complaints

Of the 156 complaints received in 2018-19 all have now been sent a formal response. Due to the increase in formal complaints received at the beginning of 2018 it had not been possible to respond to all of these within 25 days as we had been aiming to do previously. The table below shows the numbers of complaints and the response times. There was a sharp increase in complaints in Q4 2017/18 which coincided with staff sickness and an admin restructure in the GIC. As can be seen from the graph this impacted on the response times for complaints. It was not until January 2019 that response times were back to largely within 25 working days. Patients were kept informed if their complaint response was going to be longer that the target of 25 working days.



5. Complaints by Directorate and Service

Of the 156 complaints received 101 of these were relating to the Gender Identity Service so the number of complaints received by the rest of the Trust is 55. Although this is an increase from the previous year complaints are still relatively low.

The table below shows the number of complaints by directorate over the past 5 years.

Directorate	Number of Complaints					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
CYAF	5	5	19	28	143	134
A&F	7	9	6	8	7	18
Corporate	0	0	2	3	4	4
Total	**12**	**14**	**27**	**39**	**154**	**156**

Data source: Quality Portal

6. Complaints Upheld

There is a recognition that patients feel listened to when it is acknowledged that even small errors have occurred, even if the

main basis of their complaint has not been upheld. 89 complaints were upheld fully or in part. Following these decisions action plans have been completed for each complaint so that improvements can be made to the services.

Was the complaint upheld?	2014-15	2015-16	2016 - 17	2017-18	2018-19
Upheld in full	0	7	8	41	45
Upheld in part	3	7	11	21	44
Not upheld	9	9	14	50	67
Under investigation at time of report	2	4	6	42	0
Total complaints	14	27	39	154	156

Data source: Complaints database

7. Lessons learned

Complaints are always considered as opportunities for lessons to be learned, whether or not the complaint is upheld.

All complaints are fully investigated and a detailed report drawn up to address all the issues raised. When a complaint is upheld either in full or in part, an action plan is drawn up to ensure that where appropriate changes are made or further training is offered. Work is continuing to enable these action plans to be managed through the quality portal.

Complaints are have been discussed at the Professional Clinical Advisory Group so that the senior staff are made aware of any themes from the complaints and appropriate action taken.

When corresponding with the complainants we seek to ensure that they feel listened to and that their concerns are being taken

seriously. Where appropriate further appointments are offered to complainants with senior staff, to ensure that any issues over our processes and their clinical treatment is clarified.

A number of specific actions have been taken during the year in direct response to complaints and these are shown in the table below:

Topic	What was upheld	Lessons learned
Clinical	Explained that the line of questioning was necessary and appropriate to gain an understanding of the patient's gender identity before endorsing for hormone therapy which would cause irreversible physical changes.	Non-binary issues to be discussed within multi-disciplinary team meeting to re-establish criteria for non-binary patients.
Information Governance	Letter wrongly addressed. Member of staff reminded of correct.	Address for letters being sent to patient must be copied and pasted from patient record to avoid errors
Waiting Times	Apologised that waiting times had risen since patient was referred. Working with NHS England to reduce waiting times.	Working with NHS England to reduce waiting times. Pilot to call 17 year olds to support smooth transition to adult services
Values and Behaviours	Acknowledged that patient was made to feel uncomfortable because of disability and that more could have been done to address her needs.	Thought to be given as to how best to support patients with disabilities
Communication	Apologised for poor communication with clinic. An appointment is to be offered in 2 weeks.	Staff to be reminded not to correspond with patients via their own email addresses.

8. Parliamentary Health Service Ombudsman (PHSO) Investigations

If a patient is dissatisfied with a response to a complaint that they have received from an NHS Trust they have the right to refer their complaint to the NHS Healthservice Ombudsman who will review the concern and may take one of three options:

- Refer the matter back to the trust for further investigation
- Undertake an investigation itself (if the complaint involves clinical matter the Ombudsman's office is required to seek expert opinion)
- Take no action

During 2018/19 two complaints were investigated by the Parliamentary and Health Service Ombudsman, one was not upheld and one was partially upheld. An apology was sent to the complainant as directed by the Ombudsman. During the year there have been two further preliminary enquiries from the Ombudsman and information has been supplied as requested.

