The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 26th November 2019

1.30pm–4.25pm
Lecture Theatre
5th Floor
Tavistock Centre,

120 Belsize Lane,
London,
NW3 5BA

The Tavistock and Portman NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 26th NOVEMBER 2019, 1.30pm – 4.25pm
LECTURE THEATRE, 5TH FLOOR. THE TAVISTOCK CENTRE, 120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	1.30pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 24th September 2019	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	1.40pm	Verbal
2.2	Chief Executive's Report	Chief Executive	1.50pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.00pm	3
2.4	Quality Dashboard (Q2)	Medical and Quality Director	2.05pm	4
3 Items for decision or approval				
3.1	Audit Committee Terms of Reference	Deputy Chief Executive / Director of Finance	2.10pm	5
3.2	NHS Pledge on Reduction of Single Use Plastics	Director of Estates, Facilities and Capital Projects	2.15pm	6
4 Items for discussion				
4.1	Tavistock Centenary	Projects Director	2.25pm	7
4.4	Data Security – Serious Incident Report	Director of HR & Corporate Governance	2.35pm	8
5 Items for information				
5.1	Board Assurance Framework	Chief Executive	2.45pm	9
5.2	Operational Risk Register	Deputy Chief Executive / Finance Director	2.55pm	10

		Presenter	Timing	Paper No
5.3	Serious Incidents Quarterly Report (Q2)	Medical and Quality Director	3.00pm	11
5.4	Guardian of Safe Working Report (Q4)	Medical and Quality Director	3.05pm	12
5.5	CQC Action Plan update	Medical and Quality Director	3.10pm	13
5.6	Gloucester House Annual Report	Head Teacher	3.20pm	14
5.7	Student Survey and AY 2019 Student Recruitment	Director of Education & Training/Dean	3.30pm	15
5.8	Technology and Transformation Report	Director of Technology & Transformation	3.40pm	16 – Late
5.9	People Strategy Report	Director of HR & Corporate Governance	3.45pm	17
6. Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.55pm	18
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	4.00pm	19
6.3	Clinical Quality, Safety and Governance Committee	Committee Chair	4.05pm	20
6.4	Education & Training Committee	Committee Chair	4.10pm	21
8 Any other matters				
8.1	Questions from Public Observers	Trust Chair	4.15pm	
8.2	Any other business	All	4.20pm	
9 Date of Next Meeting				
	28th January 2020, 1.30pm – 5.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			

Board of Directors Meeting Minutes (Part 1)
24 September 2019 from 2.00pm to 4.20pm

Present:			
Paul Burstow Trust Chair	Dinesh Bhugra Deputy Chair / Non-Executive Director	David Holt Senior Independent Director	David Levenson Non-Executive Director
Deborah Colson Non-Executive Director	Helen Farrow Non-Executive Director	Paul Jenkins Chief Executive	Terry Noys Deputy CEO / Director of Finance
Sally Hodges Clinical Chief Operating Officer	Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Dinesh Sinha Medical and Quality Director	Chris Caldwell Director of Nursing and System Workforce Development
Rachel Surtees Director of Strategy	Craig de Sousa Director of HR & Corporate Governance	Tim Kent Divisional Director - AFS	Ailsa Swarbrick Divisional Director – Gender Services
Rachel James Divisional Director - CYAF			
Attendees:			
Fiona Fernandes Business Manager Corporate Governance (notes)	Fiona Nolan Governor – Stakeholder University of Essex	Kamalpreet Singh Care Quality Commission Inspector	
Apologies:			
None			

Actions

AP	Item	Action to be taken	Resp	By
1	1.3.1	Minor amendments to the minutes of the previous meeting.	CdS	Immed

1. Administrative Matters

1.1 Chair's opening remarks and apologies

1.1.1 Prof Burstow welcomed all of those in attendance. With a special welcome to Mr Levenson, Mr Kent and Ms Keise to their first meeting of the Board of Directors.

1.1.2 Apologies were noted, as above.

1.2 Board members' declarations of interests

1.2.1 Mr Holt declared that he is the interim chair at the Whittington Hospital NHS Trust.

1.3 Minutes of the meeting held on 30 July 2019

1.3.1 The meetings of the previous meeting were approved as an accurate record of the meeting, subject to minor amendments [AP1].

1.4 Action log and matters arising

1.4.1 All of the items on the action log were noted as completed.

2. Operational Items

2.1 Chair and Non-Executives' Reports

2.1.1 Prof Bhugra delivered a verbal report and particularly highlighted that he had:

- Recently attended a meeting for mental health and well-being of staff.
- Experienced a number of issues with arranging a service visit during the summer.
- Received interest from the National Institute of Mental Health in Bangalore about the trust's work and that the organisation would like to engage in a fuller discussion on consultative supervisions.

2.1.2 Responding to Prof Bhugra, Mr de Sousa noted that he was sighted on the issues about service visits and he and Dr Hodges would address the issue.

2.1.3 Prof Burstow reported that he had attended an event in Washington at the International Institute for Mental Health Leadership, who are looking at widening their membership to South East Asia and the Nordic areas. He emphasised that there was a striking focus on co-production being an essential component, and a clear message of lived experience and designing new innovations.

2.1.4 Mr Levenson noted that he had a full day of induction meetings that were organised and thanked those who arranged it.

2.1.5 Dr Colson reported that she had attended a King's Fund Health and Care event where the context was set on the scale of the number of patients seen in different sectors.

2.1.6 The board of directors noted the reports.

2.2 Chief Executive's Report

2.2.1 Mr Jenkins presented the report and particularly highlighted:

- A data breach had occurred affecting one of the Trust's clinical services. He expanded noting that the matter was promptly reported to the Information Commissioner's Office, the commissioners and an internal serious incident investigation was currently underway.
- Good progress continued to be made against the gender identity development service (GIDS) action plan, the work was being led by Ms Swarbrick.
- A group of parents attended the last council of governors meeting who shared the experiences of their children with gender dysphoria. He

highlighted that a meeting would be set to meet with this group of parents for a fuller discussion in due course.

- There had been a significant increase in the number of freedom of information requests connected to the gender services. A new reporting format had been developed to give the board oversight of the volume and themes of requests.

- As part of the north central London long term plan, work was being progressed to refresh the mental health chapter. He particularly highlighted that the footprint had a significant financial challenge and the programme's ambitions will need to reflect a constrained context.

- The Trust had held its welcome week with 580 new students having been enrolled for this academic year.

- Many of the issues with the electronic scheduling solution had now been resolved and the system was used to successfully deliver the 2019/20 academic room timetable.

- A chief executive's questions time was held in September focusing on environmental issues.

2.2.2 Reflecting on the GIC data breach, Dr Colson and Dr Sinha noted the issue was discussed at clinical, quality, safety and governance committee and the incident panel respectively. They emphasised that assurance was provided on the interim steps being taken to limit the number of people an email could be sent to.

2.2.3 Responding to Ms Levenson, Mr Noys noted that both the human resources and information technology functions receive a high volume of freedom of information requests.

2.2.4 In response to a question from Ms Farrow, Mr Noys noted that the subject of our freedom of information requests vary from generic ones sent to all NHS organisations to very specific ones about the Trust's services.

2.2.5 Reflecting on a question from Ms Keise, Dr Hodges noted that there remains to be turnover within the GIDS but work continues through the action plan to try and address this.

2.2.6 The board of directors noted the report.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- The Trust had achieved a year to date surplus of £105k which was higher than plan.

- Non-pay costs were below budget.

- Pay costs were below budget.

2.3.2 Responding to Mr Holt, Dr Hodges noted that the Trust had developed a clinical service activity recovery plan.

2.3.3 The board of directors noted the report.

3. Items for decision or approval

3.1 Workforce race equality standard (WRES)

3.1.1 Mr de Sousa presented the standard and particularly highlighted:

- The board of directors had received a report on the progress of the organisation's race equality strategy in July.
- The standard presented provided the granular statistical data for the board's consideration.
- There had been a marked change in the perception of black, asian and minority ethnic (BAME) staff's views on fairness of recruitment and promotion.
- There remained a disparity of BAME staff experiencing bullying and discrimination.

3.1.2 Responding to Mr Holt and Ms Keise, Mr de Sousa noted that diversity representatives were now required for all interview panels.

3.1.3 In response to a further question from Mr Holt, Mr de Sousa noted that an audit would be conducted of recruitment processes to assess how well objective appointment criteria was being utilised.

3.1.4 In response to Prof Bhugra, Mr Jenkins noted that the NHS England regional office had made WRES a priority focus area.

3.1.5 The board of directors noted the standard and approved the motion for the data to be submitted.

3.2 Workforce disability equality standard (WDES)

3.2.1 Mr de Sousa presented the standard and emphasised:

- This was a new equality standard developed by NHS England.
- There was a data gap in the number of staff declaring whether, or not, they have a disability. He emphasised this relates mainly to staff who were employed before 2007 which was before the national HR solution was introduced.
- An initial action plan was presented for consideration.
- Focus groups would be set up to take place in the new year to correlate the staff survey data and staff experience.

3.2.2 Mr Rock noted that in October a dean's forum had taken place and noted that there was

3.2.3 Responding to Mr Levenson, Mr de Sousa confirmed that disability staff quotas were abolished in the mid-90s.

3.2.4 The board of directors noted the standard, action plan and approved the decision for the statistical return to be submitted.

3.3 The foundation trust constitution

3.3.1 Mr de Sousa presented the revised version of constitution and highlighted:

- The trust was part of the first wave of foundation trusts to be established.
- The current constitution had not been reviewed in its entirety for some years.
- A new section had been incorporated which was the governance framework.
- Criteria surrounding disqualification from being a member and a non-executive director had been updated and expanded.
- New indemnity clarifications had been added to the constitution, specifically for governors.
- The constitution had, broadly, been aligned to the Department of Health and Social Care model document.

3.3.2 Responding to Mr Rock, Mr de Sousa noted that a further review of the student constituency qualification criteria would happen in due course.

3.3.3 In response to a challenge from Mr Holt, Mr de Sousa noted that a non-executive director would cease to become a member in circumstances where the disqualification criteria applied or if they cease to be a resident in England or Wales.

3.3.4 Reflecting on a comment from Mr Levenson, Mr Noys noted that the organisation's standing financial instructions would be reviewed in light of the constitutional changes to ensure consistency is maintained.

3.3.5 The board of directors approved the revised constitution.

4. Items for discussion

4.1 Clinical, quality, safety and governance committee annual review

4.1.1 Dr Sinha present the committee's annual review report and particularly emphasised:

- The committee has spent a lot of time in the last year reviewing the operational and strategic flows of assurance.
- A new assurance group had been established to improve the flow of information about estates and health and safety compliance to the committee.

- Estates compliance had significantly improved from the previous year.

- The action plan arising from the 2018 Care Quality Commission inspection process continued to be overseen and assured by the committee.

4.1.2 Responding to Mr Holt, Mr de Sousa noted that agency workers engaged by the Trust are provided by framework suppliers which issue checklists of the statutory checks that are required before a worker commences.

4.1.3 In response to Ms Farrow, Dr Sinha noted that work was continuing around the capturing and reporting of outcome measures. Dr James noted that further work was required to the electronic patient record system to facilitate this.

4.1.4 The board of directors noted the report.

5. Items for Information

5.1 Research strategy update

5.1.1 Dr Sinha delivered a verbal report on the organisation's research ambitions. He particularly emphasised:

- The current strategy requires a refresh.

- Dr Colson and Dr Sinha meet regularly regarding the organisations research endeavours.

- Work was underway to map all of the research activities that are currently active and record these on a central database.

- The directorate of education and training lead a number of areas of research which was important to note.

- The national workforce skills development unit lead on a number of national research initiatives.

5.1.2 Dr Colson noted that a number of meetings had taken place with various staff across the organisation and a permanent research group was beginning to form.

5.1.3 The board of directors noted the report.

6. Committee reports

6.1 Equality, diversity and inclusion committee

6.1.1 Mr de Sousa presented the report noting that the committee's focus had been on the preparations for black history month in October.

6.1.2 The board of directors noted the report.

6.2 Clinical, quality, safety and governance committee

6.2.1 Dr Sinha presented the report and highlighted:

- Dr Caldwell had now become the chair of the clinical quality and patient experience workstream.
- The committee received a report that there were gaps in toy cleaning compliance, however, on further review there is full compliance on this area.
- Levels of reported aggression and violence had increased and further work was being undertaken in this area, including assessing building access.
- Work was continuing to finalise the flows of assurance and the committee's terms of reference.

6.2.2 The board of directors noted the report.

7. Any Other Business

7.1.1 Mr Noys noted that the organisation had assessed it preparedness for the United Kingdom's exit from the European Union and the Trust was submitting situation reports to NHS England on a regular basis. He emphasised the impact for the Trust was minimal based on the fact that the organisation does not hold medicine supplies, medical electronics or consumables.

7.1.2 The meeting closed at 4.20pm.

Report to	Date
Board of Directors	26 November 2019

Chief Executive's Report

Executive Summary

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

Recommendation to the Board

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

All strategic objectives

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. GIDS action plan

1.1 The first phase of the work to meet the recommendations in the GIDS action plan has been to establish structures and systems across the Trust to enable continued quality and oversight as the organisation grows. Over the spring and summer, a great deal of work has been done to develop and introduce this infrastructure, which is now providing a solid framework to support the implementation of further recommendations. By Christmas we will have developed and disseminated a number of new and updated GIDS Standard Operating Procedures, including in relation to key areas such as safeguarding and consent; and will have revised and disseminated guidance for all Trust staff on raising concerns. We have also started work on addressing GIDS waiting list challenges; on scoping new processes for disseminating regularly and consistently robust referral data; and have started work to develop a new staff training and learning programme. We will publish a full annual progress update in the Spring.

2. Race Equality

2.1 As reported in my July Board report we have been progressing some additional actions for responding to issues raised with me and Paul Burstow when we attended the BAME staff network. These are summarised at **Annex A** (to follow).

2.2 We received a visit earlier this month from John Brouder the former CEO of NELFT who is now leading on Race Equality issues across London.

2.3 We enjoyed a number of excellent and well attended Trust events organised by members of the BAME Network to mark Black History Month.

3. IG Incident

3.1 Craig de Sousa has now completed his serious incident investigation into the IG incident which happened on 6th September. The report, which has now been submitted to the Information Commissioner's Office, is tabled later in the agenda.

3.2 There are some important lessons for us to learn from the incident and we are proposing to implement in full the recommendations made in Craig's report. We will ensure the Board is kept sighted on progress against these actions.

4. Environmental

4.1 I have been working with Ian Garlington, our estates consultant, to identify actions we could take to strengthen our visible commitment to reducing our environmental impact. This is an issue where there is also a significant measure of staff interest and support and I used my CEO Question Time in September to explore these issues.

4.2 In the light of this, a paper is included later in the agenda asking the Board to confirm a commitment to work to eliminating single use plastics in the Trust and to take a number of other steps to increase our profile on environmental issues.

5. Staff Wellbeing Collaborative

5.1 As the Board will be aware, the National Workforce Skills Development Unit was commissioned by HEE to produce a framework for managing stress and resilience in the NHS Workforce. The framework was launched in April.

5.2 In October I presented the framework with elements of the work we had undertaken on the ADD Wellbeing programme. As part of this we offered to establish a collaborative for NHS organisations who were interested to work together to address these issues.

5.3 A number of organisations have signed up to be part of this initiative including SW London STP.

6. Flu campaign

6.1 The Trust launched its annual influenza vaccination programme in October and to date the Trust has delivered 242 vaccinations to staff.

6.2 The campaign has been administered by the Trust's new occupational health and wellbeing provided and has seen a high level of engagement, but there is still more work to do to increase our uptake rate amongst our clinical facing workforce.

6.3 Further onsite vaccination clinics are being scheduled to happen at the Tavistock Centre in December and the Trust's HR team are also offering vouchers which staff can redeem at various community pharmacies across the country which offers better access for our satellite based staff.

Paul Jenkins
Chief Executive
19th November 2019

Report to	Date
BOARD	26 November 2019

Finance and Performance Report – September 2019

Executive Summary

The Finance and Performance Report for the six months ending September 2019 is attached.

This shows a net YTD surplus of £86k, versus a Budget deficit of £(499)k, a positive variance of £584k.

All Directorates are above Budget.

Income is £1,049k below Budget reflecting: lower than Budget new business income; lower DET income (Portfolios and Child Psychotherapy trainees); lower CYAF income (Camden CAMHS and Complex Needs); and deferral of NIHR grant income.

GIDS / GIC income is shown at budgeted levels. TAP income is also at budgeted levels and assumes the £300k risk element is fully achieved.

Staff costs are £1.136k below budget reflecting lower than Budget new business income and the fact that most of the areas within the Trust have been carrying vacancies plus some Budget staff costs are now reflected in non-staffing (consultancy) costs. Staff WTE is 678 versus Budget of 717 (a variation of 5%).

Non-staff costs are below Budget reflecting, in particular, delayed office moves.

Cash flow is better than Budget reflecting higher than Budget surplus, lower than Budget capital expenditure and better than budget performance on working capital (debtors and creditors).

Recommendation to BOARD

The Board is asked to note the report

Trust strategic objectives supported by this paper

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 6 **Sep-19**

Section

Period 6
30 September 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	26,401	**28,018**	29,067	(1,049)	**(4)%**
Staff costs	(18,737)	**(20,386)**	(21,522)	1,136	**5%**
Non-staff costs	(5,977)	**(6,429)**	(6,911)	482	**(7)%**
Operational costs	(24,714)	**(26,815)**	(28,433)	1,618	**6%**
EBITDA	1,687	**1,204**	635	**569**	**90%**
- Margin	6%	**4%**	2%		
Interest receivable	13	29	18	11	62%
Interest payable	(13)	(21)	(25)	4	(16)%
Depreciation / amortisation	(596)	(802)	(802)	(0)	0%
Public Dividend Capital	(325)	(325)	(325)	0	(0)%
Restructuring costs	(25)	0	0	0	
Net surplus	741	**86**	(499)	**584**	**(117)%**
- Margin	3%	**0%**	(2)%		

COMMENTARY

The YTD Trust surplus is £86k, which is £584k above budget.

Revenue is £1,049k below budget due mainly to reduced new business and Trainee income in DE reduced new business and complex needs revenue in CYAF and reduced levels of programme gra in Corporate research

Pay costs are £1,136k below budget, with underspends in E&T (NWSDU and Portfolios), CYAF (GI AFS (Adult Complex Needs and City & Hackney) and a range of areas within Corporate including fi

Non pay costs are £482k below budget due mainly to underspends in GIDS/GIC as a result of redu and delayed office moves and new business in DET.

	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
Intangible assets	155	155	155	155						
Land and buildings	19,771	20,052	20,396	20,573						
IT equipment	3,479	3,487	3,471	3,472						
Other	0	0	0	0						
Property, Plant & Equipment	23,249	23,538	23,867	24,045	0	0	0	0	0	0
Total non-current assets	23,405	23,694	24,022	24,201	0	0	0	0	0	0
Trade and other receivables	3,291	6,677	5,257	7,796						
Accrued Income and prepayments	6,336	3,456	3,290	3,833						
Cash / equivalents	7,426	9,866	9,768	8,537						
Total current assets	17,053	19,999	18,315	20,167	0	0	0	0	0	0
Trade and other payables	(2,552)	(2,528)	(2,413)	(2,861)						
Accruals	(4,216)	(4,017)	(5,159)	(4,416)						
Deferred income	(2,890)	(6,006)	(3,831)	(6,154)						
Provisions	(120)	(118)	(74)	(78)						
Total current liabilities	(9,778)	(12,669)	(11,477)	(13,509)	0	0	0	0	0	0
Total assets less current liabilities	30,680	31,024	30,860	30,858	0	0	0	0	0	0
Non-current provisions	(248)	(248)	(248)	(248)						
Long term loans	(4,000)	(4,000)	(3,760)	(3,778)						
Total assets employed	26,432	26,776	26,852	26,833	0	0	0	0	0	0
Public dividend capital	3,474	3,474	3,474	3,474						
Revaluation reserve	12,621	12,621	12,621	12,621						
I&E reserve	10,338	10,682	10,758	10,739						
Total taxpayers equity	26,433	26,776	26,852	26,833	0	0	0	0	0	0

Period 6

30 September 2019

	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	YTD Act £'000
Net Surplus	(315)	343	77	(20)	86
Depreciation / amortisation	401	134	132	135	801
PDC dividend paid	163	54	54	54	325
Restructuring costs					0
(Increase) / Decrease in receivables					0
Increase / (Decrease) in liabilities	(1,100)	2,202	3	(681)	424
Increase / (Decrease) in provisions					0
Net Interest paid	(1)	(1)	2		(0)
Net operating cash flow	(853)	2,732	269	(512)	1,636
Interest received		18	5	6	29
Interest paid				(18)	(18)
PDC dividend paid				(291)	(291)
Restructuring costs					0
Cash flow available for investment	(853)	2,750	274	(816)	1,356
Purchase of intangible assets	0				0
Purchase of property, plant & equipment	(290)	(310)	(150)	(415)	(1,165)
Net cash flow before financing	(1,143)	2,440	124	(1,231)	191
Drawdown of debt facilities	0				0
Repayment of debt facilities	0		(222)		(222)
Net increase / (decrease) in cash	**(1,143)**	**2,440**	**(98)**	**(1,231)**	**(31)**
Opening Cash	8,569	7,426	9,866	9,768	8,569
Closing cash	**7,426**	**9,867**	**9,768**	**8,537**	**8,538**

	6	ANNUAL £000 Fcst	ANNUAL £000 Budget	ANNUAL £000 Var	Y.T.D £000 Actual	Y.T.D £000 Budget	Y.T.D £000 Var
PROJECT							
SITS Phase 2		(0)	-	0	(0)	-	0
Endpoint Replacement 2019/20		265	259	(6)	149	43	(106)
Endpoint Procure/Config/Compliance/Monitor		174	167	(7)	77	126	49
e-Referrals System Implementation		53	54	1	38	54	16
Tavistock Centre Data Centres Power Provision		65	65	1	-	65	65
IMT Service Improvement		8	30	22	8	30	22
Digital Dictation, Transcription, & Hybrid Mail		40	-	(40)	-	-	-
Cyber Essentials		9	16	7	-	16	16
Care Notes Renewal		(15)	-	15	(15)	-	15
Health Information Exchange		350	15	(335)	116	5	(111)
MyTap Annual Upgrade 2019/20		188	41	(147)	146	41	(105)
Health & Social Care Network		28	33	4	-	33	33
Endpoint Replacement 2018/19		(16)	-	16	(16)	-	16
DET Record Management System		(3)	-	3	(3)	-	3
Scheduling & Robotic Process Automation		358	404	46	137	134	(4)
Network Replacement		47	-	(47)	17	-	(17)
STP FUNDING		(350)	-	350	(116)	-	116
IT		**1,202**	**1,085**	**(117)**	**538**	**547**	**9**
Ventilation		71	59	(12)	26	50	24
Safety		30	31	1	-	31	31
Pumps		30	29	(1)	-	29	29
Water		63	68	5	-	50	50
Electrics		54	66	13	-	48	48
Agile Working		30	33	3	6	33	27
LH - 67 Belsize Lane		46	18	(28)	46	18	(28)
Clapham Junction Re-fit		26	28	1	26	28	1
Finchley Road		241	-	(241)	1	-	(1)
Tavistock Centre - Phase 1		60	-	(60)	-	-	-
ESTATES		**714**	**396**	**(318)**	**105**	**351**	**245**
RELOCATION		**1,316**	1,322	**6**	**324**	**497**	**174**
DIGITAL ACADEMY		**228**	505	**277**	**3**	**122**	**119**
TOTAL		**3,460**	**3,307**	**(153)**	**970**	**1,516**	**546**

IT

£350k for STP funded projects (HIE) - £116k invoiced to date; internal staff capitalisation based on IT cost rates

Estates

Forecast updated - includes £300k for unbudgeted projects (£240k Finchley Road, £60k Tavistock - Phase 1)

Relocation

Forecast reflects latest timeline per Sep Programme Board adjusted for £70k of public consulation costs

Digital Academy

Based upon business case which was approved at September Trust Board.

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: November 2019

Report to	Date
Board of Directors	November 2019

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q2 quality metrics for the Trust. The Commentary section provides service updates on waiting times and 'DNAs', 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 report includes the following **highlights and improvements**:

- The total number of referrals received is a new addition to the report on page 1, which shows an increase in referrals Trust wide, and specifically for TAP, C&H and GIC. Rejected referrals for Q1 & Q2 2018/19 are ~5% whilst for 2019/20 are ~3%.
- The number of contacts is now analysed per quarter rather than YTD
- It includes waiting times improvement for Portman, C&H and most of CYAF service lines, especially for second appointments target.
- Trust DNA rates continue to perform over target
- MHSDS and DQMI continuous improvement of collection rates over the last year and shows further improvement in three areas where we have been showing consistently poor data – ethnicity; employment status (adults) and accommodation status (adults)
- Patient Safety Incidents now split across our three divisions
- Among our outcome measures, CORE improvement rates have improved compared to Q1. Goal Based Measure completion rates increased in Q2 from a dip in Q1, including Time 2 completion of 41%. There is a QI project in Camden North and South to continue to improve these.

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

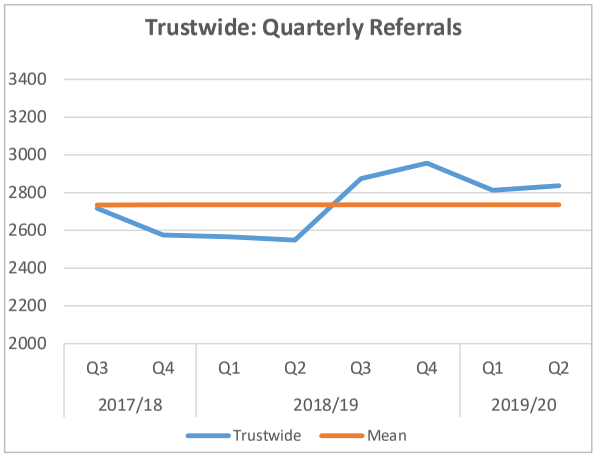
- These include the ongoing waiting times for Gender Services and Adult Complex Needs
- A review of all patient contacts seen across the Trust shows that numbers have reduced compared to Q2 2018/19. We have produced a plan for mitigation of the issues identified
- Number of complaints increased in Q2 compared to Q1 – to the highest number over the last two years
- GBM and CGAS collection rates under target, though there is some improvement compared to Q1
- CORE low collection rates for End of Treatment, report review being considered

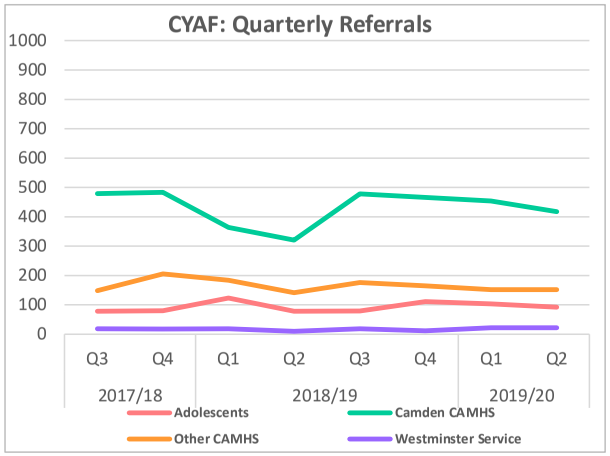
- An update of the Trust communications position specific to media particularly highlights the impact of the recent GIDS related coverage.
- HR mandatory training rate drop, the inset training days under review
- SNOMED codes for specialist service currently under CQUIN target, measures to improve compliance in development

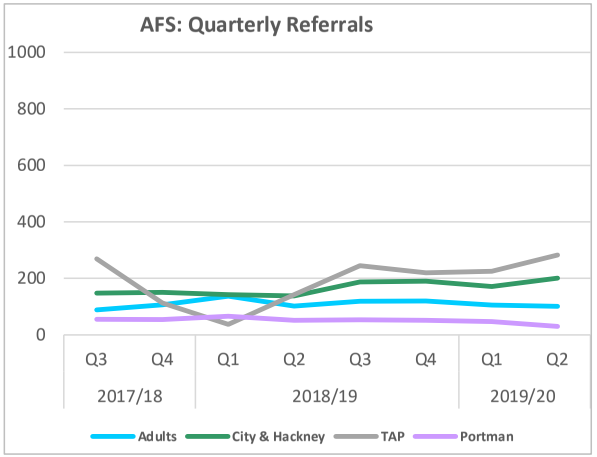
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.
Trust strategic objectives supported by this paper
Finance and Governance

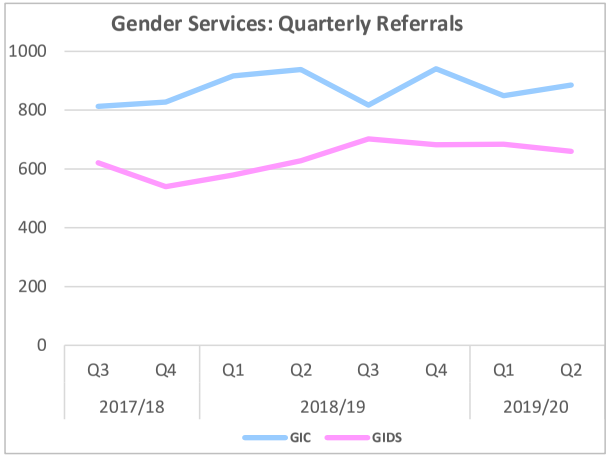
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q2 2019/20: Trust Reach – Access









Data source: 10/10/2019 SRRS (Internal Reporting System) Reported by the Quality Team

Number of Referrals Received:

This quarter we have included in this report the number of referrals received trust-wide over the last two years, including all contracts and all service lines. This includes all accepted, rejected and pending. If we compare the last 4 quarters of our data we can see an increment on number of referrals received.

Historic annual figures: If we look a the last 5 years we also noticed constant increase of referrals. 2014-15 -> **5904** 2015/16 -> **7528** 2016/17 -> **9436** 2017/18 ->**10548** 2018/19 ->**10944**

Adolescent : in Q2 received 92 referrals, the average of referrals over the last 4 quarters is 96 and in the previous 4 quarters was 90.

Camden CAMHS: has historically experienced a dip in demand in Q2, this explains the drop in 201819 but interestingly this Q2 drop seams lighter than previous year.

Other CAMHS: the number of referrals is been fairly stable over the last two year with a very slight decrease over the last two quarters.

Westminster service the number of referrals has been fairly stable over the last two years with a slight increase over the last two quarters.

Adults Complex needs: the number of referrals over the last two years in ACN has been very consistent, with an average of 111 referrals over the last 4 quarters.

Portman: Portman's trend is on a slight decrease, the average number of referrals over the last 4 quarters is 45 compared to the average of 58 they had in 2017-18.

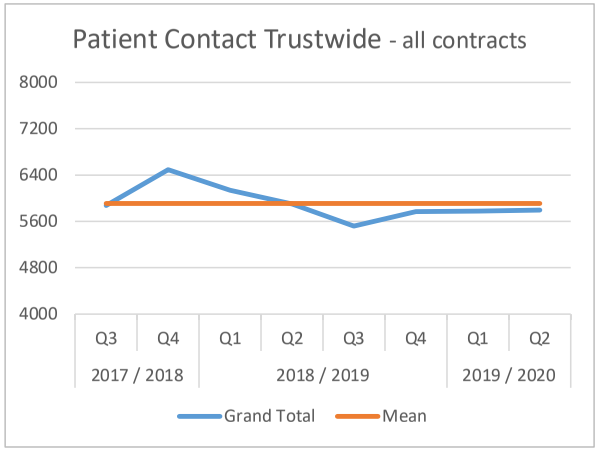
C&H PCPS: this service line has shown an increase on the number of referrals, this year they have received an average of 186 compared to 162 in 2017-18

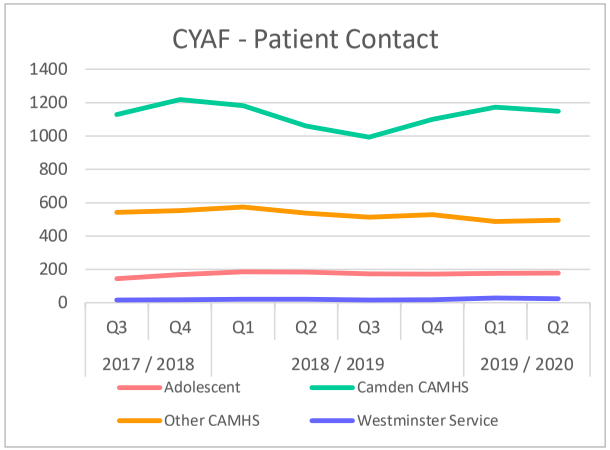
TAP: in Q1 2018-19 they did not take referrals for that quarter due to a service funding issue, the team has since increased significantly in the number of referrals every quarter since. **Please note TAP data is currently under review and has been not finalised. We are in the process of clarifying the EMIS report in order to gain a better oversight of their data.*

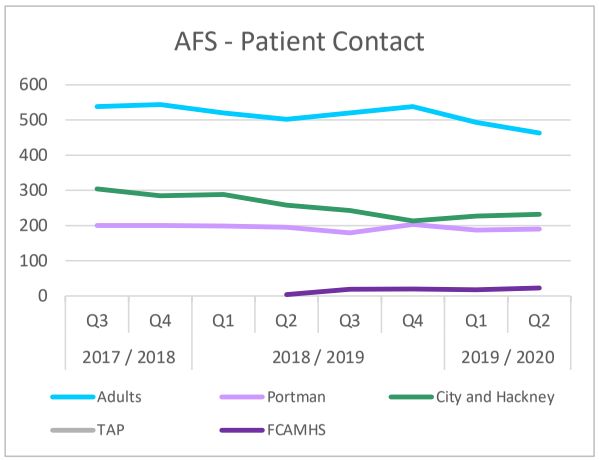
GIDS: over the last 4 quarters they have received a stable number of referrals, this could mean after the major increment and demand over the last few years is reaching its peak.

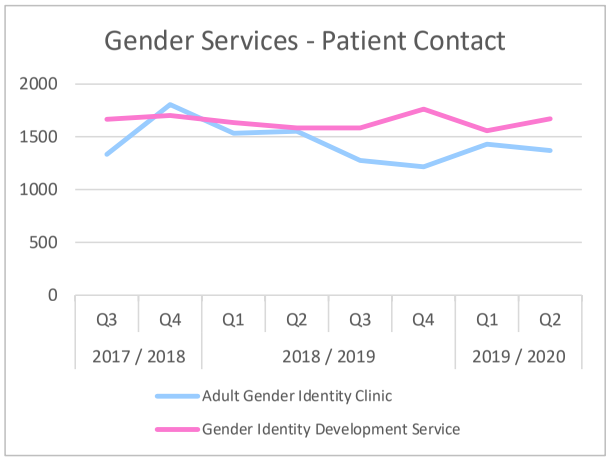
GIC: this service line receives the highest number of referrals Trustwide. The average of referrals revived other the last 4 quarters is 872 and in the previous 4 quarter we had 873, so the number remains stable.

Q2 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' Contact

The patient contact report include trust-wide data (all contracts) excluding EIS and Mosaic (TAP). We consider as 'contact' all types of appointments including telephone contacts.

The trend trust-wide over the last two years has shown a slight decrease. The average of contacts over the last four quarters was 5715 but in the previous four quarters was 6102.

Adolescent : the average number of contacts over the last two years has been stable, with an average of 175 over the last four quarters and 171 previously.

Camden CAMHS: the numbers per quarter fluctuate more than in the other service lines, if we look at the data in 12-months periods, we notice a reduction on the average: 1103 over the last four quarters and 1147 previously, saying this we need to point out that in Q2 they had 1148 contacted recorded.

Other CAMHS: similarly we noticed another drop, with an average of 506 per quarter over the last four quarters and 552 over the previous four quarters.

Westminster: this team actually experienced a slight increase in contacts.

Adults Complex needs: both in Q1 and Q2 we noticed a decrease in the number of patient contacts. In those quarters in previous years there was also a decrease, possibly due to both holidays and sickness levels.

Portman: the number of contacts has been fairly consistent with an average of 190 per quarter over the last four quarters and 198 over the previous four.

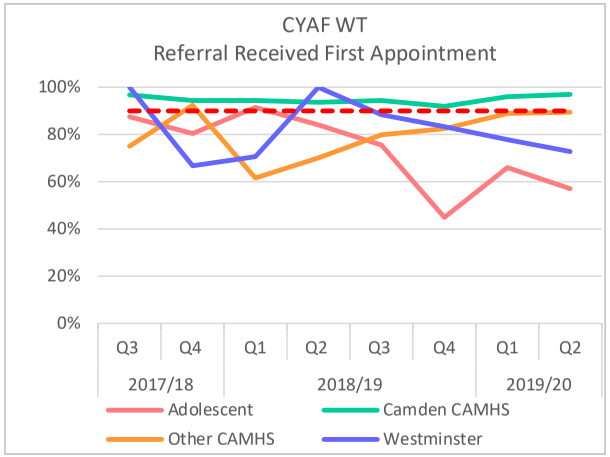
C&H PCPCS : the number of contacts showed a slight decrease, with an average of 229 over the last four quarters and 284 over the previous four quarters.

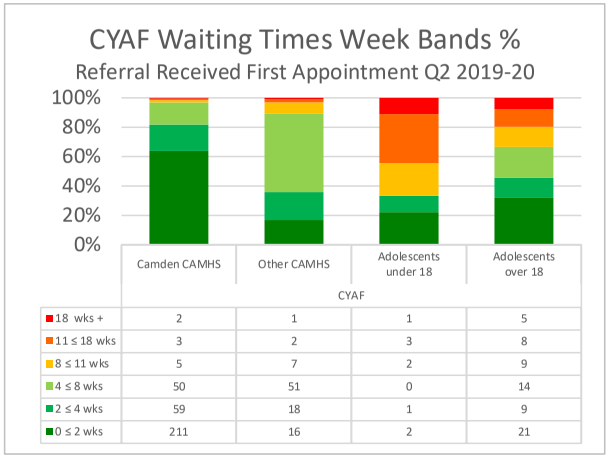
TAP: **Please note TAP data is currently under review and has been not finalised. We are in the process of clarifying the EMIS report in order to gain a better oversight of their data.*

GIDS: average of contacts recorded has been stable over the last two years.

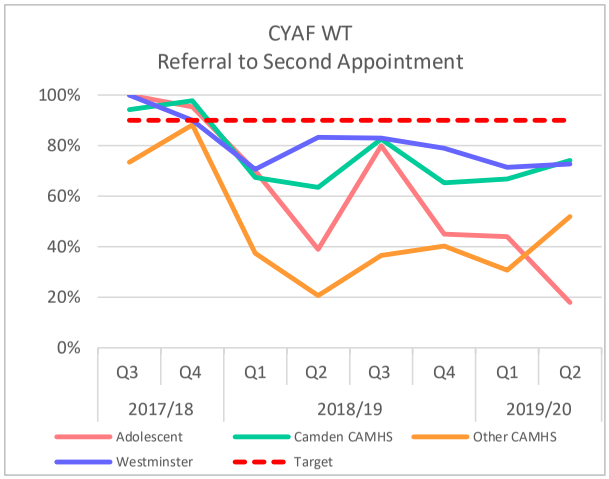
GIC: we have noticed a reduction, with an average of 1323 over the last four quarters and 1556 previously.

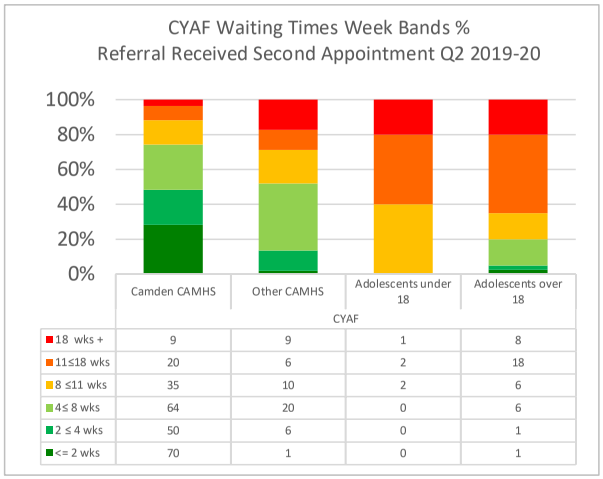
Q2 2019/20: Quality Responsive – Access





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	2	1	1	5
11 ≤ 18 wks	3	2	3	8
8 ≤ 11 wks	5	7	2	9
4 ≤ 8 wks	50	51	0	14
2 ≤ 4 wks	59	18	1	9
0 ≤ 2 wks	211	16	2	21





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	9	9	1	8
11≤18 wks	20	6	2	18
8 ≤11 wks	35	10	2	6
4≤ 8 wks	64	20	0	6
2 ≤ 4 wks	50	6	0	1
<= 2 wks	70	1	0	1

Data source: SRRS (Internal Reporting System) Reported by the Quality Team 10/10/2019

CYAF Waiting Times :

Last quarter we learned that there was a discrepancy in the waiting times target for under-18s. The target is 8 weeks for referral to a second appointment and the previous understanding was that it was 18 weeks. We have now re-run the previous quarters under the correct parameters, run charts show the new data.

First appointment. In Q1 CYAF saw 82% of patients within the contractual waiting times. In Q2 this compliance decreased to 79%.
Second appointment. In Q1 CYAF saw 53% of patients within the contractual waiting times. In Q2 this compliance increased to 54%.

Adolescent services This service line has two different parameters for WT depending on the patients' ages – so the percentages on the run chart are an average of both figures. Adolescents is currently reviewing a possible appointments data recording issue, this should help performance in Q3.
Referral to 1st appointment – in Q2 this service had a drop in compliance of 9% as their current compliance rate is 57% .
➢ Adolescents under 18 - **33%** ➢ Adolescents over 18 - **80%**
Referral to 2nd appointment - 18% of the patients had an appointment within 8 weeks. This is the lowest performance over the last 2 years.
➢ Adolescents under 18 - **0%** ➢ Adolescents over 18 - **35%**

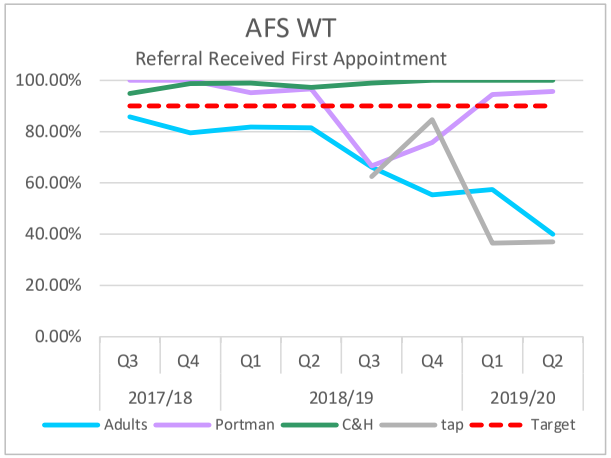
Camden CAMHS.
Referral to 1st appointment – has consistently done well since 2017/18 in Q2 the compliance rate is 97%
Referral to 2nd appointment – 74% % of the patients had an appointment within 8 weeks. This is an increment of 7.39%

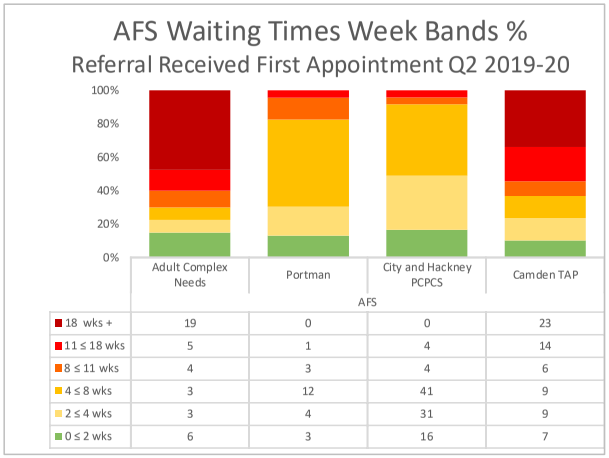
Other CAMHS
Referral to 1st appointment – have improved their performance consecutively over the last year. In Q2 they achieved a 89.47%.
Referral to 2nd appointment - 60% of the patients had an appointment within 8 weeks. This is an improvement of 21% compared to Q1 31%.