9. Compliments

From time to time we receive compliments from patients. Below are some of the examples of the emails that we have received;

Emails received following the resolution of a complaint.

Many thanks for the response from Paul Jenkins. I appreciate the response and it is reassuring, I would like to add that after this oversight happened, the staff at Charing Cross GIC have been very helpful and have sorted things quickly and that I greatly appreciate this. Things do sometimes slip through the net, but I am very thankful in regard to how it has been handled after the issue became apparent.

Thanks again,

I just wanted to let you know I don't have the words to express my gratitude for all you & your office has done for me. I was so desperate & didn't know where to turn, thank you for listening to me & being there.

May the Goddess bless you all

Warmest regards

Mission accomplished! We all got the letters yesterday.
Thank you for the time you spent on this.
I don't think this would have been sorted if it wasn't for your involvement. For that, I'll be always grateful.

Emails received during the course of treatment

Seen by myself and Dr Houlton. A patient with comorbid physical and mental health issues, including bipolar affective disorder and ADHD, with a non-binary trans masculine identity.

He told me that Dr Sahota had been the best doctor he had ever seen. He cited her ability to listen, that she was clearly interested in hearing and understanding his history, in a professional and compassionate manner.

He was happy for me to share this with Dr Sahota, which I have done.

At her final appointment with me, considering GRS, a trans feminine patient with longstanding low mood and a sense of isolation.

She told me how her speech and language therapy sessions with Carys have been so positive and transformed her life. She now feels so much more confident in her speech and communication skills and clearly also found her sessions with Carys enjoyable. This comes from a baseline of finding life rather difficult in general.

She was happy for me to share this feedback with Carys, which I have.

These emails were shared with the staff involved and with the Chief Executive.

10. Next steps

For 2019-20 the Trust is committed to ensuring that all staff are fully aware of the different ways that patients can raise concerns. Further guidance has been issued to staff and new posters have been displayed in all patient areas on who to contact should a patient wish to make a complaint.

Complaints management will continue to be promoted at staff induction and mandatory training days (INSET) and in other settings as appropriate during the year. Administration staff, the PALS Officer, the Complaints Manager and Patient and Public Involvement (PPI) staff will continue to work together as to ensure

that patients are appropriately supported when they raise an issue.

Staff who have had a complaint lodged against them will be notified of this by the Complaints Manager and offered support as appropriate.

11. Whistleblowing

There were two whistleblowing cases recorded in 2018/19. Both of the cases were fully investigated and have now concluded.

Craig de Sousa
Director of HR and Corporate Governance, July 2018

12. Report from the Freedom to Speak Up Guardian

The Trust takes the issue of staff being able to raise concerns, or 'whistleblowing', very seriously and appointed to the role of Freedom to Speak up Guardian (FSUG) in October 2015. This is in line with the Francis Review recommendations. The Trust has in place a 'Raising Concerns and Whistleblowing procedure' and regular communications go to staff to make them aware of who the Trust's Freedom to Speak up Guardian is, their role and contact details. Regular meetings are also held with staff, in particular services and teams across the Trust, to raise awareness.

During the current year staff have approached the Freedom To Speak up Guardian to discuss a range of concerns. These have included patient safety and quality; experiences of bullying and harassment; and of feeling not listened to by managers. Experiences of not having concerns taken seriously by managers can sometimes be seen as having an indirect impact on the quality of care given to patients and families. Full details of the number of staff coming forward to speak to the FSUG during each

year are now collated by the National Guardian's office and data for the Trust can be found on their website.

During the year a number of staff concerns were raised in particular about the GIDS service. Some of these were raised with the FSUG but others were raised anonymously with a staff governor who presented these in a report to the Board of Governors. Following a report and review of the GIDS service by the Trust's Medical Director, the Trust's Director of HR has been commissioned to write a report and review the Trust's Raising Concerns Policies. The FSUG will be involved in liaising over and working on any recommendations that arise as a result.

I understand from the Trust's Director of HR that there were two whistleblowing cases recorded in 2018/19. Both of the cases were fully investigated and have now concluded.

The Trust and the FSUG are committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

The FSUG maintains regular contact with the National Whistleblowing Helpline and has also joined the NHS Employers local Guardian hub where her details are on the Freedom to Speak Up Guardian map. Links have been made with the London-based Freedom to Speak Up Guardians and with Guardians based in Mental Health Trusts. There are regular meetings arranged for these groups, which provide support for the FSUG and useful information sharing. The National Guardian's office is now well established and arranges regular conferences and training events.