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

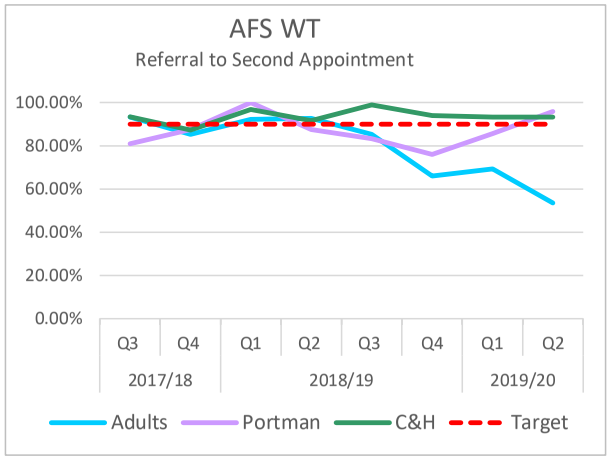
For further comments from service leads please see the commentary part of the report Page 19

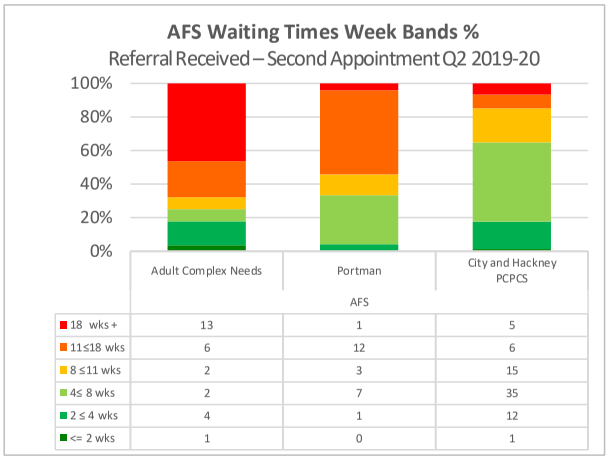
Q2 2019/20: Quality Responsive – Access





	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
18 wks +	19	0	0	23
11 ≤ 18 wks	5	1	4	14
8 ≤ 11 wks	4	3	4	6
4 ≤ 8 wks	3	12	41	9
2 ≤ 4 wks	3	4	31	9
0 ≤ 2 wks	6	3	16	7





	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	13	1	5
11≤18 wks	6	12	6
8 ≤11 wks	2	3	15
4≤ 8 wks	2	7	35
2 ≤ 4 wks	4	1	12
<= 2 wks	1	0	1

Data run and validated 10/10/19
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

AFS Waiting Times :

Referral to 1st appointment: In Q1 AFS saw 72% of patients within the contractual waiting times. In Q2 this compliance decreased to 68%.
Referral to 2nd appointment: In Q1 AFS saw 83% of patients within the contractual waiting times. In Q2 this compliance slightly decreased to 81%.

Adult Complex Needs
ACN has experienced a reduction in compliance due to staffing issues, three new members of the staff have been appointed to focus on assessments.
Referral to 1st appointment –in Q2 they had 40% compliance, a 17% reduction compared to Q1.
Referral to 2nd appointment – similarly there was a decrease of 15% when we compare Q1 and Q2. Compliance in Q2 is 54%.

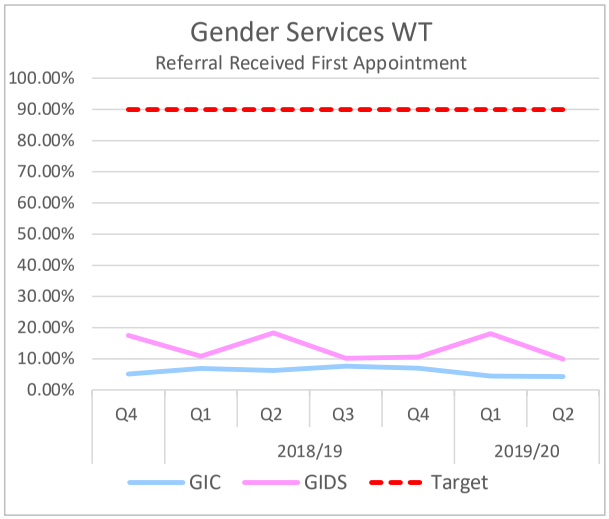
Portman
Referral to 1st appointment – has consistently improved for three consecutive quarters and met the target both in Q1 and Q2 – Q2 with 96%.
Referral to 2nd appointment – in Q1 and Q2 they improved performance, achieving the target in Q2 with 96% .

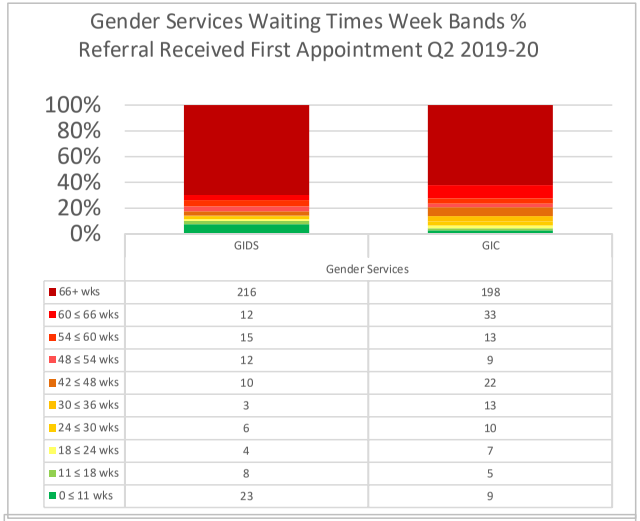
C&H PCPS
Referral to 1st appointment – the target has consistently been met for the last two years, achieving 100% compliance for the last 3 quarters.
Referral to 2nd appointment – this parameter is also met consistently for the last year. In Q1 and Q2 they achieved 93% compliance.

TAP
Referral to 1st appointment – both in Q1 and Q2 they achieved 37% compliance, still significantly lower that in Q4 when they achieved 85%.
Referral to 2nd appointment – this service does not report on second appointments as their system (EMIS) is not able to provide the data.
**Please note TAP data is currently under review and has been not finalised. We are in the process of clarifying the EMIS report in order to gain a better oversight of their data.*

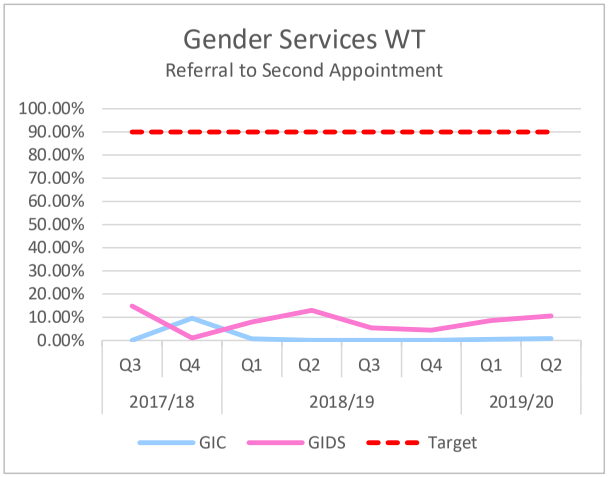
For further comments from service leads please see the commentary part of the report Page 20

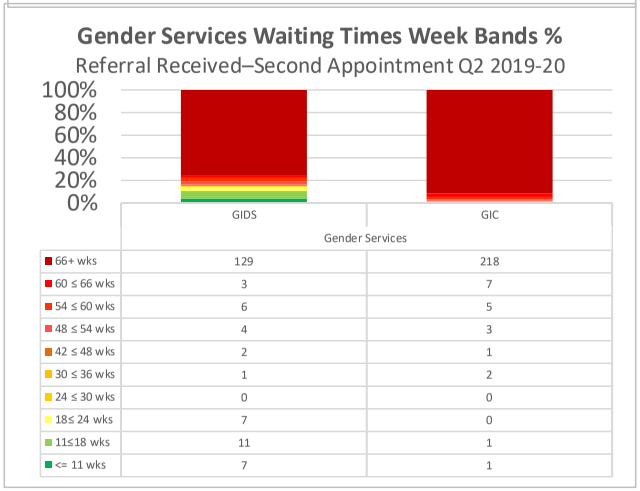
Q2 2019/20: Quality Responsive – Access





	GIDS	GIC
66+ wks	216	198
60 ≤ 66 wks	12	33
54 ≤ 60 wks	15	13
48 ≤ 54 wks	12	9
42 ≤ 48 wks	10	22
30 ≤ 36 wks	3	13
24 ≤ 30 wks	6	10
18 ≤ 24 wks	4	7
11 ≤ 18 wks	8	5
0 ≤ 11 wks	23	9





	GIDS	GIC
66+ wks	129	218
60 ≤ 66 wks	3	7
54 ≤ 60 wks	6	5
48 ≤ 54 wks	4	3
42 ≤ 48 wks	2	1
30 ≤ 36 wks	1	2
24 ≤ 30 wks	0	0
18≤ 24 wks	7	0
11≤18 wks	11	1
<= 11 wks	7	1

Data run and validated: 10/10/19
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Gender Services Waiting Times :

Gender services have an unusual and challenging demand, they have action plans in place and liaise closely with commissioners.

GIDS

Referral to 1st appointment – in Q1 achieved 18.7%. This increase compared to previous quarters could be linked to the implementation of a DNA and Cancellation policy update across the team. Unfortunately in Q2 they went back to 10%. They plan to continue with the implementation of the DNA policies and planning a QI on assessment clinics.
Referral to 2nd appointment –in Q1 they saw 9% of the patients with in the contractual timeframe, in Q2 this increased to 10.52%
Quality Assurance Department (QAD) will carry on meeting regularly with GIDS in order to support the review of waiting time issues amongst other KPIs.

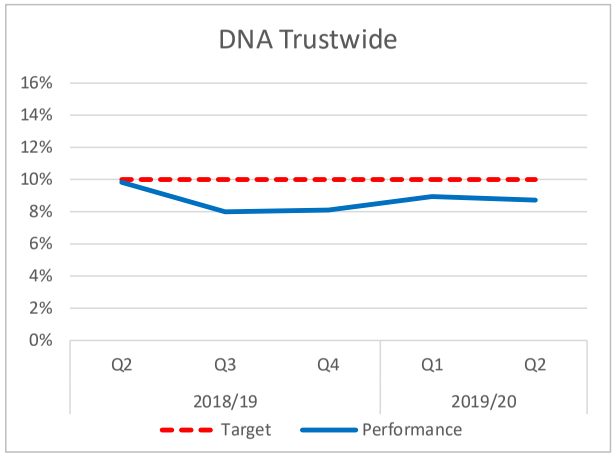
GIC

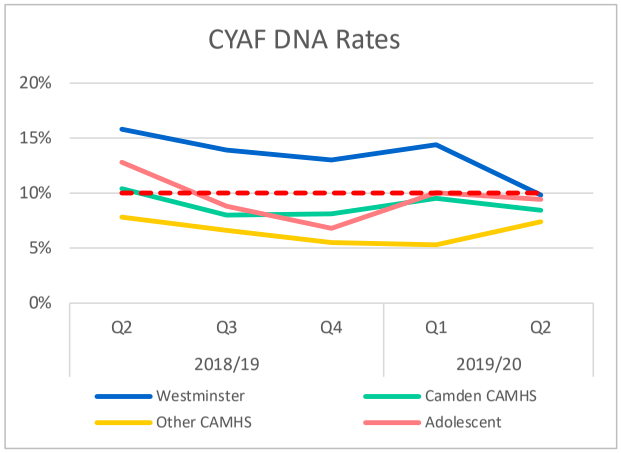
Referral to 1st appointment – Q1 and Q2 the compliance rate was unchanged at 4%. The number of people on the waiting list is at an all time high and there are groups working on this issue nationally. The number of first appointments have been reduced in the hope that this will minimise the gap with in subsequent future appointments.
Referral to 2nd appointment –in Q2 0.008% of the patients had a second appointment within time. GIC are working on a project to make the gap between appointments clinically safe.

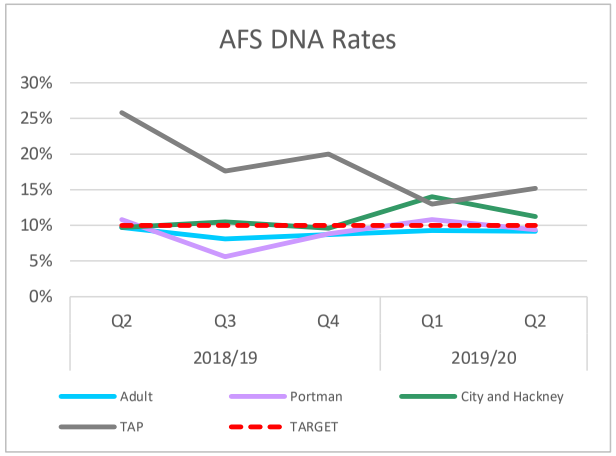
Once a referral has been screened patients receive a welcome to the waiting list letter with links to GIC online information on our website, and are invited to a whole day waiting list workshop led by the GIC lead clinician. These are twice a year inviting ~300 patient for each event. Patients are encouraged to contact the department if anything changes or they have any questions. The Quality Assurance Department (QAD) will carry on meeting regularly with GIC in order to support the review of waiting time issues amongst other KPIs, also GIC now has a dedicated administrator who will be in contact with the QAD department. We are hoping this will gradually help clear some data issues and help the team improve their performance.

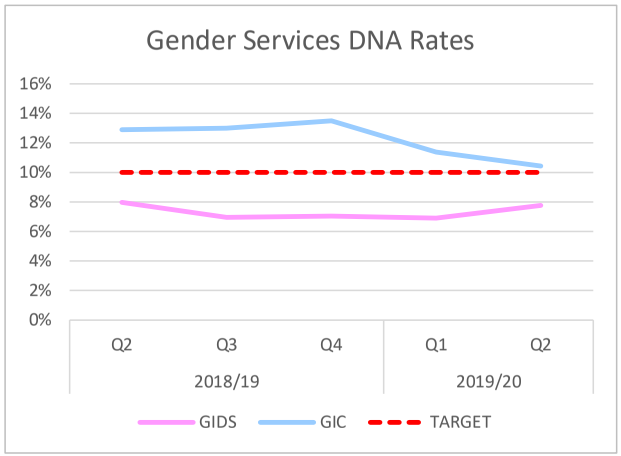
For further comments from service leads please see the commentary part of the report Page 21

Q2 2019/20: Quality Effective – Access









Data source: SRRS (Internal Reporting System) Reported by the Quality Team 10/10/2019
The definition used for DNA figures is Numerator: Total DNA / Denominator: Total Appointments (Total Attended + Total DNA appointments

Did Not Attend (DNA)

The Trustwide DNA data does not include TAP date. DNA rates are expected to be no higher than 10%. The current Trustwide rate is 9.43% which it is within the contractual target. This quarter rate has improved in relation to last quarter.

The report has recently been updated to include the GIDS factor, appointments including two clinicians, previous GIDS & trust-wide data have been rerun.

Adolescents had a DNA rate of 9.4% in Q2 – this is a slight improvement compared to 10% in Q1. Target met every quarter for the last year.

Camden CAMHS similarly this service has met the target for the last four quarters, in Q2 we saw a improvement, achieving 8.42% from 9.5% in Q1.

Other CAMHS continue to have a good rate but they have experienced an increase in Q2 with a 7.4% the highest rate since Q2 last year, still within target.

Westminster saw a significant decrease in Q2, reaching the threshold with 9.82% rate. This is the lowest DNA rate they have had since Q2 2018-19.

Adults Complex Needs have maintained a good performance over the last year, maintaining less than 10% DNAs with Q2 at 9.17%.

Portman saw an increase on DNAs in Q1, but have improved by 1.4% in Q2 resulting in 9.37% total DNAs. Portman clinicians have been working to engage patients and encourage them to contact the clinic to notify us when they are not able to attend. This work had a positive impact on their DNA rates.

C&H PCPS had an unusual rise of DNAs in in Q1 to 14%, this was due to the implementation of groups for patients difficult to engage. In Q2 it decreased to 11.23% after the facilitators developed a successful plan to reduce their DNAs.

TAP: a successful QI on DNAs and have managed to reduce rates from >20% to 13% in Q1. In Q2 this figure has unfortunately increased to 15%.

GIC had a rate around 13% over the last two years – in Q2 it decreased 10.43%. GIC has been working on SMS consent collection and reminders.

GIDS in Q2 we have seen an increase, with a rate of 10.61%. In Q2 previous year they also experienced an increase to 10.9% which is higher the this year. This could be due to seasonal holidays.

For further comments from service leads please see the commentary part of the report
Page 24, 25 & 26

Q2 2019/20: Single Oversight Framework – Access

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

Mental Health Service Data Set (MHSDS) and Data Quality Maturity Index (DQMI) Dataset Score

The DQMI was introduced into reporting in April 2018, with new data sets added in April 2019 and is in line with the Single Oversight Framework. 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 – data submitted at the end of Q2 to be published 21 October 2019.

The Quality Assurance Department uses the Data Warehouse Information, which is used for internal reporting, to identify gaps in reporting. In order to improve on DQMI and MHSDS completion rate, the reports are discussed at the Quality Assurance Meeting (previously called CDQRG) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved. The Quality Assurance Meeting (QAM) has been defining and implementing operational changes in all service lines to accommodate the new requirements: increased percentage expected for Ethnicity, Primary reason for Referral, Care Professional Service or Team Type Association and the Ex-British armed forces indicator. The most recent published DQMI is for June 2019 and the compliance achieved is 88.9%. The actions completed during Q2 to improve compliance will show in December's NHS Digital publication, hence it will be included in Q3.

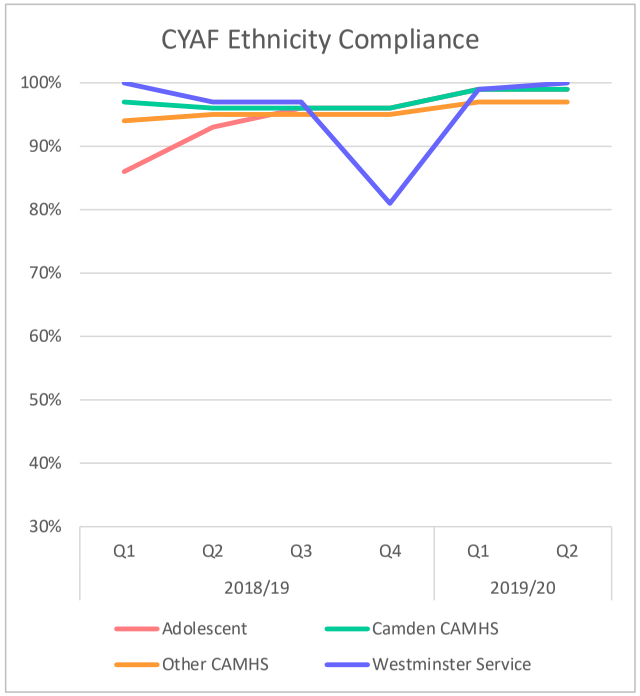
	Target %	Month 7 October 2017/18	Month10 January 2017/18	Month 1 April 2018/19	Month 4 July 2018/19	Month 7 October 2018/19	Month 10 January 2018/19	Month 1 April 2019/20	Month 4 July 2019/20
Valid NHS number	95%	99.1 %	98.6 %	98.60%	98.7%	98.90%	98.90%	99.00%	98.99%
Valid Postcode	95%	99.8%	99.7%	99.80%	99.8%	99.80%	99.80%	99.70%	100%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.5%	99.1%	99.00%	99.2%	99.00%	99.00%	99.20%	99.21%
Valid Organisation code GP Practice	95%	99.2%	98.2%	97.80%	98%	98.10%	98.20%	98.90%	98.88%
Valid Gender	95%	99.8%	99.8%	99.80%	99.7%	99.40%	99.40%	99.40%	99.44%
Ethnicity	85%	79.6%	78.4%	77.30%	76%	75.80%	76.10%	80.60%	81.88%
Employment Status (for adults)	85%	36.9%	43.4%	49.10%	50.5%	51.60%	54.00%	59.30%	59.79%
Accommodation status (for adults)	85%	36.6%	42.9%	48.50%	49.9%	51.00%	53.20%	58.30%	58.78%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%
DQMI -Data Quality Maturity Index	95%	The DQMI is not submitted in the same intervals. The July's data has not been published yet. The most recent score is from June 2019						Jun	88.9%

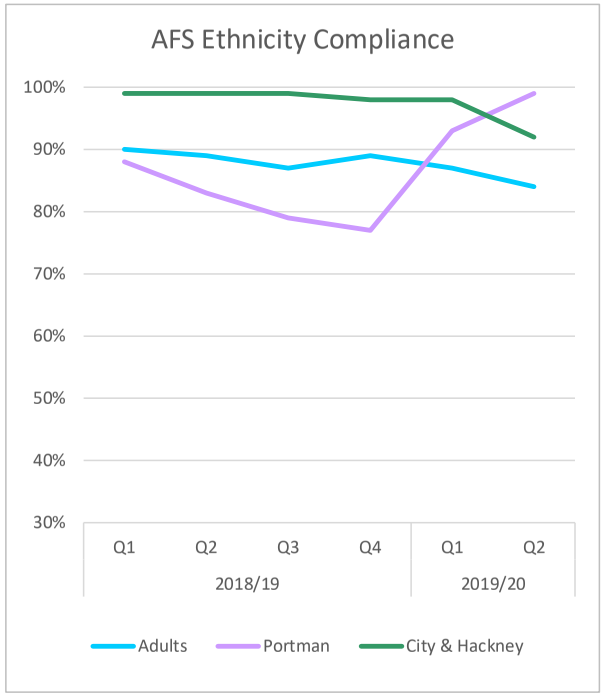
Data source: Data warehouse, informatics team 10/10/2019

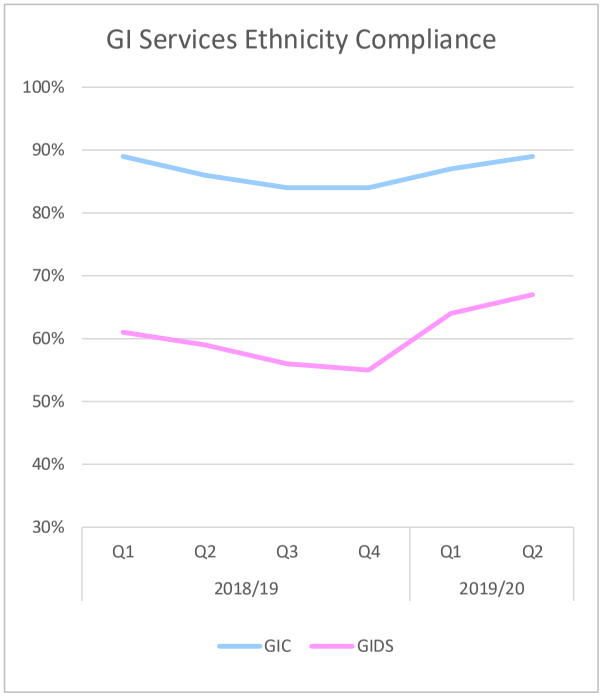
Q2 2019/20: Single Oversight Framework – Access

Ethnicity Rates

Ethnicity completion rates has been one of the most challenging MHSDS and DQMI data indicators. In preparation for one of our DQMI (Data Quality Maturity index) CQUIN, the Quality Assurance Department (QAD) have been working closely with all service lines in order to understand the difficulties collecting this data. We are pleased to see that in Q1 and Q2 we increased significantly the recording rate. The DQMI target is 95%, which is a combination of a number of factors, ethnicity being one of them. Unfortunately, despite the improvement in our performance, we have not reached the target in this particular area; the latest data available from NHS Digital is: 81.88% on Ethnicities recordings. A major aspect in not reaching the target is the large number of patients open to teams who have not been seen. If we exclude non-seen patients our rate trust-wide average is 92%. The Quality Assurance Department continue to work with teams in the QAM (previously known as CDQRG), meeting regularly to improve this data further. QAD will work with C&H and ACN analysing and addressing the drop in rate in Q2.

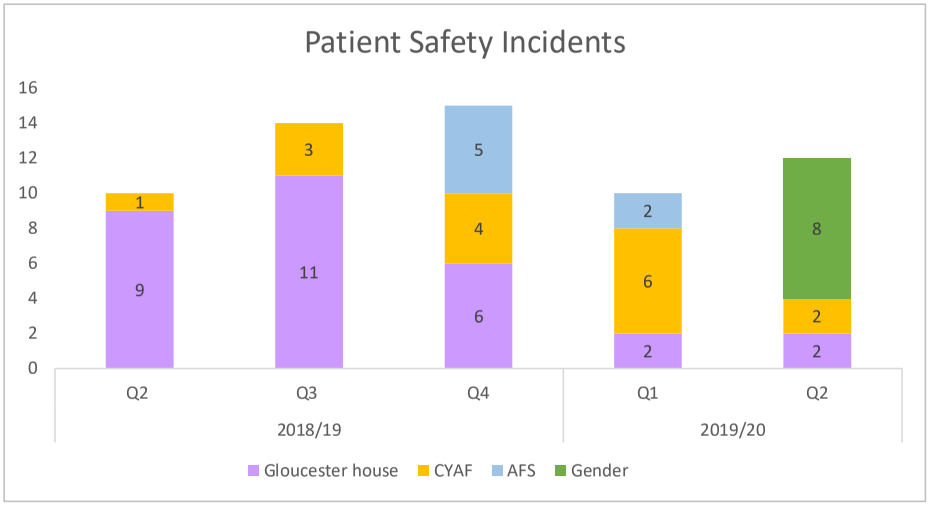


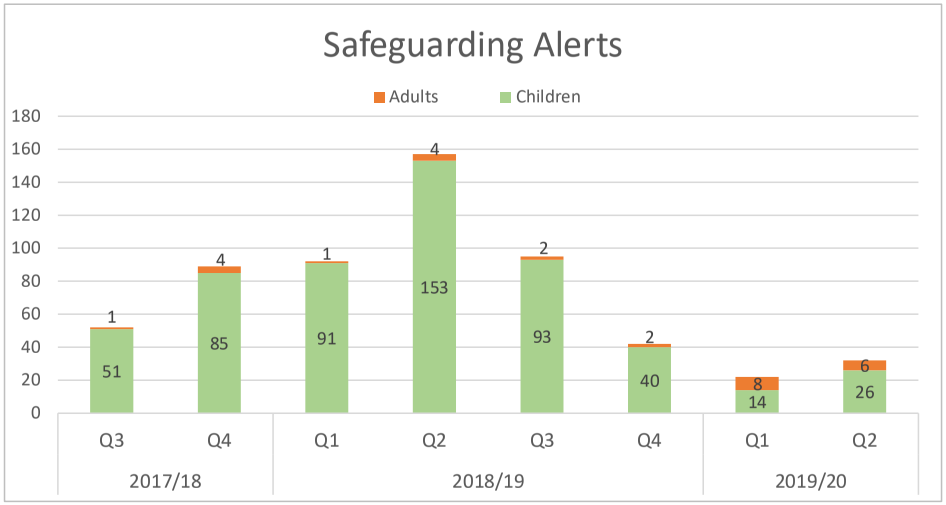




Data source: SRRS (Internal Reporting System) Reported by the Quality Team 8/10/19

Q2 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. All incidents on the Quality Portal are checked daily by the Health and Safety Manager, who will then report to NRLS. The Gender Services, GID and GIC, are now a separate from CYAF. The Gender services patient safety incidents are usually through using incorrect names of patients as data breaches, and we have followed the Duty of Candour by contacting the patient to apologise. Data source: *Health and Safety Manager 08/10/2019*

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

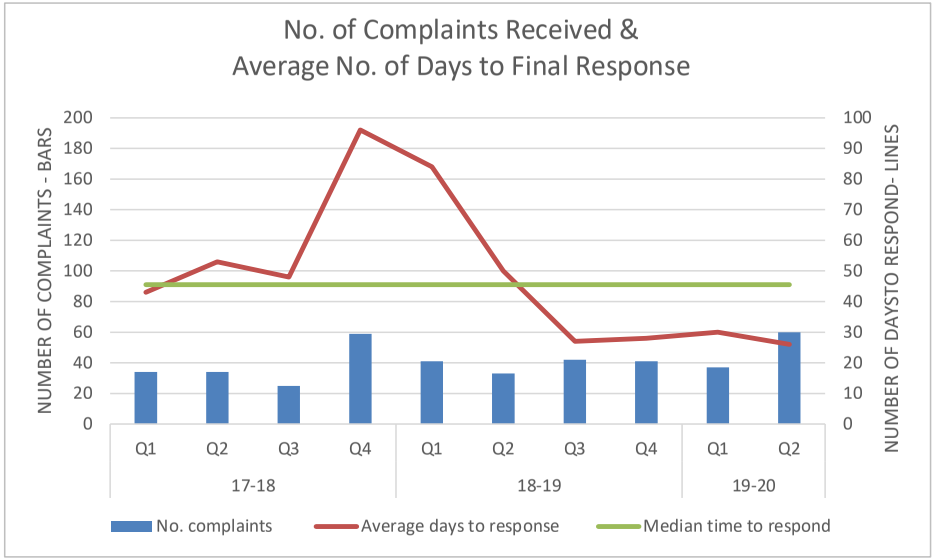
Data & commentary source: *Clinical Governance 08/10/2019*

Incidents Reported by Risk Level Trust wide	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2
1-4	81	119	88	100	65
5-8	42	35	22	28	28
9-12	7	3	9	3	12
15+	0	1	0	0	1
Total	130	158	119	131	106

The 15+ incident in Q2 relates to a child attacking their mother. Of the 12 incidents 9-12, 1 concerned a patient in crisis; 1 was the GIC data breach; 2 were IT failures; 1 was personal injury to a finger, owing to a poorly closing door; 1 concerned a unknown man who entered the Medical Directors office; 1 safeguarding and 5 physical and verbal abuse. Of these 3 related to a child attacking their carer, 1 was a verbally aggressive adult patient and one was a GIC incident. Actions taken in all cases and involvement of senior staff. Data source: *Quality Portal 31102019*

Data & commentary source: Health & Safety Department 07/10/2019

Q2 2019/20: Quality Responsive – Care



During quarter 2 a total 60 complaints were received of which 50% were responded to within 25 working days compared to 35% in Q1. The clinical directorates are now split into three divisions, Adult and Forensic, Children young Adults and Families and Gender Services. The Corporate Directorate remains unchanged. This is an increase in complaints from the last quarter by 24 which is due to a data breach in the Gender Directorate for which 28 complaints were received.
The themes of complaints include, Trust data breach, long waiting list to first appointment, lack of communication from clinic, confusion over appointments, being discharged without explanation, delays in treatment, unhappy with practice of 'closing' clinic for August and confusion over shared care arrangements with GP.

Following upheld or partially upheld complaints where appropriate action plans are written to ensure that changes are made to improve our services. A report on action plans has been produced and submitted to the Patient Safety, Clinical Risk meeting for noting.

Number of complaints per Directorate

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

Total PALS enquiries 01/07/2019 to 30/09/2019

Quarter	Total
2019/20 Q2	191
2019/20 Q1	190
2018/19 Q4	221
2018/19 Q3	175
2018/19 Q2	226

Top PALS enquiries for Q2 2019/20 remain unchanged
- Access to treatment
- Communications
- Appointments

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

Data & commentary source: Complaints Department 16/10/2019

Q2 2019/20: Quality Responsive – Care

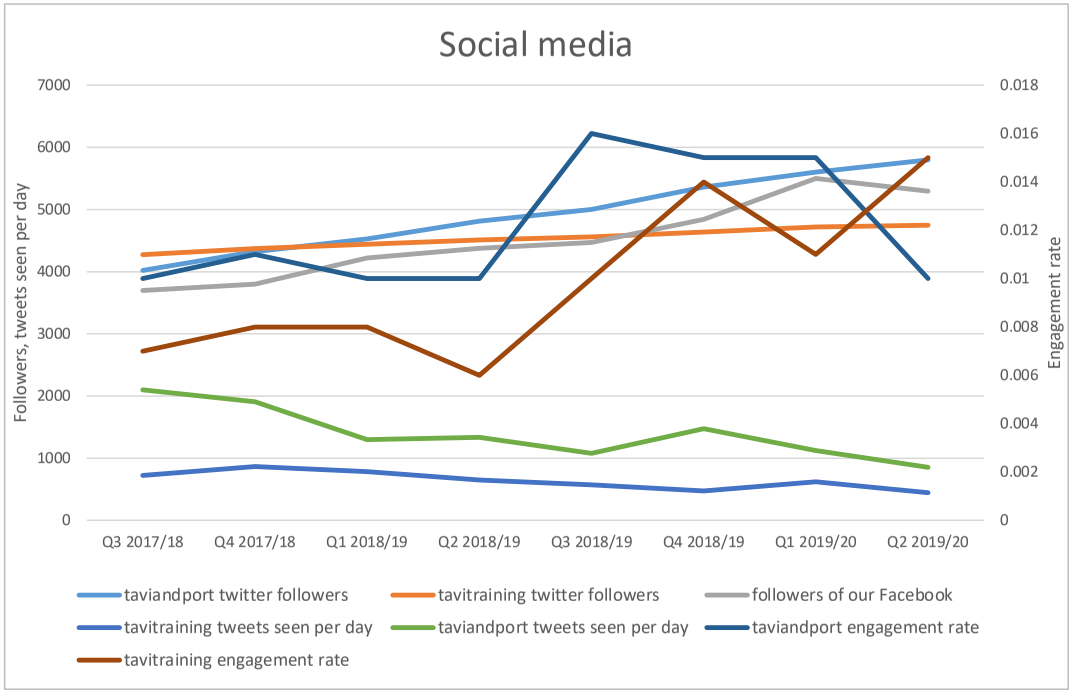
KPI London contracts			Q3 17/18			Q4 18/19			Q1 19/20			Q2 19/20		
Question number and description	Monitoring	Target	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%
Q4 from ESQ 'Views and worries were taken seriously'	Quarterly	n/a	127	121	**99%**	180	178	**99%**	140	139	**99%**	151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

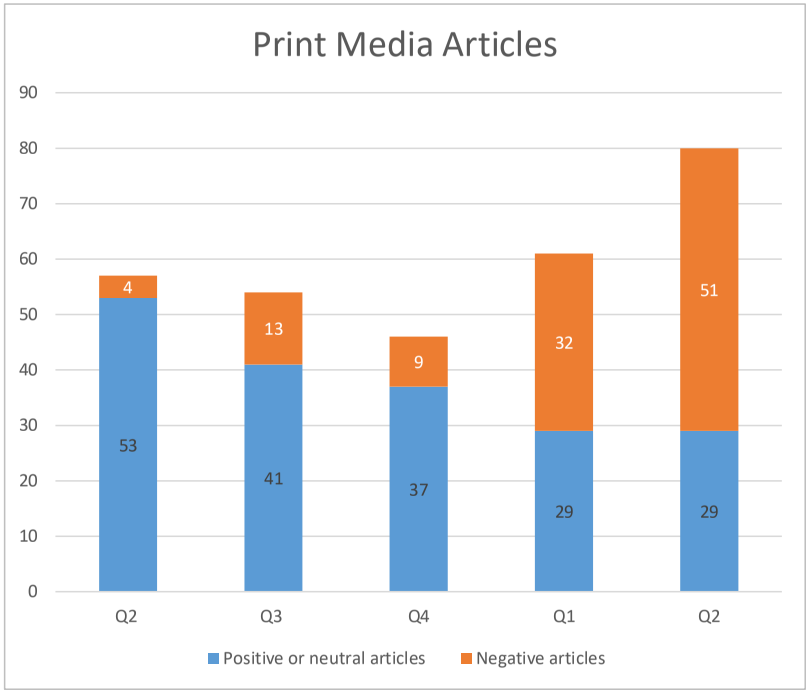
ESQ Rates

Traditionally the responses and feedback from our patients are positive and we are very pleased with the comments and scores received. But we feel that the number of forms returned could be higher. The trust is currently piloting a new form to improve the collection rates. The QAD is also liaising with all service lines to review collection point and best methods to be used.

Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/10/19

Q2 2019/20: Media – Care





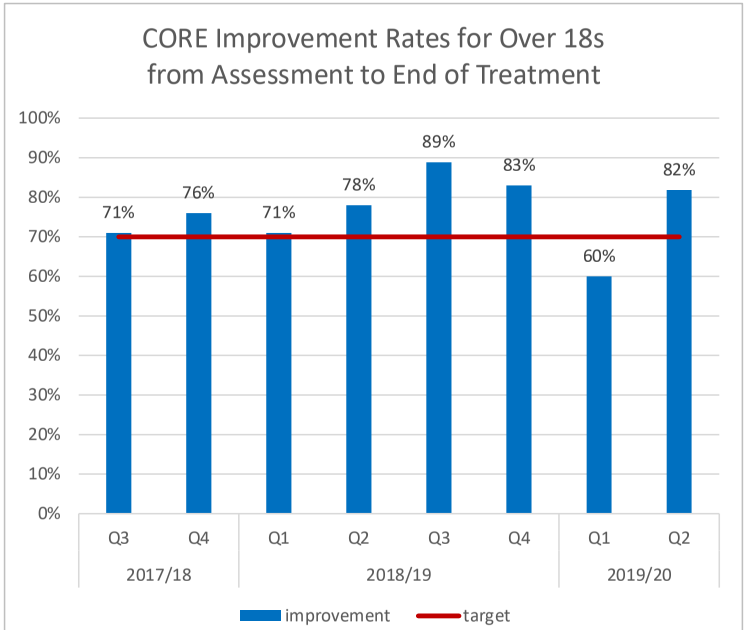
Traffic to our website and number of visitors were both higher this year than last year.
Our social audiences are increasing in size. The amount of social posting we are doing is lower due to the contested field of work and time pressures on the comms team.
About half of all website traffic goes to our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

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: 36% positive or neutral coverage, compared to 52% positive or neutral in Q1, and 89% in Q4 of 18/19.

Data & commentary source: Communications Department 11/10/2019

Q2 2019/20: Quality Effective – Outcomes

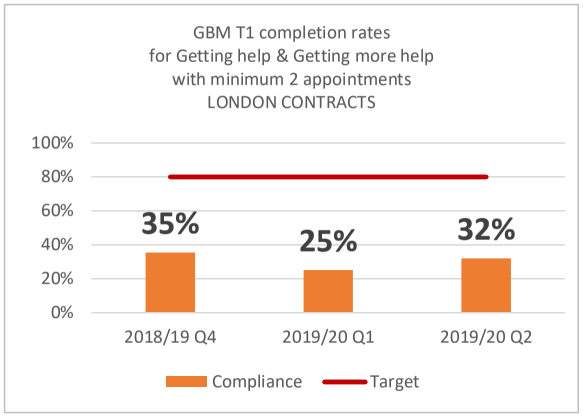
A F S and over 18 Adolescents

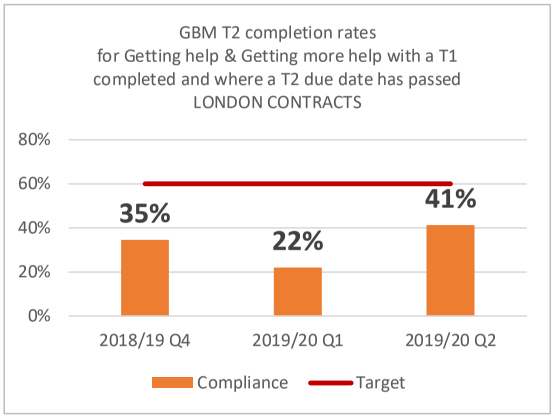


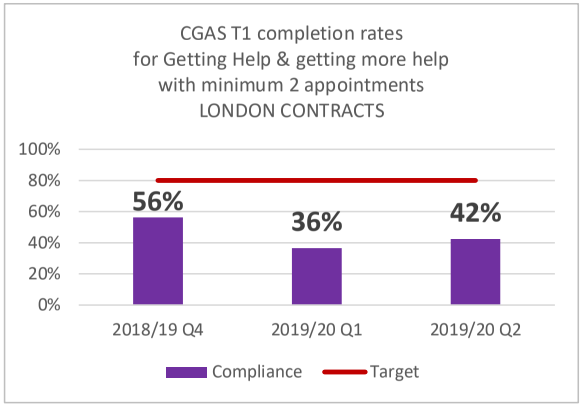
To calculate the CORE improvement rates **we compared patients with a Pre-Assessment and an End of Treatment score** (EOT) . The number of cases within these parameters is very low, but we are pleased to see an increase in the number of collected forms. The End of Treatment form is challenging to complete for services like Portman and ACN as that session tends to be an upsetting event for the patient. These services are reviewing when the last CORE should be done.
– In Q1 19/20 we had 5 patients with a Pre-Treatment and EOT score; out of those, 3 showed improved scores.
– In Q2 19/20 we had 11 patients with a Pre-Treatment and EOT score; out of those, 9 showed improved scores.

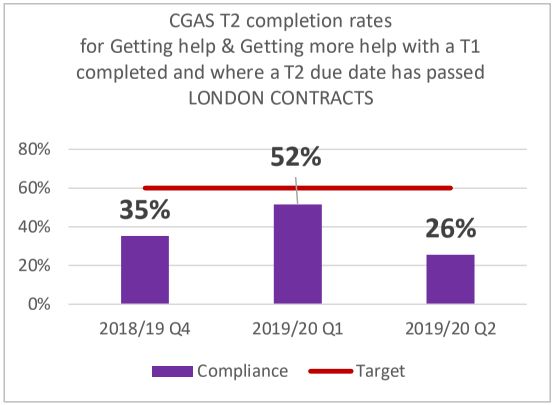
Data source: SRRS (Internal Reporting System) Reported by the Quality Team 07/10/19

C Y A F



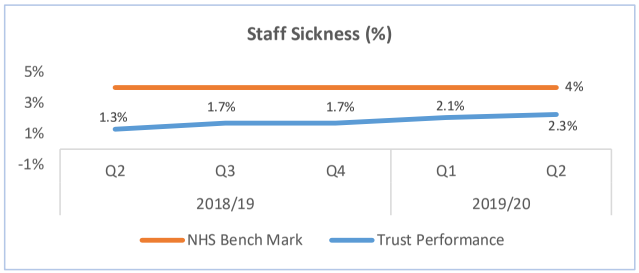


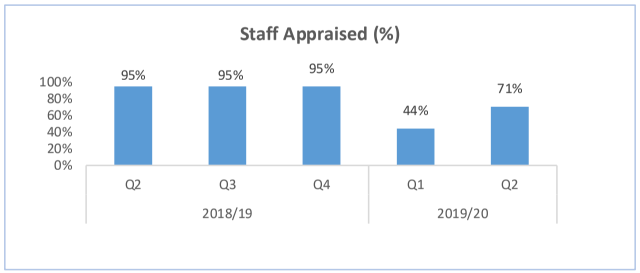


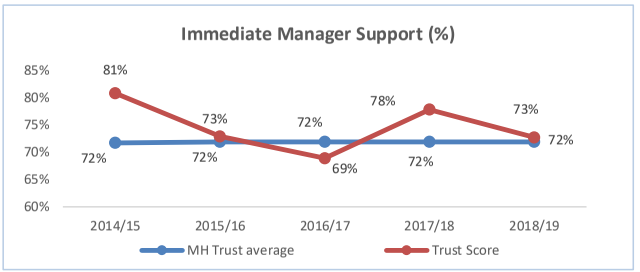


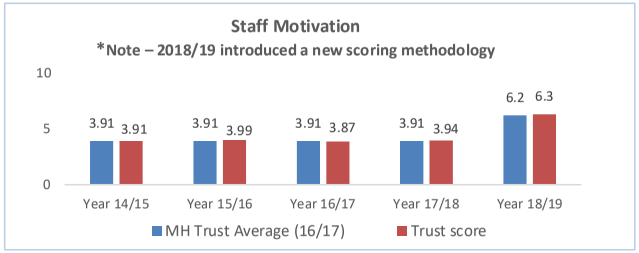
The GBM and CGAS completion rates are one of our KPIs and as such it includes London Contracts only.
The GBM completion rates: we are pleased to see that the completions rates have increased significantly over the last 3 months. In August we corrected an issue in the reminder system that affected the T1s and we think the fix had a positive impact on the improved rates. There is a QI project in Camden North and South and we are expecting improvement from these teams.
The CGAS completion rates: an increase in the T1 of 6% is an encouraging change but unfortunately the T2 dropped significantly; the teams are investigating the possible reasons for this.

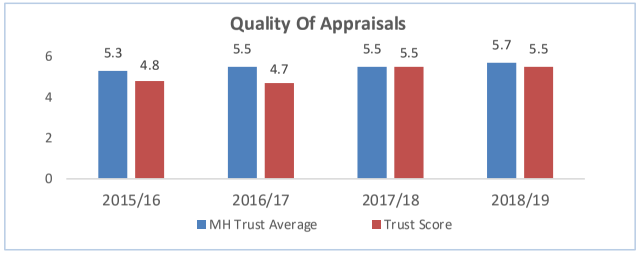
Q2 2019/20: Quality Well-Led

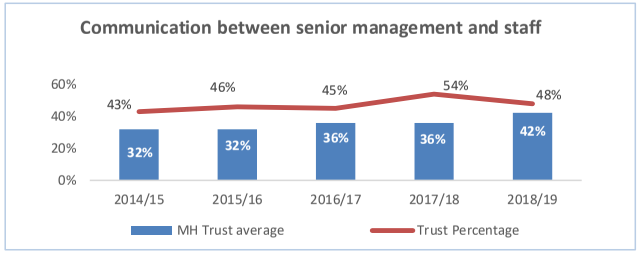


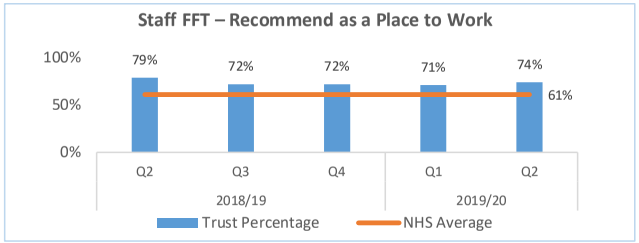


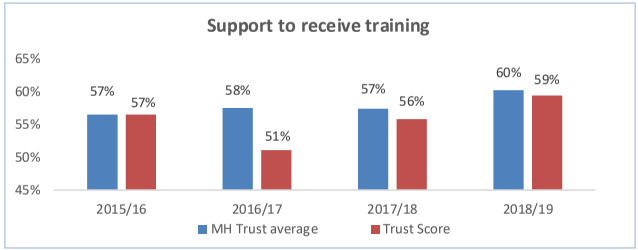


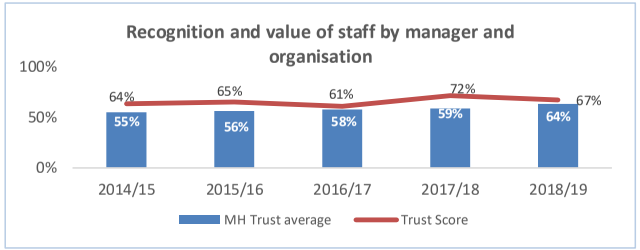


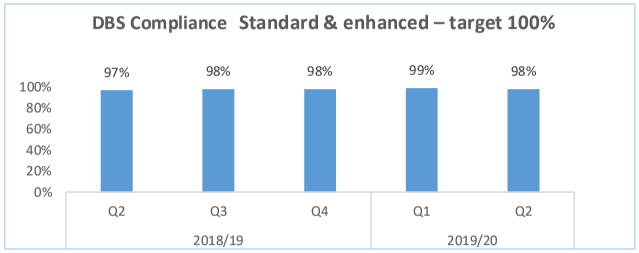


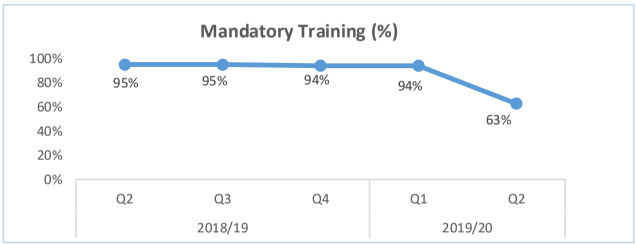








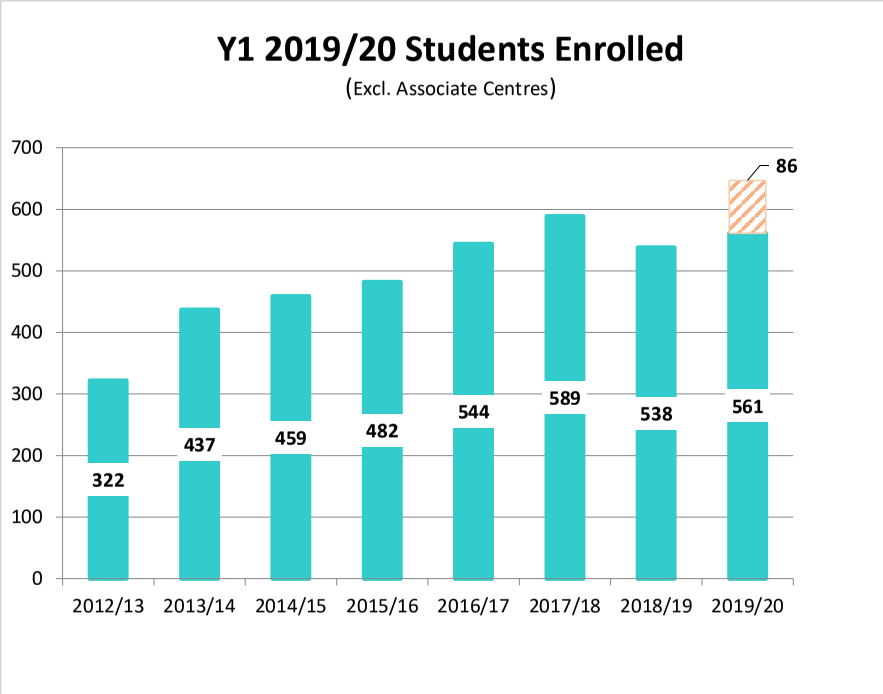




Currently the mandatory training is completed via Induction for new starters or INSET for existing staff and therefore is a static process which is repeated on an annual basis and staff will attend as and when compliance expires. The INSET is arrange for two times per year and therefore the reason for the dip would be due to staff compliance expiring and the next INSET Day is in November 2019 .The Trust is now looking to change the way we deliver mandatory training – all training expect Safeguarding adult and children level 3 and some local training can be completed via E-learning through staff My ESR portal.
The delay in meeting Q2 appraisal compliance was due to Director appraisals commencing later than the expected timescales, pushing appraisals for remaining staff into August, when many staff are on leave. Appraisals not yet submitted to HR is currently being followed up

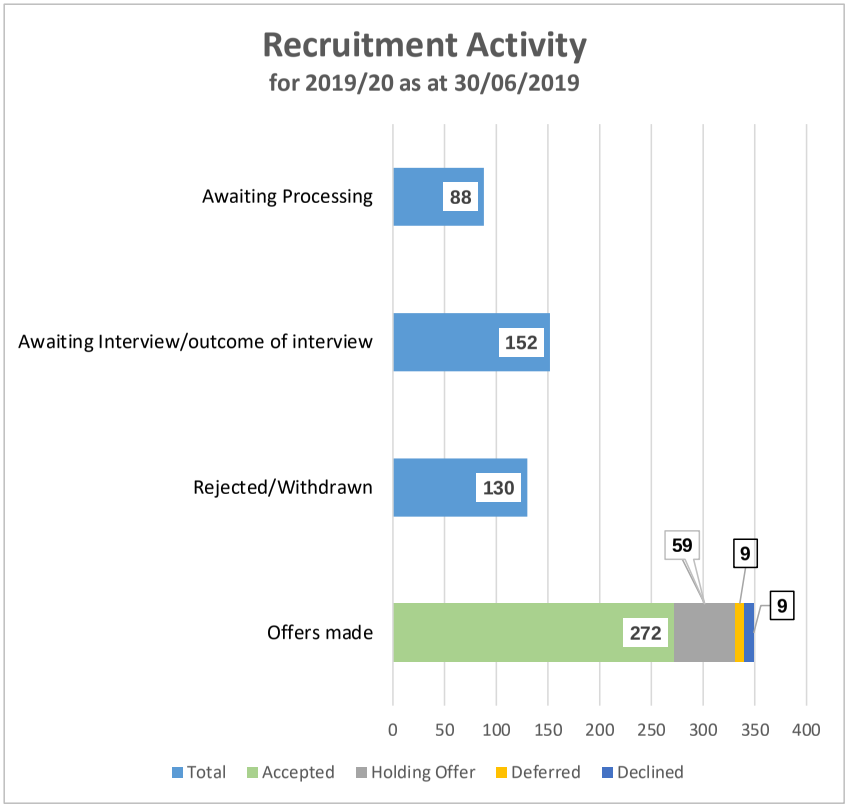
Data & commentary source: Human resources 08/10/2019

Q2 2019/20: Directorate of Education and Training (DET) – Access



An increase in enrolled Y1 figures of 4.1% compared to 2018/19. The enrolled student number includes those who have reached both pre-enrolment (i.e. fees paid and awaiting clearance of DBS checks) and full enrolment stages, but excludes those who are still at the PRV stage and also excludes Associate Centres. The number of Y1 enrolled students is likely to increase, once the follow up activity has concluded to support those students to complete enrolment who are still at the provisional enrolment (PRV) stage.

Data & commentary source: DET 15/10/2019



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.**

Q2 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	83
	Bespoke work	14	18	10	38	45	33	44
	Visitors Programme / international					23	14	5
	HEE additional in year funding						6	3
Students	**Attendee/Student Nos**	2079	2738	2063	2279	2300	2193	1567
								Identified Income to Date
Income	**Income**	501,917	556,261	493,090	£692,710	£854,710	£1,271,641	£1,021,132
	Income growth on previous year	35%	16%	-11%	40%	23%	49%	-20%
	Contribution	160,769	158,104	123,616	£197,122	£527,123	£645,292	**£622,210***
						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. An increase of £307,738 (43%) since Q1 reported Identified income but compared to FY Income for 2018/19, there is a 20% reduction. There is £203,000 of HEE activity included within this figure.

Data source: DET 15/10/19

Q2 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.

The annual Student Survey (2019) commenced on 24th April and concluded on 30th June 2019. The data is currently being analysed. There will be an update to this page for the December (Q3 2019) KPI Submission, once presented to the Education & Training Committee.

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.

Data & commentary source: DET 15/10/19

Quarterly Quality Report Commentary Q2 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 on WT DNAs and updates on QP and CQUINS

The following metrics are summarised below:

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

Waiting Times feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q2	Objective / plan for next Quarter	Lead
Adolescent /AYAS	The service continues to receive a large number of referrals and the proportion to the number of clinical staff and trainee in the service at present had an effect on the Waiting Times ratio. We are working hard to offer patients assessment in a timely manner.	The service has a QIP looking at reducing the wait for assessment and we continue to develop strategies in relation to this.	*AYAS Service Manager*
Camden CAMHS	We are pleased that we continue to meet the 8ww time target for the vast majority of our cases and this should continue as we work towards a 4ww as part of the trailblazer pilot. We are aware of waiting lists forming in some teams and are taking action now to address this to avoid an increase in future.	Continue to meet the waiting time target.	*CYAF service Manager*
Other CAMHS	We note that we are very close to the target waiting time and that this has improved consistently over the last 12 months. We will continue to monitor this in Q3	Continue to see improvement in waiting times	*Associate Director for Other CAMHS & Vulnerable Children*

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

Waiting Times feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q2	Objective / plan for next Quarter	Lead
Adult Complex Needs	We are aware of the percentage of the breaches in this period, which is mainly due to the lack of resources by maternity leave, sick leave and recruitment issues.	We have appointed 3 clinicians to see patients in assessment consultations for the next 6 months in order to reduce the length of the waiting time for the first appointment. We plan to meet the target by the end of this year.	Head of Adult Complex Needs Service
Portman:	We are pleased to report that we only had one breach of >11 weeks during the last quarter. We have looked into this, and found that there was a delay in allocating the case to a clinician, most likely linked to the fact that there had been a need to obtain more information regarding the patient's alcohol intake and also to obtain a letter from his local psychiatrist.	We have reviewed our processes regarding situations in which more information is sought regarding a referred patient, and how this is recorded on our system.	*Clinical Governance Lead*
City and Hackney PCPcS	PCPCS are very pleased with our waiting times figures for Q2 2019/20, with no breaches for the quarter. As in Q1, a majority of patients were seen within 8 weeks, and none waited longer than 18 weeks, meaning patients and referrers received care and support from the service within a good time. Seeing patients within an appropriate timescale, particularly within a primary care setting, can reduce risk, result in better patient experience, mean less mental pressure on staff, and encourage GPs to refer as 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.	*Service Administration Manager*
TAP	Since Q1 we have had 1.4 WTE maternity cover posts agreed and two staff have been appointed, one is internal which is good news but also leaves another vacancy to fill, the other is an ex-trainee. Both did very good interviews and will offer an excellent clinical service as part of the wider TAP MDT. Since we have re-negotiated a sub-contract with C&I PCMHN (Primary Care Mental Health Network) and have become increasingly integrated into the local , multi-agency MH offer in primary Care referrals are again on the increase but with reduced capacity in the team due to 2 staff on maternity leave (new staff are just about to start in post as of mid October) and the Service Lead starting a new role in the trust. We have just appointed a new service lead and are very pleased that appointee will join TAP as Primary Care service lead at the end of October. The other factors affecting waiting times are patients requesting or needing to be seen in particular GP surgeries, either because of special needs or only feeling able to make an appointment locally for a variety of emotional reasons, we try to comply with such needs but it means that such cases are dependent upon the provision of service in their local area and people reading this report should be aware that due to the high demand for space in primary Care access to clinical sessions is limited by the supply of available space.	We have asked the new T&P CCOO if it might be possible to start a conversation with C&I colleagues about ways of more realistically monitoring demand and supply of TAP clinical treatment interventions, either through capacity or criteria. Both have pros and cons. We expect there to be greater capacity in coming months but waiting times will again be dependent on numbers of referrals for new assessment and the conversion rate to treatment as currently PCMH appears to have no limits by way of either capacity or diagnostic criteria.	*Divisional 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 Q2	Objective / plan for next Quarter	Lead
GIC	The number of people on the waiting list for the Gender Clinics in the UK is 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 3 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.	*Service Manager*
GIDS	Referral to waiting times achievement continues to fluctuate in line with a decreasing overall pattern. We are aware that GIDS waiting times overall continue to increase as referrals remain high and similarly increase, so we believe this to be the cause in reducing waiting time achievement	The vast majority of young people accessing GIDS wait for over 66 weeks prior to their first appointment. We acknowledge that significantly impacting the overall waiting time within the next quarter is unrealistic, but are planning longer term quality improvement projects on assessment clinics and demand and capacity modelling which we hope will be able to be quantified more robustly in future. However within the next quarter, we will continue to implement robust DNA and cancellation policies for first (and all) appointments, evaluating the impact of that policy and making improvements to it as required. We are also currently evaluating our move from one SMS reminder to two SMS reminders.	*Service Manager*

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

DNAs Feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q2 2019-20	Objective / plan for next Quarter	Lead
Adolescent /AYAS	The DNA rate in AYAS has reduced from 10 to 9.4%. This is due to continued work within AYAS to keep in close contact with our patients and encourage them to cancel appointments they cannot attend. The re-instatement of the text message service has been vital in bringing our DNA rate back to under 10%.	To continue to engage with out patients and ensure low levels of DNA rates using text messaging and other methods of communication.	*AYAS Service Manager*
Camden CAMHS	We continue to maintain a low DNA rate and this is now a consistent pattern. We continue to work with patients to make appointments at a time that suits them to increase the chance of attendance.	Continue to arrange appointments collaboratively and continue to develop our system of sending automated reminders to patients ahead of their appointments.	*CYAF service Manager*
Other CAMHS	We continue to maintain a low DNA rate and this is now a consistent pattern. We continue to work with patients to make appointments at a time that suits them to increase the chance of attendance.	Continue to arrange appointments collaboratively and continue to develop our system of sending automated reminders to patients ahead of their appointments.	*Divisional Director CYAF*

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

DNAs feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q2 2019-20	Objective / plan for next Quarter	Lead
Adult Complex Needs	We have managed to sustain the low DNA rates for the last quarter.	We are determined to keep the low DNA rate. We have just embarked upon the clinical research for the experiences of patients while waiting.	*Head of Adult Complex Needs Service*
Portman:	We are pleased that our DNA rate is under 10%. This is despite the fact that our patient population are, by definition, often chaotic and therefore miss appointments.	We would like to think that our DNA rate is low despite the nature of the patients' difficulties due to the fact that clinicians work hard to engage patients in treatment, and also that patients are notified that when they are not able to attend, they must contact the clinic to notify us.	*Clinical Governance Lead*
City and Hackney PCPS	Following Q1's spike in DNAs, PCPCS looked deeper into the available appointment data and found that group appointments were having a disproportionately large negative impact on our DNA rates. We have discussed with group facilitators and made a plan as to how to try to manage DNAs in group setting. It is good to see the rate return to a number more in line with our historical standard. PCPCS's remit is to see hard-to-engage patients in a primary care setting and therefore, while the team works hard to keep them to a minimum, some level of non-attendance is to be expected.	We hope to improve our rate / maintain a similarly low rate in the next quarter, using letters, SMS text reminders, and phone calls to help sustain patient engagement in their treatment. We have reminded clinical staff of the service's policy in regard to DNAs, so that standards are maintained across all areas of the service.	*Service Administration Manager*
TAP	TAP have initiated a QI study to review the causes of higher DNA rates which we note are down by about 25% relative to last quarter. One notable source of inaccurate data was the EMIS software default standard for DNA. EMIS defaults to DNA in three hours after an appointment has ended if the appointment is not outcomed. Our QI lead and admin lead have advised staff how to rectify this default setting on the system to allow more accurate manual entry of outcomes such that the system does not set itself to default to DNA. In addition, we have used the team meeting to share trust policy on DNA so that all clinical and admin staff understand that cancellations can be made right up to the final minutes of a planned session. Some staff were unaware of this distinction which we believe has accounted for some inaccuracy.	In terms of qualitative aspects influencing DNA rate we have collaborated closely with our partners in Camden and Islington NHS-FT to ensure that referrals made through the new single point of entry (SPE) are made to the highest standards of clinical appropriateness and patient/GP involvement to reduce unnecessary DNA through inappropriate referral, multiple referral or referral without adequate consent or sharing of essential information	*Divisional Director*

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

DNAs Feedback and action plan from Service Leads – Gender Services			
Service line	Commentary Q2 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.	*GIC Service Manager*
GIDS	The GIDS DNA rate has now escalated to above target from above 9.5% to above 10.5%. We believe this is seasonal and due to the placement of Q2 within the summer months. Of note, the total DNA rate 10.5% is lower than Q2's 2018/19 DNA rate, which was nearly 11%. We believe this positive reduction is in part due to a revised DNA policy and analytical work on DNA rates.	We will continue to administer the DNA policy, as well as analytical work to further inform systematic change to improve attendance rates across the system.	*GIDS Service Manager*

3. **Quality Priorities**

Quality Priority	1. Improve identification and management of high-risk patients	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust.	Clinical Risk Assessment workshops will continue to run quarterly. This is face to face teaching and learning from clinical cases. The "go live" of an enhanced risk assessment module available to staff on the ESR has been delayed until Q3. In addition risk assessment/risk management is usually incorporated into the presentation and discussion at the quarterly learning lessons event. High risk patients are discussed at team meetings.	
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.	A case notes audit has been undertaken in CYAF. 2 smaller team based audits are currently underway. The reports will be triangulated when the audits are completed.	
Continue to audit recording of clinical risk assessments and actions taken	CYAF cases notes audit of completion of risk assessment forms on Care Notes has been completed. In CYAF 2 smaller team-based audits are being undertaken. A similar audit has been completed in AFS and is being written up. The results of all audits will be triangulated and reported to Clinical governance meetings in AFS and CYAF during Q3	

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

Quality Priority	2. Experience of Service Questionnaire (ESQ) Review	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Further consultation with the Quality Advisory Group before completing and testing the new forms	Complete	
Test streamlined forms in one service initially and review and evaluate effectiveness	The newly designed Service Experience questionnaire (provisionally named Your Experience of Our Service) began a trial period of use in two Camden CAMHS teams (MOSAIC and Intake team) in July 2019. In MOSAIC patients are generally given the questionnaire in person by a clinician at assessment and 6 monthly reviews; it is completed alone and handed to reception. In the intake team an administrator will call a patient/parent to complete the form over the phone following 2 assessment appointments. In quarter 3, completion data and qualitative feedback from patients/clinicians will be gathered.	

3.3 **Quality Priority 3**

Quality Priority	3. Improve patient and carer involvement in care planning in CYAF teams	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Improve quality of patient and / or carer involvement in the development of care plans	Over Q2, the admin lead has done a review of the qualitative comments from parents and carers and CYP recorded on care plans. In Q3 this will be reviewed in detail. The report produced from Carenotes for Q1 and Q2 showed of those seen for a second time in the period in Q1 that had an assessment summary 41% recorded that treatment was discussed with the patient and 69% with the parent. In Q2 these figures were 37% and 55%. Going forward in to Q3, we will share this baseline data from Q1 and Q2 with all team managers with a view to increasing the level of involvement. In addition, over Q1 and Q2 we have delivered training to staff in the use of i-THRIVE Grids to facilitate shared decision making, and have begun recording their use from Q2.	
Increase the quality of data recorded of care plans shared with patients and referrers	It has been difficult to identify a consistent way to review the quality of care plans. In Q3 we will audit 20 completed care plans from across the directorate to evaluate completeness and content against feedback from service users in previous focus group. Through discussions with IM&T, we have clarified that the generation of care plan field cannot be made mandatory as this would need to be completed at draft stage, resulting in the potential generation of incomplete care plans. In reports tracking the sending of care plans, we can now identify assessment summaries where the 'create a care plan' box has been checked, and the admin team in North Camden have just started following up on unchecked care plans to increase completion rates (30% blank in Q1, 34% in Q2). This will be further reviewed in Q3.	
Increase the percentage of care plans shared with patients and referrers	The report created by IM&T is now functioning on the assessment care plan. Of those in Q2 where the assessment summary is complete, they have had two or more face to face appointments, and the clinician has checked the box saying admin to send to GP 82% have had a care plan created and for those where the clinician has checked for box to share with patient 76% have had a care plan created. The report for the review stage requires further validation. Of those who had an initial care plan created in Q4 2018/19, 40% had a review care plan completed.	

3.4 **Quality Priority 4**

Quality Priority	4. Provide Effective Sleep Management Information	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Establish an adolescent only group for patients experiencing sleep difficulties *(those aged 14 – 18)*	The adolescent group failed to get enough attendees to facilitate a group, however 1 patient who met the criteria was provided with treatment.	
Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input	Sleep hygiene information has been written, and it will get sent to our PPI group for feedback in Q3	
Develop and disseminate information for clinicians on sleep in adolescence	This guide is still in progress, but will be completed and published on the intranet by Q4	
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.	

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

Quality Priority	5. Improving waiting time experience from end of assessment to first treatment session in Adult Complex Needs	
Key Workstreams	**Quarter 2 Narrative Updates**	**RAG Rating**
Reduce the number and % of patients dropping out between end of assessment and first treatment episode	We have looked into the data of dropping out of patients at the starting point of therapy. The dropout rate was found to be 7.8% (8 of 102 patients). Further information will be gathered on the number of patients who start therapy during Q3.	
Obtain feedback from service users on their experience of the gap period	Although the dropout rate is fairly low we will obtain feedback from patients – specific plans for obtaining this feedback will be made at the end of October 2019 when the new QI Lead is in post.	
Review reasons for drop out and patient experience to improve the service for both patients and staff	We need to wait and see the feedback by patients.	

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

Quality Priority	6. Embed meaningful use of outcome measures in services	
Key Workstreams	Quarter 2 Narrative Updates	RAG Rating
80% of children and young people with Thrive categories, 'getting help' and 'getting more help' have a Time 1 goal recorded for the Goal Based measure (GBM) and CGAS measure.	32% up from 25% in Q1. This issue is the subject of a Quality Improvement project and the issue of low responses has been debated there. The feedback from clinicians in the QI group is that doing the goal based measure at the first or second assessment appointment may not be the appropriate time to do it. The QI project is going to explore this further. GBM remains the key measure that we are wanting to use.	
	42% up from 36% but still a long way from 80% target. One possibility for low completion is that the form on Carenotes contains a number of unnecessary drop down lists that could be removed to make the form more user friendly. We are making a request to Informatics to make these changes to the form. Then we will have a communication exercise to staff and offer refresher training to teams	
Obtain service user feedback on the use of outcome measures to feedback on progress.	Unfortunately we were unable to gain service user feedback in Q2, this falls in school holidays and it is challenging to run these groups at this time. We will address this in Q3	
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	41% up from 22% which is a significant improvement from the previous quarter. Alongside the QI project we anticipate a gradual improvement towards our goal. Please also see GBM Time 1 commentary.	
	26% down from 55%. Unclear why this figure has gone down. Will need to review the figure next quarter to look for trends. Please see CGAS Time 1 commentary	
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 project to get young people involved in a project to look at the outcome measure charts and give us feedback has not been logged as a QI project with Andy Wiener in the lead, supervising a junior doctor and a trainee who will carry out the project, including working with informatics to get the charts working properly.	

4.1 **CQUINS**

Quarter 2 Targets	Quarterly Performance Against Targets	Associated Issues / Risks	RAG Rating
Achieve an 80% uptake of Flu Vaccinations by frontline clinical staff	**Tavistock & Portman: Flu Vaccination Communications Programme** The communications plan includes: • National campaign posters being delivered & distributed across key sites • Intranet news stories giving information on when & where to get Flu Jab • Pictures & news stories about CEO getting their jab • Updates on when & where to get Flu Jab to appear in Trust's Digest • Interim statistics to be gathered comparing compliance with other Trust's to introduce competition • Intranet and e-mail message from Trust's Medical Director promoting Flu Jab Four 'all-day' Flu-Vaccination clinics have been set up, running 29th October 2019 – 5th November 2019 across the Trusts sites. In addition, any staff unable to attend one of the above clinics will be provided a free Flu Jab vaccination voucher, redeemable at Tesco pharmacies, ASDA pharmacies, Superdrug, Well (formerly Co-op pharmacies), Lloyds pharmacies, Morrison's pharmacies and many more well-known high-street pharmacies. Flu Vaccinations clinics will be up and running during the next Quarter, this is when the Trust will begin administering vaccinations and start recording compliance against 80% target	No issues or risks associated with this quarter	

4.1 **CQUINS**

CQUIN CCG5a: Mental Health Data Quality: MHSDS Data Quality Maturity Index (All Contracts)				
Quarter 2 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**Workforce Plan for Next Quarter**	**RAG Rating**
Achieve a 95% DQMI score	The DQMI is published with a 3-month delay and the most recent published DQMI is June's MHSDS data where the compliance achieved is 88.9%. The actions completed during Q2 to improve compliance will show in the data published at the end of December 2019, hence it will be included in Q3 report. We are nonetheless able to comment on the actions completed to improve our performance across Q2. The DQMI is the combination of several factors and a significant amount of work has been done on those where the scoring was low: **Ethnicities**: the Q2 all service lines reduced the number of missing ethnicities, putting a emphasis on seen patients. Our compliance is January was 76% and in June we achieved 81% **Care Professional Service or Team Type Association**: some of the CYAF teams did not have an MHSDS code allocated. Teams were asked to choose an appropriate code and the changes were done on Care Notes. Our compliance is January was 79% and in June we achieved 100% **Primary Reason for Referral**: awareness of missing data and service lines was highlighted and corrected. Our compliance is January was 84% and in June we achieved 96%. **Source of referral:** Background codes not linked properly from Care Notes to the MHSDS code were identified and corrected. Our compliance is March was 79% and in June we achieved 100% **Referral Closure reason**: Awareness about insufficient use of this field on CareNotes was raised. It was agreed at the end of September to make this field mandatory. This change will be active from 1st Oct and this should have an effect on the DQMI published in January 2020. **Ex-British Armed Forces indicator**: all service lines have now included this information on referral forms and most of the patient questionnaires. Our compliance is January was 0% and in June we achieved 27%. **Clinical Response Type**: we corrected background codes not linked properly from Care Notes to the MHSDS code. **Activity Location Code:** we corrected background codes not linked properly from Care Notes to the MHSDS code. This change should have an effect on the DQMI published in January 2020. Our compliance is March was 56% and in June we achieved 66%.	**Hour Care Contact, Referral Receive Time and Indirect Activity Time**: This parameter has been questioned with Commissioners as this is penalising us for having too many appointments on the hour. This is a problem for us as at least 60% of our services are now running towards clinic models, where the appointments are an hour long, so they would end up on the hour.	To carry on monitoring compliance and identifying areas for improvement. This is a regular item on the Quality Assurance Meeting	Trust assessment based on improvement trends. National DQMI score for Q2 due January 2020.

4.2 **CQUINS**

CQUIN CCG5b: Mental Health Data Quality: Interventions (London Contracts)				
Quarter 2 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**Workforce Plan for Next Quarter**	**RAG Rating**
No Specific Q2 Targets, so request is for an update on associated work streams - with an eye on achieving 70% intervention target by Q3	London Contract considered (001-Camden Adult,002-Barnet,003-Enfield,004-Haringey,005-Ealing,007-Cental London,010-Camden CAMHS,011-Islington,013-Hammersmith&Fulham,014-West London,015-Brent,018-Hertfordshire,048-City&Hackney). For period JUL2019-SEP2019, there were 440 cases in the cohort, among which 426 cases had SNOMED code present – which makes the intervention measurement to be approx. 96.82 %		Informatics have analysed the appointment activity over the past 12 months. Informatics have highlighted the Event types used within the last 12 months which have no SNOMED code recorded. The Events have been sent to the Data Quality Team who will ask the teams to code correctly - Informatics will then populate Carenotes with the codes. Events which are not used and have no SNOMED codes but are still active on Carenotes will be discussed at the next Quality Assurance meeting. These Events will be made in-active if no longer required. There is a SNOMED report now available via Reporting Services which will allow Data Quality to monitor the appointment SNOMED activity.	

4.3 **CQUINS**

CQUIN CCG5b: Mental Health Data Quality: Interventions (NHSE Specialist Contracts)				
Quarter 2 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**Workforce Plan for Next Quarter**	**RAG Rating**
No Specific Q2 Targets, so request is for an update on associated work streams - with an eye on achieving 70% intervention target by Q3	NHS England Specialist Commissioning (008-GIDS,065-Portman,178-GIC,215-FCAMHS). For period JUL2019-SEP2019, there were 408 cases in the cohort, among which 189 cases had SNOMED code present – which makes the intervention measurement to be approx. 46.32%.		Informatics have analysed the appointment activity over the past 12 months. Informatics have highlighted the Event types used within the last 12 months which have no SNOMED code recorded. For example: All GIC appointments have no SNOMED codes mapped to their events. The Events have been sent to the Data Quality Team who will ask the teams to code correctly - Informatics will then populate Carenotes with the codes. Events which are not used and have no SNOMED codes but are still active on Carenotes will be discussed at the next Quality Assurance meeting. These Events will be made in-active if no longer required. There is a SNOMED report now available via Reporting Services which will allow Data Quality to monitor the appointment SNOMED activity.	

4.4 **CQUINS**

Local CQUIN: Anxiety Disorders and RCADS Outcome Measurement			
Quarter 2 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**RAG Rating**
Build new reports to enable establishment of baseline for RCADS use	Reports are now in place that allow us to accurately report on completion of RCADS at time one and time two	Need to establish who will run the reports and frequency of those to monitor compliance and how this will sit alongside other reporting	
Set trigger on Carenotes for completion of RCADS form	Changes have now occurred in Carenotes to trigger RCADS as set out above. This will now be communicated to teams	This is yet to be tested in teams and there may be issues yet to be identified	
Set up visual workflow for RCADS Time 1 & 2	Visual Workflow produced to depict form completion process and associated reporting measures.	n/a	
Baseline RCADS use	At this stage completion is low with the peak in August likely a reflection of the low number due. This is likely partly caused by the fact that until the end of Q2 Carenotes logic had not been changed and therefore SDQs were still generating for patients over 8 years old instead of RCADS	There remain issues with the new carenotes logic in generating forms in the assist panel which we have employed workarounds to manage	

4.5 **CQUINS**

Local CQUIN: Telemedicine / Virtual Patient Sessions		
Quarter 2 Targets	**Quarterly Performance Against Targets**	**RAG Rating**
Review and update documentation originating in previous years of the telemedicine CQUIN including documentation relating to information governance, consent, clinical and service user guidance and protocols and experience surveys	The review, updating and redrafting of documentation relating to information governance, consent, clinical and service user guidance and protocols and experience surveys used in previous Telemedicine CQUINS is currently underway. In collaboration with the Trust's Assistant Director of IG & Information Security & Data Protection Officer (who started in post w/c 30 September 2019) and colleagues with IT expertise, a new DPIA is being completed taking account particularly of the implications of using a cloud-based videoconferencing tool. Consent forms are being updated to reflect recent IG guidance and differences in the way in which personal data is processed by the new videoconferencing platform, REFERO.	
Create additional experience survey to be completed by GIDS clinicians and external professionals who used telemedicine in network and other professional meetings	The attached completed version is intended specifically for professionals in CAMHS, but a more generic version will also be produced for other professionals in the network, including social workers and teachers.	
Identify clinicians to lead and be members of the Project Team	In view of difficulties experienced in previous Telemedicine CQUINS and current pressures on the service, it has been decided that clinicians will only be closely involved once the proposed videoconferencing system has already been proven to work consistently across multiple browsers, operating systems and on a combination of devices. The Project Team is currently composed of GIDS project managers, Trust colleagues from Informatics and IT and technical support from CINOS, the company that has developed REFERO. Testing of the system following a combination of rubrics drawn from previous Trust Telemedicine testing plans and one provided by CINOS is currently underway. A number of clinicians in both London and Leeds have expressed a strong interest in participating in the project and we anticipate a small number will join the project team and a larger number will be trained once testing is completed and a preliminary phase of using REFERO successfully in the context of remote professional network meetings.	
Identify professionals who would benefit from having network meetings using Telemedicine	An initial phase of this work has been completed by a clinical staff member in Leeds and an Assistant Psychologist in London who are particularly interested in the mobilisation of Telemedicine in support of professional network meetings.	

Report to	Date
Board of Directors	26 November 2019

Audit Committee Terms of Reference

Executive Summary

The Audit Committee reviews its ToR on an annual basis.
The Committee reviewed its ToR at its meeting on 10 October 2019.
No amendments to the ToR are proposed on this occasion and the Audit Committee recommends approval of the ToR by the Board.

Recommendation to the Board

Members of the Board are asked to approve this report.

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Non-Executive Director
Terry Noys, Deputy Chief Executive / Director of Finance	David Holt, Chair Audit Committee

The Tavistock and Portman NHS
NHS Foundation Trust

Audit Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	[26 November] 2019
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued:	
Review date:	October 2020

AUDIT COMMITTEE

TERMS OF REFERENCE

CONSTITUTION

1. The Board of Directors hereby resolves to establish a committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

MEMBERSHIP

2. The Committee will be appointed by the Board of Directors.
3. All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.
4. The Committee shall consist of at least three members.
5. The Board should appoint the Chair of the Audit Committee from amongst its independent Non-Executive Directors.
6. At least one member of the Audit Committee should have recent and relevant financial experience.

ATTENDANCE

7. The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.
8. At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
9. The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
10. The Chief Executive and the Medical Director should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.
11. The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

QUORUM

12. This shall be at least two members.

SECRETARY

13. A Secretary shall be appointed for the Committee.

FREQUENCY OF MEETINGS

14. The Committee shall meet at least four times per year.
15. The external or internal auditor may request a meeting whenever they consider it necessary.

AGENDA & PAPERS

16. Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
17. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

MINUTES OF THE MEETING

18. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
19. Approved minutes will be forwarded to the Board of Directors for noting.
20. In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

AUTHORITY

21. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.
22. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

DUTIES

Governance, Risk Management and Internal Control

23. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

24. In particular, the Committee will review the adequacy of:

    24.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

    24.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

    24.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

    24.4 the policies and procedures for all work related to fraud and corruption as set out by the *NHS Counter Fraud Authority*

    24.5 the financial systems

    24.6 the Internal and External Audit services, and counter fraud services

    24.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

25. The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

    25.1 the process for the completion and up-dating of the Assurance Framework;

    25.2 the relevance and quality of the assurances received

    25.3 whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and

    25.4 Whether the Assurance Framework remains relevant and effective for the organisation.

26. The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

27. In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

28. The Committee shall review at each meeting a schedule of debtor balances, with material debtors more than six months requiring explanations/action plans.

29. The Committee shall review at each meeting a report of tender waivers since the previous meeting.

INTERNAL AUDIT

30. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

    30.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

    30.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

    30.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

    30.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

    30.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

    30.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

EXTERNAL AUDIT

31. The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:

    31.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

    31.2 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor

31.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

31.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

31.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

31.6 discussion with the External Auditors findings in respect of the Quality Report and Accounts.

OTHER ASSURANCE FUNCTIONS

32. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

33. These will include, but will not be limited to, any reviews by NHSi, Department of Health arm's length bodies or regulators / inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

34. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Clinical Quality, Safety, and Governance Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

35. In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

36. The Audit Committee should incorporate within its schedule a review of the underlying processes for the Data Security and Protection Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

MANAGEMENT

37. The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

38. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

FINANCIAL REPORTING

39. The Committee shall review the Annual Report and Audit Committee Report before submission to the Board of Directors, focusing particularly on:

    39.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

    39.2 changes in, and compliance with, accounting policies and practices

    39.3 unadjusted mis-statements in the financial statements

    39.4 major judgemental areas

    39.5 significant adjustments resulting from the audit

40. The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

APPOINTMENT, REAPPOINTMENT, AND REMOVAL OF EXTERNAL AUDITORS

41. The Committee shall make recommendations to the Council of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Council of Governors with information on the performance of the External Auditor

42. The Committee shall approve the remuneration and terms of engagement of the External Auditors

OTHER MATTERS

43. At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

44. The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the Committee, considering those areas highlighted within this paper.

SOURCES OF INFORMATION

45. The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

REPORTING

46. The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.

47. The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

48. The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	26 November 2019

NHS Pledge on Reduction of Single Use Plastics

Executive Summary

The NHS is well placed to lead by example in supporting government commitments to eliminate avoidable plastic waste.

NHS England are asking all providers, retailers and suppliers to the NHS, as well as a number of partner organisations, to sign up to a plastic reduction pledge. Through the scheme, signatories commit to:

- eliminate avoidable single-use plastics in NHS catering facilities
- by April 2020, no longer purchase single-use plastic stirrers and straws, except where a person has a specific need, in line with the government consultation
- by April 2021, no longer purchase single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics
- by April 2021, go beyond these commitments in reducing single-use plastic food containers and other plastic cups for beverages – including covers and lids

The Tavistock & Portman NHS FT is ideally placed to use these standards as a platform to make the delivery of our services as sustainable as possible within the pledge timescales. Going beyond single use of plastics in catering, the Trust will ensure that the wider environmental impact is owned by the Board.

Recommendation to the Board

Members of board are asked to approve the recommendations and commitments in this paper

Trust strategic objectives supported by this paper

People and Services

Author	Responsible Executive Director
Director of Estates, Facilities and Capital Projects	Chief Executive

NHS Pledge on Reduction of Single Use Plastics

1. Introduction

The Trust has a long standing ethical and sustainable approach to its work and has recognised the need to bring this conversation to the fore front in order to engage patients, students and staff in this important topic.

Building on the work of previous years, the CEO dedicated an entire question time during September 2019 to Environmental issues.

2. Our current thinking

We have already reduced the amount of carbon used by 360 tonnes, and we want to lose another 50 tonnes by the end of 2019/20. We are positive this is corporately achievable with reductions largely achieved in how we source our refuse processing. Other reductions can be found in how we renew our energy contracts and we are currently exploring a green energy source provider.

The Trust also needs to look at our existing car parking policies. For a Trust situated in Inner London we are lucky to have a substantial number of car spaces at the Tavistock Centre site. The Estates Team are exploring how this facility can be made more environmentally friendly – perhaps through a car pool or car share system and the installation of rapid electric vehicle charging.

Additionally, we are working with the Toza Café on issues around local sourcing, production and serving.

3. Future developments

In relation to the Tavistock Centre Relocation Programme, the Team will explore over the next few years the environmental impact on development/design options. For example, in regard to energy this can involve solutions such as microgeneration (small scale systems that generate electricity). Other considerations include how might we clad a future building, ie. by installing a system where the cladding is made up of photovoltaic cells, leading to a carbon neutral solution which provides good insulation and a conversion rate so good it pays dividends.

Other ideas could include installing ground-source heat pumps, which can save huge amounts of energy, not feasible at the Tavistock Centre but possible at a new site.

4. What's important to our staff, patients and students?

At the CEO question time with staff the audience posed the following themes:

- Very practical energy saving things like timer lights and motion sensors
- Introduction of reusable containers for take away food
- Better water fountains to promote reusable bottles
- Remove hard landscaping and introduce more soft landscaping
- Better awareness of recycling with a wider number of recyclable items (www.terracycle.com)
- A staff working group dedicated to environmental issues

5. Next steps

5.1 Support the NHS by signing up to the pledge to eliminate avoidable single-use plastics in NHS catering facilities

5.2 Work with NHSE by confirming two points of contact for sustainable development within their organisation:

- a senior responsible officer (Director level)
- sustainable development lead for the Trust

5.3 Strengthen staff engagement by establishing a staff forum on environmental initiatives

5.4 Communications to increase awareness and celebrate success on NHS Sustainability Day (19 March 2020) Market an increased staff awareness of 'bring your own' policies by:

- the introduction of reusable coffee/tea cups (other Trusts have reported Year 1 reduction of up to 67% in single use coffee cups)

- the Introduction of a ‘latte levy’ – a discount for using reusable mugs and other reusable items such as takeaway cutlery, and takeaway boxes

- working with suppliers to purchase more sustainable solution for to-go items in order to provide a range of alternatives to plastics for e.g. paper straws and recyclable takeaway food containers

- encourage the use of crockery for customers staying within the building via a return surcharge (think bottle deposit)

- install more and clearer recycling points to raise awareness

- develop a set of promotional materials for display in restaurants and common areas

Appendix 1 – Top drivers for sustainability

Top 5 drivers to have in your back pocket

Type	Title	Overview
International treaty	United Nations' Sustainable Development Goals	17 goals, providing a framework for action by 2030 to achieve a better and more sustainable future for all.
International treaty	Paris Agreement under the UNFCCC (2015; UK ratified 2016)	An international agreement to keep a global temperature rise this century well below 2 degrees Celsius above pre-industrial levels, and to pursue efforts to limit the temperature increase to 1.5 degrees Celsius. The IPCC recently published a special report on the impacts of global warming of 1.5 °C above pre-industrial levels, and related global greenhouse gas emissions pathways. It aims to strengthen the global response to the threat of climate change, sustainable development and efforts to eradicate poverty.
UK law	Climate Change Act (2008)	Long-term legally binding framework to **reduce carbon emissions, mitigate and adapt to climate change**. It states that we must reduce **CO_2e by 80% by 2050 on a 1990 baseline**, with these additional targets: • 2020: 34% reduction • 2025: 50% reduction • 2050: 80% reduction
UK law	Public Services (Social Value) Act (2012)	Places a requirement on commissioners in all public bodies to consider ***economic, social and environmental*** benefits when buying goods and services, taking a value for money approach (not lowest cost) to assess contracts. You can find an introductory guide at www.gov.uk/government/publications/social-value-act-introductory-guide and SDU resources at www.sduhealth.org.uk/areas-of-focus/social-value.aspx
Health policy	NHS Constitution: Principle 6	All NHS bodies and private and third sector providers supplying NHS services must take account of the NHS Constitution. Principle 6: "The NHS is committed to providing best value for taxpayers' money. It is committed to providing the **most effective, fair and sustainable use of finite resources**."

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Trust Board	November 18th 2019

The Trust Centenary

Executive Summary

This paper gives an outline of the events planned to celebrate the centenary of the Tavistock Clinic in 2020. The centenary is an opportunity to celebrate the work of the Tavistock and Portman.

A wide range of events will showcase our current work, its roots in our history and will look forward to our future.

Events will link with organisations with historic links to the originating organisation and with current partners.

Where possible, live streaming will make the events available to a wider audience and some events will take place in venues outside London.

Recommendation to the Board of Directors

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

Trust strategic objectives supported by this paper

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.

Author	Responsible Executive Director
Projects Director	Chief Executive

Contents

Project Context

The Tavistock Clinic was established in 1920 by Hugh Crichton-Miller and the first patient was seen on 27th September 1920 by Dr Hamilton Pearson, Director of the Children's Department. Over the last hundred years, the work of the clinic has continually evolved to reflect new learning and develop new methods. In that time, it has been joined by other organisations, such as the Child Guidance Training Centre and the Portman Clinic. It has also given rise to a range of now separate organisations including the Tavistock Institute of Human Relations and Tavistock Relationships.

The Tavistock became an independent NHS Trust in 1994 and at the same time joined forces with the Portman Clinic. In 2006 and Trust achieved Foundation Trust status. Many services are now delivered outside of the Tavistock Centre.

In celebration of the Tavistock's centenary, a programme of events will be held in the year 2020. A centenary preparations committee was formed in November 2018 to plan and oversee the programme of events. The committee includes representatives from across the organisation and reports formally to the Executive Management Team and External Relations Committee.

Whilst it is the centenary year of the Tavistock Clinic, we will refer to the programme as the Tavistock & Portman centenary in our promotional material.

Committee Member	**Role / Representative of**
Louise Lyon	Chair & Projects Lead
Laure Thomas	Communications
Glenn Gossling	Communications
Julian Stern	AFS
Sarah Helps	CYAF / replaced Ailsa Swarbrick from 9/2019
Nell Nicholson	CYAF & Gloucester House
Sarah Wynick	CYAF
Brian Rock	DET
TBC	Project Manager
Bank Staff	Project Administrator

It has been agreed that the centenary will be inclusive of all the organisations within and connected to the Tavistock and Portman NHS Foundation Trust and the committee will actively explore possibilities for partnership work.