The FSUG also arranges regular meetings with other senior staff with responsibilities for staff wellbeing, and meets with the CEO, Ned with raising concerns responsibilities and other managers of

services when they may need to be made aware in general of issues that are causing concern.

The FSUG will continue to keep the profile of the Guardian in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness where staff are encouraged to speak up about both patient safety and stressful work issues, knowing that their concerns will be welcomed, taken seriously and responded to quickly.

Gill Rusbridger
Freedom to Speak Up Guardian

Report prepared by
Amanda Hawke, Complaints Manager
on behalf of Chief Executive Officer

May 2019

Report to	Date
Board of Directors	30 July 2019

Report on Audit Committee Meeting – 16 May 2019

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 16 May 2019.
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 16 MAY 2019

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 16 May 2019.

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

2. CQSGC MINUTES

2.1 The Committee reviewed the draft minutes of the Clinical Quality, Safety and Governance Committee ("CQSGC") meeting of 20 February 2019. They also received a report from the Medical Director (and Chair of CQSGC).

2.2 The Committee noted the on-going discussion around the remit and terms of reference of the CQSGC and the establishment of new work streams for Research and Estates and Facilities. The Committee welcomed the reassurance from the Medical Director that there were no "overwhelming concerns" regarding patient safety and that an Incident Panel had been established, aimed at ensuring lessons from incidents were properly understood and disseminated.

3. QUALITY REPORT

3.1 The Committee reviewed the Quality Report and the external auditor's report thereon. Whilst the Committee welcomed the comment by the external auditors that the Quality Report was much improved, the Committee also noted its disappointment that the Quality Report was, again, qualified. The Committee asked that the executive team think more carefully in future about the quality indicators to be audited.

4. HEAD OF INTERNAL AUDIT ("HoIT") REPORT

4.1 This remained unchanged from the prior year – being set at level 2 – however it was noted that this was a good result given that the majority of trusts audited by RSM had seen their HoIT reports decline. The Committee noted it was pleased with the continued progress made in this area.

5. ANNUAL REPORT AND ACCOUNTS

5.1 The 2018/19 annual report and accounts ("Accounts") were scrutinised by the Committee and, in particular, the key accounting judgments underpinning the accounts, notably: Going Concern, the revaluation of property assets and the capitalisation of Relocation expenditure.

5.2 After scrutiny and discussion with the external auditors – in particular regarding the capitalisation of Relocation expenditure – the Committee approved the Accounts (together with the letter of representation).

5.3 The Committee noted that the Accounts were unqualified.

Terry Noys
Finance Director
17 July 2019

The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 4th July 2019

Key items to note

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

Staffing

The committee were informed that there had been strong interest in the Operations Director role and interviews are taking place on 24th July. The Continuing Education Development Unit (CEDU) has recruited a new operations manager. This will allow the Head of CEDU to take on a more strategic role in relation to short course and bespoke development. The new System Portfolio Manager Esther Usiskin-Cohen has started in role following Yvonne Ayo's retirement.

Long course development

The committee noted that work was progressing well in developing two proposed long courses with the University of Essex, including conducting market research with employers and students.

Fee Review

The committee noted that the fee review action plan was being implementing, and that progress had been made in relation to a number of documents, including reviewing terms and conditions and drafting a communication to students about their fees and what they have committed to pay over the course of their training.

Student Recruitment

The committee were informed that the Trust was around 30% ahead on offers accepted as compared this time last year. The Trust has received nearly 700 applications, 265 of which have now been interviewed and had offers of study accepted on them. The committee noted the work of weekly recruitment meetings involving DET exec and recruitment team in monitoring recruitment and picking up any issues with Portfolio Managers and course teams.

QAA Annual Monitoring Visit

The committee praised the work of the Directorate of Education & Training in achieving a very positive result from the QAA Annual Monitoring Visit in April 2019. The final report had been received from the QAA who had concluded that the Trust is making commendable progress with continuing to monitor, review and enhance its higher education provision since the May 2018 monitoring visit. The Chair asked the Director of Education & Training to convey the committee's appreciation for this outcome.