Project Objectives

The purpose of the centenary programme is to:

1. Celebrate the Tavistock Clinic's history and success
2. Raise awareness of the Tavistock and Portman brand
3. Raise awareness of the Tavistock and Portman approach
4. Generate income for the Tavistock and Portman Charity and support the charity re-launch.

Project Workstreams

1. External conference
2. Internal celebration
3. Public lecture series
4. Scientific meetings
5. Arts
6. Policy seminars
7. Tavistock Thinking Spaces
8. Centenary Group Relations Conference

Underpinning Workstreams

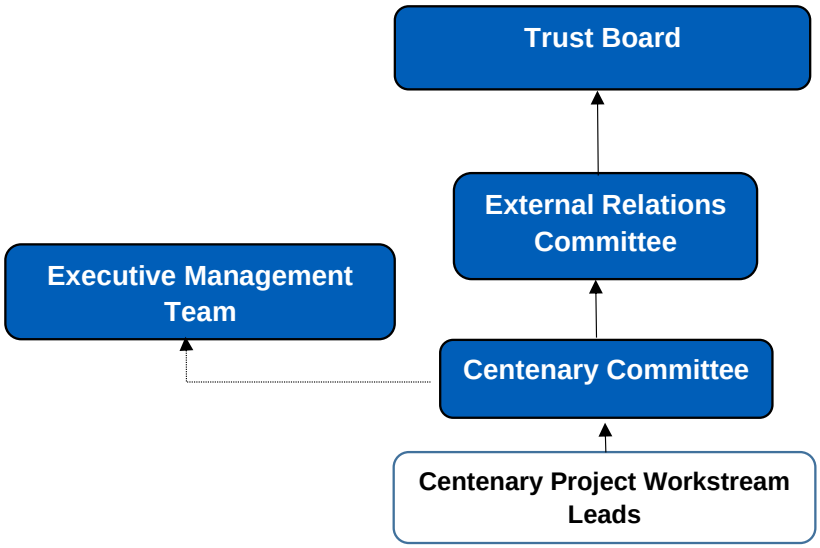
9. Tavistock history archive and timeline
10. Scope the potential for involvement of BAME, LGBTQI+ networks and other groups
11. Media content creation
12. Comms engagement and marketing strategy

Assumptions

- A budget has been made available to support programme administration.
- EMT has agreed that the Trust will underwrite the financial risk of the conference.
- Each workstream lead, responsible for co-ordination and content, will take responsibility to drive the workstream forward within their existing resources.

Project Organisation, Control and Governance

The chart below displays the governance structure and interaction within the Centenary Committee, Executive Management Team and Trust Board.



Governance occurs on three levels to provide assurance and control:

- **Centenary Committee Level**: The committee meets on a fortnightly basis to review workstream progress and risks. The Project Manager liaises with workstream leads and provides a summary update at committee meetings.
- **Executive Management Team**: The Executive Management Team are appraised on any matters that may impact organisational risk and advise the committee on key decisions through the Communications Director and, when necessary, the Centenary Committee Chair.
- **External Relations Committee**: The External Relations Committee are kept appraised of the centenary programme through the Communications Director.
- **Trust Board**: The Trust Board receives quarterly updates on progress.

Communication Management Plan

A Communications Plan will be worked up and put to the External Affairs Committee for approval. It will seek to support the aims of the Centenary Celebrations:

1. Celebrate the Tavistock Clinic's history and success
2. Raise awareness of the Tavistock and Portman brand
3. Raise awareness of the Tavistock and Portman approach
4. Generate income for the Tavistock and Portman Charity and support the charity re-launch.

It will include a comprehensive promotion campaign for all Centenary events, using already developed 100 years branding. This will include the marketing of events, particularly the Centenary Conference, the dissemination of content pertaining to events, the reskinning of the website and revamping of its history and about us sections, and the creation and sale of 100 years merchandise (from calendars to lanyards), etc. It will also seek to encourage staff to use the 100 years branding in all appropriate settings and develop relevant collateral (pop up banners, PowerPoint templates, etc). It will also seek to keep all our different stakeholders, internal and external, abreast of plans in the most appropriate and relevant way. Much of this work is already underway.

The Communications Team is also supporting the wider Centenary project work in a broader way and making a substantial contribution to certain workstreams, including working on the history and timeline projects and the public lecture series. This is putting further strain on the team given the already high volume of work it faces. A paper will be coming to EMT about resourcing for the team.

Involvement

The committee will actively involve staff, patients and network groups in the centenary planning process.

Budget Management Plan

A budget has now been agreed for the centenary programme and recruitment will take place in December. To date the project has been supported by a seconded Project Manager .1 WTE (now returned to substantive role) and .2 WTE Band 4 Administrator

Programme Timeline

The year of celebrations will start in January 2020 and continue through the calendar year.

Progress So Far

The centenary committee have engaged with staff through a survey and call for materials. The committee have also engaged with the BAME and LGBTQI+ network groups. The Tavi100 branding and logo has been agreed and finalised. The external conference venue has been secured and the format of the conference has been agreed. A draft conference theme has been approved and the development of the conference programme is in progress. The Tavistock and Portman 2020/21 postgraduate prospectus will be launched at the end of the month leading with the centenary

branding and featuring a timeline of education and training at the Tavistock. The majority of individual workstream leads have been identified and workstream plans are in development.

Draft Timeline of events

Centenary Programme 2020

Month	Date	Event	Location & Time	Lead Contact
January	13th	Scientific Meeting	Tavistock Centre	Julian Stern
February	10th	Scientific Meeting	Tavistock Centre	Julian Stern
March	9th	Scientific Meeting	Tavistock Centre	Julian Stern
April	TBC	Scientific Meeting	Tavistock Centre	Julian Stern
May	11th	Scientific Meeting	Tavistock Centre	Julian Stern
	21st	Thinking Space	Tavistock Centre	Frank Lowe
June	8th	Scientific Meeting	Tavistock Centre	Julian Stern
	11th	Charity Gala launch party		Louise Lyon
	18th	Thinking Space	Tavistock Centre	Frank Lowe
July	10th–12th	Centenary Group Relations	Tavistock Centre	Sarah Wynick
	13th	Scientific Meeting	Tavistock Centre	Julian Stern
August				
September	14th	Scientific Meeting	Tavistock Centre	Julian Stern
	24th	External Conference	Kings Place	Louise Lyon
	25th	Internal Conference	Tavistock Centre (Lecture Theatre)	TBC
October	12th	Scientific Meeting	Tavistock Centre	Julian Stern
November	9th	Scientific Meeting	Tavistock Centre	Julian Stern
December	14th	Scientific Meeting	Tavistock Centre	Julian Stern

[Public lecture series and Policy Seminar dates TBC]

Linked Activities (not managed through the Centenary Programme)

- A book of anecdotal history of the Tavistock and Portman, edited by Margot Waddell and Anton Obholzer
- A centenary Quality Improvement Workshop in April 2020, led by Dinesh Sinha and Chris Caldwell.
- A research day at the University of Essex, led by Dinesh Sinha and Andrew Cooper
- A Tavistock and Portman and Tavistock Institute of Human Relations joint event around the Wellcome Trust archives (lead TBC)
- A centenary themed art exhibition on the ground floor autumn 2020.

To Note:

- Discussions are in place to link Tavistock Relationships to perhaps one or more of the above events.

Workstream Plans

1. Centenary Conference

An external conference will be held at Kings Place on Thursday 24th September 2020.

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Centenary Conference	Celebrate the Tavistock Clinic's history and success Raise brand awareness Raise awareness of the Tavistock & Portman approach	Barnaby Grainger	Louise Lyon	Louise Lyon	Tavistock Relationships Current & previous T&P staff	Conference Program developed Contact details for invitees confirmed Speakers confirmed and secured Conference promoted in publication of prospectus Marketing materials completed Conference Programme published Invitations sent Online Conference Registration launched Second venue deposit due Online Registration closed Final venue deposit due Final details sent to the venue **Conference date**	October 2019 October 2019 October 2019 November 2019 December 2019 December 2019 Dec 19 – Jan 2020 Dec 19 – Jan 2020 July 2020 August 2020 August 2020 September 2020 **24th Sept 2020**	Approved budget Trust assurance

To Note:

- There has been an agreement in principle for 'The Tavistock and Portman Charity' to contribute towards concessionary tickets and evening reception. The amount has not yet been finalised and will depend on pricing structure for tickets.
- A part-time event manager / co-ordinator will be recruited from funds allocated to the centenary

- The proposed conference theme is ‘Continuity and change- looking at the past, present and future, across the lifespan’. Title to be determined.
- The external conference will be a ticketed event. The conference team is working on the pricing model with the aim of breaking even.

2. Internal Celebration

An internal celebration for past and present staff, patients and families will be held in the Lecture Theatre on Friday 25th September 2020.

What	Why	Who - Responsibility				How	When	
Workstream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S’holders**	**Key Activity**	**Key Dates**	**Dependencies**
Internal Celebration	Celebrate the Tavistock Clinic’s history and success	TBC- Divisional Directors will invite members of current staff to form a small steering group	TBC	Louise Lyon	Past T&P staff Current T&P staff Patients and families	Lecture Theatre booked Workstream lead agreed Agenda developed Save the date sent out **Internal celebration date**	August 2019 Novmeber 2019 December 2019 January 2019 **25th Sept 2020**	

To Note:

- Although key activity will be held at the Tavistock Centre, we will make provisions to accommodate external venues e.g. providing tea at other venues and providing zoom access.

3. Public lecture Series

Approximately 10 public lectures will be held in partnership external venues. Proposed venues include Camden, Leeds, Essex, UEL, and UCLP.

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Public lecture Series	Celebrate the Tavistock Clinic's history and success Raise brand awareness Raise awareness of the Tavistock & Portman approach	Laure Thomas	Paul Dugmore	Louise Lyon	Current T&P staff Previous T&P staff	Programme development in progress	Lectures to be held throughout the year of 2020.	Policy Seminars Scientific Meetings Thinking Spaces External conference

4. Scientific Meetings

11 Scientific meetings will be held at the Tavistock Centre. Final programme of meetings will be available in November 2019.

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**

Scientific Meetings	Raise awareness of the Tavistock & Portman approach Celebrate the Tavistock Clinic's history and success	Julian Stern	Julian Stern	Louise Lyon	Current T&P staff Previous T&P staff	Draft programme available	November 2019 Proposed meeting dates: 13th Jan 2020 10th Feb 2020 9th March 2020 April 2020 (TBC) 11th May 2020 (TBC) 8th June 2020 13th July 2020 14th September 2020 12th October 2020 9th November 2020 14th December 2020	Policy Seminars Lecture Series

To Note

- A series of scientific meetings will be held on the second Monday of each month in 2020, excluding the month of August.
- The meeting date in April is TBC.

5. Arts

The committee will work with the Tavistock Art Board to encourage a creative workstream that might involve exhibitions, music and social events.

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**

Arts	To include artistic contribution to the centenary programme	Chris Caldwell	Chris Caldwell	Louise Lyon	Art Board	Tavistock Open Art Exhibition	December 2020	

6. Policy Seminars

The committee will work alongside Andrew Cooper to ensure the Policy Seminars link into the centenary programme. An additional seminar policy may be held in collaboration with the Tavistock Institute of Human Relations (TIHR).

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Policy Seminar Series	Raise awareness of the Tavistock & Portman approach Celebrate the Tavistock Clinic's history and success	Andrew Cooper	Andrew Cooper	Louise Lyon	Current T&P staff Previous T&P staff	Programme in development	TBC	Lecture Series Scientific Meetings

7. Tavistock Thinking Spaces

Two centenary Thinking Spaces will be held at the Tavistock Centre.

What	Why	Who - Responsibility	How	When

W'stream	Purpose	Co-ordination	Content	Sign off	S'holders	Key Activity	Key Dates	Dependencies
Tavistock Thinking Spaces	To encourage thinking about the past, present and future in relation to the T&P	Frank Lowe	Frank Lowe	Louise Lyon	Current T&P staff Previous T&P staff	Content completed	December 2019 Potential Thinking Space dates: 21st May 2020 18th June 2020	Public lecture Series Scientific Meetings Policy Seminars

8. Centenary Group Relations Conference

A centenary themed Group Relations Conference will be held at the Tavistock Centre from 10th-12th July 2020.

What	Why	Who - Responsibility				How	When	
W'stream	Purpose	Co-ordination	Content	Sign off	S'holders	Key Activity	Key Dates	Dependencies
Centenary GRC	To celebrate and increase awareness of group relations methodology as a unique part of the Trust's way of educating, training and promoting psychodynamic and systemic thinking about organisational life.	Sarah Wynick	Sarah Wynick	Louise Lyon	TBC	TBC	: 10th – 12th July 2020	

To Note:

- Discussions are in place to ensure this event is linked to TIHR via a member of staff working on the Group Relations Conference.

Underpinning Workstream Plans

9. Tavistock History Archive & Timeline

This workstream will develop a narrative account of the organisation's history, identify the geographic spread of the organisation's influence and outline a history of ideas associated with the organisation. The information will be presented both in a timeline and a family tree.

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Tavistock History Archive & Timeline	Celebrate the Tavistock Clinic's history and success	Glenn Gossling	Glenn Gossling Supported by: Sarah Helps Melissa Midgen	Laure Thomas	Current T&P staff Previous T&P staff	First draft available	23rd October 2019	Centenary Conference

10. Scope the potential for involvement of BAME, LGBTQI+ Networks and other groups

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Scope the potential for involvement of BAME, LGBTQI+ networks and other groups	Celebrate the Tavistock Clinic's history and success	Irene Henderson & Jos Twist	Irene Henderson & Jos Twist	Louise Lyon		Scoping in progress.	TBC	

11. Media content creation

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Media content creation	Raise brand awareness Raise awareness of the Tavistock & Portman approach Celebrate the Tavistock Clinic's history and success	Laure Thomas	Laure Thomas Nell Nicholson Sarah Wynick	Louise Lyon Laure Thomas	Current T&P staff Previous T&P staff	Possible film or radio programme. Articles, blogs and tweets linked to other activity.	TBC	Public lecture Series Scientific Meetings Policy Seminars

To Note:

- The committee explored the possibility of commissioning a documentary series through a TV Production Company but were unable to progress due to there being a lack of relevant archive footage available. Other media possibilities, such as radio, will continue to be explored.

12. Comms Engagement & Marketing Strategy

What	Why	Who - Responsibility				How	When	
W'stream	**Purpose**	**Co-ordination**	**Content**	**Sign off**	**S'holders**	**Key Activity**	**Key Dates**	**Dependencies**
Comms Engagement & Marketing strategy	To communicate relevant centenary activity to stakeholders	Laure Thomas	Laure Thomas	Laure Thomas Louise Lyon		To follow from Comms	TBC	

To Note:

- The committee recognises that there is likely to be other centenary related activity throughout the Trust in the year 2020. In order to ensure the Tavi100 branding is used consistently, a 'Moodbook' has been created to provide a consistent look and feel throughout the organisation. This will include the logo, e-signature and PowerPoint presentation addendum.
- The media marketing strategy may include the following:

  - A sell-in to a national media outlet (preferably television: BBC, C4, radio: Radio 4). Plus regular releases and stories to national press.
  - Regular London press releases, targeted at the Evening Standard, Metro or BBC London News. Regular releases to professional press e.g. The Psychologist, The International Journal of Psychoanalysis, New Associations Psychoanalysis & History
  - Locally tailored press releases that cover each borough where we have a presence.
  - Publication in the Psychoanalytical Psychotherapy ACP journal.

Report to	Date
Board of Directors	26 November 2019

Data Security – Serious Incident Report

Executive Summary

On 06 September 2019 two emails were sent to 1,781 patients (one containing 912 recipients and the second containing 869) inviting them to participate in a public and patient involvement activity.

Erroneously, the email addresses were keyed in to the 'to' field on the Outlook email application rather than the 'blind copy field'.

A full serious incident investigation was conducted which concluded that:

- There was no intention for the incident to occur, it happened as a result of human error.
- The organisation's exchange server did not have in place a policy to prevent large scale emails being sent.
- Distress had been caused to those patients affected by the incident but there was no further clinical impact.
- The operational response to the incident was well managed and those who contributed to the fact finding process did so in an open and candid way.

Recommendation to the Board

Members of Board of Directors are asked to note the contents of this report and discuss the themes and learning arising from this process.

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Director of HR & Corporate Governance	Deputy Chief Executive (SIRO)

Confidential

Serious Incident Investigation Report

QP TID /STEIS Reference	QP TID:10650 STEIS:2019/19694 ICO ref: COM0872155
Incident Date	06 September 2019
Incident Synopsis	Data breach – unauthorised disclosure - failure to use bcc when sending email. Involved 1777 patients with invitation to participate in art project
Date Reported on STEIS	06 September 2019
Date Report and Action Plan signed off by the Director Technology and Transformation	18/11/2019
Review Team	Craig de Sousa, David Wyndham-Lewis, Paul Jenkins
Review Level	Comprehensive
Report Author/s	Craig de Sousa, HR and Governance Director
Report Completion Date	15/11/2019
Document Version	FINAL
Distribution List for the Final Report and/or Executive Summary	Gender Services Divisional Director, CCIO, Board

Contents

Executive Summary

Incident Date	06 September 2019
Incident Type	Data breach – unauthorised disclosure
Service User Demographics • **Age** • **Gender** • **Ethnicity**	1,777 patients Gender identity clinic patients Various ages, genders / natal sex and ethnicities
Division	Gender services
Scope of the review	To explore the root cause of the incident on the above date and any similar cases dating back to 2017
Involvement and support of patient and/or relatives	All patients affected were sent an apology, details of support available and the method for raising a formal complaint on 06 September 2019
Notable practice (care and practice that had a positive impact and may provide learning opportunities): **Good Practice (expected standard of care and practice but well executed)**	• The Trust has an excellent approach to engaging those that use its services. The level of activity and creative ways in which those who receive care and treatment at the organisation is well developed and has further potential • Operational and strategic response to the incident was very well managed. The timescales demonstrate swift action being undertaken in a reflexive way that demonstrates careful thought and detailed execution. • The staff that contributed to the SI investigation were very open and candid, demonstrating evidence of a good culture around transparency.
Care and Service Delivery Problems	Distress was caused to the patients affected by this breach but there have been no ongoing care or service delivery issues.
Contributory Factors	Equipment and resource factors - no block on the number of recipients it is possible to send emails out to in Outlook Individual factors - human error
Root Causes	Human error – without any intended malice. Trust's email server did not have a maximum recipient limitation policy applied to Outlook to prevent the incident from occurring.
Lessons Learned	• The status quo for mass communications is no longer acceptable and must be addressed

	• Such tasks which have the potential to be prone to error should involve checks and balances before the communication is issued. • Information technology policies – specific to the exchange of information – do not provide adequate defence
Recommendations	• All policies and procedures which are out of date require urgent review – specifically, the Email, text message and internet use procedure and the Incident reporting procedure. • An exchange policy to be applied ensuring no emails can be sent out more than a determined number of recipients • Trust should seek to procure software that allows mass marketing • Process for sharing Director on call rota with Reception to be updated • Forms for obtaining correspondence data to be reviewed with the view to expand the detail surrounding the potential use of information
Arrangements for shared learning	Learning from this incident was shared by the chief executive to all trust staff and it has been encouraged to be raised at team meetings.

1 Introduction

1.1 On 06 September 2019 two emails were sent to 1,781 patients (one containing 912 recipients and the second containing 869) inviting them to participate in a public and patient involvement activity. Of these emails sent 4 were returned as undeliverable. The email was intended to assist with increasing the participation of a certain patient group.

1.2 The email originated from the Trust's patient and public involvement team and was intended to communicate the message but not expose the personal email addresses with the group of recipients. Erroneously, the email addresses were keyed in to the 'to' field on the Outlook email application rather than the 'blind copy field'.

1.3 This report sets out the findings of a serious incident investigation process.

2 Methodology

2.1 This investigation has been conducted in line with the Trust's incident reporting procedure and reviewing a single incident but one that had an impact on multiple patients.

2.2 A root cause analysis approach has been used to assess the issues which have occurred.

2.3 Throughout the course of this investigation a number of Trust staff have been given the opportunity to provide statements of detailing their recollection of the events to the best of their ability.

2.4 Where I felt it appropriate, I have interviewed individuals or corresponded with them to expand on the information they provided. It should be noted from the outset that all participants have engaged positively in the fact finding process.

2.5 Finally I undertook a review of correspondence, policies and procedures to inform my findings.

3 Terms of reference

3.1 On 10 September 2019 I was commissioned by the director of technology and transformation to conduct an investigation and prepare a report of my findings against the following areas.

a) Confirm the scope of data breach, including those impacted and what data was released about each individual.

b) Confirm the scale of both privacy and clinical impact likely to the impacted individuals, including any cases received as complaints.

c) Confirm the chronology of events leading up to the data breach. Confirm all standard operating procedures and tools used in operating the activities that triggered the incident.

d) Identify and review the relevant Trust policies and procedures that relate to the activity that caused the breach, specifically, you should confirm whether or not these were followed in this case.

e) Identify and review the relevant Trust policies and procedures that relate to the response by all engaged teams following the breach and confirm whether or not these were followed in this case.

f) Identify and review relevant risks held on the Trust risk register that relate to this type of incident and confirm whether actions to mitigate those risks are adequate in light of this incident.

g) Identify whether there are any other areas of Trust activity where similar processes (electronic communications being issued to multiple individuals, patients, students or staff) are being regularly undertaken to inform a lessons learned process. Identify and review locally held standard operating procedures for these activities and confirm their compliance with Trust policies.

h) Undertake a root cause analysis, with a view to:

- establish how recurrence may be reduced or eliminated;
- formulate SMART recommendations; and
- provide a report as a record of the investigation process and a means of sharing lessons from the incident.

3.2 The scope of the investigation remained unchanged from the initial commission.

4 Policies and procedures

4.1 Throughout the course of my investigation I have paid due regard to the following policies and procedures.

- Email, text and internet usage procedure
- Information governance policy
- Incident reporting procedure
- Risk management procedure
- Risk management strategy and policy
- Serious incident procedure

5 Chronology of events

5.1 Throughout the following sections, I detail the chronology of events which led to the data breach occurring. To do this, I have compiled events that happened some time before the incident occurred to give context and outline the contributory factors which led to the issue happening.

Events prior to the data breach occurring

5.2 On 01 April 2017 the Trust acquired the clinical service from another host NHS trust on an interim basis until such a time that a national procurement activity could occur. On acquisition all the service's existing forms and templates surrounding the capture of consent to communicate were migrated and initially adopted by the Trust to ensure continuity.

5.3 Following the acquisition the Trust commenced a process of standardisation for the service's operating procedures and in 2018 more extensive work was undertaken to review the organisation's processes and ensure these were compliant with the emerging Data Protection Act 2018.

5.4 Around late 2018 (the exact date could not be confirmed) the service's most senior operational manager undertook a piece of work with a specialist adviser from the information and technology directorate to review the data consent forms issued to patients at their first appointment. The consent form is designed to capture correspondence data for the patient to facilitate the best mechanism of communication whilst they are undergoing treatment with the Trust.

5.5 In January 2019 (again, the exact date cannot be confirmed) a revised consent form was implemented for new patients being seen at the service.

5.6 On the 01 July 2019 the clinical service formally requested to engage a bank worker to undertake a short project around the décor and art work displayed at the clinical service's site. This site is a satellite located away from the Trust's main headquarters. Employment checks in line with the national standards were conducted on the individual prior to their commencement. It was agreed, at the time, as the individual's work would be aligned to the Trust's patient engagement activities that they should be supervised by a member of staff from the public and patient involvement team.

5.7 Following the individual's initial work it was agreed on 12 August 2019 that patients would be invited to participate on the project and to do this they would need to be corresponded with.

5.8 On 23 August 2019 a public and patient involvement officer specifically aligned to the service requested a report from the Trust's informatics service detailing the clinical service's patients' contact details.

5.9 27 August 2019 an executive assistant made an adjustment to the director on-call rota accounting for the fact that the nominated individual for the week of 03 September would be absent due to elective surgery.

5.10 On 03 September 2019 a public and patient involvement officer from the corporate service followed up the initial request with the informatics team as the data had not been provided at the point. From the correspondence received it is clear that due care was being made to identify the correct parameters of consent obtained in order

to communicate via email. Exclusion criteria was also confirmed to ensure that patients who were serving a prison sentence were excluded as they would not be able to participate.

5.11 On 05 September 2019 the final data set was agreed and confirmed as the appropriate group that should be communicated with.

5.12 On 06 September 2019 at 08:48am the corporate public and patient involvement officer sent an email to a member of the information communication and technology team asking for guidance about how to send an email to >5,000 recipients with non-Trust email addresses. At 12:29ppm on the same day a response was received that provided the following advice:

> *You can allegedly send 5k at once*
> *However I would suggest 5 emails of 1k each to be on the safe side*

The incident and steps taken immediately after

5.13 At 02:22pm on 06 September 2019, the corporate public and patient involvement officer had compiled the two emails for the patient group and pasted, from an Excel spreadsheet, the email addresses in to the 'to' box and hit the send button.

5.14 The individual that sent the email identified their error and at 02.30pm on 06 September 2019 attempted to invoke the 'recall' functionality that Outlook offers. This was done in collaboration with an information communication and technology officer.

5.15 At 02:35pm, the corporate public and patient involvement officer met with an officer responsible to assisting with the reporting of incidents and advised them of the error.

5.16 Following the report, the incident officer approached the senior manager at 2.45pm that is responsible for corporate risk and safety matters and advised them of the incident and requested the executive director on call's mobile telephone number to advise of the issue. At the same time she also contacted the clinical service's senior manager to advice of the incident.

5.17 By 02.48pm on 06 September 2019, a patient who had received the email made the error aware via Twitter.

5.18 At approximately 02.50pm the communications team received a telephone call from a journalist who had been alerted to the data breach. At the same time, the executive director on-call was notified who in turn notified the complaints service that the issue had occurred.

5.19 At 03.12pm on 06 September 2016 one of the Trust's directors, who was absent due to elective surgery, received a telephone call from a manager in the directorate of education and training alerting them to the incident. The director advised they were not on-call and the manager explained they had obtained the information from the reception team.

5.20 At 03.40pm on 06 September the incident action was taken to formally record the matter on the Trust's incident management solution.

5.21 At 03.45pm on 06 September a director from the operational service notified the local commissioner of the incident occurring. Having not received a timely response

another executive director was asked to call the national commissioner to also report the incident.

5.22 A teleconference was then co-ordinated and took place at 3.34pm on 06 September with three of the Trust's directors to agree the operational response to the incident. On this teleconference a press statement was agreed between the three individuals.

5.23 From 03.37pm on 06 September onwards press statements were issued to several different journalists using the agreed response.

5.24 At 03.57pm on 06 September, an email was sent to those who had been sent the email erroneously by a Trust officer confirming the incident had occurred and apologising.

5.25 At 4.00pm on 06 September the operational services director visited the corporate public and patient involvement team to check on their wellbeing following the incident occurring. Following the meeting, at 4.30pm on 06 September, the individual who made the error was sent home as they were in a clear state of distress.

5.26 By 04.36pm on 06 September the incident had been recorded fully on the electronic incident management system.

5.27 At 04:41pm on 06 September 2019 the Information Commissioner's Office was notified of the incident via the NHS data security and protection toolkit.

5.28 At 04.42pm on 06 September a statement was published on the Trust's website about the incident.

5.29 At 04.57pm on 06 September the national commissioners were sent a copy of the statement and details of the out of hours contacts should they need to liaise further with a Trust officer.

5.30 At 05.05pm on 06 September the media statement was publicised by a patient using Twitter.

5.31 At 05.33pm on 06 September 2019 the incident was reported on the strategic executive information system (StEIS).

5.32 On 09 September 2019, a draft terms of reference for a serious incident investigation was developed and consulted upon.

5.33 There was a planned meeting of the Trust's executive management team which took place on 10 September 2019 between 09.00am and 10.00am where a terms of reference was ratified and the investigating officer appointed.

6 Findings of fact – analysis and root cause

6.1 In this section, I detail my findings of fact by drawing together the chronology of events, interviews that took place, the correspondence received and finally of any policies and procedures that are in place.

6.2 For the purpose of clarity, the below sections relate to each point of the terms of reference.

A	Confirm the scope of data breach, including those impacted and what data was released about each individual.

6.3 The breach affected 1,777 patients being seen by one of the Trust's clinical services.

6.4 The data was obtained from a report generated from the organisation's patient record solution.

6.5 The extract only included email addresses and did not include any other demographic details.

6.6 The list of email addresses included a subset that are of the format firstname.lastname@domain.com or similar. We have reviewed the full list of email addresses impacted and a majority are email addresses on public domains such as @gmail.com or @hotmail.com with either the first name or last name or initials in some way visible in the address.

6.7 Given the above, we confirm that some patient names would be identifiable, though it is important to emphasise that only email addresses were disclosed in error and there was no other identifiable data in the content of the email messages.

6.8 All individuals affected by this incident provided consent for electronic communication and we hold a data item indicating their current confirmed consent status and a scanned copy of their consent form on our electronic patient record.

6.9 No further explicit consent was sought for this art project, and the Trust does communicate with our patients electronically on matters that are indirectly associated to their care and patient community, for example to offer opportunities for patients to join representative groups.

B	Confirm the scale of both privacy and clinical impact likely to the impacted individuals, including any cases received as complaints.

6.10 The scale of the breach is described earlier in this email and as a result of this 30 individuals have lodged formal complaints through the formal process. Some of the complaints have been lodged on a collective basis and therefore there are currently 27 active complains awaiting a response.

6.11 Having undertaken an extensive review of all of the complaints received, at the time of writing this report:

- 24 are generic in nature with patients expressing their dissatisfaction about the incident occurring.

- 1 has content which details that the Trust has exposed the individual to another who may cause ongoing harassment over email.

- 2 contain content that the incident has had an impact on their mental health and wellbeing.

6.12 Further to these complaints, I have reviewed the consent forms which the patients provided their correspondence details. Upon my review, I noted that the individuals consented using the form inherited from the previous host Trust and also the more up to date form. Having reviewed both of those forms, it is clear that the content relates to obtaining consent to receive correspondence about their clinical appointments it is not sufficiently detailed that they could also be used for engagement activities.

6.13 To gain a clinical perspective, I consulted with one of the Trust's senior clinical directors who explained that:

> *The data breach would have caused a number of the intended recipients distress as a result of their personal email address being disclosed to a group of individuals who they were not familiar with nor gave their consent for.*
>
> *Reflecting on this carefully, the email was intended as positive approach to engaging with a patient population by inviting them to attend an activity which brings a group together outside of a clinical consultation. Those within the email group all attend the same clinical service and whilst it is likely to have caused distress it is not the case that those have been identified to patient groups who do not share the same clinical presentations.*

C	Confirm all standard operating procedures and tools used in operating the activities that triggered the incident.

6.14 Throughout the course of my investigation process, I was not directed to any specific service specific standard operating procedures surrounding public and patient involvement activities. There are, however, very established customs and practices which have been adopted for quite some time.

6.15 Through the investigative process, the public and patient involvement officer who made the error shared with me a number of email examples where they had corresponded with patient groups and followed the established Trust procedure for blind copying recipients.

6.16 As a result of this, I have come to the conclusion that there are processes in place within the public and patient involvement team which have historically been followed correctly ensuring confidentiality of communication. Taking in to account the individual's candour, remorse and that the issue is more of a systemic problem which I address later in to the report.

D	Identify and review the relevant Trust policies and procedures that relate to the activity that caused the breach, specifically, you should confirm whether or not these were followed in this case.

6.17 At the beginning of this report I identified a number of documents which I have used to inform this review. Specific and related to this incident the email, text and internet usage procedure applies.

6.18 First, the procedure was due to be reviewed in September 2017 and whilst it still applies, it is out of date.

6.19 Second, the procedure is explicitly clear that:

> *Unless you have permission to share people's contact details you should not do so; this applies to all external contacts but may, in certain circumstances, apply internally as well. To avoid inadvertently sharing other people's email addresses, recipients should be selected in the 'Bcc' box, not the 'To' box. This method is also useful if you wish to keep your recipients from knowing who the other recipients are, and prevents recipients starting new 'reply-all' email trails, which can often multiply alarmingly.*

6.20 Thirdly, its tone is directive with several lists of dos and do nots and could be summarised and made much more user friendly.

6.21 Furthermore, I have also looked at the overarching information governance policy which sets out the organisation's statement on maintaining confidential information. The policy is sufficient but I was subsequently advised it needed further updating.

6.22 In relation to mandatory and statutory training requirements, all staff should undergo data security training at least once a year. In this case, the public and patient involvement officer who was involved in the incident had completed this training within the year time period set.

6.23 To conclude, of the above, the email procedure described above was not followed.

E	Identify and review the relevant Trust policies and procedures that relate to the response by all engaged teams following the breach and confirm whether or not these were followed in this case.

6.24 For this I have carefully reviewed the incident reporting procedure first. When I went to obtain this from the Trust website the link clicks to nowhere and does not provide the document. I subsequently obtained it from the central policies and procedures drive. The document is out of date was due for review in May 2018. Having reviewed it, it is clear the content is no long current as it describes the manualised process that existed before an electronic solution was implemented.

6.25 Second, I reviewed the serious incident procedure and followed through all of the steps which are set out. In so far as the investigation process that this report covers, all of the necessary steps have been followed.

6.26 In concluding this, I can confirm that these procedures have been followed. However, by way of observation it is unclear why the Trust has two separate documents when one would be much more user friendly.

F	Identify and review and relevant risks held on the Trust risk register that relate to this type of incident and confirm whether actions to mitigate those risks are adequate in light of this incident.

6.27 Having reviewed the Trust's operational risk register there is an entry on the document which identifies the potential risk of:

Breach of confidential information could result in harm to patient and/or investigation by the Information Commissioner

6.28 With a current risk scoring of three for likelihood and three for consequence.

6.29 The control measures are described as:

Attendance at induction which includes training on confidentiality.

Availability of Caldecott Guardian and IG Lead for advice.

Confidentiality Code of Conduct

Procedure on sending person-identifiable information by e-mail requires the use of nhsmail accounts (not Trust e-mail), with restrictions on the recipients' accounts. Alternative (Cryptshare) is provided where this is not possible.

Incident reporting and investigation.

information governance e-learning assessment

6.30 Of these, they do not identify control measures which technology could play an important part in preventing significant future breaches. These include suggested measures like limiting the recipient policy on the exchange server and providing marketing technology for mass email communications.

6.31 Through the course of my investigation, my attention was drawn to two incidents which occurred in 2017 where the same type of issue, but with a different clinical service, occurred. However, in these incidents they were not of the same level of impact and did not reach the external reporting threshold for Information Commissioner's Office.

6.32 Therefore, to conclude, I have come to the conclusions that the email, text message and internet procedure was not followed.

G	Identify whether there are any other areas of Trust activity where similar processes (electronic communications being issued to multiple individuals, patients, students or staff) are being regularly undertaken to inform a lessons learned process. Identify and review locally held standard operating procedures for these activities and confirm their compliance with Trust policies.

6.33 Throughout the investigation, I made informal enquiries to understand if there are similar practices for mass communication with external parties. In short, there are a number which range from patient group communications within clinical services to mass marketing with students and alumni.

6.34 For the patient related activities, the approach of blind copying recipients is used. Therefore, there is a system control weakness and this has resulted, previously, in other incidents happening of a similar nature. To the best of my ability I was able to determine two.

6.35 With student communications and marketing, the directorate of education and training the Trust spends revenue funds to send mail shots via a technology solution called Pure360. For this, the Trust purchases credits to send marketing materials which addresses emails to individual email accounts rather than as a mass group making it a secure way of communication.

H	Undertake a root cause analysis

6.36 The root cause of this incident is very clear, it was a case of a human error occurring and one that was done in a way that did not have any intended malice.

6.37 A secondary root cause, is that the Trust's email server did not have a maximum recipient limitation policy applied to Outlook and as such there was no defence mechanism to prevent the incident from occurring.

6.38 There were a number of contributing factors throughout the course of events which ought to have led to a number of the Trust's officers having reflected on the best course of sending out a mass email to a high number of recipients who were patients. These included the clinical service's managers reflecting on whether or not this was the best communication mechanism; the information and technology service not querying the planned large email communication; and, a lack of checking systems to prevent the error.

7 Lessons learned

7.1 The key lesson learned from this investigation is that the status quo for mass communications is no longer acceptable and must be addressed.

7.2 Further lessons which have emerged is that for tasks that have a potentially prone for error should involve a checks and balances system where one person initiates a task and another cross checks before the communication is issued. Whilst this will not stop an incident happening it provides a control mechanism.

7.3 The information technology policies (specific to the exchange) did not provide adequate defence.

8 Notable practice

8.1 The Trust has an excellent approach to engaging those that use its services. The level of activity and creative ways in which those who receive care and treatment at the organisation is well developed and has further potential.

8.2 Having compiled the chronology of events it is very clear that the operational and strategic response to this incident was very well managed. The timescales demonstrate swift action being undertaken in a reflexive way that demonstrates careful thought and detailed execution.

8.3 The staff that contributed to this investigation have done so openly, candidly and has made concluding this process in a timely way possible. This is evidence of good culture around transparency in the event of an issue and should be formally noted.

9 Final conclusions and recommendations

9.1 The incident which occurred was unfortunate but it was the result of a human error following on from a number of systemic weaknesses within the Trust's processes.

9.2 The following are my recommendations as a result of this investigation which should be further developed in to an action plan and implemented.

10 Action Plan

Action	Responsible	By
The Trust's directors should urgently review all policies and procedures which are out of date and ensure they are reviewed without delay. Specifically and with the highest priority, the: • Email, text message and internet use procedure • Incident reporting procedure	Director of Technology and Transformation Medical and Quality Director	30 November 2019
An exchange policy should be applied ensuring that no Trust member of staff can send an email to more than an appropriately determined number of recipients. If possible, this should limit the activity to addresses not held on the exchange server's address book.	Assistant Director of Information Management and Technology.	31 October 2019
The Trust should seek to procure, or explore whether it already has in existence through its Microsoft Office 365 licences, software that allows mass marketing.	Director of Technology and Transformation	31 January 2020
When updates occur the director on-call rota it should be sent to the reception desk or other sharing mechanisms (a shared drive with the document detailing the updates) is implemented.	Rota Co-ordinator	Ongoing
The forms to obtain correspondence data should	Assistant Director of Information Governance and	30 November 2019

Action	Responsible	By
be reviewed with the view to expanding the detail surrounding the potential use of the information.	Security with input from the operational clinical services	

Craig de Sousa
Director of Human Resources and Corporate Governance

Report to	Date
Board of Directors	26 November 2019

Board Assurance Framework
Executive Summary
The following Assurance Framework (BAF) identifies key risks to achieving the Trust's strategic objectives for 2019/20. There are three risks rated 16 – 20 and four rated 12. See page 3 for summary. There are three changes to risks with Risk 4 increasing from 6 to 9, Risk 7 reducing from 8 to 6 and Risk 10 proposed to close. A new risk has been added as 10b. It relates to Growth and Development and impact on the Trust Control Total. The development of the new electronic risk register module is still being tested and will not be used for reporting until 2020.
Recommendation to the Board
The Board are asked to discuss the board assurance framework
Trust strategic objectives supported by this paper
All Trust Strategic Objectives

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

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

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

1.3 The BAF Heatmap presents all BAF risks on a single page as an overview of the current position. The direction of travel for each risk from last assessment will be included in the next quarterly BAF report.

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

2. APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

3. RISK SUMMARY [risk descriptions are shortened]

3.1 The three red rated risks identified July 2019 are unchanged.

- 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. The four risks rated 12 identified in July 2019 are unchanged.

- 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

3.3. There are three changes to risks: 4, 7 and 10

3.3.1. Risk 4: National Training Contract – likelihood of the risk occurring increased from 2 'unlikely to occur', to 3 'could occur' increasing the risk from 6 to 9 owing to organisational change and uncertainty in the ALBs and especially leadership changes in HEE.

3.3.2. Risk 7: the risk to the reliability of data systems has decreased from 4 'likely to occur' to 3 'could occur', decreasing the risk from 8 to 6 owing to a new IM&T structure and approach to operational data entry and data analysis which appears to be having an impact on the reliability of data.

3.3.3. Risk10 is now closed as skill and capacity issues within the Business Development Team have been addressed.

RISK APPETITE

4.1 Risk Appetite Statement:

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

Overarching risk appetite descriptions

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

Risk Appetite assessment against Strategic Aims

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

3. CONCLUSION

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

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

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**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
1	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.	DoHRCG	People	1	8 (2x4)		8 (2x4)			**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)		12 (4x3)			**Yellow (2x3)**
3	The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	DoHRCG	People	3	12 (3x4)		12 (3x4)			**Yellow (2x4)**

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
4	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	DoN	People	4	6 (2x3)		9 (3x3)			**Green (1x3)**
5	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	DoF	People	5	15 (3x5)	15 (3x5)	15 (3x5)			**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)		6 (3x2)			**Green (2x2)**

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
7	The risk that our data systems do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	CCOO	Services: Clinical	6	8 (4x2)	2)	6 (3x2)			**Green (2x2)**
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)		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)	16 (4x4)	16 (4x4)			**Amber (3x3)**

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
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 Development	11	6 (2x3)		6 (2x3)			**Closed Yellow (2x3)**
10b	The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total.	DoS	Growth and Development	11			9 (3x3)			**Yellow (2x3)**
11	The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision	DoET/ DeanPGS	Services: Education	12	12 (3x4)		12 (3x4)			**Amber (3x3)**
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)		8 (2x4)			**Green (1x4)**

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

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

Strategic Aim: People

Corporate Objectives:

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

<table>
<tr><td colspan="2">RISK 1): The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.</td></tr>
<tr><td><u>Risk Owner</u>: Craig de Sousa</td><td>Date reviewed November 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 2 x Consequence 4 = 8 (no change November 2019)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
The Trust has established a race equality strategy to a number of recurrent themes around black, asian and minority ethnic staff experience.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee

Race Equality Champion appointed and BAME network established: regular communication between the Champion and the Director of HR and</td><td><u>Assurances received</u> (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)

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

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: November 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 TARGET risk rating 2 x 4 = 8 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12 (no change November 2019)	
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) (DoHRCG Mar 2020) Staff Education Programme (DoHRCG Mar 2020) New OD and People Strategy 2020 – 2023 (DoHRCG 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: November 2019
INITIAL risk rating (at identification): Likelihood 2 x Consequence 3 = 6 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9 ↑	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE increased from risk level 6 to 9 despite the positive profile of the NWSDU and exposure in year through conferencing and the engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity. Organisational change and uncertainty in the ALBs and especially leadership changes in HEE has increased the risk.	
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 Exposure of Stress & Resilience work to Cavendish Square and 'Top Leaders' groups	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:	Action plans in response to gaps identified: *(with lead and target date)*
None identified	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: November 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 67 Belsize Lane Finchley Road	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of Tavistock Centre Strategic Programme Board (+/-) Minutes of Scheduling Project Programme Board (+/-) Estates and Facilities Work stream reporting into CQSGC (+/-)
Gaps in controls/influences: Uncertainty over Relocation project Uncertainty over impact of Scheduling project	Action plans in response to gaps identified: *(with lead and target date)* Competitive Dialogue process (IG 31 December 2019) Remodelling of space at Tavistock Centre (IG 31 Dec 2019)

Strategic Aim: Services: Clinical

Corporate Objectives:

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: November **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. The QI forums have reported poor engagement, however the QI board process was relaunched in October with renewed focus on engagement. The newly created Operations board will monitor engagement however this is in its infancy. There has been a general improvement in the quality of patient information on Carenotes.	
Controls/Influences *(what are we currently doing about this risk?)*: New divisional director structure to ensure engagement New Operations Delivery Board will provide a drive to engagement and will address issues that prevent engagement	Assurances received *(independent reports on processes; when; conclusions)*: Directors appointed July 2019 (+)

Gaps in controls/influences: New board and new general manager roles need to bed in.	Action plans in response to gaps identified: Work on structure and engagement, led by CCOO, new structure to be in place by October 2019, embedded by April 2020

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.	
Risk Owner: Sally Hodges	Date reviewed: November **2019**
INITIAL risk rating (at identification): Likelihood 4 x Consequence 2 = 8 CURRENT risk rating: Likelihood 3 x Consequence 2 = 6	TARGET risk rating 2 x 2 = 4
Rationale for current score: Data reports from different sources e.g. team reports and contract still not consistent. Staff concerned that data does not reflect their experience. New IM&T structure and approach to process management appears to be having an impact, data becoming more reliable	
Controls/Influences *(what are we currently doing about this risk?)*: Group overseeing data process set up	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of working group (+) Data strategy in place (+)
Gaps in controls/influences: Improvements required in relation operational data entry; and data analysis, operations delivery board will need to oversee some of this	Action plans in response to gaps identified: *(with lead and target date)* Work on data to continue (DWL with data strategy fully implemented by April 2020) and Operations board

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	
Risk Owner: Paul Jenkins	Date reviewed: November 2019
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	TARGET risk rating 3 x 3 = 9
Rationale for current score: Wider financial pressure across the STP	
Controls/Influences *(what are we currently doing about this risk?)*: Strong engagement with the STP with CEO as SRO for Mental Health Work close with partner provider organisations Engage in development of Medium-Term Financial Plan Commitment on protecting MH investment	Assurances received *(independent reports on processes; when; conclusions)*: Agreement by Regulators of Medium-Term Financial Plan (+/-) STP plan for mental health (+)
Gaps in controls/influences: Decisions of the regulators Wider financial position across the STP	Action plans in response to gaps identified: *(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)

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: November **2019**
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 TARGET risk rating 3 x 3 = 9 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (unchanged November 2019)	
Rationale for current score: Staff morale low in service because of frequent external criticism. Many staff have left leaving significant vacancies, 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 through the trust management structure(+)
Gaps in controls/influences: Work needs to be done to get plan in place	Action plans in response to gaps identified: *(with lead and target date)* Structure to be implemented (AS, Dec 2019 onwards)

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: November **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. This risk no longer exists and can be closed. A new risk was approved by EMT 12/11/2019 and appears as Risk 10b.	
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)*

RISK 10b): The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total.	
Risk Owner: Rachel Surtees	New Risk: November **2019**
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	TARGET risk rating 2 x 3 = 6
Rationale for current score: The NHS is in a period of change with the accelerated pace of development of Integrated Care Systems. A consequence of this is that there has been a sharp reduction in the number of CCG commissioned procurement exercises that are designed to encourage competition between different providers. Alongside this, Q3 and Q4 are traditionally busy points in the business development cycle and typically sees the release of a high number of tenders for services that will begin in the new financial year. However, with the announcement of a general election in December, the majority of commissioning bodies who we work with are restricted in engaging in new procurement exercises until the end of purdah in mid-December.	
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).	Assurances received *(independent reports on processes; when; conclusions)*: Pipeline report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-)

- Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG). - Named target markets, including areas outside of health commissioning, to enable better focus and prioritisation on our target routes to growth and diversification of income source	Contribution forecast report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Regular Business Development representation at Divisional & DET Executive Management meetings (+/-)
Gaps in controls/influences: Lack of income generation opportunities that don't rely on traditional CCG tender-led exercises. Restrictions in the level of upfront investment available to support income generating activities outside of the context of funding secure through a tender. Trust-wide strategy for spanning growth, maintenance and transformation planning required.	Action plans in response to gaps identified: *(with lead and target date)* Development of income generation opportunities that don't rely on traditional CCG led tender exercises (e.g. service developments, or service provision outside of health contexts) (ongoing RS) Active engagement with the potential to form or join integrated care partnerships (31/3/2020 RS) Development of Trust-wide strategy spanning growth, maintenance and transformation planning (30/6/2020)

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: November **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 development. Digital Academy was signed off at the September Board and Phase 2 has now commenced with a planned launch in 2020. Whilst this project carries a high degree of risk, this is in line with the Trust's risk appetite for new business developments. In preparation for FY20/21 with the further reductions in the NTC funding, we will renew our focus on addressing our delivery across the core provision to achieve better sustainability. Some developments in our long courses is underway with our University Partner for AY20/21. Better coordination of our international development has also been put in place to get more impetus in building a more solid operational foundation for growth.	
Controls/Influences *(what are we currently doing about this risk?)*: Clarity in the focus on the international strategy and plan. Project team established for Phase 2 of the DA. Successful procurement leading to the identification of preferred partner.	Assurances received *(independent reports on processes; when; conclusions)*: Agreement on international strategy at ETC (July 2019) (+) Board sign-off on phase 2 of the DA (Sept 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. Scoping of Phase 3 underway. Working group with internal and Essex representatives underway of scoping new long course development with agreed milestones including focus groups with students and employers.	
Gaps in controls/influences: International plan being delivered to within BAU due to other competing priorities including OfS registration, Improving conditions and processes for new developments and further reach in existing provision.	Action plans in response to gaps identified: *(with lead and target date)* 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 setting approach for Phase 3 (DoET /DoF – Dec 2019) Development of DET strategy and operational plan (DoET) (March 2020)

Strategic Aim: Finance and Governance

Corporate Objectives:

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

<table>
<tr><td colspan="2">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</td></tr>
<tr><td><u>Risk Owner</u>: Paul Jenkins</td><td>Date reviewed: November 2019</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 2 x Consequence 4 = 8</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
CQC report positive but with some actions which are being addressed.</td></tr>
<tr><td><u>Controls/Influences</u> (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</td><td><u>Assurances received</u> (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 (+)</td></tr>
</table>

	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 (+) Service Line self assessments for CQC compliance (+/-)
Gaps in controls/influences: Current service line assessment of CQC compliance required	Action plans in response to gaps identified: *(with lead and target date)*

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	
Risk Owner: Terry Noys	Date reviewed: October, November 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: Additional in-year costs have been incurred and in-year contribution from new business substantially below Budget. Contribution from TAP risk share assumed to be zero. A number of contract losses being incurred, with uncertainty over any related redundancy costs. Potentially signioficant, unbudgeted legal costs being incurred. Anticipated that staff costs will continue to run at below Budget levels. Potential for negative impact depending on outcome of Relocation	
Controls/Influences *(what are we currently doing about this risk?)*: Board approved Budget (setting out key assumptions) Management accounts reviewed monthly by EMT and Board Regular reforecasting of full year out-turn Business Development Group and Strategic and Commercial Committee review new business pipeline	Assurances received *(independent reports on processes; when; conclusions)*: Management accounts reviewed monthly by EMT and Board (+ / -) In-year forecasts reviewed by EMT and Board (+ / -)
Gaps in controls/influences: Uncertainty over contribution from new business Uncertainty over staff spend	Action plans in response to gaps identified: *(with lead and target date)* Financial reforecast to be undertaken (TN: November) Review of historic accruals (UC: November) Additional income opportunities being sought (RSt)

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	26 November 2019

Operational Risk Register

Executive Summary

Operational risks graded 15+ and new risks are brought to the attention of the Board. There is one other risks which has increased this quarter – Risk 2. All changes are highlighted in Red. There are currently 85 risks on the Operational Risk Register which are open. The following report includes information on seven risks:

Open Risks

- Risk 2 relates to the reputational and financial risks to the Trust as a result of failing to meet contract requirements with possible impact on finances and reputation. The likelihood has increased from 'unlikely' to 'could occur', increasing the score from 6 to 12. An action plan is currently held by the COO and Divisional Directors for delivery by end Dec 2019.

- Two GIDs risks (Risks 127 and 128) relating to staffing and waiting times, remain unchanged in risk levels at 20 and 16. Actions are in place for both which are being monitored in the Gender Executive meeting.

- New FNP Risk 129 replaces Risk 113 and concerns the monitoring and review of FNP programme data at a national level.

Closed Risks

- FNP Risk 113 relating to the procurement of a new information system for the national unit has changed. This risk has been closed and a new risk 129 added.

- FNP Risk 114 relating to risk to the end of FNP contract has closed.

- GIC Risk 125, relating to accommodation, has reduced from 16 to 4 as suitable accommodation has now been secured for GIC in the form of Finchley Road. This risk has now been closed.

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 (renamed to Data Security and Protection) and reported to the Integrated Governance Committee. The Operational Risk Register was reviewed by the Executive Management Team on Tuesday 12th November 2019.

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

The Tavistock and Portman
NHS Foundation Trust

	Date raised	Risk Owner	Scope of risk	Risk Category	Risk Summary	Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	Risk Description Detail: Event (what then is the possible resulting event?)	Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps	L	C	Current Risk	Action Plan	Actions update	Operational Lead	Operational monitoring group	Review Cycle	Last reviewed	Next Review	Governance and reporting group	L	C	Target Risk
2	April 2015	Head of Contracts	Contracts	Financial, reputation and compliance	Reputational and financial risks to the Trust as a result of failure to meet contract requirements	If we don't take actions to implement contract, KPI and CQUIN requirements or input accurate and timely data into Carenotes	we may fail to meet our contract requirements	with resulting impact on finances and reputation	3	3	9	contracting and invoicing, robust system for identifying underperformance and not meeting our KPIs via CQRG. good working relationships with CSU (single core point of contract) escalation process for contract issues	access to core contract materials as required regular meetings between trust contracts team and CSU staff strong link between Quality and Contract teams - sharing information on KPIs and CQUIINs so that financial targets can be set by Contracts. Regular feedback reports to services and EMT about KPI and CQUIN compliance CCG and Spec Com contracts underperforming at month 6	Delivery of contract referral requirements	4	3	12	Action plan in place held by COO and Divisional Directors with support by general managers and contracts team. (COO, Dec 2019)	Stronger links built and working well with Quality team	Amy Le Good	Strategic and Commercial Committee	Quarterly	07/11/2019	2 January 2019	Clinical Quality Patient Experience Workstream	2	3	6

Operational risk register

The Tavistock and Portman NHS Foundation Trust

	113
Date raised	26/10/2018
Risk Owner	DoIT
Scope of risk	CYAF, FNP National Unit, FNP teams
Risk Category	Financial, Delivery
Risk Summary	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.
Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	A new information system is not procured in time and the current contract renews for another year or not at all, as NHS Digital are unwilling to continue supporting the current infrastructure
Risk Description Detail: Event (what then is the possible resulting event?)	Substantial increased costs incurred through inaction
Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	inability to meet NU business development and improvement ambitions, failure to meet terms of PHE contract, and violation (non-compliance) of the FNP license
Initial Risk L	4
Initial Risk C	5
Initial Risk	20
Controls (measures in place to reduce the risk)	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.
Assurance (evidence of the controls)	Commissioned an interim reactive maintenance service ; Identified preferred supplier and in negotions reagrds costs; Governance group established with representation from NU/Tavi/PHE.
Gaps	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.
Gaps L	3
Gaps C	5
Current Risk	20
Action Plan	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)
Actions update	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. Reviewed at EMT. This risk no longer exists as the service is leaving the Trust from 1 April 2020.
Operational Lead	Ailsa Swarbrick
Operational monitoring group	EMT
Review Cycle	Monthly
Last reviewed	08/10/2019
Next Review	
Governance and reporting group	CGR workstream
Target Risk L	3
Target Risk C	2
Target Risk	6

Target Risk	2	4
C	5	2
L	3	2
Governance and reporting group	CGR workstream	Estates and Facilities Workstream
Next Review	N/A	CLOSED
Last reviewed	01/11/2019	05/11/2019
Review Cycle	Monthly	Monthly
Operational monitoring group	FNP National Unit group	Executive Management Team
Operational Lead	Ailsa Swarbrick	Frances Endres
Actions update	Statue update shared with SMT January 2019.	Suitable accommodation for GIC to move to in the form of Finchley Road was confirmed w/c 11 November 2019. Risk to be closed.
Action Plan	Continued engagement with PHE (Director NU, DATE)	
Current Risk	2	4
C	1	4
L	1	1
Gaps	None identified	
Assurance (evidence of the controls)	PHE Confirmed decision to take FNP NU in house from April 2020.	Alternative accommodation has been secured (+)
Controls (measures in place to reduce the risk)	Quarterly Contract meetings with PHE	Alternative accommodation has been secured.
Initial Risk	20	16
C	5	4
L	4	4
Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	Possible service loss (primary) and therefore financial loss	resulting in loss of clinical staff, under performance and further delays in patient care
Risk Description Detail: Event (what then is the possible resulting event?)	This would trigger a new procurement process with unknown specifications.	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
Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	The FNP National Unit contract ends in March 2020 and no further extension is possible	If accommodation is not found, we will have clinicians with no space to work in, and nowhere to sit.
Risk Summary	If the FNP National Unit contract ends in March 2020 a new procurement process with unknown specifications would be triggered leading to possible service and financial loss.	GIC staff accommodation
Risk Category	Financial, Delivery	Quality of care, Reputation
Scope of risk	FNP National Unit, CYAF	GIC service
Risk Owner	FNP NU Director and CYAF Director	Director of E&F
Date raised	26/10/2018	24/07/2019
	114	125

The Tavistock and Portman
NHS Foundation Trust

	Date raised	Risk Owner	Scope of risk	Risk Category	Risk Summary	Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	Risk Description Detail: Event (what then is the possible resulting event?)	Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps	L	C	Current Risk	Action Plan	Actions update	Operational Lead	Operational monitoring group	Review Cycle	Last reviewed	Next Review	Governance and reporting group	L	C	Target Risk
127	25/07/2019	Gender Divisional Director	GID Service, Communications staff, senior management	**Delivery**, financial, Quality of care, Safety, Reputation, Compliance	GIDS staffing	If internal and external scrutiny GIDS continue to escalate and involve Trust staff	Some staff may feel the work becomes too stressful, with an impact on morale, quality and staff retention	Resulting in a negative impact on service delivery and a further growth to waiting list.	5	4	20	Support from Director and Executive leads with the GIDS team and from Trust senior management through meetings, supervision and other fora; Consultation support service; Staff satisfaction survey review; Proactive communications taking forward recommendations of GIDS action plan.	Staff satisfaction survey; information from meetings with staff individually and in groups. (+/-) Communications presentation at service awayday 15th October 2019 (+) Analysis of Exit Interviews (+/-)	Further work to deliver GIDS action plan recommendations. Increased visiblity of and contact with senior Trust staff. Comms exercise to support positive media attention around patient experiences. Further detailed analysis of Exit interviews, Build on positive staff survey results and ESQ	5	4	20	Strategy for supporting staff (~~30/9/2019~~ 31/11/2019 KH) Analysis of Exit interviews (ongoing) Agree actions to progress from the positive survey results (30/9/2019 KH/PC) Leadership CPD for senior management team (Nov 2019)	Strategy to boost local morale includes continued provision of reflective groups, offer of complex case discussion panel chaired by members of the GIDS exec. Team social gatherings, e.g., e.g., having lunch together Comms spoke at the service awayday on 15th October 2019. This was very well received. Exit interviews continue to be undertaken. We have taken HR advice re how we act on findings and who needs to know. Leadership CPD for the senior management team has been very well received and has continued with some further sessions.	Polly Carmichael	Gender Executive	Monthly	06/11/2019	06/12/2019	PSCR	3	3	9
128	25/07/2019	Gender Divisional Director	GID Service, Trust	**Safety**, delivery, financial, Quality of care, Reputation, Compliance	GIDS waiting times	If action is not taken to increase flow through the service waiting times will continue to increase.	The needs of young people and their families at a vulnerable time in their lives would not be met.	There may be an increased chance of a serious incident for a YP on the waiting list, and increased anxiety and stress for those patients waiting. Poorer quality service delivery if staff time is spent addressing urgent clinical and managerial issues arising rather than delivering well managed services and attending to longer term quality	4	4	16	Increases in staff, 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. Projects testing different approaches to reducxing the waiting list, including better information gathering at referral;	Continued monitoring of waiting list and other data Monthly audit activity data (+/-)	Data on impact of initiatives being taken and planned to address the issue.	4	4	16	Commencement of further data analysis work by service to understand referral trends, and initiation of relevant Quality Improvement work (Sept 2019 and ongoing AS)	First meeting in September 2019 with NHS improvement representatives to discuss the demand and capacity strategy. Monthly activity audit data is sent round to GIDS senior team and is a standing item on GIDS senior team agenda in order to identify any emerging problems.	Polly Carmichael	Gender Executive	Monthly	06/11/2019	06/12/2019	PSCR	2	4	8

	Date raised	Risk Owner	Scope of risk	Risk Category	Risk Summary	Risk Description Detail: Cause ('IF' - what could go wrong to cause non achievement of the objective? Describe in one sentence)	Risk Description Detail: Event (what then is the possible resulting event?)	Risk Description Detail: Effect (Highlight where the MOST impact will be: Safety; Financial; Reputation; Compliance; Delivery)	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps	L	C	Current Risk	Action Plan	Actions update	Operational Lead	Operational monitoring group	Review Cycle	Last reviewed	Next Review	Governance and reporting group	L	C	Target Risk
								improvement and sustainability. Potential for loss of faith in the service by families waiting Burden on primary care increases.				support for local services to manage concerns locally. Other quality improvement projects being scoped as part of GIDS action plan. Monthly audit activity data standing item on GIDS senior team agenda.							Service manager (GIDS) has liaised with informatics to build a report to collect required data where gaps are identified									
129	Oct-19	Ailsa Swarbrick	FNP National Unit, FNP teams, PHE	Financial, Service Delivery, Contract breach	Timely FNP data system requirement impacting on the ability to meet business development and improvement ambitions or contract requirements	If we are unable to provide FNP teams with a way to enter and report on FNP data to local commissioners	we will be unable to monitor and review the FNP programme data at a national level for quality assurance and quality improvement purposes	leading to a breach of contract requirements, Trust reputation, FNP National Unit business development and improvement ambitions and increased costs to implement a solution in a shorter timeframe.	3	4	12	Dedicated project to oversee the procurement and implementation of a new information system. Procurement to be overseen by the FNP NU with support from IMT	Project meetings and documentation (+) Discussions with accountable colleagues (+)	Despite control measures being agreed and work in progress, there have been delays and slow progress to implement because of limited capacity in IMT and Finance (procurement), thereby increasing the risk and likely consequences	3	4	12	Procure new information system (11/09/2019 Alex Stevenson) Review governance arrangements to ensure the project has Trust support and ownership and can be handed over to PHE in good shape. (Alex S and AS)	Risk reviewed and approved at EMT 5/11/2019	Ailsa Swarbrick	FNP National Unit, reporting to CYAF Director	quarterly review	05/11/2019	more frequently than quarterly?	Patient Safety workstream	3	2	6

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	14th November 2019

Serious Incidents – Quarterly Report – Q2 2019/20

Executive Summary

This quarterly serious incident summary report for the Board covers Q2 2019-20.

Good progress has been made in the implementation of the relevant actions following the last CQC inspection (Aug/Sept 2018) and this continues to be monitored.

There were 3 serious incidents were logged externally on StEIS in Q2, although 2 of these incidences had occurred in Q2/3 2018/19. There was a death of a young person from multiple injuries, the other 2 incidents related to knife crimes. A third incident related to knife crime has been logged on the Quality Portal in Q3. A thematic case review is now planned (of the three cases referenced here) for Q3-Q4 and will be reported on in due course.

Action plans from previous serious incident investigations will continue to be monitored during Q3 and Q4. Lessons from these and other incidents are reviewed at the monthly incident panel and disseminated through Trust wide learning lessons events as well as through directorate and team-based meetings.

The findings and recommendations from a piece of work to look at work related violence and aggression as well as case material was presented at the learning lessons event in September 2019. There is still further work to do in relation to ensuring staff safety at work.

The themes from analysis of complaints remains unchanged (compared to Q1-Q4 2018/19 and Q1 2019-20) particularly in relation to long waiting lists for Trust Gender Services.

The Trust had been unable to recruit a PREVENT lead despite advertising the role on three separate occasions, but an interim lead is now in post until end of December 2019 with a further recruitment exercise underway to recruitment to a joint post of Named Safeguarding Lead for Vulnerable Adults and Trust PREVENT lead.

Recommendation to the Board

The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper	
Clinical Services	
Author	**Responsible Executive Director**
Clinical Governance and Quality Manager	Medical Director

Report to	Date
Trust Board	28th October 2019

Guardian of Safer Working Hours 2019-2020 Quarter 2

Executive Summary

The number of exception reports over this quarter have reduced compared to the previous quarter. This is particularly prominent for September which is usually a busy month. The JDF are making decisions around how to spend the money raised through fines and are looking at purchasing additional books and a medico legal training for all psychiatric trainees.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Sheva Habel	Dinesh Sinha

Guardian of Safe working hours 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 Q2

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
July	8	5	3	0
August	4	3	1	0
September	3	2	1	0
Totals	15	8	4	0

The number of exception reports has reduced substantially over the last 2 months. This is possibly due to the nurse led service at the RFH reducing the burden on the Spr on calls and will be reviewed over time for clarification.

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 11
- There are currently 16 trainees on the CAP training scheme with 14 available for on calls.
- There have been no formal requests for a work schedule review.

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

There will be 3 vacancies in the Medical Psychotherapy training (single accreditation) in February.

2.4 Locum

The NROC is currently being staffed by Trainees.

	Number of shifts	Number Covered	Number Vacant	Clinicians
July	2	2	0	Sprs
August	1	1	0	
September	4	4	0	

2.5 Fines

	Extra hours worked Normal	Enhanced	Total fine	Amount paid to trainees	Fine Remaining
July	10.5	0	930.52	348.92	581.60
August	3	0.5	326.54	122.45	204.09
September	0.5	0	44.31	16.61	27.70
Totals			1301.37	487.98	813.39

Fines accrued 2018-2019

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

Fines accrued 2019 – 2020

	Total hours	Total fines	Total paid to trainees	Amount accrued
Totals	21	£2122.96	£766.09	£1326.85

3. Junior Doctors Forum (JDF)

The junior doctors have discussed how they will be spending their fine amount, this currently includes text books and a medico legal training day. The JDF have agreed that the GoSWH will provide an appendix of fine disbursement as part of this report every 6 months. The first of these will be in the January (Q4) report. Please see attached guidance document for information around how fines are agreed.

The CAP Trainee reps and the GOSWH are going to work together to produce clear guidelines as to how to allocate time working and time resting when on call. HR will support this.

The GOSWH explained that they will be stepping back from the role at the end of January as the position was a three year fixed term. The next JDF will be the last for the current GOSWH.

4. Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC on 14th October 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

Appendix 1:

Penalty Fine Money Expenditure for Doctors in Training

Principles of Fine Money Allocation & Application Form

The 2016 Terms and Condition of Service for NHS Doctors and Dentists in training includes the levying of fines by the Guardian(s) of Safe Working (GoSWH) where certain contractual working conditions have been breached. Within this document the term 'junior doctor' refers to all doctors training on the 2016 national terms and conditions of service contract.

Following consultation with the Trainees it has been agreed that the fine money will be allocated by the elected junior doctor representatives of the Junior Doctor Forum (JDF) in association with the GoSWH with reference to the following principles.

I. All Junior Doctor trainee representatives' are expected to attend Guardian Junior Doctor Forum meetings.

II. Fine money should be allocated for the benefit of all junior doctors training in the trust but can on agreement, in the JDF, be allocated for the benefit of either the CAP trainee groups or the AFS trainee groups separately.

III. The money raised through fines must be used to benefit the education, training and working environment of trainees.

IV. The funds must not be used to supplement the facilities, study leave that can be supported by HEE as well as IT provision and other resources that are defined by HEE as fundamental requirements for doctors in training and which should be provided by the employer/host organisation as standard.

V. The release of funds will be discussed at every JDF and appropriate activities funded through completion of the attached form.

VI. Trainees must have the activity approved prior to booking and provide receipts for the expenditure of fine money to the GoSWH and monies will then be reimbursed.

VII. A report detailing fine money expenditure will be released by the GoSWH and the JDF every 6 months submitted with the GoSWH report to the board as an appendix.

VIII. These principles will be reviewed on an annual basis and will not be altered without consultation with the junior doctors in the Trust.

Penalty Fine Money Expenditure for Doctors in Training

Application Form

Name of applicant:	
Date:	
Email:	
Proposed expenditure: Brief description e.g.: Book Subscription Training course	
Expenditure applicable to: All trainees CAP trainees AFS trainees	
Amount applied for (£)	
Budget code:	

Details of expenditure (please attach relevant quotations/receipts/other evidence):

I confirm my application complies with the agreed principals of fine money allocation and has been discussed and agreed at the JDF on _____

I will use allocated money as detailed above.

Signed –
applicant:_____

Signed –GOSWH:_____

Please forward this signed form to Simone Silverstein at ssilverstein@tavi-port.nhs.uk

Agreed on:

Appendix B

Appendix B

Report to	Date
Trust Board	26 Nov 2019

CQC Action Plan Update

Executive Summary

1. The CQC action plan has been updated. Significant progress has been made in many of the actions

2. Further work continues on the following

   2.7 AFS Administrator supervision – to be established in primary care and Adult Complex Needs services; has been established at the Portman.
   2.9 AFS safeguarding supervision – figures presented but not %. There isn't a cohort of staff identified in AFS who need to complete these forms as there is more than one way of recording safeguarding supervision.
   3.3 Care plans and crisis plans review – undertaken but robust evidence still required. Ongoing work AFS and the Quality Assurance Team
   3.4 Completion of risk assessments for every patient – review undertaken but ongoing work AFS and the Quality Assurance Team
   3.5 Portman – meets the CQC requirement to 'record their signature on written records of sessions'. This was completed when the service moved over to using Carenotes. A casenote audit undertaken in February 2019 showed mixed results for completion of aspects of Carenotes information. Work is being undertaken with staff and a further audit will be undertaken in January 2020.
   3.6 CQC requirement – for the trust to ensure there is a clear policy about information sharing with external agencies and that staff are aware of this policy. Action field will be further updated.

Recommendation

To review the CQC action plan and discuss.

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Associate Director – Quality and Governance	Medical and Quality Director

		Action No.	CQC requirements	Success criteria	Timescale	Lead (Executive Lead in Bold)	RAG Rating	Action Plan Reference
Action the Trust MUST take to improve	Other Specialist Services (Gender identity services for adults)	1.1	The Trust must ensure people and other healthcare professionals receive letters following appointments in a timely manner. Regulation 12(2)(1)	Patient letters to be posted within 4 weeks of appointment date.	Q1 2019-2020	**Chief Clinical Operating Officer** **Director of Gender Services** General Manager, GIC		1.1_GICMUST
		1.2	The Trust must ensure people who use the service know how to make a complaint and that all complaints are responded to within the agreed timescale. Regulation 16(2)	All patients who want to make a complaint are clearly signposted to the process.	August 2018	**CEO** General Manager, GIC		1.2_GICMUST
		1.3	The Trust must ensure they continue to work with commissioners to reduce patient appointment waiting times. Regulation 9(1)(a)	Patients arrive with improved readiness for care through access to improved information whilst on waiting list. Work with NHS England to deliver a system wide approach across all GIC's. Design and develop other provision within the healthcare system to reduce number of patients coming to specialist services.	Ongoing	**Chief Clinical Operating Officer** **Director Gender Services** General Manager, GIC Lead Clinician, GIC		1.3_GICMUST
Action the Trust SHOULD take to improve	Trustwide	2.1	The trust should review how they hold service lines to account to ensure this happens in a consistent and robust manner.	Process for reviewing service lines and directorates agreed and rolled out to cover the entire trust	May 2019	**CEO** **Medical Director**		2.1_TWSHOULD
		2.2	The trust should review its accountability framework, considering the use of standard agendas for governance and team meetings to ensure information was presented, reviewed and discussed in a consistent manner.	Revised clinical governance meeting arrangements. Review of the CQSG	~~May 2019~~ November 2019	**Medical Director** **Director of HR & Corporate Governance**		2.2_TWSHOULD
		2.3	The trust should continue its work to ensure team leaders have access to a dashboard of information to support their management roles.	Improved use of data to support management	March 2020	**Director of Transformation & Technology**		2.3_TWSHOULD
		2.4	The trust should continue its plan to ensure complaints across the trust are addressed in a timely manner.	Complaints are responded to within 25 working days	January 2019	**CEO** Complaints Manager		2.4_TWSHOULD
		2.5	The trust should continue its work to address discrimination and lack of career progression for BME staff.	Positive changes in staff survey results. Increased likelihood of BAME candidates being appointed following shortlisting.	March 2020	**Director of HR & Corporate Governance**		2.5_TWSHOULD
		2.6	The trust should complete its work to ensure health and safety issues including fire safety are addressed across the trust sites.	compliance with the Health & Safety policy is achieved and evidenced	June 2019	**Director of Finance and Deputy CEO** Director of Estates, Facilities and Capital Projects		2.6_TWSHOULD
		2.7	The trust should ensure administration staff have access to regular formal supervision.	All administrative staff report that they have access to regular supervision.	May 2019	**Director CYAF Services** **Director Gender Services** **Director of Adult and Forensic Services** CYAF Service Manager Gender Services Managers AFS Admin managers		2.7_TWSHOULD
		2.8	The trust should ensure staff complete safeguarding adults and clinical risk assessment training.	All clinicians should update their knowledge and skills on clinical risk assessment through attendance at internal workshops and/or online training and via team based and case based discussion.	May 2019	**Medical Director** Associate Medical Director		2.8_TWSHOULD

		2.9	The trust should ensure staff complete and record safeguarding supervision sessions.	80% of staff will have had safeguarding supervision and recorded it appropriately.	Q3 2019-20	**Medical Director**		2.9_TWSHOULD

Action the Trust SHOULD take to improve	Other specialist services (Gender identity services for adults)	2.10	The trust should ensure they complete planned annual fire evacuation drills.	Complete annual fire drills	Annual	**Director of Finance and Deputy CEO** General Manager, GIC		2.10_GICSHOULD
		2.11	The trust should ensure staff record and report calls taken on the on-call rota for people who called in distress in line with the trust's procedures.	All distressed calls are recorded and reported.	Q4 2018-19	**Chief Clinical Operating Officer** **Director of Gender Services** Lead Clinician, GIC		2.11_GICSHOULD
		2.12	The trust should ensure that administration staff have regular structured supervision.	All administrative staff report that they have access to regular supervision.	Q4 2018-19	**Chief Clinical Operating Officer** **Director of Gender Services** General Manager, GIC		2.12_GICSHOULD
		2.13	The trust should ensure they continue to develop their service user engagement strategy.	For the GIC to have a robust PPI plan in place and functioning.	Q1 2019-20	**Director of Nursing** **Chief Clinical Operating Officer** **Director of Gender Services**		2.13_GICSHOULD
		2.14	The trust should ensure they share patient feedback with people who use the service.	Service Users are aware of what other Service Users are saying about the GIC.	Q1 2019-20	**Chief Clinical Operating Officer** **Director of Gender Services** General Manager, GIC		2.14_GICSHOULD
		2.15	The trust should ensure they continue to explore options to find a suitable building to accommodate the growing numbers of staff required to deliver the service.	New accommodation sourced and secured.	Q2 2019-20	**Chief Clinical Operating Officer** **Director of Gender Services** General Manager, GIC Relocation Team		2.15_GICSHOULD
		2.16	The trust should continue to implement the work needed to comply with the accessible information standard.	A variety of resources are available that meet the information and communication needs of GIC patients Agreed data sources for gathering information and communication needs are in place and consistently used across the service. Clear processes for recording, accessible information requirements within patient records. Clear processes for sharing and informing relevant staff of communication / information needs Meet communication and information needs identified	Q3 2019-20	**Chief Clinical Operating Officer** **Director of Gender Services** General Manager, GIC		2.16_GICSHOULD
n the Trust SHOULD take to improve	Specialist community mental health services for children and young people	2.17	The trust should ensure fire safety of the environment and quality assurance processes such as fire drills are completed as per trust policy.	Documented fire drills with lessons learnt plans for dissemination and implementation	June 2019	**Director of Finance and Deputy CEO** Health and Safety Manager, Risk Manager		2.17_SCSHOULD
		2.18	The trust should ensure there are robust systems in place to ensure a timely and effective response from staff should there be an incident whilst staff are seeing patients for therapy on site.	Development of a trust wide guidance for managers to interrogate service level systems to ensure safety of staff involved in incidents in clinical settings	May 2019	**Medical Director**		2.18_SCSHOULD
		2.19	The trust should ensure toys used by children are cleaned after use and staff keep records of this to maintain infection control. This includes toys in the communal areas and toys kept by individual clinicians.	The completion of cleaning programme logs	January 2019	**Medical Director** Health and Safety & Non Clinical Risk Manager CYAF Service Manager/Head of Facilities CYAF Service Manager		2.19_SCSHOULD

Actio		2.20	The trust should continue to ensure that staff complete and record risk assessments for all young people, review these regularly, and share information on risk with other health professionals involved in young people's care and treatment. The trust should ensure that all staff are up to date with the clinical risk training.	All clinicians complete risk assessments on all children and young people. Any concerns about risk are documented, shared with other health professionals particularly GPs , in writing usually. All clinicians should update their knowledge and skills on clinical risk assessment through attendance at internal workshops and/or online training and via team based and case based discussion.	Q4 2018-19	**Medical Director** Associate Medical Director		2.20_SCSHOULD

		2.21	The trust should ensure that staff know which incidents to formally report. This ensures managers have oversight of incidents and teams can learn from when things go wrong.	Staff aware of what incidents to formally report and lessons learned are shared across the Trust.	Q4 2018-19	**Medical Director**		2.21_SCSHOULD
		2.22	The trust should ensure that there is a formal system in place to provide staff with feedback on lessons learned from incidents, complaints and audits within the team and other CAMHS teams. Teams should also have access to the risk register so they can escalate risks and see what action is being taken.	A formal system is in place. A learning lessons workshop takes place x4/year and is open to all staff. Representation from each team in the Trust will be expected during 2019. The Quality Portal Dashboard includes a rolling list of lessons learned immediately visible on entering the portal. Findings from audits to presented at clinical audit meetings	June 2019	**Medical Director** Complaints Manager Associate Medical Director		2.22_SCSHOULD
		2.23	The trust should ensure there is appropriate training for all staff to ensure have a good understanding of the need for consent, and act in accordance with the Mental Capacity Act.	Clinicians understand the principles of the MCA, know when it applies and how to undertake a Capacity Assessment. Attendance at MCA lecture	Q2 2019-20	**Medical Director** Associate Medical Director		2.23_SCSHOULD
		2.24	The trust should ensure information is provided in accessible formats for younger children, and continue to implement the work needed to comply with the accessible information standard.	A variety of resources are available that meet the needs of younger children (as identified by themselves or their parents/carers) that give them the information they want about our services.	~~June 2019~~ March 2020	**Director of Nursing** CYAF Service Manager		2.24_SCSHOULD
Action the Trust SHOULD take to improve (from previous inspections)	Other specialist services (Gender identity services for children and young people) - from inspection in May 2016	3.1	The trust should ensure that a proactive approach is taken to complaints and sharing information with young people and parents about what will happen to complaints when they are made.	Complaints process information easily available. Complaints information easily found on the Trust internet GIDs staff clear of the Trust complaints process	January 2019	**CEO** Complaints Manager		3.1_GIDSHOULDPRV
		3.2	The trust should make sure that staff continue to involve and share information with all young people and parents or carers so that they are aware of the pathways and options for treatment throughout the period of care.	Increased awareness by patients and parents / carers of the options for treatment. The GID Service continues to hold this in mind. The sharing of information and pathways and options is central to the work of the service. It underpins our work and informs any new innovations i.e. telemedicine or new service letters.	October 2019	**Director of Gender Services** GIDS Director		3.2_GIDSHOULDPRV
	Specialist psychological therapy services - from inspection in February 2017	3.3	The trust should ensure that all patients who meet the trust definition of needing a crisis plan have one in place.	All patients needing a crisis plan have one in place-this to be measured in an audit and minimum 90% compliance rate to be attained	December 2019	**Medical Director** **AFS Director**		3.3_SPTSHOULDPRV
		3.4	The trust should ensure staff undertake and record risk assessments for every patient.	All patients need a risk assessment in place after the completion of assessment-this to be measured in an audit and minimum 90% compliance rate to be attained	Q2 2019-20	**Medical Director** **AFS Director**		3.4_SPTSHOULDPRV
		3.5	The trust should ensure staff at the Portman Clinic record their signature on written records of sessions.	Already delivered successfully	December 2018	**Director of Adult and Forensic Service** Portman director		3.5_SPTSHOULDPRV
		3.6	The trust should ensure there is a clear policy about information sharing with external agencies and that staff are aware of this policy.	There will be a clear policy on information sharing with external agencies adopted by the Trust. All staff will be aware of this policy via INSET and Induction.	Q1 2019-20	**Medical Director** Associate Medical Director		3.6_SPTSHOULDPRV

RAG Rating Key

Actions completed
Actions on track to deliver by deadline
Actions not on track to deliver by deadline

CEO - Paul Jenkins
Director of Finance and Deputy CEO -Terry Noys
Chief Clinical Operating Officer (all clinical services) - Sally Hodges
Director of CYAF Services -
Director of Gender Services - Ailsa Swarbrick
Director of Adult and Forensic Services - Julian Stern
Medical Director - Dinesh Sinha
Director of HR and Corporate Governance – Craig de Sousa
Director of Transformation and Technology – David Wyndham Lewis
GIDS Director- Polly Carmichael
Portman Clinic Director- Jessica Yakeley
Associate Medical Director- Caroline McKenna
Associate Director of Quality and Governance- Marion Shipman
GIC Lead Clinician – James Barrett
GIC, General Manager- Frances Endres
CYAF Service Manager- Fiona Hartnett
Health and Safety and Non Clinical Risk Manager- Lisa Tucker
Complaints Manager- Amanda Hawke
Director of Estates, Facilities and Capital Projects- Ian Garlington
Head of Estates and Facilities Management- Alessandro Ruggeri

Action Plan Reference:	**1.1_GICMUST**
CQC Requirement:	The Trust must ensure people and other healthcare professionals receive letters following appointments in a timely manner. Regulation 12(2)(1)
Success Criteria:	Patient letters to be posted within 4 weeks of appointment date.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
1.1A_GICMUST	Clinic working with current staff to set timelines and targets for completions.	Chief Clinical Operating Officer Director of Gender Services General Manager, GIC	Aim for letters at a 4 week turn-around time by Q1 2019-2020 - Completed	**Completed** As of the 21 February 2019, we are currently typing within 5 days of the appointment date. GIC website information on waiting times is updated monthly Weekly review of lead administrators for timeliness of patient letters
1.1B_GICMUST	Service Manager investigating using an offsite typing/posting service to improve the administrative turn-around time.			

Action Plan Reference:	**1.2_GICMUST**
CQC Requirement:	The Trust must ensure people who use the service know how to make a complaint and that all complaints are responded to within the agreed timescale. Regulation 16(2)
Success Criteria:	All patients who want to make a complaint are clearly signposted to the process.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
1.2A_GICMUST	Clear instructions for how to complain are posted on the website.	General Manager GIC	Aug-18	The actions here are **completed.** Leaflets on how to complain are available at GIC clinic. Information on GIC website. GIC complaints, PALS and PPI Manager in post.
1.2B_GICMUST	Leaflets for how to complain are available at the front desk in the clinic.	General Manager GIC	Aug-18	
1.2C_GICMUST	GIC Complaints PALS and PPI Manager post recruited to and any training complete	General Manager GIC	June-18	

Action Plan Reference:	**1.3_GICMUST**
CQC Requirement:	The Trust must ensure they continue to work with commissioners to reduce patient appointment waiting times. Regulation 9(1)(a)
Success Criteria:	Patients arrive with improved readiness for care through access to improved information whilst on waiting list. Work with NHS England to deliver a system wide approach across all GIC's. Ensure programme of waiting list events and information sessions for both patients and GPs to improve appropriate use of specialist provision

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
1.3A_GICMUST	Work with NHSE to obtain a larger building and recruit additional staff who are able to see more patients.	Lead Clinician, GIC	Ongoing Procurement dependent - GIC bid expected decision 29 November 2019. Notice given on Fulham Palace Road by the Owner by 31 March 2020.	**November 2019 update** Confirmation GIC to move to Finchley Road accommodation by Q1 2020. The waiting times are an ongoing concern. The need for a larger budget to recruit more staff are currently waiting the outcome of the procurement process to be completed.
	Ensure that training structures for new staff are robust	General Manager, GIC	Ongoing Whole staff Inset day – May 2019 - **Completed**	Met - Agreed areas for further investigation.

Action Plan Reference:	**2.1_TWSHOULD**
CQC Requirement:	The trust should review how they hold service lines to account to ensure this happens in a consistent and robust manner.
Success Criteria:	Process for reviewing service lines and directorates agreed and rolled out to cover the entire trust

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.1A_TWSHOULD	The trust will agree a quarterly schedule for a quality based review of significant service lines/ directorates. The reviews will be led by the CEO and Medical Director.	CEO Medical Director	01/05/2019 - Completed	**Completed** The quality review framework has been agreed and was launched in May 2019 with common agendas for review of significant service lines. Quality Review meetings are now in place and task are on schedule with all relevant stakeholders.

Action Plan Reference:	**2.2_TWSHOULD**
CQC Requirement:	The trust should review its accountability framework, considering the use of standard agendas for governance and team meetings to ensure information was presented, reviewed and discussed in a consistent manner.
Success Criteria:	Revised clinical governance meeting arrangements Review of the CQSG

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.2A_TWSHOULD	Undertake a full review, using external reference points, of the Trust's assurance flows.	Medical Director Director of HR & Corporate Governance	Completed	Initial review paper considered by the CQSGC in March 2019. A further programme of work will be undertaken to explore options and configuration of the committee. August 2019 - comments from a small subgroup have been collated. The terms of reference have been updated reflecting the comments and a map of assurance flows have been prepared. A next iteraiton draft will be discussed at the September CQSG meeting with a final set of proposals put to the September / November board of directors meeting. Further work required on this action, the Executive Management Team will discuss the governance framework at a meeting on 22 October 2019. **November 2019 update** Agreed extension by EMT for review to extend into 2020.
2.2B_TWSHOULD	Clarify the reporting and construct arrangements for all clinical governance committees / groups.	Medical Director Director of HR & Corporate Governance	~~30/10/2019~~ Q1 2020	

Action Plan Reference:	**2.3_TWSHOULD**
CQC Requirement:	The trust should continue its work to ensure team leaders have access to a dashboard of information to support their management roles.
Success Criteria:	Improved use of data to support management

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.3A_TWSHOULD	**Develop new report templates as needed on current reporting system to deliver the outputs of the structured workshops** i. Update and publish datawarehouse reports for "Per Clinician Activity" for use at team meetings ii. Update and publish new datawarehouse report prioritised as part of the 2.3B_TWSHOULD workshops	Director of Transformation & Technology	i. November 2019 ii. January 2020	Project work up to detailed project brief has identified key milestone for the delivery of this improved utilisation in Trust decision making. Project in initiation to consolidate and publicise available reports. On track to complete by March 2020. Milestones in 19/20 year (now badged as phase 1), have been added under actions. **10/07/2019** Actions have been superseded. The capital plan for this year has been reduced by 20% - as a result this project has been postponed to 2020/21. It has instead been agreed that the existing reporting platform will be used to deliver the output of action 2.3B_TWSHOULD. **November 2019 update** There has been no progress against this plan – though progress has been made against this objective by other means and other areas. These alternate actions can be seen in 2.3B_TWSHOULD below.
2.3B_TWSHOULD	**Initiate and deliver a series of structured workshops on existing available reporting, operational reporting cycles and department level action planning.** i. Schedule workshops for ~~each of~~ CYAF ~~and AFS~~ at directorate and at pilot team level. ii. Elect trial teams to work on new operational working arrangements – building upon the existing work of the Data Quality team with CYAF clinical governance. iii. Publish best practice guides to other trial teams highlighting any operational management opportunities utilising existing warehouse and reports. iv. Create specification for report updates to Informatics for action 2.3A_TWSHOULD.	Director of Transformation & Technology	i. September 2019 ii. October 2019 iii. January 2020 iv. October 2019	**November 2019 update** i. Progress has been made in engaging Trust clinical managers in understanding and utilising the existing available reports. Rather than undertake this work in separate workshops this has been integrated into existing clinical governance meetigns within each of the clinical divisisions. This is now established for CYAF and is imminent for gender and AFS. **Ongoing.** ii. This action is superceded and so effectively compelte with CYAF as a division utilising the revisied reporting arrangements as a pilot for the other divisions. **Complete.** iii. CYAF practice is being utilised as a model for gender and AFS. This should complete within the expected timesacles with the gender and AFS commencement. Ongoing. iv. The Quality Assurance Team are providing a feedback loop to Informatics to refine existing and develop new reports based on the requirements of the clincial governance meetings. The first additional reports are complete and being implemented. **Ongoing.**

Action Plan Reference:	**2.4_TWSHOULD**
CQC Requirement:	The trust should continue its plan to ensure complaints across the trust are addressed in a timely manner.
Success Criteria:	Complaints are responded to within 25 working days

	Actions	Responsible Person(s)	Expected Completion Date	Update
2.4A_TWSHOULD	Continue to ensure that investigations are completed and reports submitted within 3 weeks of receiving complaint	CEO Complaints Manager	**Completed**	Achieved 10/1/2019 **Update 6/11/2019** % of response compliance within 25 working days report information included in Board Quality and Commentary report from Q2 2019/20. Complaints are assigned to a Director and then investigation lead within 3 days of being received. Reminders are sent to investigation leads if reports are not received within a month.

Action Plan Reference:	**2.5_TWSHOULD**
CQC Requirement:	The trust should continue its work to address discrimination and lack of career progression for BME staff.
Success Criteria:	Positive changes in staff survey results. Increased likelihood of BAME candidates being appointed following shortlisting.