Scheduling and Timetabling

The committee noted the work of the lead Course Administrator and Strategic Projects Lead & Operations Coordinator in engaging Course Leads in User Acceptance Testing of the long course timetables. All courses have been built within the Scheduling system with module codes, named events, numbers of groups, time, duration, and week pattern. Following User Acceptance Testing, all amendments have been submitted to the Scheduling Team for implementation, prior to rooms being allocated to activities. Course Leads will then be engaged in further testing prior to sign-off.

On balance, the work undertaken before the next year in terms of process and timing has increased confidence in a good outcome in terms of the publication of the timetable to students, staff and VLs for AY19/20.

Alumni Strategy

The committee noted that progress is being made with the development of the alumni strategy with discussions being concluded to understand how alumni activity and data is currently managed, and to discuss allocation of resources from reassignment of TSP within the Trust. The alumni strategy is under review and an operational plan will be developed and brought back to the committee in the autumn.

HESA/HESES

The committee were informed of progress in relation to the action plan for our HESA/HESES returns due later this year. The internal audit report with the responses from the Tavistock & Portman have been shared with Essex internal committees and the Office for Students (OfS).

Annual Learning & Teaching Conference

The Annual Learning and Teaching Conference was held on 24th June 2019 and was well attended by members of our teaching staff, professional services and the wider Trust. The conference topic was 'Learning from our Learners' and the programme was developed following a consultation with a group of students in January 2019. The event began with a keynote debate between Katie Argent (Portfolio Manager and Head of Discipline) and Dom Micklewright (Dean of Partnerships at the University of Essex): 'Debating the Brand: the Tavistock Model in Higher Education'.

Office for Students Registration

The committee discussed the recommendation that we progress with applying for registration with the Office for Students. This would allow us to maintain our tier 4 licence and enable us to continue to recruit international students. The committee noted that there were a number of issues to be resolved. Registration will have implications in terms of administrative provision, and we are working to ascertain the implications of registration. The University of Essex is being supportive and is engaged with us and the OfS in discussion to understand the best way forward. The committee agreed that an application to register should be made and requested a report on the implications of this on the directorate strategy, and assurance around the business process changes that would need to take place.

Annual Student Survey

The committee noted that there had been a higher turnout rate (65 % as compared 59%) and that the overall satisfaction rating had increased from 83% to 92%. These initial results are very pleasing. A fuller report with qualitative data will be brought to the next ETC meeting.

UKVI Audit

The committee noted that the actions from the audit had been completed. Some of these were planning actions, for example in relation to what students need to be informed of during induction, and we will need to ensure that these are completed. The learning was noted, and it was agreed that we should consider having our internal spot check. Compliance and monitoring will flow through the operational managers to the Education & Training Executive.

Honorary Doctorates Process

The committee approved the nomination and approval process for honorary doctorates.

International Strategy and Resource Plan

The committee received a report on the international strategy, which outlined the three key pillars of the strategy: 1. Visitors Programme; 2. Transnational Education; 3. International Students. The committee reviewed the action plan, governance arrangements and request for resources. The committee agreed in principle to the action plan, but agreed that work was required on the business case and the outcome measures and KPIs. The governance arrangements will be kept under review.

Digital Academy

The committee received an update on the work undertaken with Pearson in order to develop a clear commercial case. There has been good engagement from staff, and two workshops have taken place: 1) Products and Market; 2) Learning design workshop. Emerging themes in terms of product mix are to have a self-directed cheaper product, and a higher engagement, higher cost model that would be stackable and modular. A B2B model is being explored in relation to selling shorter CPD courses. The committee noted the need for a contracting workstream, and work in relation to an operational delivery plan.

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	07 November 2019

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Clinical Quality, Safety and Governance Committee (CQSGC) for Q4 2018/19

Key items to note

The CQSG Committee met on 15th May 2019 to consider the Q4 reports from the following work streams:

- **Information Governance**
- **Patient Safety & Clinical Risk**
- **Clinical Quality and Patient Experience**
- **Corporate Governance and Risk**
- **Estates and Facilities**
- **Research and Development**

Information Governance Update:

The Data Security and Protection Toolkit (DSPT)

End of year compliance for the DSPT has been achieved. We passed on the 32 assertions with evidence and met the 10 data items in the DSPT. D WL also confirmed that the deep SPT will involve year-on-year to include cyber essentials this year, which is not yet mandatory.