Action ID:	Action(s)		Responsible Person(s)	Expected Completion Date	Update
2.5A_TWSHOULD	Continue to implement the Race Equality Strategy.		Director of HR & Corporate Governance	Ongoing	Second year action plan approved by the Trust Board in January 2019.
2.5B_TWSHOULD	Develop and implement a year two plan of actions.		Director of HR & Corporate Governance	Ongoing	Year two action developed and approved by Board. Staff survey results will be used to enhance action plan where indicated.
RES ACTION PLAN					
2.5C_TWSHOULD	**Influence the wider system to increase access for under-represented 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	Ongoing Meeting held in September 2019 with the DoHRG, CCOO, DET/DPGS and DoN to agree an initial plan on this activity.
2.5D_TWSHOULD		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	Sep-19	One bursary fund has been launched for CAP trainees.
2.5E_TWSHOULD	**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	Requirement incorporated. Audit planned of the appraisal content will happen in August 2019. Audit planned for November 2019 surrounding compliance with this.
2.5F_TWSHOULD		Evaluate the impact of the race Thinking Spaces which took place in 2018.	Director of HR & Corporate Governance	Jun-19	**Completed**
2.5G_TWSHOULD		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.			**Completed**

2.5H_TWSHOULD		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	Requirements scoped and a provider being sought. August 2019 - provider selected, Inclusive Employers. A workshop design session is scheduled for September 2019.
2.5I_TWSHOULD		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	May-19	**Completed** Statement is included on all adverts. The Trust is commited to equality, diversity and inclusion. We are particularly keen to attract candidates from under-represented backbgrounds to better meet the needs of the service users and students that we serve.
2.5J_TWSHOULD		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-19	**Completed**
2.5K_TWSHOULD		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	Oct-19	Scheduled for the end of October 2019
2.5L_TWSHOULD		Audit the progression of BAME students from the point of application to final outcome.	Director of Education and Training / Dean of Postgraduate Studies	Oct-19	
2.5M_TWSHOULD		Roll out further events for the student body focused on equality, diversity and inclusion.	Director of Education and Training / Dean of Postgraduate Studies	Ongoing	

2.5N_TWSHOULD	**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.	Director of Adult and Forensic Services, Director of Children, Young Adults and Family Service and Director of Education and Training / Dean of Postgraduate Studies.	Oct-19	
2.5O_TWSHOULD		Agree a methodology or consistent approach for equality focused discussions to happen at clinical team meetings. Informed by data.	Clinical Chief Operating Officer	Oct-19	Reports received at the September EDI committee. Varied approaches being used.
2.5P_TWSHOULD		Develop a programme of work to increase compliance with protected characteristic data capture and recording on CareNotes.	Director of HR & Corporate Governance	Jun-19	Action plan in place and being monitored by Clinical Data Quality Review Group. Work is ongoing. Director lead changed May 2019. Positive changes being reported via the Quality Dashboard with better compliance against the MHSDS
2.5Q_TWSHOULD		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	~~01/06/2019~~ 31 March 2020	Director lead changed in May 2019. Revised due date March 2020.

Action Plan Reference:	**2.6_TWSHOULD**
CQC Requirement:	The trust should complete its work to ensure health and safety issues including fire safety are addressed across the trust sites.
Success Criteria:	compliance with the Health & Safety policy is achieved and evidenced

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.6A_TWSHOULD	New estates compliance work stream (reporting into CQSG Committee) provides board reporting governance structure.	Director of Finance and Deputy CEO Director of Estates , Facilities and Capital Projects	June 2019	**Completed** Estates work stream now established and gaining maturity. Formal reporting through to Board in place and operational via CGR.
2.6B_TWSHOULD	New H&S compliance dashboard in place to monitor and record compliance.			**Completed** Compliance dashboard for all sites in place, evidence is present for assurance.
2.6C_TWSHOULD	Estates data centre setup as single repository for all compliance evidence.			**Completed** In place and working. Being updated with new information as received.
2.6D_TWSHOULD	Revised Planned Preventative Maintenance (PPM) schedule in place and undertaken by external provider – NHS Procurement framework currently being interrogated for a sustainable solution.			**Completed** PPM schedule in place and being undertaken by interim provider. New frame work contractor selected and contracts in production for commencement on the 1st April 2019.
2.6E_TWSHOULD	External provider contract extended to 31st March to allow final evaluations and mobilisation of final solution			

Action Plan Reference:	**2.7_TWSHOULD**
CQC Requirement:	The trust should ensure administration staff have access to regular formal supervision.
Success Criteria:	All administrative staff report that they have access to regular supervision.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.7A_TWSHOULD	CYAF - as part of our restructure process it was mandated that all staff had minimum bi-weekly 1:1s with their manager. This will be audited through the year and monitored through our weekly admin leads and monthly all admin meetings.	Director CYAF Services CYAF Service Manager	In progress as of 1st January 2019	**In place - completed for both a) and b) CYAF** Bi-weekly 1:1s taking place at regular intervals and discussed regularly at Lead Admin meetings. Formal audit conducted on 15th March 2019. Quarterly audits to be undertaken. Job descriptions for line managers in CYAF require them to conduct at least fortnightly supervision of their direct reports. In practice this has varied due to the needs of the team and the wishes of the supervisees themselves with some finding this too frequent and agreement has been reached to have monthly supervision. Those staff where it is indicated that supervision is provided as required are part of teams that all sit together and all have confirmed that they are happy with the existing supervision arrangements and feel supported by their line managers. We will continue to explore this with them and highlight the benefits of 1:1 sessions with these staff to encourage a more formal approach. We will review the frequency of supervision again in 6 months (September 2019). At this point supervision arrangements for new staff will also have been agreed and put into practice. **AFS update November 2019** Portman - fortnightly supervision for administrators undertaken. Access to Service Manager and annual appraisals Primary care - TAP and C&H admin supervision to be set up by end December 2019 Complex Needs - one supervision has been held with Administrators in November. Ongoing supervision programme to be set up.
2.7B_TWSHOULD	AFS- AFS is instituting a regular meeting for each administration staff member within each of the AFS service lines (minimum frequency = monthly) with their manager. This will be audited through the year and monitored.	Director of Adult and Forensic Services AFS Admin managers	~~May 2019~~ December 2019	
2.7C_TWSHOULD	GIDS administrative staff have monthly supervision with their line manager, a monthly administrative team meeting and a monthly senior admin meeting. This will be audited through the year and monitored through the senior admin meetings. We record admin supervision on a shared drive spreadsheet to audit as we go	Director of Gender Services GIDS service managers	Complete	GIC action for this matter is covered under 2.12A

Action Plan Reference:	**2.8_TWSHOULD**
CQC Requirement:	The trust should ensure staff complete safeguarding adults and clinical risk assessment training.
Success Criteria:	All clinicians should update their knowledge and skills on clinical risk assessment through attendance at internal workshops and/or online training and via team based and case based discussion.

Action ID:	Action(s) *(HOW)*	Responsible Person(s) *(WHO)*	Expected Completion Date *(WHEN)*	Update
2.8A_TWSHOULD	Plan for workshops for 2019.	Medical Director Associate Medical Director	Completed First workshop is planned for 18/04/19. All workshops now in place until 2020.	This is in hand with the review of available online resources, source training for quality and ensure coverage. Teams will do a quarterly session on risk assessment, as part of discussion of clinical issues. There will be specific themes of risk assessment and management in learning lessons and other trust level forums. **Online Risk Assessment Training** Online training resource is available via the training sectin of ESR **October update**: the lead has provided HR with the online training resource for clinical risk training and HR. AFS Clinical Risk Assessment training agree dates: There was an AFS cross departmental training focussing on risk assessment and 'learning lessons' from 2 SI's on the 24th October 2019. There are two further departmental meetings planned for January 2020, which will also include clinical risk assessment. **November 2019 update** CYAF Clinical Risk Assessment training agreed dates: 25th July 2019, 8th October 2019 and 6th February 2020. All CYAF clinical staff are invited to attend. AFS Clinical Risk Assessment training date: 24th October 2019. Two further planned for January 2020.
2.8B_TWSHOULD	Available NHS online training modules on risk assessment to be reviewed for suitability.	Medical Director Associate Medical Director	Ongoing	

Action Plan Reference:	**2.9_TWSHOULD**
CQC Requirement:	The trust should ensure staff complete and record safeguarding supervision sessions.
Success Criteria:	80% of staff will have had safeguarding supervision and recorded it appropriately

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.9A_TWSHOULD	CYAF - reports on outstanding supervision are sent by the admin manager monthly. Anyone that appears as non-compliant on the list twice will have this escalated to their team manager	Medical Director	Beginning November 1st 2018	This work is on-going in CYAF with a regular reporting/escalation system in place. **November update** Regular CYAF compliance reports are in place. Work to do to ensure the right cohort of staff are aware of the need to complete and record safeguarding supervision.
2.9B_TWSHOULD	AFS- training workshops for staff in Adult and Forensic services are already under way. The 3 service leads in AFS will establish mechanisms whereby safeguarding supervision sessions are completed and tracked.	Medical Director	Q3 2019/20	**November 2019 Update:** Although a lot of training has been delivered (10 records of group supervision and 7 of 1 to 1 sagefuarding supervision), there is currently no cohort who are mandated to complete and record safeguarding supervision and therefore there are no compliance reports in place. New AFS director to confirm how the AFS services will reach compliance and ensure onward monitroing. The current patient risk report is updated to include form completion rates by all AFS services for all relevant patients. AFS have now completed the audit to ascertain the completion rate of adult safeguarding forms on Carenotes. This audit showed a very low number of completed safeguarding forms and highlighted the need for further staff training in this area. There is now a plan in place to deliver this training to all 9 AFS units by the end of Q2 19/20 and will be delivered by the AFS assistant psychologist at the start of each of the unit staff meetings. This will be re-audited in Q4 to ensure training has increased compliance. Compliance is managed by each unit running a monthly compliance report. AFS training has been delivered to 4 out of 5 Adult complex needs units, between July - September 2019. Vacant assistant psychologist role means training halted until appointment. Portman Clinic are in the process of arranging risk training for their staff.

Action Plan Reference:	**2.10_GICSHOULD**
CQC Requirement:	The trust should ensure they complete planned annual fire evacuation drills.
Success Criteria:	Complete annual fire drills

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.10A_GICSHOULD	Complete annual fire drills.	Director of Finance and Deputy CEO General Manager, GIC	Annual	**Completed** Annual fire drills have been scheduled for the foreseeable future with the Health and Safety Manager and are following the guidance of the fire safety manual. The Tavistock Centre Fire Drill was carried out on 11th December 11 2018. All other sites delivered spring 2019. Evidence of fire alarm reports kept by Estates team.

Action Plan Reference:	**2.11_GICSHOULD**
CQC Requirement:	The trust should ensure staff record and report calls taken on the on-call rota for people who called in distress in line with the trust's procedures.
Success Criteria:	All distressed calls are recorded and reported.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.11A_GICSHOULD	To circulate and retrain those on the On call Rota in what to do once a call has taken place.	Chief Clinical Operating Officer Director of Gender Services Lead Clinician, GIC	Q4 2018-19	**Completed** The on call rota and process were discussed in the Clinical Information Group (CIG) on the 25 February 2019. All clinicians agree they are comfortable with the process and know where the documents are if needed. **November 2019 update** Spreadsheet for logging 'distress' calls is in place.

Action Plan Reference:	**2.12_GICSHOULD**
CQC Requirement:	The trust should ensure that administration staff have regular structured supervision.
Success Criteria:	All administrative staff report that they have access to regular supervision.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.12A_GICSHOULD	All admin staff have bi-weekly 1:1s with their manager. This will be audited through the year and monitored through our weekly admin leads and monthly all admin meetings.	Chief Clinical Operating Officer Director of Gender Services General Manager, GIC	Q4 2018-19	**Completed** Regular, structured, supervision has now been scheduled with all administrators and each admin will have had a minimum of 1 supervision session by 1 April 2019

Action Plan Reference:	**2.13_GICSHOULD**
CQC Requirement:	The trust should ensure they continue to develop their service user engagement strategy.
Success Criteria:	For the GIC to have a robust PPI plan in place and functioning.

	Action(s)	Responsible Person(s)	Expected Completion Date	Update
2.13A_GICSHOULD	To support GIC to work in line with Trust PPI strategy through the GIC Complaints, PALS and PPI Officer to work closely with the Trust PPI team to develop and implement the PPI strategy in GIC.	PALS Officer PPI Officer	Q1 2019-20	**Achieved** GIC Complaints, PALS and PPI Officer in post Evidence of involvement with PPI team
2.13B_GICSHOULD	General Manager GIC and Officer to work with Chief Clinical Operating Officer, Director of Nursing and PPI Team Manger to develop GIC specific strategy, retaining some elements of the existing West London strategy, by June 2019 Officer will be supervised once monthly by PPI Team Manager in her PPI coordinator role.	Director of Nursing Chief Clinical Operating Officer Director of Gender Services General Manager GIC PPI Team	~~01/06/2019~~ August 2019	**Achieved** August There is now an updated Trust PPI strategy which includes GIC. This is available on the Trust intranet and internet. There is an active GIC service user forum and involvement project underway in the service.
2.13C_GICSHOULD	Officer to attend Trust PPI team meetings monthly from 19th March 19		Mar-19	**Achieved.** Officer dials into PPI Team meetings.
2.13D_GICSHOULD	Training day to be provided in April 2019 to familiarise Officer with approach and resources of Trust PPI team		Apr-19	**Completed:** The GIC Patient Involvement coordinator is working with the PPI team and attending the Tavistock Centre where possible. The Senior Involvement coordinator is visiting the GIC monthly moving forward.

	2.14_GICSHOULD
CQC Requirement:	The trust should ensure they share patient feedback with people who use the service.
Success Criteria:	Service Users are aware of what other Service Users are saying about the GIC.

	Action(s)	Responsible Person(s)	Expected Completion Date	Update
2.14A_GICSHOULD	GIC Complaints, PALS and PPI Officer to send PEQ data to PPI Team Manager to assess suitability for the website March 2019	Chief Clinical Operating Officer Director of Gender Services PALS and PPI Officer Chief Clinical Operating Officer Director of Gender Services	~~01/03/2019~~ Sept 2019	**Completed - Ongoing** August update Data has been passed to the communications team and was added to the website in August 2019. Ongoing. PPI Manager viewed the PEQ report for a patient forum on July 4th.
2.14B_GICSHOULD	GIC Complaints, PALS and PPI Officer to discuss patients views on how they would like feedback to be presented at next forum meeting, March 2019	GIC Complaints PALS and PPI Officer Chief Clinical Operating Officer Director of Gender Services	~~01/03/2019~~ Sept 2019	**Completed** August update There is an active GIC service user forum and involvement project underway in the service. GIC patient forums are taking shape. The GIC is planning quarterly patient forums. The first of these was in May 2019 and the second took place on 4 July 2019. Feedback from patients was heard and is being actioned on the website. **Novem ber 2019 update** GIC patient forum meetings are minuted
2.14C_GICSHOULD	GIC General Manager to liaise with Trust Comms team to allow website information to appear on screen in GIC waiting room by May 1st 2019	GIC General Manager Chief Clinical Operating Officer Director of Gender Services	~~01/05/2019~~ July 2019	**Completed:** The slides are complete and went live 4 July 2019 See GIC waiting room screen for website information

Action Plan Reference:	**2.15_GICSHOULD**
CQC Requirement:	The trust should ensure they continue to explore options to find a suitable building to accommodate the growing numbers of staff required to deliver the service.
Success Criteria:	New accommodation sourced and secured.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.15A_GICSHOULD	Work with the Relocation Team at to find new, suitable accommodation. This will undoubtedly be linked with the new procurement which is due to launch in Q4 2018-2019.	Chief Clinical Operating Officer Director of Gender Services General Manager, GIC Relocation Team	Q2 2019-20	November 2019 - a suitable property has been found for GIC to move to.

Action Plan Reference:	**2.16_GICSHOULD**
CQC Requirement:	The trust should continue to implement the work needed to comply with the accessible information standard.
Success Criteria:	A variety of resources are available that meet the information and communication needs of GIC patients Agreed data sources for gathering information and communication needs are in place and consistently used across the service. Clear processes for recording, accessible information requirements within patient records Clear processes for sharing and informing relevant staff of communication / information needs Meet communication and information needs identified

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.16A_GICSHOULD	Identify service leaflets and letter templates held by the GIC for patient and carers	Chief Clinical Operating Officer Director of Gender Services	31 March 2019 - completed	Initial scoping of service leaflets completed. The identification of documents which are required in Easy Read has occurred. 'Consent' and 'What to expect from GIC' Easy Read leaflets to be drafted by 30 September Directors / Comms feedback in October and patient review 1 November. First draft of 'What to expect from GIC' Easy Read leaflet. Patient feedback will be sought 1st week November 2019. Consent leaflet to await Trust review of consent following GIC data breach incident.
2.16B_GICSHOULD	Ascertain which documents are required in easy read format	General Manager, GIC	30 June 2019 - completed	
2.16C_GICSHOULD	Write easy read format documents with patient feedback	GIC and Comms Team	~~30 Sept 2019~~ 30 November 2019	
2.16D_GICSHOULD	Ensure that patients know they may request any information in an easy read format if needed – review and where required	GIC and Comms Team	31 December 2019	
2.16E_GICSHOULD	Review data gathered from referrers and patients to ensure that it identifies information and communication needs where they relate to disability, impairment or sensory loss.	General Manager GIC	30 June 2019	**Completed.** Data has been reviewed. Where gaps occur, the clinic is in touch with the referrer to confirm patient needs.
2.16F_GICSHOULD	Review processes for documenting accessible information requirements in a patient file	General Manager GIC	31 March 2019	**Completed**. All patient communication needs are highlighted in the electronic patient record.
2.16G_GICSHOULD	Liaise with Admin and Clinicians to agree processes for highlighting and sharing information and communication needs consistently.	General Manager GIC	30 April 2019	**Completed.** All information received from the patient and referrer are captured on Carenotes so that Appointments team are aware if interpreters are needed. Communication requirements for appointments e.g. interpreters, are arranged and added as an Alert to the patient record. Clinicians review patient information and Alerts in advance of appts. Booking Appointments Policy is in place
2.16H_GICSHOULD	Review processes for ensuring information and communication needs are met appropriately.	General Manager GIC	30 June 2019	**Completed**

Action Plan Reference:	**2.17_SCSHOULD**
CQC Requirement:	The trust should ensure fire safety of the environment and quality assurance processes such as fire drills are completed as per trust policy.
Success Criteria:	Documented fire drills with lessons learnt plans for dissemination and implementation

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.17A_SCSHOULD	External fire training advisors (healthcare specialists) identified and appointed.	Director of Finance and Deputy CEO Health and Safety and Non Clinical Risk Manager	Dec-18	**Completed** Named lead from Fire Training Bucks & MK
2.17B_SCSHOULD	Authorised Engineer (Fire) appointed.		Dec-18	**Completed** Named authorised Engineer (Fire) appointed from Fire Training Bucks & MK
2.17C_SCSHOULD	Fire marshal training undertaken for all sites		Jun-19	**Completed** Fire Marshall refresher training is completed as e-learning modules

Action Plan Reference:	**2.18_SCSHOULD**
CQC Requirement:	The trust should ensure there are robust systems in place to ensure a timely and effective response from staff should there be an incident whilst staff are seeing patients for therapy on site.
Success Criteria:	Development of a trust wide guidance for managers to interrogate service level systems to ensure safety of staff involved in incidents in clinical settings

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.18A_SCHSCHOULD	Guidance will be produced with input from a range of internal stakeholders.	Medical Director	May-19	**November 2019 update** Series of actions being trialed through Operational Delivery Board to address issues of: - environmental safety - incident response - staff support A group led by the AMD has been set up to create guidance and any other recommendations. It will report to the incident panel, which is chaired by the Medical Director. A group has been established and is reviewing the current guidance. To be cascaded once completed. **October update**: the updated guidance will be reviewed at the November Incident Panel and cascaded appropriately to all teams once ratified. Aggression Against Staff Training Slides were presented at the July Incident Panel. The Medical Director has emailed all staff requesting they ensure they wear their ID badges at all times and asked that we challenge people who are not wearing a badge if appropriate. The sub group led by CMK has fed back to the incident panels, and this has also been forwarded to PCAG & EMT for further discussion.
2.18B_SCSCHOULD	Guidance will be cascaded to all service line managers who will be asked to discuss and agree systems within services.	Medical Director	May-19	

Action Plan Reference:	**2.19_SCSHOULD**
CQC Requirement:	The trust should ensure toys used by children are cleaned after use and staff keep records of this to maintain infection control. This includes toys in the communal areas and toys kept by individual clinicians.
Success Criteria:	The completion of cleaning programme logs

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.19A_SCSCHOULD	An infection control procedure is awaiting sign off from the Trust EMT.	Medical Director Health and Safety and Non Clinical Risk Manager CYAF Service Manager/Head of Facilities CYAF Service Manager	Jan-19	**Completed** The toy cleaning programme is in place, including a system to monitor compliance going forward. We are able to provide assurance for toy cleaning in public areas. Local solution for toys in clinical rooms have been agreed with individual clinicians confirming cleaning to FH. This information has been cascaded to all relevant CYAF staff. Toy cleaning in public areas is now completed regularly on a rota basis during termly holidays by estates staff.
2.19B_SCSCHOULD	Dates will be set for toy cleaning as per the schedule set out in the procedure.		Jan-19	
2.19C_SCSHOULD	Communications to staff on how to access to cleaning facilities as well as their individual responsibilities.		Jan-19	

Action Plan Reference:	**2.20_SCSHOULD**
CQC Requirement:	The trust should continue to ensure that staff complete and record risk assessments for all young people, review these regularly, and share information on risk with other health professionals involved in young people's care and treatment. The trust should ensure that all staff are up to date with the clinical risk training.
Success Criteria:	All clinicians complete risk assessments on all children and young people. Any concerns about risk are documented, shared with other health professionals particularly GPs , in writing usually. All clinicians should update their knowledge and skills on clinical risk assessment through attendance at internal workshops and/or online training and via team based and case based discussion.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.20A_SCSHOULD	Completion of risk assessment forms on Care Notes (Electronic Patient Record) and communication about risk concerns will be audited as part of annual case notes audit.	Medical Director Associate Medical Director	Ongoing but Case Notes Audit during Q4 2018-19	August 2019 update - Case note audit on recording clinical risk assessment completed CYAF completed August 2019 and findings to be presented to the Clinical Governance meeting. Additionally, at least two teams in CYAF are auditing case notes focusing on assessments, referrer letters, session notes, safeguarding and risk forms and review and closure forms. Case note audit in AFS is in progress to be reported in Q3. Audit of the standard of medical appraisal summaries is in progress. On completion and review, recommendations and further action plans may need to be produced.
2.20B_SCSCHOULD	Planning for workshops for 2019.		Completed	**November 2019 update** CYAF Clinical Risk Assessment training dates: 25th July 2019, 8th October 2019 and 6th February 2020. AFS Clinical Risk Assessment training dates: Lessons Learned Events 2019: 27/06/19 & 17/09/2019 2020 Dates: 4/02/2020, 2/04/2020, 8/06/2020, 7/09/2020 & 3/11/2020. Interprofessional Events 2019: 2/05/2019 & 16/10/2019. 2020 Dates: 6/01/2020, 3/02/2020, 6/04/2020, 8/06/2020, 3/10/2020 & 5/10/2020. **Oct 2019 update:** See 2.8 actions on clinical risk assessment workshops in place until February 2020. Online clinical risk trainng resouce reviewed and with HR for implementation. Patient safety lead will continue to run risk assessment workshops quarterly. Workshop dates to be determined. Patient safety lead will develop and/or identify an electronic training which Trust will adopt. Online resource to be determined. All teams will do a session on risk assessment, as part of their discussion of clinical matters on a quarterly basis and to minute this discussion.
2.20C_SCSCHOULD	Available NHS online training modules on risk assessment to be reviewed for suitability.		Completed	
2.20C_SCSCHOULD	Available NHS online training modules on risk assessment to be reviewed for suitability.		Completed	IH to confirm with HR if we are to monitor who has read the documents.

Action Plan Reference:	**2.21_SCSHOULD**
CQC Requirement:	The trust should ensure that staff know which incidents to formally report. This ensures managers have oversight of incidents and teams can learn from when things go wrong.
Success Criteria:	Staff aware of what incidents to formally report and lessons learned are shared across the Trust.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.21A_SCSHOULD	Use of forums, including learning lessons, CQSG, directorate clinical governance forums, MD blog and INSET days to improve awareness and learning.	Medical Director	Ongoing End of Q4 2018/19	**Completed** This work has been completed and continues via Inductions and INSET and two MD blogs have been formally published. **Completed** Formal incident reporting training documentation has been completed and will be made available to staff via the intranet and promoted via the daily digest. Medical Director's blog planned. Lessons Learned Events planned to disseminate information. Incident Reporting Training Slides on the intranet available to all staff. **November 2019 update** Medical Director's blogs now published on the intranet for all staff. Lessons Learned Events: 27/06/2019, 17/09/2019 2020 Dates: 4/02/2020, 2/04/2020, 8/06/2020, 7/09/2020 & 3/11/2020. Incident Reporting Intranet: Training Slides available to all staf

Action Plan Reference:	**2.22_SCSHOULD**
CQC Requirement:	The trust should ensure that there is a formal system in place to provide staff with feedback on lessons learned from incidents, complaints and audits within the team and other CAMHS teams. Teams should also have access to the risk register so they can escalate risks and see what action is being taken.
Success Criteria:	A formal system is in place. A learning lessons workshop takes place x4/year and is open to all staff. Representation from each team in the Trust will be expected during 2019. The Quality Portal Dashboard includes a rolling list of lessons learned immediately visible on entering the portal. Findings from audits to presented at clinical audit meetings

	Actions	Responsible Person(s)	Expected Completion Date	Update
2.22A_SCSHOULD	Arrange dates for all learning lessons workshops during 2019	Medical Director	Ongoing Workshops have been planned and the final agreed dates are in the evidence list.	**Completed** This work is in hand and lessons learned are now on a rolling platform on the Quality Portal as a visual immediate reminder for staff. Trust wide lessons learned workshops have been arranged for the rest of the financial year and all clinical staff are encouraged to attend these workshops, which are advertised in the daily digest.
2.22B_SCSHOULD	Develop robust process for quarterly complaints feedback to service line managers to include information from actions taken.	Complaints Manager	30 June 2019 30 Oct 2019	**Completed** All issues raised following complaints will be compiled and reported to the CQSGC via the PSCR workstream from Q4 2018/19. **Current** Smart Reporting capability from the QP system is being developed to provide automated quarterly action plan reports to Service Line Managers. Until the smart reporting is in place the Complaints Manager will take the information from the QP and report it manually via the PSCR as described above. **Update 6 November 2019** Development of Quality Portal smart reporting delayed until 2020
2.22C_SCSHOULD	Clinical audit lead to arrange audit programme for 2019/20	Associate Medical Director	Mar-19	**Completed** Clinical audit programme for 2019/20 has now been formally agreed and published.

Action Plan Reference:	**2.23_SCSHOULD**
CQC Requirement:	The trust should ensure there is appropriate training for all staff to ensure they have a good understanding of the need for consent, and act in accordance with the Mental Capacity Act
Success Criteria:	Clinicians understand the principles of the MCA, know when it applies and how to undertake a Capacity Assessment. Attendance at MCA lecture

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.23A_SCSHOULD	Arrange MCA lectures for 2019.	Medical Director Associate Medical Director	Lectures to begin during Q2 2019/20	The Trust has agreed that MCA E-Learning training level 1 will be completed by all relevant clinicians. Lectures have commenced. To put Capacity and Risk Training onto ESR for New Managers, INSET and Induction. **October 2019 update - Completed** Mental Capacity Act Training is now on ESR. Those who need to complete this are advised by their manager on starting at the Trust. The MCA lectures took place on 22nd Jan 2019 and 9th April 2019. No further dates have yet been planned. Uptake was so limited on the first two dates, that the lead is considering how best to ensure staff attend this non mandatory training. **November 2019 update** No further MCA lecture dates planned. Adult safeguarding training slides on ESR. This covers MCA information.
2.23B_SCSHOULD	Explore option of clinicians accessing online MCA training.		Agreement to be reached on exploration of MCA online training by end Q2 2019/20	**Completed** The adult safeguarding lead will also address MCA and issues of capacity in Adult Safeguarding training.

Action Plan Reference:	**2.24_SCSHOULD**
CQC Requirement:	The trust should ensure information is provided in accessible formats for younger children, and continue to implement the work needed to comply with the accessible information standard.
Success Criteria:	A variety of resources are available that meet the needs of younger children (as identified by themselves or their parents/carers) that give them the information they want about our services.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
2.24A_SCSHOULD	Review current information available on services and identify where the gaps are. This will include • Trust website • Service Leaflets • Letter templates • Signage in waiting areas Complete work on updating the "CAMHS Den" site	Director of Nursing Associate Director of Quality and Governance Divisional Service Managers x 3	All new methods of communication to be in place or have a timeline for completion by the end of ~~June 2019.~~ March 2020	Initial scoping of issues with CAMHS Den site is already complete and a decision will be taken as to how to progress this. Project plan devised and in progress. A plan has now been confirmed for the update of CAMHS Den and we are taking planning to attend some local schools in half term to get feedback from young children on how they would use the site. Review of leaflets, letters and signage is taking longer than anticiapted and there is a need to reveiw and formalise the plans that were initally proposed **November 2019 update** Comms database of patient/user leaflets Publication number applied to all discovered leaflets by Comms team Trust templates created for patient -facing leaflets (via Comms team) Gateway/sign off process created for Trust documents CYAF review of service leaflets and patient letters report.
2.24B_SCSHOULD	Produce materials necessary to meet the needs of younger children. Deciding what these resources are and the content will be done in collaboration with children and their parents Implement Accessible Information Standards requirements across the whole Trust.		Introduction of new materials complete by ~~June 2019~~ March 2020 Full Trust review and implementation March 2020	Initial meetings with the Trust PPI team to agree how to engage children and parents/carers on what information would be helpful will take place in the coming weeks. Focus groups to be set up for parents of children attending treatment at the Trust and for older teenagers up to the age of 18. Digital material on the Trust's internet and intranet to be reviewed and updated. Trust wide plan to be reviewed August 2019. Focus groups took place however we were only able to get older children to attend. THerefore we are approcahing shcools as outlined above. Paper to be presented to the Trust EMT on 15th October outlining remaining requirements to introduce AIS Trust-wide and agree plan of action **November 2019 update** CYAF project plan for appropriate informiiton for younger children Accessible information standard report reviewed by EMT October 2019 - to be monitored for implementation via the newly formal Clinical Operational Group

Action Plan Reference:	**3.1_GIDSHOULDPRV**
CQC Requirement:	The trust should ensure that a proactive approach is taken to complaints and sharing information with young people and parents about what will happen to complaints when they are made.
Success Criteria:	Complaints process information easily available. Complaints information easily found on the Trust internet GIDs staff clear of the Trust complaints process

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.1A_GIDSHOULDPRV	Develop easy read complaints leaflet	CEO Complaints Manager	01/01/2018	**Completed** Easy read complaints leaflet in place
3.2B_GIDSHOULDPRV	Review and update internet information on complaints		01/01/2018	**Completed** Information on Trust internet site re complaints, is correct.
3.2C_GIDSHOULDPRV	Ensure clarity of complaints processes within the GIDs service		01/01/2018	**Completed** Weekly communication with GIC complaints and PALS manager

Action Plan Reference:	**3.2_GIDSHOULDPRV**
CQC Requirement:	The Trust should make sure that staff continue to involve and share information with all young people and parents or carers so that they are aware of the pathways and options for treatment throughout the period of care.
Success Criteria:	Increased awareness by patients and parents / carers of the options for treatment. The GID Service continues to hold this in mind. The sharing of information and pathways and options is central to the work of the service. It underpins our work and informs any new innovations i.e. telemedicine or new service letters

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.2A_GIDSHOULDPRV	GIDS has a new set of specifications which lay out pathways.	Director of Gender Services GIDS Director	Ongoing	Service specifications from NHS England went live mid 2016. There are details of pathways in these. A gender programme Board has been convened by NHS England led by James Palmer. They have focused on adult services, but intend to focus on child services in the near future. The specifications will likely be reviewed in light of this. KH update Oct 19: NHSE service specifications will be reviewed by our commissioners as current specifications lapse out of date in April 2020. GIDS will be involved in this process.
3.2B_GIDSHOULDPRV	Links to new specifications on website.		**Complete**	The service specifications are made publically available by GIDS and NHS England. There is a link to the service specifications on the website.
3.2C_GIDSHOULDPRV	Information on the website about options for treatment.		**Complete**	Links on website to detailed information about pathways including physical treatment.
3.2D_GDCSHOULDPRV	GIDs will standardise team practice around the documentation and involvement of patients and/carers for individualised care pathways on Carenotes.		Sep-19	Consent forms, where appropriate to aspects of clinical care have been developed and are now uploaded as standard onto patient records on carenotes. Under recommendation from our information governance lead, they are now stored separately from other forms of documentation. Standard operating procedures regarding the correct local use of carenotes is currently in draft. This will include standardised documentation. Implementation date to be determined. Consent forms for the receipt for SMS and Electronic Communications and for Research are currently being reviewed with the support of the Trust's new Assistant Director of Information Governance, Data Security and Data Protection Officer.A standardised 'assessment report' template has been developed with a careplan laid out. This is shared with families and saved as a template on carenotes. Two emails have gone to clinicans seeking views and
3.2E_GIDSHOULDPRV	Individualised care pathways laid out at the end of assessment reports, which families and clients have a copy of.		01/10/2019 COMPLETE with on-going review	Assessments are shared with families and care pathways agreed at the end of the assessment. The next step will be to standardise the assessment report structure and ask families to sign agreed care pathways. Implementation date to be determined. .A standardised 'assessment report' template has been developed with a section for the careplan to be laid out. This is shared with families and saved as a template on carenotes. Two emails have gone to clinicans seeking views and implementing as standard practice, this will be reinforced at the awayday on 15/10/19. The Seniors and team have had opportunities to feed into this.
3.3F_GIDSHOULDPRV	Care plan form on care notes to be updated when plans evolve/change.		Dec-19	Standard operating procedures regarding the correct local use of carenotes is currently in draft. This will include standardised documentation. Implementation date to be determined. Following on from the completion of a careplan section in the standardised assessment report a new form will be created to update the careplan when plans change or evolve.
3.2G_GIDSHOULDPRV	Service protocol is currently being revised and the revision will need to take into account SU perspectives.		Complete – with additional work to commence as the need arises.	Regular service user groups are held by GIDS, who review relevant material such as published literature and service information; the most recent was held on the 6th of August 2019. The next service user's group will be the 29 October 2019. As per 3.2A the protocol is likely to be revised following the NHS England Service Review Implementation date to be determined.

E:\SOPS\Record keeping and carenotes\GIDS

E:\CQC\2019\ INITIAL REPORT CARE PLAN (IRCP)

E:\SOPS\Record keeping and carenotes\GIDS

Action Plan Reference:	**3.3_SPTSHOULDPRV**
CQC Requirement:	The trust should ensure that all patients who meet the trust definition of needing a crisis plan have one in place.
Success Criteria:	All patients needing a crisis plan have one in place-this to be measured in an audit and minimum 90% compliance rate to be attained

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.3A_SPTSHOULDPRV	**AFS:** For the previous CQC visit (2016) , AFS (all 3 service lines) defined a set of criteria, defining patients for whom a crisis plan would be required, operationalising this and then auditing the completion rate, which was excellent.	Medical Director AFS Director	2016	**Completed** Crisis Plan criteria agreed.
3.3B_SPTSHOULDPRV	**AFS:** Care plans- "Care plans", are completed at the end of each assessment.		Ongoing	**November 2019 update** Assessment summary review of careplans and crisis plans completed. Process issues for timing of completion to be confirmed November. <u>October update</u> Care plan and crisis plan audits continue. All issues taken up in team or unit meetings. Care plan information is included within the patient assessment summary. A newly created carenotes report is currently being validated to support ongoing monitoring and compliance. <u>August update</u> To be reviewed by new AFS Director. Awaiting confirmation that the audit for crisis and care plans will be completed by end of Q2 - September. By the end of Q1, the AFS assistant psychologist will audit 20 randomly selected, recently assessed, cases within Complex Needs services, to ascertain the current Care Plan completion rates on CN. This audit will be repeated in Q2 for Adult Primary Care Services and the Portman. During Q4 all AFS service lines will be re-audited to ensure increased compliance
3.3C_SPTSHOULDPRV	**AFS:** A further audit/QI project, to assess the completion rate of both Crisis plans and care plans, is planned for 2019 within AFS		Further AFS audit to be completed by December 2019	

Action Plan Reference:	**3.4_SPTSHOULDPRV**
CQC Requirement:	The trust should ensure staff undertake and record risk assessments for every patient.
Success Criteria:	All patients need a risk assessment in place after the completion of assessment-this to be measured in an audit and minimum 90% compliance rate to be attained

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.4A_SPTSHOULDPRV	AFS: Risk assessments are completed at the end of any assessment of all new patients, and at other intervals should the clinical situation dictate this. These are completed on the CARENOTES ERS, and GPs/referrers are alerted if there is an issue with risk. The completion rate of risk assessments in all service lines to be audited as part of a QI project.	Medical Director AFS Director	Q2 2019/20 Audit Completion Recommendations and actions to be completed by December 2019	**November 2019 update** Assessment review completed but the current reports available do not provide numbers of completed risk assessments aganst all patients, so the report is being amended by clinical governance to ensure it provides number of completed forms for all patients in AFS services. Critieria updated to 90% but work required to enable compliance reporting. AFS department meeting 24/10/2019 'lesarning lessons from SIs'. Two trainings planned for January 2020. **October 2019 update** All issues are being taken up in team or unit meetings. August 2019 update Audit is currently being undertaken in AFS. Audit target is a minimum of 90% clinicians to have completed risk assessments on Care Notes at the end of assessment. By the end of Q1 19/20, the AFS assistant psychologist will audit all 3 AFS service lines, by randomly selecting cases to ascertain the current Crisis Plan completion rates on Carenotes. AFS held a cross departmental meeting focussed on risk assessment and 'learning lessons' from 2 SI's on the 24th October 2019. A further two departmental meetings planned for January 2020.

Action Plan Reference:	**3.5_SPTSHOULDPRV**
CQC Requirement:	The trust should ensure staff at the Portman Clinic record their signature on written records of sessions.
Success Criteria:	Already delivered successfully

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.5A_SPTSHOULDPRV	The Portman clinic staff all now enter records on the CareNotes ERS The requirement for Signatures on written records is no longer relevant Clinician reminders about completing therapy progress notes for each patient appointment at fortnightly unit meetings, individual and group sessions and weekly clinic updates. 6-monthly spot audits of records - therapy progress notes for each appointment	Director of Adult and Forensic Service Portman director	01/12/2018 Audit - November 2019	**Completed** Portman Unit and weekly meeting minutes Feb 2019 audit of therapy progress note completion (Portman)

Action Plan Reference:	**3.6_SPTSHOULDPRV**
CQC Requirement:	The trust should ensure there is a clear policy about information sharing with external agencies and that staff are aware of this policy.
Success Criteria:	There will be a clear policy on information sharing with external agencies adopted by the Trust. All staff will be aware of this policy via INSET and Induction.

Action ID	Actions	Responsible Person(s)	Expected Completion Date	Update
3.6A_SPTSHOULDPRV	The Caldecott Guardian will ensure current processes for data and information sharing with external agencies are reviewed.	Medical Director Associate Medical Director Director for Transformation & Technology	30/06/2019 Completed March 2020	There are a suite of policies relating to data protection and information governance. Data protection policy and IG Framework updated June. **November 2019 update** Full review of IG policies and procedures underway by new Assistant Director IG and Data Security.
3.6B_SPTSHOULDPRV	The AMD will raise staff awareness through targeted communication and the use of appropriate forums		March 2020	**November 2019 update** Data sharing procedure requires updating The Caldicott Guardian will work with the DPO to ensure there is a separate Information sharing with external organisations policy and that this is shared with staff – at INSET, induction, cascading to team managers. Update on policy from Data Security & Protection Manager to be received by 13th May for sharing with external agencies.

Report to	Date
Board of Directors	26 November 2019

Gloucester House – Annual Report

Executive Summary

The purpose of this report is to monitor quality, safety and progress of Gloucester House during the academic year 2018-2019

Recommendation to the Board

The Board of Directors is asked to note this report

Trust strategic objectives supported by this paper

All Trust strategic objectives

Author	Responsible Executive Director
Head Teacher	Sally Hodges COO

Gloucester House, The Tavistock Children's Day Unit

1. Introduction

Gloucester House is a specialist school for children with social, emotional and mental health difficulties. We are a multidisciplinary service across mental health and education. We work with up to 21 children and their families at any one time. We work with children of primary and early secondary age. See www.gloucesterhouse.net for more information.

We have an outreach service attached to the core provision that offers flexible packages developed in collaboration with staff and networks to support the learning and development of SEMH children in schools and other settings.

Gloucester House core service has been operating a revised service model since 2014/15 and the Outreach Service has been in formal operation since 2016.

In this paper we provide an update in relation to progress over the year. We also outline the current position and provide an overview of other significant developments, risks and achievements at Gloucester House.

Key areas of work during the academic year have been:

- November (2018) the 50th Anniversary of Gloucester House.
- Challenge Partners review February 2019 (see Appendix 1).
- Developing leadership skills across the service.
- Developing policy and practice in relation to staff wellbeing (see Appendix 2).

2. Occupancy

2.1 - Last year continued the trend of steady occupancy rates and more demand for the service than we were able to accommodate. Table 2.2 gives the figures for the last four years.

2.2 **Occupancy 2014- present:**

	2015/2016			2016/2017			2017/2018			2018/2019		
	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer
Occupancy	18	15	19	18	18	20	18	20	19	18	18	17
Admissions	5	2	3	3	3	2	2	1	2	2	2	1
Discharges	3	0	3	2	3	3	2	1	5	1	1	2

2.3 - The children came from the following local authorities: Barnet, Hackney, Haringey, Enfield, Ealing, Hounslow, Merton, Waltham Forest, Islington, Brent. Barnet are maintaining their SLA for 6 children.

2.4 – The Outreach Service have worked with Camden, Islington, Hackney, Islington, Enfield, Haringey, Barnet, Bromley, Lambeth, Brent.

3. **Demand and capacity:**

3.1 - In academic year 2018-2019 we received approximately 8 enquiries and 27 referrals. In the previous academic year of 2017-2018 we had approximately 11 enquiries and 21 referrals. This was a 28 % increase in referrals with approximately a third of the enquiries being received from new Local authorities interested in a placement at Gloucester house.

Despite having a waiting list numbers we have maintained numbers rather than increase for the following reasons: 5 children left in July 2018 and we stagger new admissions in order to maintain quality and safety; we have had significant clinical gaps due to recruitment issues and staff absence.

3.2 – The outreach service**:**

Background –

- Operating formally since 2016 in response to LA requests.
- Have worked with 13 London boroughs and three boroughs outside London supporting 36 children/institutions between 2016-2019.
- We work with schools, children's homes, LAs to support children, institutions and networks.

Outcomes-

- Academic progress for individual children – e.g. improvement in reading, writing & spoken language levels despite profound resistance to, and anxiety about, academic learning.
- Improvements in CGAS & SDQ data for individual children following intervention with general functioning improving (CGAS) and impact of difficulties lessening (SDQ).
- 95% of evaluations rated our training as good/excellent.
- 100% of our intervention evaluations stated that 'the service mostly or completely meets the needs of the children'
- 71% scored the quality of our service as excellent.
- 85% thought our service was very good or excellent value for money.
- *"it was extremely helpful to be able to work with professionals who understood our young person and maintained the behaviour management whilst supporting a therapeutic approach."*

The outreach service continues to maintain and grow. We are intending to offer more clinical services as part of outreach and are currently exploring accountability, risk and supervision structures for this.

We are focusing on the strategic development of this service with the BDU. We held a stakeholder event/workshop on 14.11.19 to work with LAs on their development needs and intend to diarize more events of this nature during the year (see Appendix 3).

3.3 - Financial position:

In 2014 we recovered from a significant decline in numbers by remodeling the service. We remodeled on the basis of breakeven at 14 in 2014-15. Due to increase in capacity this was revised to 17 for the financial year 2015-16. An additional contribution was factored into our breakeven figure. In 2017-18 breakeven was set at 18.

This financial year to date we are maintaining a breakeven average in terms of numbers of children in the service. The Outreach Service is continuing to increase income and scope.

Teacher and NHS pay rises have impacted our budget considerably and we haven't had a price increase since the beginning of the new model in 2014. We are likely to apply a price increase in September 2020 and are currently working with the Business Development Unit to formulate a new pricing structure that will ensure we are financially viable while remaining competitive in the market. We have adjusted our 1:1 staffing cost for boroughs who pay additional 1:1 for children and have applied it for our newest admission.

4. Staffing

We have approximately 35 staff (a mixture of FT/PT and trainees) across a full range of clinical disciplines and education.

4.1 - Gaps in the clinical staff team affected capacity to increase pupil numbers last year. The CNS post was recruited to mid year and the child psychotherapist returned from maternity leave in September 2019, which puts us in a stronger clinical position this academic year; however there are ongoing gaps in other parts of the clinical offer that we are currently addressing.

4.2 - The deputy headteacher is leaving to take up a head of school role in December 2019. We have a plan to manage the gap by offering additional authority and responsibility to two of our teachers internally. They are both keen to take up this opportunity.

4.3 - Many of our support staff will move on during or at the end of the academic year to secure training or higher banded posts. Whilst we are really proud of the training opportunities we provide, we have been considering the cost of recruitment and the comprehensive training package support staff receive at Gloucester House. We intend to review our staffing model to see whether there would be alternatives that might address this.

4.4 – Governance arrangements for Gloucester House have been adjusted to fit with Trust governance structures. The Steering Group is now chaired by a NED (Debbie Colson); we also have an additional associate NED who was previously a governor but who we wanted to keep due to her experience and knowledge of education (Celestine Keise).

5. Safety and IRFs

2017-18	Q1	Q2	Q3	Q4
Date	**April- June**	**July- Sept**	**Oct- Dec**	**Jan- March**
Number of children on roll	**20**	**20**	**18**	**19**
Incidents reported	75	74	61	75
Average per child:	4	4	3	4

2018-19	Q1	Q2	Q3	Q4
Date	**April- June**	**July- Sept**	**Oct- Dec**	**Jan- March**
Number of children on roll	**18**	**19**	**17**	**18**
Incidents reported	66	62	92	57
Average per child:	4	3	5	3

Academic year 2018-19	Summer term		
Date	**23/4 – 23/7**		
Number of children on roll	**18**		
Incidents reported	59		
Average per child:	3		

Numbers of incidents proportional to the number of children in Gloucester House remain broadly consistent.

6. Areas of Risk and/or Concern:

- Potential relocation and uncertainty around relocation has the potential to have a financial and qualitative impact on Gloucester House.

- The forthcoming price increase has the potential to affect referral numbers and thus have a negative impact on the service.

We will attempt to mitigate these concerns through careful planning and consideration.

7. Outcomes 2018-19

Outcome measures show that Gloucester House continues to support the educational and social and emotional development of children who attend. (Outcome Report available on request).

7.1 - From low starting points academically (100% of children significantly underachieving in maths and writing at baseline and over 75% significantly underachieving in reading and spoken language) the children make expected and above rates of progress**.**

Some children make exceptionally good progress. For example one child increasing their reading age by 4 years in 1 year and another child 4 years progress in 2 years in spelling.

7.2 – Clinical data – 85% of pupils increased their CGAS scores (indicating an improvement in general functioning for all). SDQ data indicates a decrease in total difficulties for pupils with particularly strong evidence that the Gloucester House model has a significant positive impact on conduct type problems.

8. Feedback from stakeholders

8.1- Exit data – ESQ (Experience of Service Questionnaires) Parent feedback – *"my daughter has excelled due to this service. Many more services like this are needed"*
Things to improve *"The meetings are always at the school's convenience and there was little flexibility"*

. Pupil feedback *"It was really helpful. Helped me with talking about my feelings and with children who have the same sort of difficulties."*

Things to improve *" I don't like recovery time being in a separate room. I think classes should be clearly separated by age. I think holding should be the last resort."*

8.2 – Parent carer survey feedback – 100% felt Gloucester House informs parents/carers of topics being taught; 100 % felt comfortable about approaching Gloucester House with questions, a problem or a complaint.

"Gloucester House is outstanding at providing a great balance of meeting my child's SEMH needs and his academic targets. Any school is only ever as good as the staff and the staff are incredibly skilled and gifted with vocational attitudes."

8.3 – Partner agency feedback –

'The service has had a holistic approach in managing the pupil concerned, and the input of the service has been very significant in the positive progress made by the pupil. The pupil presented with complex challenges, and periodically needed intensive support, but this was consistently met by the service.

With regards to our service user, the input was flexible, and responsive to his specific needs.
We were very satisfied with the service.'

(Fostering Social Worker Barnet)

'The collaborative stance that Case Co-ordinator has taken has been so helpful. I don't think we would have been able to continue a joint therapeutic intervention without it.
I also think the option and availability of intensive psychotherapy has been fantastic.

In an ideal world there would be a second (or more) Gloucester House available in different boroughs in London. At the moment, there is not enough of this provision available and so my patient (and their family) are having to travel too far.'

(Hackney CAMHS)

9. Significant achievements of 2017- 18

- Maintained good rate of referral to core and outreach service
- Maintained positive feedback from stakeholders
- Maintained good and better outcomes for children and families in the service.
- A second 'Outstanding' grade from Challenge Partners.
- Very successful 50th Anniversary Conference and party in November 2018 including past and present staff and pupils as well as outside participants. We had extremely positive evaluations from the event and managed to break even costs and expenditure through paid places, donations, fundraising and a contribution from the Trust charity.
- Key note speeches at 3 conferences during the year – the TES SEN conference, AP conference in Manchester, ACES conference in London. Two different parents and one child joined our presentations which audiences found moving and engaging.

11. The future:

- Growth/development of Outreach Service/ consultation aspect of the service.
- A book on therapeutic education to be published, edited by Gloucester House (there is provisional agreement for this with Routledge).
- Further revision of the staffing model to be considered to facilitate more opportunities for staff to be promoted internally.

Nell Nicholson
November 2019

QUALITY ASSURANCE REVIEW

REVIEW REPORT FOR GLOUCESTER HOUSE, THE TAVISTOCK CHILDRENS' DAY SCHOOL

Name of School:	Gloucester House, The Tavistock Childrens' Day Unit
Head teacher:	Nell Nicholson
Hub:	North London Special School Hub
School type:	Independent special
MAT:	Not Applicable

Estimate at this QA Review:	Outstanding
Date of this Review:	18/01/2019
Estimate at last QA Review	Outstanding
Date of last QA Review	23/02/2018
Grade at last Ofsted inspection:	Good
Date of last Ofsted inspection:	16/11/2017

Quality Assurance Review

The review team, comprising of host school leaders and visiting reviewers agree that evidence indicates these areas are evaluated as follows:

School Improvement Strategies	OUTSTANDING
Outcomes for Pupils	OUTSTANDING
Quality of Teaching, Learning and Assessment	OUTSTANDING
Area of Excellence	Not presented at this review
Previously accredited valid Areas of Excellence	Not applicable
Overall Estimate	OUTSTANDING

Please note that a Challenge Partners Quality Assurance Review is not equivalent to an Ofsted inspection, and agreed estimates from the review are not equivalent to Ofsted judgements.

1. Context and character of the school

- Gloucester House is an independent special day school catering for up to 21 pupils. The boys and girls, primary and lower secondary aged, have social, emotional and mental health needs (SEMH). Most pupils have additional learning needs, including autistic spectrum disorder (ASD) and language and communication difficulties. There are currently 16 pupils on roll.
- All pupils have education and health care plans (EHCPs) and join the school after significant previous disaffection and/or problems with attending education settings. All pupils have either been involved with, or referred to, their local child and adolescent mental health services (CAMHs).
- Pupils attend the school from a wide range of London boroughs. Currently, pupils come from nine London boroughs.
- The school provides a holistic and fully integrated provision, including psychiatry, psychoanalytic psychotherapy, individual and group work, family therapy occupational and speech and language therapy. Leaders ensure that service delivery is fully integrated. The school provides outreach support to pupils and their families. Outreach services are being further developed so that the school's expertise can be shared more widely.
- The school is part of the Tavistock and Portman NHS and Foundation Trust. It has been providing educational and therapeutic provision for over 50 years.
- Approximately half of the pupils are from minority ethnic backgrounds, the remainder from a white British background.
- The school works extensively with parents, carers and families to build resilience and develop long term solutions.
- Gloucester House is a centre of excellence for therapeutic education, providing a safe and secure environment, promoting the overall development of children with SEMH. Pupils are supported to overcome their barriers to learning in order to make measurable differences to their, and their families', well-being.
- The school sees itself as a medium-term intervention, supporting pupils to get their lives back on track. The lives of all pupils after attending the school is significantly improved, resulting in re-integration to mainstream school or attending other appropriate education settings.

2.1 School Improvement Strategies - Progress from previous EBIs

- At the last review, the recommendation was to develop high quality assessment procedures and evaluation tools to benchmark against similar schools and national indicators. Leaders have evaluated systems to replace their previous

assessment software, BSquared (pupils tracking and evidence of learning software.) They have selected SOLAR, an online assessment tool. Pupils were assessed to establish a baseline at the end of the 2017-18 academic year. Data was collected at the end of the autumn term. This has been cross-referenced and moderated in school. Leaders report that the system better meets the needs of the school. The next step is for the school to benchmark standards against other schools who use SOLAR.

2.2 School Improvement Strategies - What went well

- School leaders have detailed knowledge of the pupils and staff at Gloucester House. They are unrelenting in their drive to improve pupils' lives. They continue to improve outcomes for very troubled young people by leading, developing and supporting a committed and highly skilled staff team. Leaders encourage staff and pupils to take responsibility for their learning, to be brave and to take appropriate risks in a safe and supportive environment.
- Leaders measure the effectiveness of the school, using internal and external feedback. This includes lesson observations, learning walks, work scrutiny and the use of attainment and progress data. Leaders consult pupils, parents and carers, referring authorities and the Tavistock steering group for feedback on how well the school is doing.
- The quality of staff at the school is extremely high. This is due to a rigorous interview process which involves pupils, staff and parents or family carers. High quality induction and continuous professional development (CPD) ensures that staff are well equipped for their demanding roles.
- Teaching and learning and mental health and well-being CPD for support staff has been thoughtfully designed by the school. It is in the process of trying to gain external accreditation. Appraisal and performance management is based on 360-degree feedback. Staff performance targets are linked to the School Development Plan (SDP), pupil progress and staff personal development aims. Teaching is highly effective across the school.
- Staff are well supported by a holistic, therapeutic system of individual group and clinical, as well as line management, supervision. Staff have additional support available from the Tavistock Staff Support.
- Leaders regularly involve pupils in the wider running of the school through the school council and various committees. These include, building and furniture, restraint reduction and anti-bullying committees. All pupils contribute to at least one committee. The current World War Two topic was chosen by the pupils.
- The broad, imaginative curriculum has been carefully tailored to meet the individual needs of pupils and statutory requirements. There is a three-year topic cycle to ensure appropriate curriculum coverage. Pupils take part in practical science and topic based work, while English and mathematics form the core of

the academic studies. Curriculum delivery is differentiated and challenging to ensure that pupils have opportunities to develop core skills and prepare them for life after school.

- Pupils are carefully supported when they first join the school. There is a well thought-out process to integrate pupils into the school, including the use of buddies, family and carer involvement and extensive liaison with previous education settings. The process to leave the school is similarly well thought out, rigorous and highly effective.
- Senior leaders ensure that there is rigorous internal and external moderation of standards to ensure that school assessment judgments are robust and accurate.

2.3 School Improvement Strategies - Even better if…

…all improvement and development plans consistently used smarter targets, which can be measured by their impact on pupil progress.

3.1 Quality of Teaching, Learning and Assessment - Progress from previous EBIs

- The previous review identified that the school needed to increase opportunities for pupils to work with partners and to be more independent learners. Each teacher has made significant progress using different approaches according to the needs of their pupils. These actions include pairing more able and less able learners in the learning carousel of activities and including more independent tasks. Another class has set whole class independence goals with pupils and have paired pupils to complete life skill tasks together. In another class, pupils have had to learn to share their classroom, using games to facilitate this. Tasks are carefully planned, so that pupils can complete them with reduced teacher support. In science, sessions are set up to investigate in pairs. A particularly helpful approach has been to use older pupils as role models to support younger pupils. Younger pupils say that they really value this approach.

3.2 Quality of Teaching, Learning and Assessment - What went well

- Due to high levels of respect, recognition and warm relationships there is a positive learning culture and supportive environment across the school. Teaching staff have high expectations and provide pupils with well thought out challenge.

All staff show trust in the pupils, which allows these vulnerable pupils to be brave and take appropriate 'risks' in their learning.

- Teachers have excellent knowledge of their subjects and how pupils learn, resulting in high levels of engagement and progress in most lessons. Teachers' planning is rigorous. Differentiation is strong with personalised learning for all. Teachers provide appropriate scaffolding, which the pupils readily use in order to move their learning forward. In an English class, pupils chose whether to use laptops or pens and were supported with a variety of writing starter materials.
- Staff teams use praise specifically and thoughtfully, to support and motivate each pupil. They model key words and behaviours which pupils adopt to improve their learning and conduct. Staff use carefully chosen questions to check pupils' comprehension and to extend and deepen learning.
- Pupils take responsibility for their behaviour and learning. They use the 'Strategy tray' to effectively support their learning. There are many examples of pupils supporting each other in their learning and problem solving. The culture of appropriate challenge and risk taking results in pupils becoming increasingly independent.
- Class teamwork is very strong. Staff are clear, consistent and proactive. They are able to improvise when required, to take opportunities to extend and deepen learning and respond to behavioural issues.
- Pupils show that they can ask for help. A pupil who was finding it difficult to finish a lesson, appropriately negotiated a five-minute break, using her words and a visual symbol to enable her to regulate her behaviour in a socially acceptable way.
- Teachers thoughtfully provide stimulating visual environments, including working walls and visual timetables. Pupils can see their learning journeys. Pupils use working walls well. The Word War Two timeline and "what I know / what I need to know" working displays about the war, encourage pupils to enquire and share information.
- Almost all transitions are effective. Pupils take responsibility and ownership of their conduct and learning. A pupil who was in the 'wrong place' between lessons was honest enough to admit that this was the case and went back to the 'right place.'
- Pupils value and use the daily target system. They show great pride in their work. There is a clear marking and feedback system in place.
- The reward system uses a virtual currency which can be exchanged in the school shop. The items provided in the shop support the development of life and social skills. There are no sweets on offer.
- Teaching staff regularly use sensory tools to support pupils' sensory regulation. This results in minimal loss of learning time. Pupils clearly articulate how they use these tools to support their sensory, emotional and behavioural regulation.

3.3 Quality of Teaching, Learning and Assessment - Even better if…

…teachers ensured that pupils more frequently responded to marking before taking the next steps in their learning.

4. Outcomes for Pupils

- Over time, pupils make consistent, excellent progress from their starting points at Gloucester House. In reading, mathematics and spoken language, most pupils joined the school below or well below age-related expectations. All pupils enter the school with a record of under achievement, poor attitudes to learning and negative experiences of school. In writing, all pupils were below age-related expectations and all pupils were well below age-related expectations in personal and social development (PSD).
- Given the learning and emotional needs of pupils, progress is not steady and linear. However, over time almost all pupils make excellent progress from their starting points. Pupils who were previously hardly attending school, choose to attend the school. Attendance is rising to a level comparable to the national average for a mainstream school. This commitment to the school and their learning enables pupils to make accelerated progress and close attainment gaps to their age-related expectations.
- In 2018, all pupils made expected or better progress in at least one core area of learning. Most pupils made expected or better progress in four or more areas of learning. Most pupils made or exceeded expected progress in reading and mathematics. There is no significant difference in the progress of pupils who are considered to be deprived.
- In 2018, using the Children's Global Assessment Scale (CGAS), the Strengths and Difficulties Questionnaire (SDQ) and internal recording of behaviour, pupils were shown to make significant improvements in their mental health and behaviour.
- All pupils' reading age and spelling age levels are assessed at least annually. In 2018, most pupils made progress at least in line with age related expectations. One pupil made six years progress in one year. Almost all pupils made progress at least in line with age-related expectations.
- In 2018, almost all goal-based measures were fully or partially met. Goal based measures are set with pupils, families and teachers in the areas of education, SEMH and home/school targets. They are closely linked to EHCPs.
- In 2018, seven pupils left the school to attend mainstream or specialist SEMH settings. All pupils who left the school during this academic year, had significantly closed the gap between their chronological age and age-related expectations in

English and mathematics.
- Current year data is now available for the first term of this academic year using the new SOLAR tool. This shows that in the core subjects almost all pupils are making at least expected progress. Data is now available for foundation subjects. Progress is especially strong in physics. Evidence from work scrutiny and classroom observations support data presented.
- Parents and pupils surveyed are consistently clear that the school has significantly improved the trajectory of pupils' progress and life chances.

5. What additional support would the school like from the Challenge Partners network, either locally or nationally?

The school does not require additional support from Challenge Partners at this time.

This review will support the school's continuing improvement. The main findings will be shared within the school's hub in order that it can inform future activities.

Staff wellbeing Initiative September 2019

Supporting staff wellbeing at Gloucester House

Rationale

The Interim NHS People Plan acknowledges that 'there is compelling evidence that the more engaged our people, the more effective and productive they are, and most importantly, the higher the quality of care they deliver… our patients know that to be true – they tell us clearly that they want the staff who look after them to be well cared for themselves' within this NHS systems and services have been tasked with 'developing systems to make the NHS a better place to work'. It refers to an ambition for the NHS to be 'the best place to work' which requires a positive, inclusive, reflective, receptive, compassionate, and improvement focused workplace culture (Interim NHS People Plan June 2019 NHS)

Gloucester House is an immensely rewarding place to work but given the nature of the work it can also be both physically and emotionally challenging. With this in mind and based on feedback via the NHS staff survey 2018 – 2019, we formed a working group to specifically look at this area with the fundamental belief that our workforce is our biggest asset.

Aims

The aim of the wellbeing initiative and is to generate a workplace culture that attends more widely to our collective responsibility for our mental and physical wellbeing. The role of working group is to initiate, energise and lead on this process but not to take full responsibility. The aim is for a culture shift that maintains momentum.

Process

June - July 2019

Whole Team meeting reflective and small working group sessions around staff wellbeing. Feedback gathered.

Ideas board in staff room for written ideas around staff wellbeing for staff who were maybe less inclined to talk in a group, were unable to attend or had more ideas after initial discussion.

Working group formed – members from all levels of the organisation, self selected. Half termly meetings.

Staff wellbeing baseline taken form Staff Survey 2018 – 2019.

What do we do already?

We debated whether to include supervision in this document. On balance we agreed that to not have supervision would be detrimental to our staff wellbeing so decided to but with some context.

Supervision is a core and mandatory part of NHS clinical practice. The aim is to provide a regular reflective and supportive space to think about the needs, dynamics and impact of our client group as individuals or groups. Notably 'Supervision is different from staff support or counselling, which focuses on the member of staff's experience of his/her job. In this process the staff member is the focus of the discussion whereas in supervision the aim is to support the staff member with work tasks and challenges. However, it is recognised that staff stress may impact on the capacity to manage their work" (Schools in Mind Anna Freud 2019).

Supervision and Reflective Practice

- Regular, planned 1:1 supervision for all staff (by a clinician).
- Staff encouraged to request extra supervision if required.
- Weekly Reflective Staff Group
- Peer Reflective Practice (support staff - monthly)
- Class Supervision (3 weekly facilitated by clinicians)
- Daily Debrief (facilitated by SLT/Senior Clinician)

Specialist Support

- Referral Staff support service if required.
- Referral to Occupational Health.

Knowledge and Skills

- Work Discussion Groups (3 weekly facilitated by Child and Adolescent Psychotherapists)
- Whole Team Meeting (Weekly)
- Internal CPD Programme for support staff (once a month offered by the MDT)

Physical Wellbeing and Self Care

- Monthly funded chair massage (15 minute slots, self sign up, up to 8 per session)
- Staff yoga offered weekly by support worker (free)

Environment

- Work on staff spaces – Shared office, structural work to enable more work space and decrease clutter thus improving physical environment – ongoing.

- Staff toilet regularly stocked with nice hand wash and hand creams.

Team as a social community

- Shared breakfast and bring a dish lunch on inset days.
- End of term social events (Christmas and Summer)

Wider Tavistock /NHS

- Massage
- Yoga
- Mindfulness
- Tai Chi,
- Choir (subsidised)
- Cycle to work scheme

These do get circulated in addition to Daily Digest bulletins but people don't seem to attend – be good to know why?

- NHS Discounts – food, gym etc - do we need to publicise this more internally, is in induction packs but a lot in there so may be overlooked.

Initiatives actioned this academic year through working group and SLT:

- Staff wellbeing activity to be included in all INSET days e.g. Staff Quiz, meditation, team games, mindfulness, tool box of self care, yoga.
- Action for Happiness monthly calendars displayed in staff room and bathroom.
- Cup half full #mugged initiative.
- Random acts of kindness (RAK) postcards or wellbeing gifts to notice if someone is working particularly hard or if they may be struggling due to a tough couple of weeks. This is about everyone being noticed and feeling valued.
- Wellbeing days to be actioned – 1 days per academic year for all staff.
- Morning welcome or afternoon well done gestures in staff room – herbal tea, coffee, fruit.
- NHS discounts circulated to all staff as specific stand alone email.
- Whole School Mindfulness MindUp initiative to be embraced more fully by whole team and whole school approach.

- Staff leading debrief to promote a culture of transparency and reflection around challenges but also noticing positives in children and one another.
- Named SLT member of staff rota'd each day to be contacted by staff member if they have been particularly impacted by an incident that day (be that emotional or physical).
- Staff wellbeing back to work pro forma to be used for back to work meeting if staff member off due to incident at work (emotional or physical) as opposed to illness.

- Greater emphasis on Learning from Experience to reflect on incidents and mitigate future incidents – system of when this process can be triggered and by whom in process.
- More use of a model of cross hierarchy working groups to lead on decisions/initiatives.

- Creative Relaxation Space (open studio) one a month 4.30 - 6 Wednesday (led by art therapist). To gather interest – possibly open to wider Tavistock or nursing discipline. Running club to be considered – to gather interest

Evaluation

- To gather data form NHS Staff Survey 2019 – 2020
- To gather qualitative feedback from staff team.
- To consider measuring sickness data from previous years.
- Possible MSc research project to measure impact of staff wellbeing on patient care – in process via UCL.

Author Kirsty Brant

(Input from Staff Wellbeing Working Group – Kirsty Brant, Richard Lafferty. Jamie Williams, Erin McCarthy, Lottie Carlebatch, Isobel Nelson)

October 2019

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Gloucester House School and Outreach Service

A model for modern therapeutic education:

"Working together for learning and development"

Headteacher: Nell Nicholson
Outreach Lead: Nimisha Deakin
https://gloucesterhouse.net
Twitter: @gloucesterhous3

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Agenda

- 12:30 – arrival and lunch
- 1:00 – introductions, presentation of outreach work
- 1.30 – explore services and interventions you use and value. Feedback on our approach/model
- 2:00 – service development
- 2:15 – break for tea and coffee
- 2:30 – presentation – our service level agreement model
- 2:45 – discussion and feedback
- 3:00 – individual questionnaires
- 3:15 – plenary
- 3:30 – close

Gloucester House

The Tavistock and Portman NHS Foundation Trust

The health and education landscape – relevance for Gloucester House Outreach Service

Recent DoH / SC / DfE and NHS England strategic objectives / vision / guidance / consultation fit with Gloucester House model

- The Adverse Childhood Experiences Study (May 2014)
- Future in Mind (Department of Health 2015)
- The 5 year forward view for Mental Health (NHS England Mental Health Taskforce 2016)
- Transforming children and young people's mental health provision (DFE Green Paper 2017)
- Joined up approach to mental health support … to reach those most in need
- Joined up and collaborative services
- Whole child and whole family approach
- Emphasis on early intervention

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Support offered at the following levels:

Individual child

- We provide psychosocial and educational assessments and interventions and facilitating & coordinating of multi- disciplinary networks around the child

Institutional

- We provide multi- disciplinary advice, consultation and capacity building for teams looking to develop or improve systems, staff wellbeing and outcomes for children

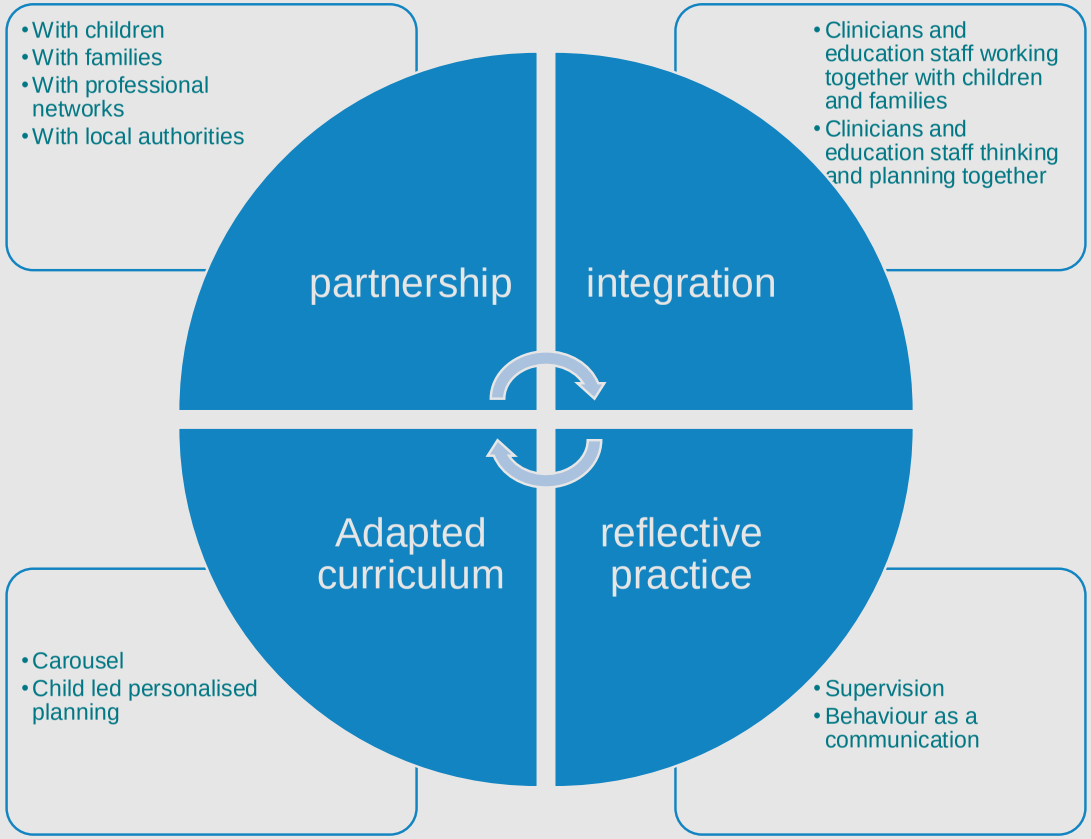
Training

- We provide bespoke one off or series of trainings which are available following consultation; choose from a menu of twilight or day trainings

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Foundations of our model, ‘Working Together for Learning and Development’



Gloucester House

The Tavistock and Portman NHS Foundation Trust

Introduction to the service

Background:

- operating formally since 2016 in response to LA requests
- worked with 11 London boroughs supporting 36 children/institutions between 2016-2019
- we work with schools, children's homes, LAs to support children, institutions and networks.

Outcomes:

- Academic progress for individual children – e.g. improvement in reading, writing & spoken language levels despite profound resistance to, and anxiety about, academic learning
- Improvements in CGAS & SDQ data for individual children following intervention with general functioning improving (CGAS) and impact of difficulties lessening (SDQ)
- 95% of evaluations rated our training as good/excellent
- 100% of our intervention evaluations stated that ‘the service mostly or completely meets the needs of the children’
- 71% scored the quality of our service as excellent
- 85% thought our service was very good or excellent value for money
- “It was extremely helpful to be able to work with professionals who understood our young person and maintained the behaviour management whilst supporting a therapeutic approach.”

Gloucester House

The Tavistock and Portman NHS Foundation Trust

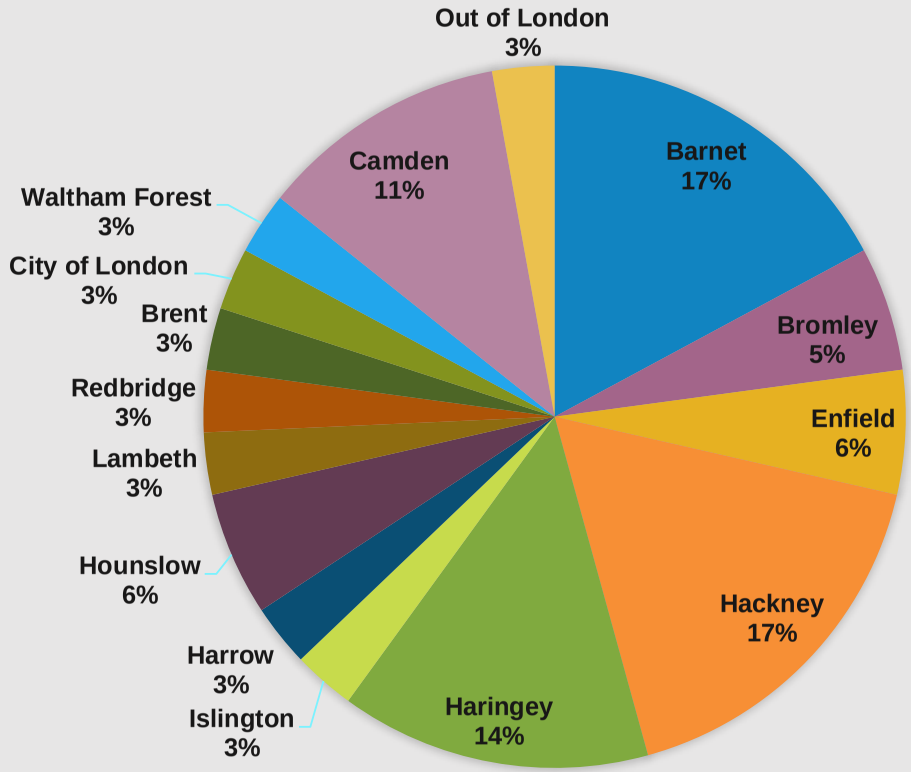
Profile of individual children/groups of children referred to Gloucester House Outreach Service

- 100% have 1 or more Adverse Childhood Experiences
- 100% have complex and severe SEMH difficulties
- A high proportion have language and communication difficulties
- A high proportion have other specific learning needs or global delay
- A high proportion have had a disrupted education many with at least two prior schools/placements
- A high proportion of adopted or looked after children

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

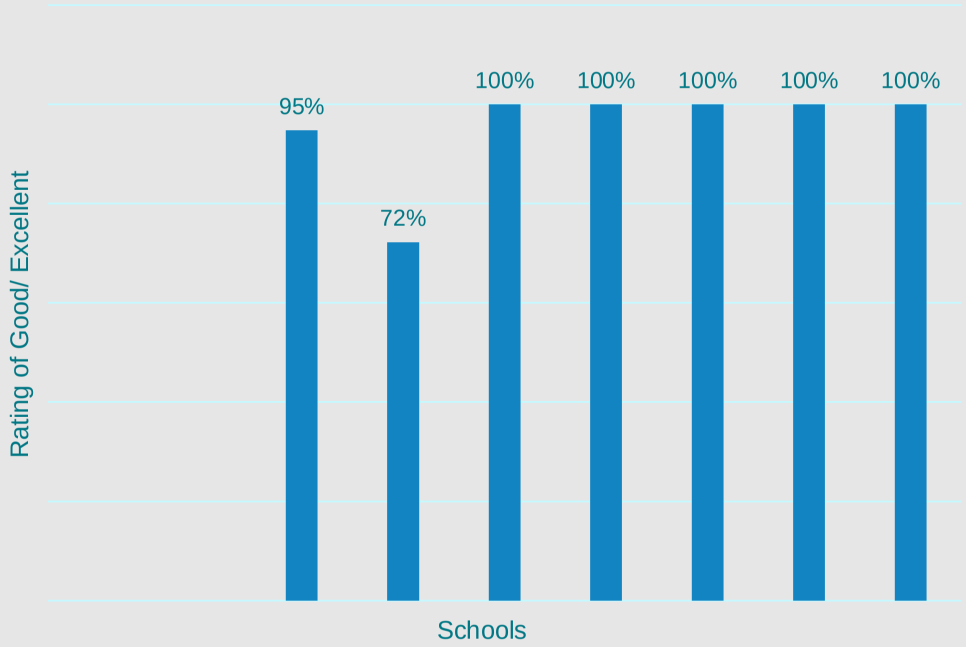
Home boroughs by local authority



Gloucester House

The Tavistock and Portman NHS Foundation Trust

School Training Evaluations



The majority of schools rated our training / workshops as good or excellent.

Most schools strongly agreed that the training / workshop was relevant to their setting.

Most schools agreed that the trainers were knowledgeable on the topics in question.

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Vignette 1 – *Jacob*

Context

- 15 year old boy
- Adopted-early trauma and attachment difficulties
- Known to CAMHS for a number of years – but inactive
- Moved school after bullying in the old school
- Relationship between school and parents was strained
- Risk taking behavior- self harming, running away, challenging staff

Intervention

- Partnership working
- Training for staff
- Reflective practice

Outcome

- Improved communication between parents and school
- CAMHS actively involved
- Reduction in risk
- Increase in staff capacity in responding to the presenting needs
- Child remained in mainstream and supported to transition to college

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Vignette 2 – *Primary School*

Context

- Primary school in special measures.
- Group of year 6 children who were causing disruption and were at risk of exclusion
- Staff in the school felt the children were disrupting the working environment
- Parents felt let down by the school who had had significant changes of staff
- Request from the Executive Head for intervention – limited funds

Intervention

- Work with the parents/carers
- Work with the whole staff including training
- work with core staff to set up a nurture group

Outcome

- Children supported to remain in school
- Parents more positive about their child's learning
- Increase in staff capacity to set boundaries and understand behaviour.
- School developed a new behaviour system/policy based on Gloucester House School behaviour materials and systems.

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Service Developments

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Educational Psychotherapy (EPT) as part of the GH Outreach Service

What is Educational Psychotherapy?

- A way of helping CYAP overcome their **emotional barriers to learning**.
- A way of assessing an individual's **engagement in and attitude towards** an **adult-directed task**.
- A **bridge** between **education** and **therapeutic exploration**.
- A way of improving a child's **emotional well-being, capacity to learn and engagement with/ attendance at school**.

UKCP
UK Council for Psychotherapy

Gloucester House

The Tavistock and Portman NHS Foundation Trust

How can Educational Psychotherapy be used in an Education Setting?

- **3 to 4 week Therapeutic Assessment periods for CYAPs in school**
- **Short or longer term 1:1 Educational Psychotherapy in schools**
- **Therapeutic groups**
- **Family groups**
- **Work with staff and other education practitioners:**

-Reflective spaces for staff

-Work discussion groups to help staff think about individual children who are struggling in class.

-Bespoke staff training, eg. “behaviour as a means of communication”.

UKCP UK Council for Psychotherapy

Gloucester House

The Tavistock and Portman NHS Foundation Trust

Service Level Agreements (SLA):

a behaviour support model to problem solve and capacity build within schools

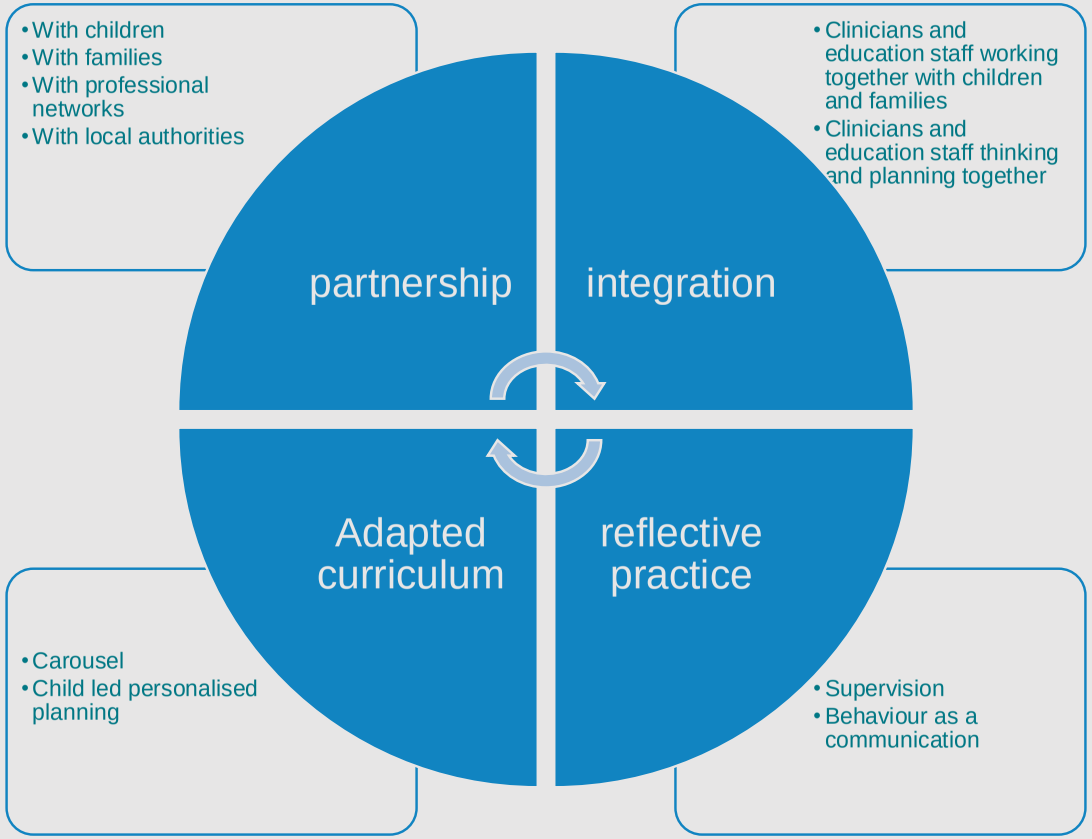
Suggested model of SLA with schools/LAs. Packages could include:

- Whole school behaviour audits and interventions around policy and practice
- Training in mental health and behaviour
- Reflective practice groups
- Support/consult to leadership teams
- Surgeries for staff working with children where they're 'stuck'
- Planning, monitoring and advising re support and interventions for individual children/groups of children
- We anticipate SLAs would cost approx. £3000 yearly
- Packages of support can be used in a planned way or used as problems arise (with an agreed structure around how much notice we would need)
- More support can be purchased in line with capacity of the GHOS.

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Foundations of our model, ‘Working Together for Learning and Development’



Gloucester House

The Tavistock and Portman NHS Foundation Trust

Gloucester House Outreach – Example SLA

Assessment and Support Package 1

- Free assessment of need
- 2 hours of senior consultation
- 10 hours of specialist intervention
- Report and follow up meeting

Cost: £3750

**Hours to be used flexibly as required*

Purchasing packages of support through our SLA model ensures access to specialist support as soon it's required.

Gloucester House

NHS
The Tavistock and Portman
NHS Foundation Trust

Parent: "Getting a holistic view of the situation, developing trusting and supportive relationships to be able to move things forward for the child in a positive way."

Whole school intervention: "The response was very efficient and this enabled any queries to be dealt with immediately as well as enabling the nurture group to be established robustly."

Member of support staff: "I used strategies and ideas with other children I work with ... very useful."

Child: "the teacher listened to me and I could tell him everything."

SENDCO: "Gloucester House Outreach input provided a personalised approach to the child and family circumstances which led to a positive impact on the child's social, emotional and mental health needs. They also supported the family in visits to schools and looking at provision that can meet needs."

Training evaluation comment: "The team provided excellent resources and were very knowledgeable."

ACTIVITY AND OUTCOME MONITORING REPORT

Academic Year
2018 – 2019

Contents

1) Introduction

This report presents measures and evaluates activity and outcomes for all children and young people at Gloucester House, The Tavistock Children's Day Unit over the last academic year Sept 2018 – July 2019.

The outcome figures themselves are not the only way the progress of each is monitored. Review meetings (to assess progress and make decisions about future care planning) attended by members of the professional network, the child and the family, are held regularly in Gloucester House. There are also reports provided for the annual reviews of Education, Health and Care Plans and an end of year education report on every child in July. All of these reports are submitted to the relevant Multi Agency Commissioning body, and give a more qualitative overview of an individual child's holistic progress and outcomes.

Summary of our educational and mental health outcome this year demonstrate that:

Children who have previously failed to thrive made academic and personal, social and emotional progress; e.g. 100% of children have exceeded expected progress rates over time at Gloucester House in one key area (English, Maths or PSD) and 95% exceeded expected rates over time in at least one aspect of Maths or English. 47% of children have made significant improvements in their reading age and 56% in their spelling age.

Children who attend our provision have complex Social Emotional and Mental Health (SEMH) needs. As part of our service all children have individual CAMHS care plans led and coordinated by one of the clinicians in our multi-disciplinary team. This care plan is reviewed termly and mental health outcome data is gathered annually through multiple measures and sources.

CGAS figures increased from baseline in 85% of our pupils meaning their general daily functioning and capacities have improved.

SDQ data shows that 'total difficulties' score reduced for 62 % of our pupils. The level of 'impact' on daily life for our parents and carers due to their child's complex needs has reduced significantly for 67 % of parent/carers – meaning day to day life is more stable.

Admission to discharge mental health data shows that our holistic integrated model has a significant positive impact on children's mental health over the course of their treatment with diagnostic indicators showing that:
75 % of pupils moved from **probable** to **unlikely** for Conduct difficulties and 50% progressed from **probable** to **unlikely** for 'any disorder'.

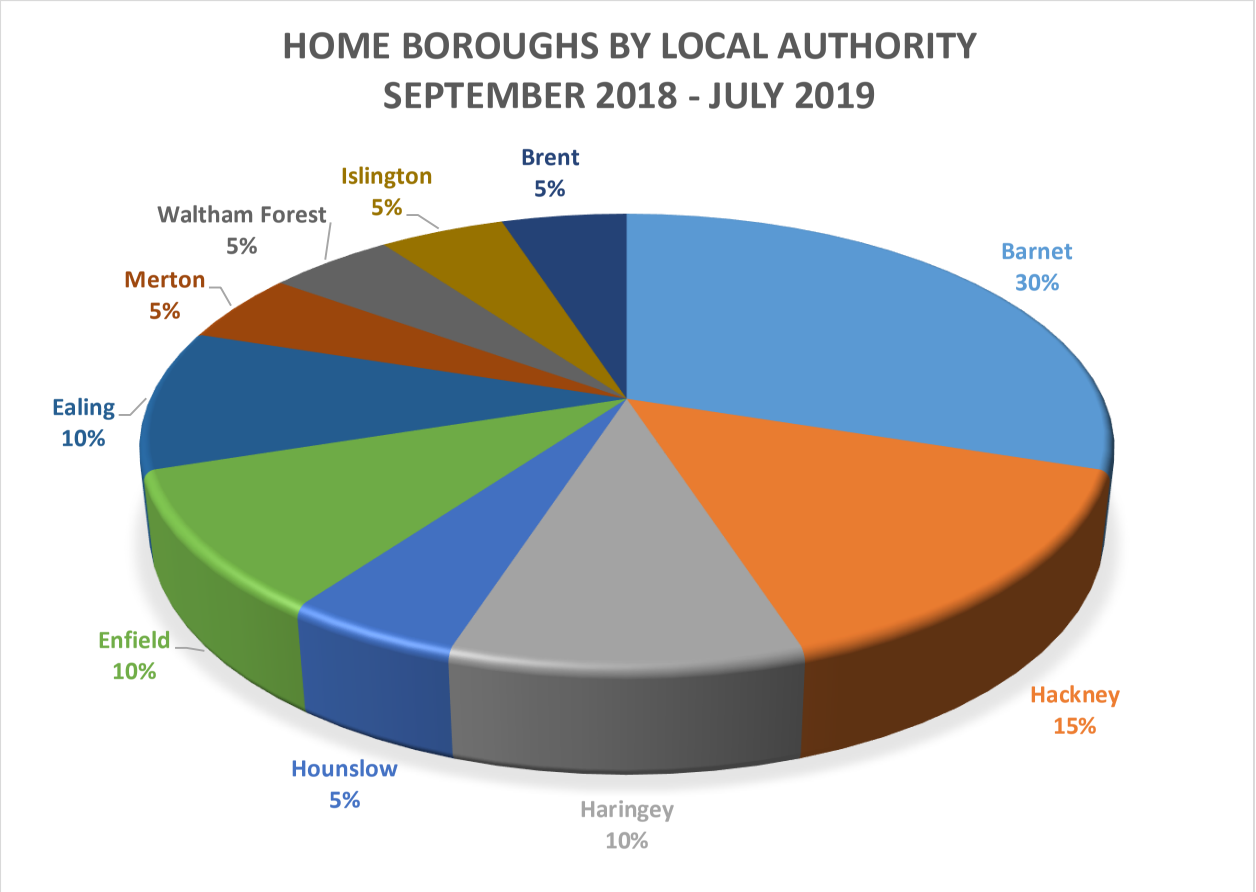
Our education and mental health outcomes suggest that the integrated model of Gloucester House continues to significantly reduce the attainment gap for these children and to change their future trajectories.

Feedback from stakeholders and service users about quality and efficacy of provision continues to be extremely positive.

2) Profile of children/young people

This section outlines the cohort on roll during the academic year of 2018-2019. In total we have had 20 children on roll over the academic year. A total of 5 children left by the end of the academic year; one in Autumn 2018, one in Spring 2019 and three who left at the end of the Summer 2019.