He noted an increase in FOIs and also an increase in the complexity including the recent public publicity surrounding some of our services and sadly this is the first time we are behind though still above 80% and further efforts will be made to try to reach hundred percent.

Business Continuity Planning (BCP)

DWL confirmed that this is not part of the IG work stream it should actually sit under the corporate governance and risk work stream and noted the absence of an up to date full trust wide disaster recovery plan. DWL confirmed that a disaster recovery exercise for the trust is now planned for 5 June and this should provide the knowledge on our current BCPs and their effectiveness.

ICO Reports
There was one reportable ICO incident during Q4 and the ICO opted to take no further action is the trust's immediate response including completing our duty of candour was considered to be an adequate response.

The committee accepted the green rating for this work stream for Q4.

Patient Safety & Clinical Risk Update:

Clinical Incidents
CMK confirmed there had been no serious incidents reported in Q4 but there had been two deaths in April; 1 within the GID service and one within the GIC service. Both were apparent suicides and both are now subject to a formal SI investigation and have been reported externally on StEIS.

DS also confirmed that when a death occurs within the service whether the patient has ever been seen or not, at least an internal concise report or mortality review will be completed and submitted to the incident panel, which will then consider what further action needs to be taken.

Although clinical incidents remained consistent in Q4 and there were less reported in relation to scheduling, which has been a huge stress for staff and has on occasion impacted on patient care.

CMK highlighted the recent IG breaches and how problematic they are in relation to patient letters and some administrative processes, noting a particular example where a victim of domestic abuse had a letter sent home which her partner saw, which could have very serious implications for the patient. CMK stated we must be more robust about this in our actions and confirmed plans are in place locally to ensure clinicians and administrative teams have clear protocols in relation to sending patient letters.

Clinical risk management
CMK confirmed the clinical risk management had now been added to the trust wide risk register. There was a brief discussion around the gaps identified when the named professional had been off sick between February and April and it did impact on the of the level III children safeguard training. CMK also confirmed

there were plans for outsourced help and staff were working together to plug the gaps.

CQC compliance
CMK confirmed that all actions within the medical directorate area of the CQC action plan are on track these are currently being monitored by a fortnightly conference call chaired by the medical director. It was also noted that the EMT will monitor the CQC action plan on a regular basis and that we are expecting an inspection at some point in the autumn.

Clinical claims
CMK confirmed there were no ongoing clinical claims. On discussion, the committee asked for some detail such as if it will have an impact on clinical practice and/ or limited information, including a rough content and cost.

Complaints
Complaints CMK confirmed most of the complaints were from the GIC service, again mostly in relation to waiting times but also confirm that the service is doing its best for the patients with the current in the current clinical setting.

Safeguarding
CMK noted the gaps in safeguarding training provision and these have been addressed and the named professional was now back at the trust. CMK confirmed adult safeguarding alerts are still quite low in number, which the adult safeguarding lead is interrogating. This area of safeguarding had featured in the CQC action with plans in place to address issues.

The committee accepted the overall green rating for this work stream for Q4.

Clinical Quality and Patient Experience Update:

Outcome Monitoring
LL confirmed there were still problems with outcome measures and although there has been some improvement we need a real review regarding the number and appropriateness of measures. There are many challenges, including clinicians not always able to provide the outcome monitoring forms and often a lack of patients completing and returning the forms. LL stated that we may need to think about using new technology to increase compliance in outcome

monitoring, but also confirmed that overall we are in a good place taking into account that we have twice as many patients as we had two years ago.

CQUINs

LL noted the following CQUIN performance:

- healthy food – congratulations to Toza Catering for updating their offerings to include healthy options. Toza have been asked to do a presentation to the NHS in relation to achieving healthy eating options.
- the Living well programme has also gained more traction. 61.5% is the highest compliance we have reached on flu vaccination but we didn't reach the Cquin
- the staff survey was completed by many staff but disappointingly we did not achieve the target.

The committee accepted the overall amber rating for this work stream for Q4.

Corporate Governance and Risk Update:

Business continuity plans (BCPs)

Site visits continue to be made and agreed BCPs are now in place for most services.

Non-clinical incidents

DS asked if the number of incidents reported at Gloucester House tally with the figures and percentages presented in CMK's report and requested that going forward all reported data needs to be consistent.

Health and Safety Compliance

Work has been done to ensure compliance in both fire drills and evacuations.

Maintaining an Effective Workforce

3 doctors and 2 nurses remain outstanding with their mandatory BSL training and MS confirmed the reasons for non-compliance had been considered acceptable such as someone long term sick leave. It was noted that the new ToR should include clarity around work stream report ratings.

CGR Terms of Reference

The committee accepted the updated terms of reference for this work stream.

The committee accepted the overall amber rating for this work stream for Q4.

Estates and Facilities Update:

Overall the work undertaken and reported in this work stream has achieved continual improvement in compliance for the following areas:

- External sites – performing well in estates compliance
- Statutory and non-statutory compliance remains good with the introduction of new policies and procedures
- Health and safety – new dashboard introduced for monitoring this compliance
- Improved understanding in relation to the various leases and service level agreements in place across the Trust.

Improvements have been achieved with the newly introduced system of Premises Assurance Management (PAM), which puts the Trust in a good place overall in terms of estates compliance.

Fire Compliance
There is further work to do in relation to this area, and in some of our external sites, it is the responsibility of the landlord to ensure fire compliance in terms of regular fire drills and evacuation testing.

The committee accepted the overall amber rating for this work stream for Q4.

Research and Development Update:

The Trust is the leader on 10 externally funded grants, 5 of which were awarded in the last year.

Recruitment to research studies – this has funding implications and this year's intake has been weak but this is expected to increase in take up next year.

The LOGIC longitudinal study begins in July 2019 and as many of the recruited staff will need to provide 3 months' notice period so this has implications for our HR recruitment processes.

The Trust has had unsuccessful grant applications and although it is important to learn from these, many of which have been led by our university partners rather than the Trust itself.

The CQC report was very positive in relation to R&D and noted the strong external academic and research links the Trust has built up and noted the Trust's influence in evidence-based research and clinical practice.

We continue to work well with our external research management office Noclor who assist with the provision of data reported in relation to studies and recruitment.

The Comprehensive Local Research Network (CLRN) have been very supportive especially in relation to our collaboration in Camhs research and funding remains generous. We also have plans to improve our participation next year in other studies.

The committee accepted the overall amber rating for this work stream for Q4.

Actions required of the Board of Directors

For information, discussion and noting.

Report from	Dinesh Sinha, Medical Director
Report author	Irene Henderson, Clinical Governance & Quality Manager
Date of next meeting	n/a

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 30th JULY 2019, 2.00pm – 4.15pm
LECTURE THEATRE. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Deputy Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Deputy Chair		Verbal
1.3	Minutes of the meeting held on 28th May 2019	Deputy Chair		1
1.4	Action log and matters arising	Deputy Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Deputy Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Quality Dashboard (Q1)	Medical Director	2.30pm	3
2.4	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.40pm	4
3 Items for decision or approval				
3.1	Raising Concerns Review Report	Director of HR & Corporate Governance	2.45pm	5
4 Items for discussion				
4.1	RES Strategy Update	Director of HR & Corporate Governance	3.00pm	6
5 Items for information				
5.1	Board Assurance Framework	Chief Executive	3.15pm	7
5.2	Quality and Performance Reviews	Medical Director	3.20pm	8
5.3	Serious Incidents Quarterly Report (Q1)	Medical Director	3.25pm	9
5.4	Guardian of Safe Working Report (Q1)	Medical Director	3.30pm	10

		Presenter	Timing	Paper No
5.5	Responsible Officer's Revalidation Annual Report	Medical Director	3.35pm	11
5.6	Operational Risk Register	Associate Director of Quality & Governance	3.40pm	12
5.7	Complaints and Whistleblowing Register	Complaints Manager	3.45pm	13
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.50pm	14
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.55pm	15
6.3	Training and Education Committee	Committee Chair	4.00pm	16
6.4	Strategic and Commercial Committee	Committee Chair	4.05pm	Verbal
6.5	Clinical Quality, Safety and Governance Committee	Committee Chair	4.10pm	17
8 Any other business				
9 Date of Next Meeting				
	24th September 2019 – 1330 – 1700 – The Lecture Theatre, Tavistock Centre, Belsize Lane, London, NW3 5BA			