We had 4 new pupils who joined us over this same period; one in autumn 2018, two in spring 2019 and one in summer 2019.



In academic year 2018-2019 we received approximately 8 enquiries and 27 referrals. In the previous academic year of 2017-2018 we had approximately 11 enquiries and 21 referrals. This was a 28 % increase in referrals with approximately a third of the enquiries being received from new Local authorities interested in a placement at Gloucester house.

Pupil Profiles

- 100% of our learners have 1 or more of the following risk factors (Adverse Childhood Experiences) in their backgrounds – maltreatment including experiences of abuse and neglect; violence including exposure to sexual and/or domestic violence and domestic abuse; loss, bereavement or parental abandonment; dis or re-location including complex family breakdown, being looked after or adopted; adult responsibilities including caring for adults or siblings; parental mental health issues, adults experiencing drug & alcohol misuse in the household and poverty.
- 5 % of the 2018/19 cohort are 'looked after children'. A further 50% are adopted (i.e. 55% of the cohort live with people other than their birth parents).
- 40% have had some social care involvement (2018/19) and of these 63% were subject to a CIN Plan and 27% were subject to a safeguarding plan during 2018/19.
- 65% were known to community CAMHS upon referral.
- 100% of our learners have Education Health Care Plans (EHCPs)
- 100% of our learners have complex and severe Social Emotional and Mental Health (SEMH) difficulties.
- 78% of the children have language and communication difficulties either identified in their EHCPs or identified by us.
- 65% of the children have other specific learning needs or global delay identified in their EHCPs.
- 100% of the children have had a disrupted education many with at least two prior schools/placements -and often more before joining Gloucester house.
- 30% were out of school; 35% attended a PRU, tuition service or special school before joining Gloucester House; 35% came from a primary school where they had been attending part time (often less than 50%), all separated from peers with 1:1 or 2:1 support.

3) Attendance

Expected outcome: Improved attendance, (both) at school, and at clinical appointments
Method of evidencing: School register

100% of the children have had a disrupted education many with at least two prior schools/placements before joining Gloucester house.

School Attendance Results

List of Pupil (non-identifiable marked)	Attendance Prior to Admission (percentage)	Autumn 2018 *(based on full time attendance)*	Spring 2019 *(based on full time attendance)*	Summer 2019 *(based on full time attendance)*	Average for 2018 – 19	Percentage change *(prior attendance compared to average attendance at Gloucester House)*
Pupil A	50% attendance in school until Feb 14 then out of school	85%	81%	61%	80%	+30%
Pupil B	Full time attendance in school: 100% (with full time 2:1 TA support separate from peers)	93%	91%	98%	94%	-6%
Pupil C	Out of school	92%	95%	93%	93%	+93%
Pupil D	Out of school	100%	91%	92%	95%	+95%
Pupil E	Out of School	97%	96%	86%	94%	+94%
Pupil F	Part time attendance in school: 95%	88%	95%	96%	93%	-2% (note previous figure based on part time attendance)
Pupil G	Attendance in school: 96%	93%	94%	13%	69%	-27%
Pupil H	Full time attendance PRU: % unknown	99%	99%	98	99%	99%
Pupil I	In school until April 2016 then on reduced timetable – approx. an hour a day: 64%	99%	93%	94%	95%	+30%
Pupil J	Out of school	85%	-	-	88%	+85%
Pupil K	Mainstream: part time 97%	93%	100%	90%	95%	-2% (note previous figure based on part time attendance)
Pupil L	PETTS: 97%	97%	99%	97%	98%	+1%
Pupil M	Full time attendance in SEMH school: 95%	94%	98%	94%	95%	No difference
Pupil N	Mainstream: Part time	100%	90%	98%	96%	No difference (note previous attendance part time)
Pupil O	Part time attendance in SEMH school: 30%	100%	90%	98%	96%	+66%
Pupil P	Out of school 2:1 tuition part time in community centre.	-	81%	93%	86%	-
Pupil Q	Mainstream: Half days timetabled of which attendance was 60%.	-	-	98%	-	+38%

Pupil R	**PRU – Part time attendance**	**-**	**-**	**91%**	**-**	**-**
Pupil S	**Out of school**	**-**	**-**	**-**	**-**	**-**

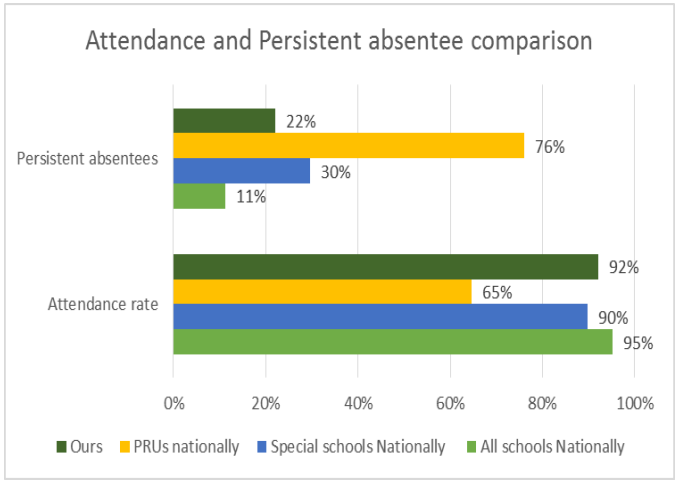
Commentary

Attendance rate improvement from baseline:

- 74% of pupils had above 90% attendance for the academic year; with 47% attending 95% or above.
- 20% of pupils had attendance that increased by 80% or upwards.

The majority of the children were either out of school on part time timetables before joining us and are now able to participate in fully in school life – achieving an average attendance rate of 92%.

Attendance



Attendance rate	
All schools Nationally	95.2%
Special schools Nationally	89.8%
PRUs nationally	64.7%
GLOUCESTER HOUSE	92%
Persistent absentees	
All schools Nationally	11.2%
Special schools Nationally	29.6%
PRUs nationally	76.1%
GLOUCESTER HOUSE	22%

Data from DFE Pupil absence in schools in England: 2017 to 2018

4) Education

Baseline data for this group illustrates that:

- 77% were below age related expectations in reading.
- 100% were below age related expectations in maths.
- 78% were below age related expectations in spoken language
- 100% were below age related expectations in writing
- 100% were well below age related expectations in personal and social development (PSD)

National curriculum levels progress:

The (nationally) expected rate of progress is based on how much of the national curriculum program of study (POS) they have attained. For example; If a child starts the year having completed 33% of the year 5 POS in reading and finishes the year having completed 33% of the year 6 POS they would have completed 1 year of the POS in 1 academic year they would have made expected progress.

Progress in 2018-19 compared to National Expectations

From teacher assessment and formal / standardised testing across English, Maths and Behaviour during 2018/19:

- 100% of children making nationally expected rates of progress or better in at least one area and 75% of children making nationally expected rates of progress or better in four or more areas, often from low starting point.
- 91% of children making nationally expected rates of progress or better in Reading.
- 77% of children making nationally expected rates of progress or just below in Number.
- Using the QCA behaviour scale, all children showed progress over the year.

Reading age data: Out of 14 children for whom we have more than one reading assessment 100% have improved their reading age; 6 making very good progress (more progress than the amount of time) and some above age related expectations; 2 making progress in line with age related expectations and 3 children have moved from UTA (unable to asses) to being accessible to the assessment process. Some of these progress rates are very rapid – for example 3 years in 10 months for 1 child; 4 years in 9 months for another; 4 years in 1 year for another.

Spelling age data: Out of 14 children for whom we had more than 1 spelling assessment 100% have improved their spelling age; 5 making very good progress (more progress than the amount of time) and some above age related expectations and 1 has made progress in line with age related expectations; 2 children have moved from UTA to being accessible to the assessment process. Some of these progress rates are very rapid e.g. two of 2 years progress in a year and some accumulate over time e.g. one of 4 years in 2 years.

SATs: we had two children who were Year 6 this academic year, Both of these children were achieving significantly under age related expectations, so we didn't enter any children for SATs this year.

Summary:

Progress from baseline indicates that despite academic underachievement on entry and significant barriers to learning we are able to positively impact both behaviour for learning and pupils academic progress over time.

Achievement for many is good and for some rapid when compared to baseline or prior achievement levels/rates of progress. This demonstrates growth in children's knowledge and improving attitudes to learning from low starting points.

For some children there are periods when academic progress plateaus or even deteriorates. This is to be expected in a therapeutic context and losses are made up and exceeded for most of the children.

We make outstanding progress in personal and social development.

Gloucester House as an intervention service, reduces attainment gaps and gives value for money over time, at least matching and at times exceeding national average progress rate expectations.

5) MEASURES OF MENTAL HEALTH OUTCOME DATA

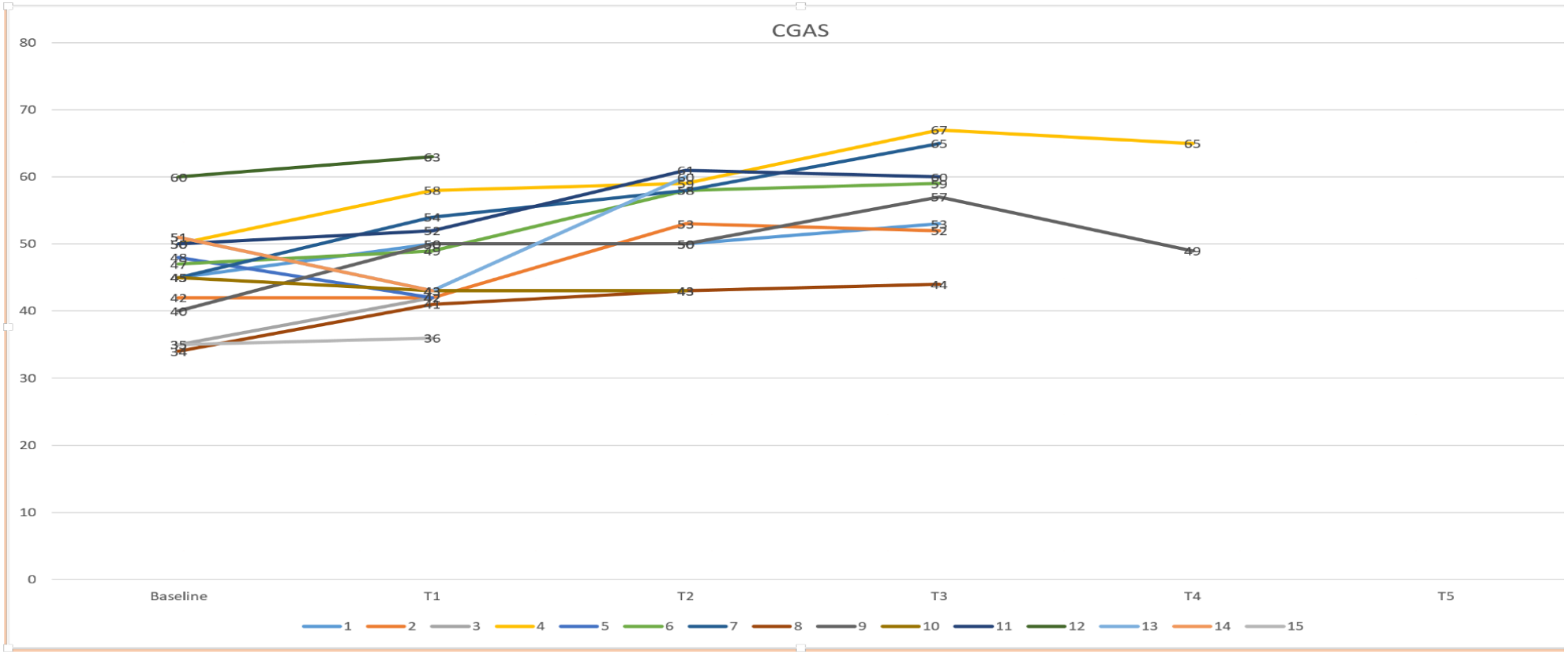
As an integrated special education and specialist CAMHS provision – in addition to measuring academic and behavioral data we also measure mental health outcomes to evaluate progress. The measures we use aim to capture a holistic perspective from clinical/education team, parents/carers and self (aged >11yrs).

For this cohort we were able to evaluate data from 15.

CGAS; joint assessed by class team (teacher, Therapeutic Support Worker, Progress Support workers), case co-ordinator (clinician) and therapist (if applicable)

CGAS (Children's Global Assessment Scale 0 -100) used by mental health clinicians to rate the general functioning of children under the age of 18.

An increase in the CGAS figure indicates an improvement in general functioning.



Pupils with at least 2 measures of CGAS (15)

CGAS figures increased from baseline in 85% of GH pupils with an average increase of 10 **meaning for these pupils their general functioning has improved.**

SDQ Data (17)

The Strengths and Difficulties Questionnaire (SDQ) is an emotional and behavioural screening questionnaire for children and young people. The tool can capture the perspective of children and young people, their parents and teachers. The 25 items in the SDQ comprise 5 scales of 5 items each. The sub scales include:
1) Emotional symptoms 2) Conduct problems 3) Hyperactivity/inattention 4) Peer relationships problems 5) Prosocial behaviour

The SDQ can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening. (Child Outcomes Research Consortium CORC)

SDQ data: (Parent/Carer)

The **total difficulties** score reduced for 62 % of our pupils.

The **impact** score reduced for 67 % of parent/carers, for 20% it remained stable and for 13 % the impact increased. This measures the overall day to day distress and impact for the family.

In relation to **key diagnostic indicators**:

CONDUCT

- At baseline 80% of parents/carers rated their child as PROBABLE for conduct difficulties. This was reduced by 27% to 53 % at most recent measure.
- 13% rated their child as POSSIBLE at baseline – this remained at 13 % of the cohort (but not with the same pupils)
- The number of children rated as UNLIKLEY (and so not presenting with conduct difficulties) increased from 7% to 34 % - a 27% increase.

EMOTIONAL

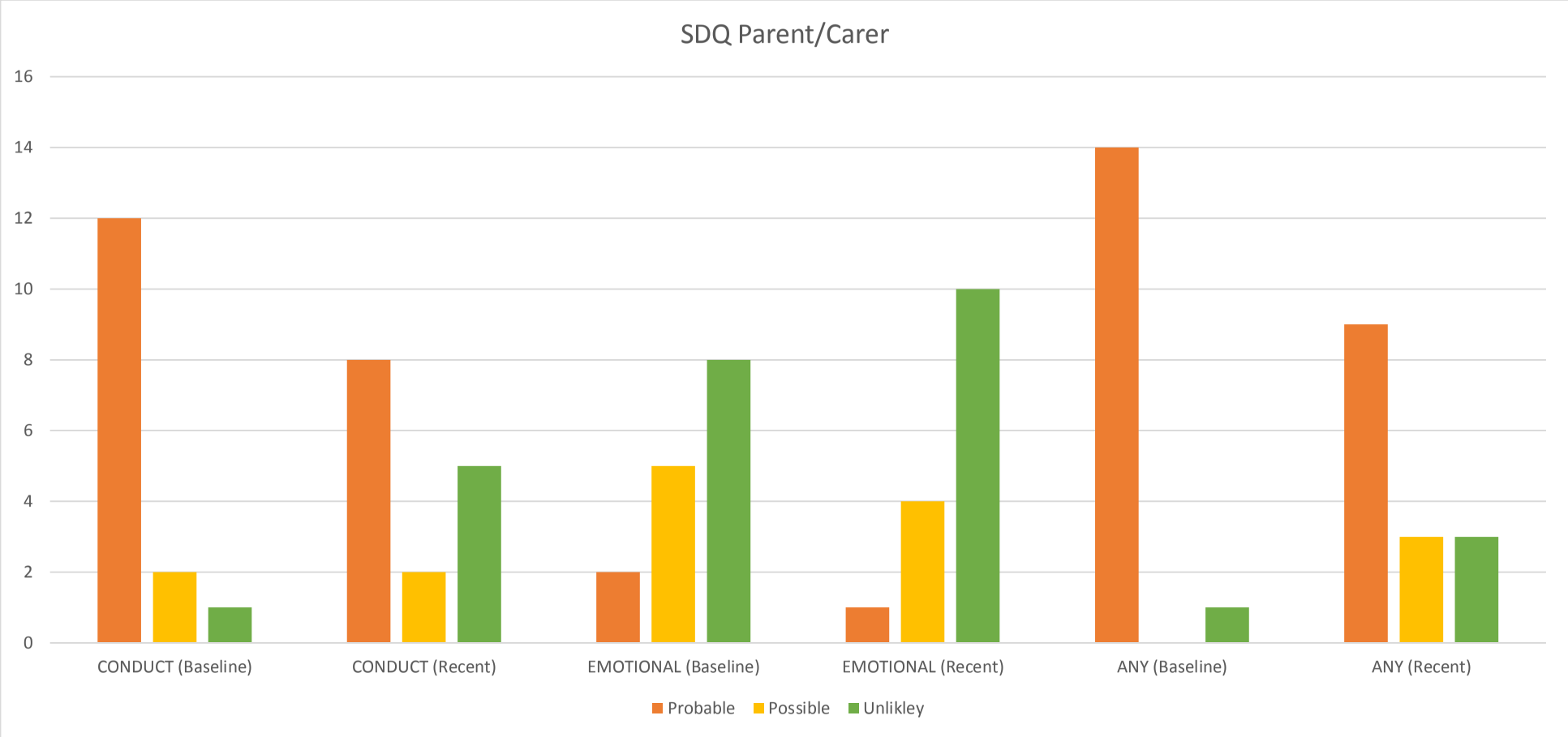
- At baseline 13% of parents/carers rated their child as PROBABLE for emotional difficulties. This was reduced to 7% at most recent measure.
- 34% rated their child as POSSIBLE. This reduced to 27% at most recent measure.
- The number of children rated as UNLIKLEY (as so not presenting with emotional disturbance) increased from 53 % to 67 %.

It is noticeable from the data that baseline ratings from both parents/carers and teachers in the area of ‘emotional’ difficulties are lower than one might expect. On reflection, this seems to highlight that for our client group their ‘conduct’ type difficulties can overshadow their underlying emotional needs or vulnerabilities. This is an important observation for us to consider during assessment and ongoing work with families, but also with staff.

Our view is that emotional needs/difficulties are in fact higher upon entry but are expressed or dominated by externalising ‘conduct’ type responses. This suggests that the emotional progress in this area is could be more significant that it appears.

ANY

- At baseline 93 % of the pupils were rated as PROBABALE for ‘any’ mental health diagnostic indicator. The remaining 7 % were UNLIKLEY.
- At most recent measure PROBABALE has reduced by 33% to 60 %, with 20% POSSIBLE and 20% now in the UNLIKLEY category.



SDQ (TEACHER)

CONDUCT

- At baseline teacher rated data placed 75 % in the PROBABLE category, 17% in the POSSIBLE and 8 % in the UNLIKLEY.
- At most recent measure there were 50% in PROBABALE (a 25% reduction), 42% in POSSIBLE and 8% rated as UNLIKELY.

EMOTIONAL

- At baseline 25% PROBABLE, 42% POSSIBLE and 33% UNLIKELY.
- At most recent measure: 8% were rated as PROBABLE (a 17 % reduction), 25% were POSSIBLE (a 17% reduction) and 67% UNLIKLEY (a 34% increase)

Admission to Discharge Overview:

4 pupils were clinically discharged in this period.

- 75% showed an increase in **CGAS** scores (which indicates general improvement in day to day functioning).

Diagnostic indicators (Parent/Carer):

- For one pupil ranges remained stable.
- For the other **75 %** all moved from **PROBABALE to UNLIKLEY for CONDUCT difficulties.** This is remarkable progress over time.
- 50% moved from PROBABLE to UNLIKLEY for any disorder and 25 % moved from PROBABLE to POSSIBLE.

Again this data supports that over time the Gloucester House model has a significant positive impact on children's mental health and wellbeing. There are particularly good outcomes in relation to on Conduct Type presentations and emotional disturbance. This is strong evidence of our impact particularly bearing in mind the number of adverse experiences our children have encountered.

In evaluating and dissecting this data it is interesting that baseline ratings from both parents/carers and teachers in the area of 'emotional' difficulties are lower than one might expect. On reflection, this seems to highlight that for our client group their 'conduct' type difficulties can over shadow their underlying emotional needs or vulnerabilities. This will be an important observation for us to consider during assessment and ongoing work with families but also with our staff.

There is the question as to whether emotional needs/difficulties are in fact be higher upon entry but are expressed or dominated by externalizing 'conduct' type responses. It may be that if we can more accurately capture this 'emotional' baseline then progress in this area could be even more pronounced that it appears.

6. GOAL-BASED MEASURES

Expected outcome: Behavioural improvements including a decrease in anti-social behaviours, increase in pro-social functioning, improved executive functioning, development of age appropriate independence skills (in both learning and life skills), improvements in emotional regulation/emotional literacy etc
Method of evidencing – see below

- This outcome measure involves using data from Goal Based Measures. Goals are set termly with each individual child and tailored to their particular needs and difficulties. Goal Based Measures are assessed and re-set at the beginning of each term. 3-4 goals are set, inked with education, mental health, and home/school. They are set jointly by the child, their parent/carers, teacher and case co-ordinator. They are then "scored" at the end of term. This provides a measure that is specific to each child and their individual development.

Here is an example of Goal Based Measures
Example
Goal 1, Education - I can check through my written work and correct any mistakes most of the time
Goal 2, SEMH - I will usually respect people's differences
Goal 3, Home/School linking My Mum and I can improve my bedtime routine and sleep pattern (most of the time)

We have added in success descriptors to make the target setting 'SMARTer'
Scoring involves a four point scale (2 = target met, 1 = target part-met, 0 = not met, -1 = if there is a deterioration). If a child scored 2 for all of their targets they would achieve 100%, if they scored 1 for all their targets they would score 50% etc.

Over the academic year 2018 – 2019

- Total of ICP targets met or partially met – 81%
- 63% of children had fully met over 66% of their targets in 18-19.
- No child had more than 1 target not met in the year

"*Gloucester House is outstanding at providing a great balance of meeting my child's SEMH needs and his academic targets. Any school is only ever as good as the staff and the staff are incredibly skilled and gifted with vocational attitudes" comment from parent questionnaire"*

7. Exit data:

Of the four leavers over the year 2 transitioned to special schools for learning, one transitioned to day SEMH and one to residential.

Of the two leavers at the end of the year the academic data available indicates:

Maths: both children close to, at and above expected rates of progress across the different areas of the subject.
Reading: both above expected rates of progress
Writing: One below and one above expected rates of progress

8. Service User Feedback

ESQ - Experience of Service Data 2018 – 2019 (gathered by case coordinators on discharge from parents/carers and service users)

What was really good about your care?

Parent/Carer
"GH worked with me and my son to get to know us well."

"They took the time to get to know and understand my daughter, for me she wasn't just another number and they understood that."

"My daughter has excelled due to this service. Many more services like this are needed."

Pupil
"Talking to adults about difficult feelings. The boundaries even though I hate to say it."

"Kids have been very supportive."

"It was really helpful. Helped me with talking about my feelings and with children who have the same sort of difficulties."

Was there anything you didn't like or needs improving?

Parent / Carer
"Some of the teaching is not always the right teaching at the right time. A school year is a long time and no change in between can leave children in the wrong class.
The meetings are always at the schools convenience and there was little flexibility."

Pupil
"I don't like recovery time being in a separate room. I think the classes should be clearly separated by age. I think holding should be the last resort."

Partner Agency Feedback

‘The service has had a holistic approach in managing the pupil concerned, and the input of the service has been very significant in the positive progress made by the pupil. The pupil presented with complex challenges, and periodically needed intensive support, but this was consistently met by the service.

With regards to our service user, the input was flexible, and responsive to his specific needs.
We were very satisfied with the service.’

(Fostering Social Worker Barnet)

‘The collaborative stance that Case Co-ordinator has taken has been so helpful. I don’t think we would have been able to continue a joint therapeutic intervention without it.
I also think the option and availability of intensive psychotherapy has been fantastic.

In an ideal world there would be a second (or more) Gloucester House available in different boroughs in London. At the moment, there is not enough of this provision available and so my patient (and their family) are having to travel too far.’

(Hackney CAMHS)

9. Gloucester House School based Questionnaire

Views of parents/carers about the school and its provision?

Parents/ Carers have positive views of the provision. This is evidenced by questionnaires. (One set administered in September 18 the second in June 19)

The high attendance rate we have for parents/carers at individual meetings, group meetings, celebration days demonstrates their appreciation of our work and their involvement in the life of Gloucester House. 100% of parent/carers attended at least one of the parents' days during the year. 100% of parents/ families are engaged and attending parent/family work meetings.
From the parents/carers who completed questionnaire. The majority of parents/carers scored the statements in either the agree and strongly agree categories.

Particular highlights in last year were:

- 100% of parents / carers felt Gloucester House informs parents/carers of topics being taught.
- 100% of parents / carers felt comfortable about approaching Gloucester House with questions, a problem or a complaint.
- 93% of parents / carers felt:
    - well informed by Gloucester House staff
    - bullying and other incidents are dealt with well at Gloucester House.
    - teaching is good at Gloucester House
    - Gloucester House helps my child manage and reflect on their behaviour
    - Staff treat my child fairly
    - There is a good range of activities that my child finds interesting and enjoyable
    - I find the daily target sheets helpful
    - Staff encourage my child to become mature and independent
    - Gloucester House seeks the views of parents/carers and takes account of their suggestions and concerns

Comments included:
“We value all the work of all staff at Gloucester house…it shows in my child’s progress”

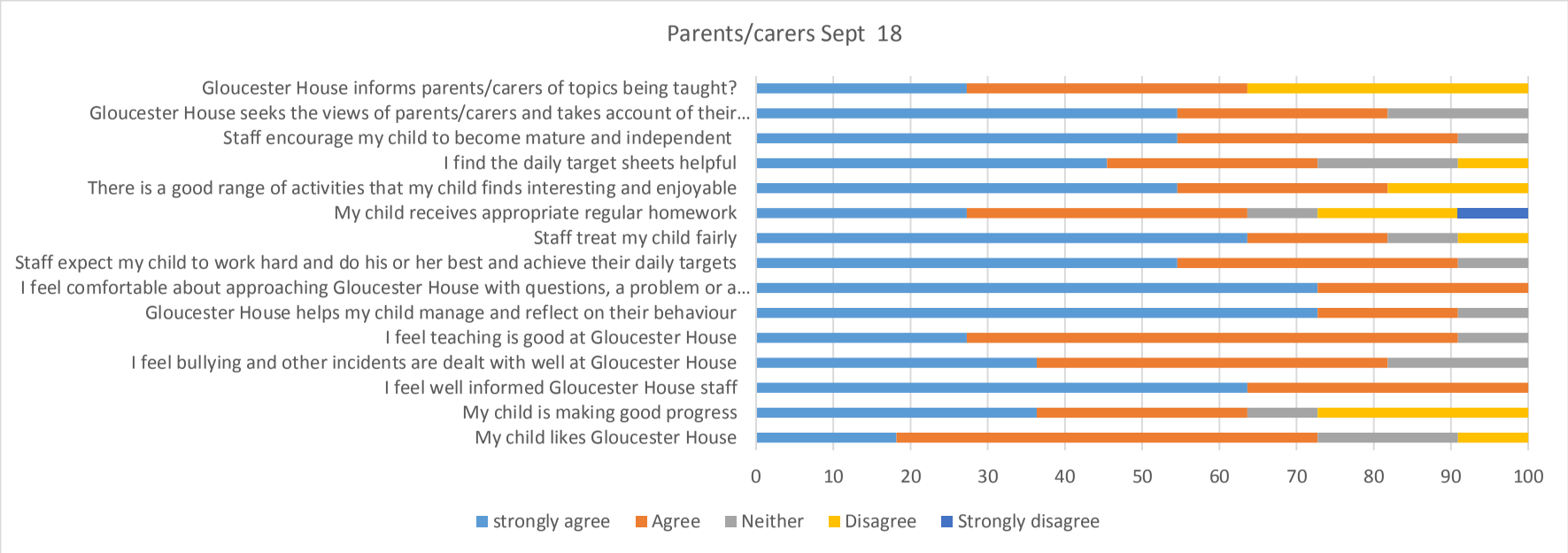
“We feel that Gloucester house provides a safe and nurturing environment where our child makes good progress and enjoys his time at school”

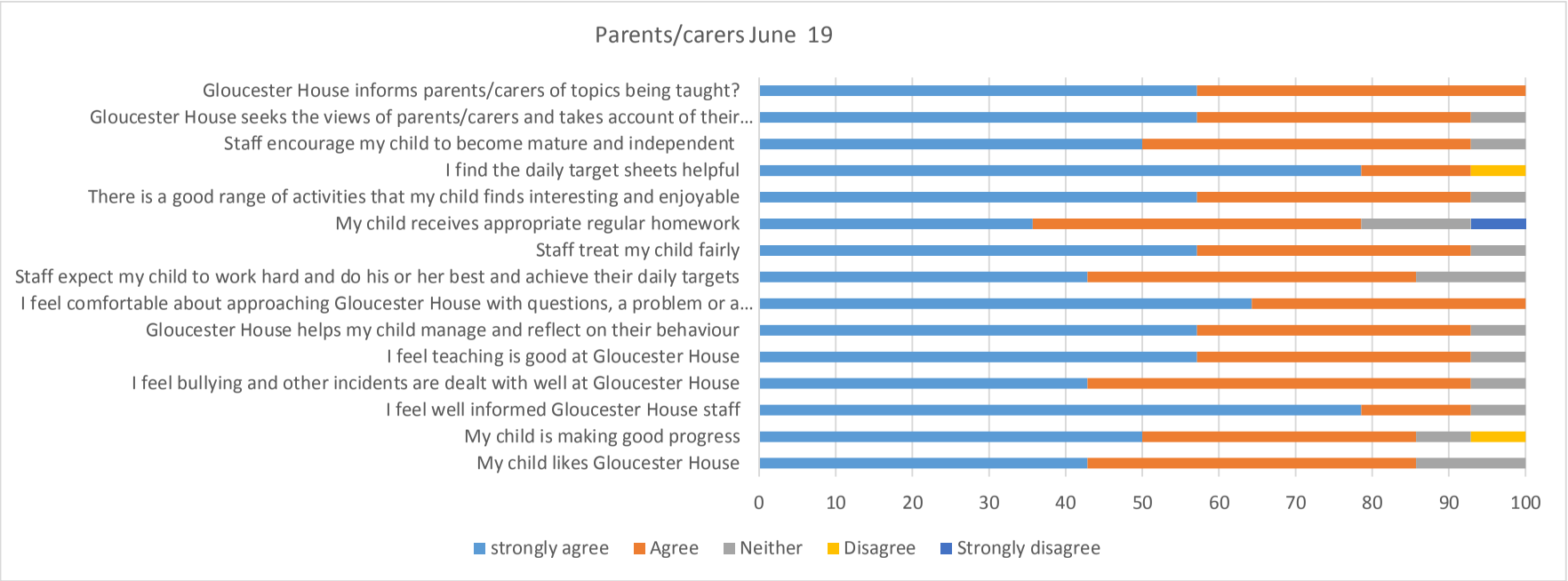
Areas of focus:
A minority of parents / carers neither agreed or disagreed with the statements

- My child is making good progress

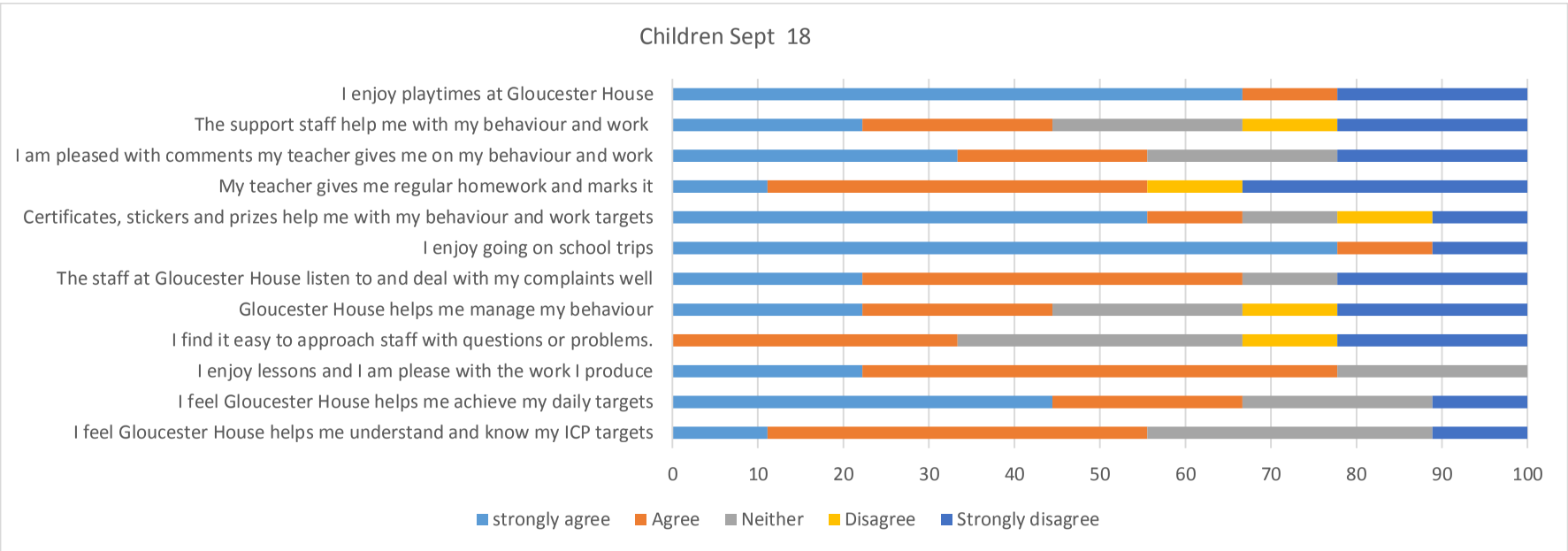
[4 parents in Sept dropping to 2 parents in June: Neither (agreed or disagreed) or disagree – ACTION Discussion in target setting meetings & possible future session with parents about what good progress would look like – feed into new assessment system / policy? SDP?]

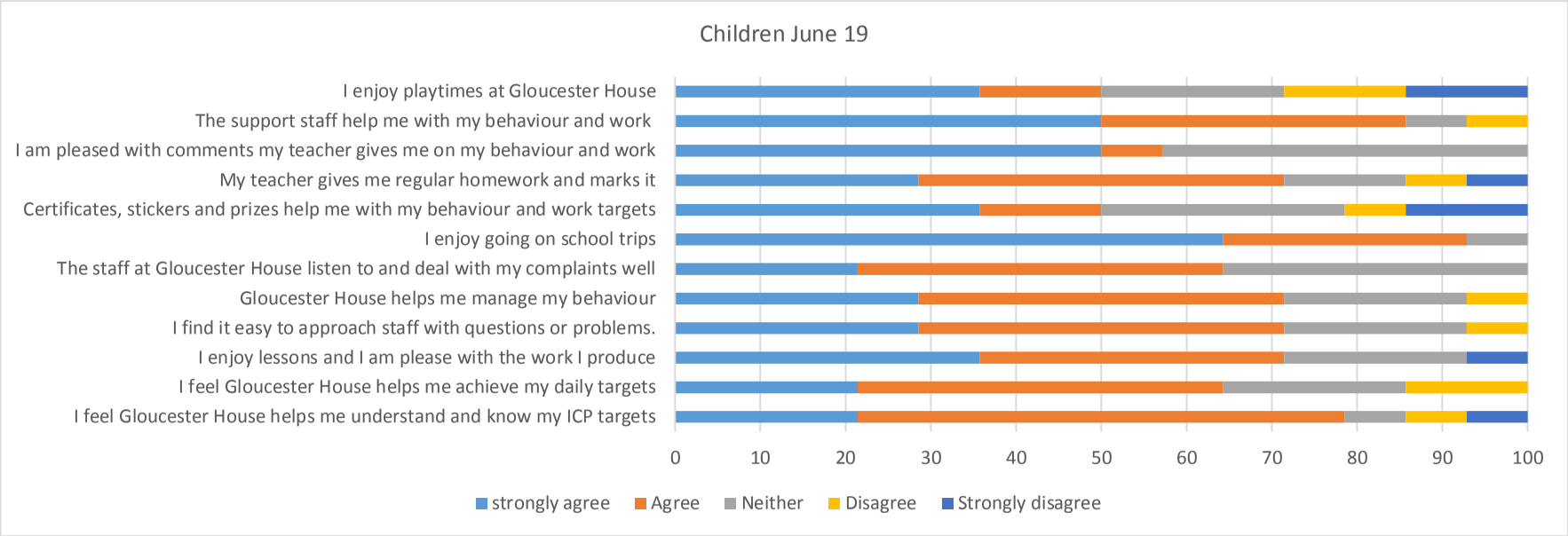
- My child receives appropriate regular homework
  [4 parents in Sept dropping to 3 parents in June: Neither (agreed or disagreed) or disagree - ACTION Discussion in target setting meetings, communication issue raised with teachers and case co-ordinators, use of Parent mail to ensure parents informed]
- Gloucester House informs parents/carers of topics being taught?
  [4 parents in Sept dropping to 0 parents in June: Neither (agreed or disagreed) or disagree – ACTION Discussion in target setting meetings, communication issue raised with teachers and case coordinators





Children's Questionnaires





Questionnaire data:

Some of the highlights in the children's responses were:

- 67% felt that Gloucester house helped them achieve their daily targets.
- 78% felt that they enjoy lessons and were pleased with the work they produce
- 78% felt that enjoy playtimes at Gloucester House
- 79% said they feel Gloucester House helps them understand and know their ICP targets
- 71% felt that their teacher gave them regular homework and marks it
- 93% felt that they enjoy going on school trips

10) Summary

Overall the data demonstrates that children and young people who have previously failed to thrive make academic, personal, social and emotional progress at Gloucester House. The school continues to significantly reduce the attainment gap for these children, many of whom have levels of learning significantly below age-related expectations at baseline and have experienced numerous adverse childhood experiences.

Feedback from service users and commissioners about quality and efficacy of provision continues to be extremely positive.

The integrated model of education and mental health continues to be successful in achieving both short-term and longer-term progress for the children who come here. It also supports in building personal and familial resilience and wellbeing.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	26th November 2019

Recruitment and the Annual Student Survey

Executive Summary

Following discussion at the recent November Education Training Committee, it was requested that a fuller report on the outturn of our student recruitment cycle and the results of our Annual Student Survey be reported in more detail.

We have achieved the highest level of Y1 Student Enrolments and excellent participation rates and levels of student satisfaction. The survey summary report is included as a separate document (Appendix 1) for reference.

This reflects the hard work and perseverance of our student recruitment and marketing team as well as course leads and teaching staff. Portfolio Managers and members of the DET Training Executive have been very engaged in achieving these outcomes. It is also a reflection of the improvement in our marketing and the understanding of the market as well as better processes.

The report also comments on the positive achievements in increasing the diversity of our student group with more granular analysis by course/portfolio coming to the February 2020 Education & Training Committee.

Recommendation to the [Board / Council]

Members of the Board are asked to note this paper.

Trust strategic objectives supported by this paper

7c: Extend existing and develop new services to respond to changing demand / new opportunities, including, where appropriate, the use of technology / 9: Develop the Trust's position in national and transnational education including the launch of a Digital Academy 14: Continue to meet regulatory standards with QAA / 16: Meet our Control Total for 2018/2019

Author	Responsible Executive Director
Brian Rock Director of Education and Training/Dean of Postgraduate Studies	Brian Rock Director of Education and Training/Dean of Postgraduate Studies

Recruitment and the Annual Student Survey

1. Introduction

1.1. The Education & Training Committee received updates on student recruitment for 19/20 and the Annual Student Survey 2018-19 at its meeting on 7th November 2019.

1.2. The Director of Education & Training/Dean of Postgraduate Studies has been asked to present this paper to update the Board of Directors on the outcome of the Annual Student Survey for 2018-19 and to report on the recruitment cycle for academic year 2019-20.

2. Recruitment Cycle 2019-20

2.1. I am pleased to be able to report an extremely positive outcome in relation to our student recruitment for AY 19/20. We have achieved a nearly 13% increase in the number of Y1 student enrolments to 625 students who are studying at the Tavistock Centre and alternative centres from this point last year. The percentage growth in student numbers is even greater given the additional attrition of students beyond this point last year. We do not expect there to be nearly as much attrition this year.

2.2. This has been achieved on a slightly lower number of applications from the previous year (1005 v 1022). The conversion rate has increased from 49.6% (AY18/19) to 56.6% (AY19/20) – not including Associate Centres. There are 30 Y1 students studying at Associate Centres.

2.3. We have also recruited 15 social work students to a new course running in Hertfordshire this year: Working with complex needs in contemporary social work practice.

2.4. This is not included in the final numbers because, while a long course, it is essentially running as a bespoke course this year. Next year we will be opening it out and promoting it alongside other courses.

2.5. We are looking closely at the application to enrolment figures to establish the profile of students from BAME backgrounds and the LGBT community. A fuller report will be brought to the February 2020 Education & Training Committee.

Early indications is that we have achieved a six percent increase in students from more diverse groups.

2.6. With regard to students from the EU, from data for the last three recruitment cycles, while students declaring themselves as from the EU (people who have either just moved to the UK or who are coming to the UK specifically for the course) represent a small proportion of our Y1 student group (around 4%/22 students), we have seen a significant reduction by almost half in this current cycle (around 2%/12 students). We are now looking more closely at the numbers across specific portfolios and courses in terms of numbers and possible impact and mitigations.

2.7. We have far more EU students who are ordinarily resident here and, like overseas students who have lived here legally for more than 3 years, we would expect them to continue to be entitled to home fees.

2.8. Clearly the ongoing uncertainty around Brexit and the possibility of a no-deal is having an impact. I do not think this is necessarily an issue around fees but about the uncertainly in relation to the possible requirements for visas etc. The biggest issue at present is probably perception of the UK. Once (if?) Brexit happens any visa requirements could be a barrier, especially due to Home Office fees. I anticipate the sector re-adjusting in terms of overseas fees to continue to be competitive across Europe and the world.

2.9. Staff from the recruitment team to course teams have pulled together and worked hard on achieving a good outcome. There have been inevitable tensions around numbers and focus at points in the process though I would invite the ETC to show its appreciation for the tremendous effort that has been made.

2.10. This achievement also reflects the improvement in the quality of applications supported by better information to prospective students in the process and a more meticulous and diligent approach to conversion from application to enrolment.

2.11. There have been some courses that have not achieved the level of expected growth. We are examining how we might improve on recruitment for these courses in the next cycle; some courses are not running. However, most courses have met or exceeded target. My view is that we are reaching a ceiling in relation to the possible growth in students studying at the Tavistock Centre

and that further growth will be achieved through new provision.

2.12. The working group established with Essex to scope and develop possible new long course programmes for launch in AY 20/21 has been making progress on a new postgraduate course. The first programme in development is linked to Human Behaviour and Relationships in the Workplace, aimed at people stepping off undergraduate programmes in psychology, business studies, etc. who would be interested in further study aimed at preparing them for the world of work and enhancing their understanding and capacity to work effectively in organisations. We are confident that we are on track for launch in AY20/21 subject to positive responses by student / employer focus groups.

2.13. I am working with my team and others in the Trust to consider how we can promote new developments, more broadly. To my mind this will be as much a function of better processes in the organisation and DET to facilitate, as much as improving the 'conditions' for growth. Notwithstanding the pressures and service-specific requirements, I am optimistic about the benefit of greater synergies with the new divisional structure in clinical services.

3. Annual Student Survey 2018-19

3.1. The annual student survey, based on PTES and PRES, with additional Trust specific questions was carried out between 24/04/19-05/07/19. Please refer to the attached survey summary document.

3.2. There was a positive engagement with the survey and an increased participation (63%) by comparison to last year (59%).

3.3. New questions were introduced to survey student's experience in relation to well-being and equality. Branching questions were expanded in order to obtain more focused and granular information.

3.4. Positive outcomes have been noted, in particular an increase in overall satisfaction – 92% for overall satisfaction. The results indicate an above average level of satisfaction of Trust provision by comparison to the NSS, PTES and PRES.

3.5. It is significant to note that increased satisfaction has been achieved in relation to the experience of doctoral students. This has been a recurring theme and so it is pleasing to see a positive shift due to the number of actions

taken to make improvements. Other areas of significant improvement are noted in the report.

3.6. Areas for further improvement include support for students and aspects f operational management.

3.7. The Trust has implemented a multifaceted and integrated approach to the gathering of feedback, the creation and implementation of action plans, and communication with students and faculty.

3.8. A similar approach will be taken in response to this survey. However, it is anticipated that this year we will be able to achieve greater integration between the AGQA and L&T domains through a more co-ordinated approach between action- focused work streams.

3.9. Consideration needs to be given to the timing of the survey and the capacity to influence the experience of students in a timely manner. A recommendation has been made to introduce a mid-year 'flash' survey in order to increase our responsiveness to students.

4. Conclusions and Recommendations

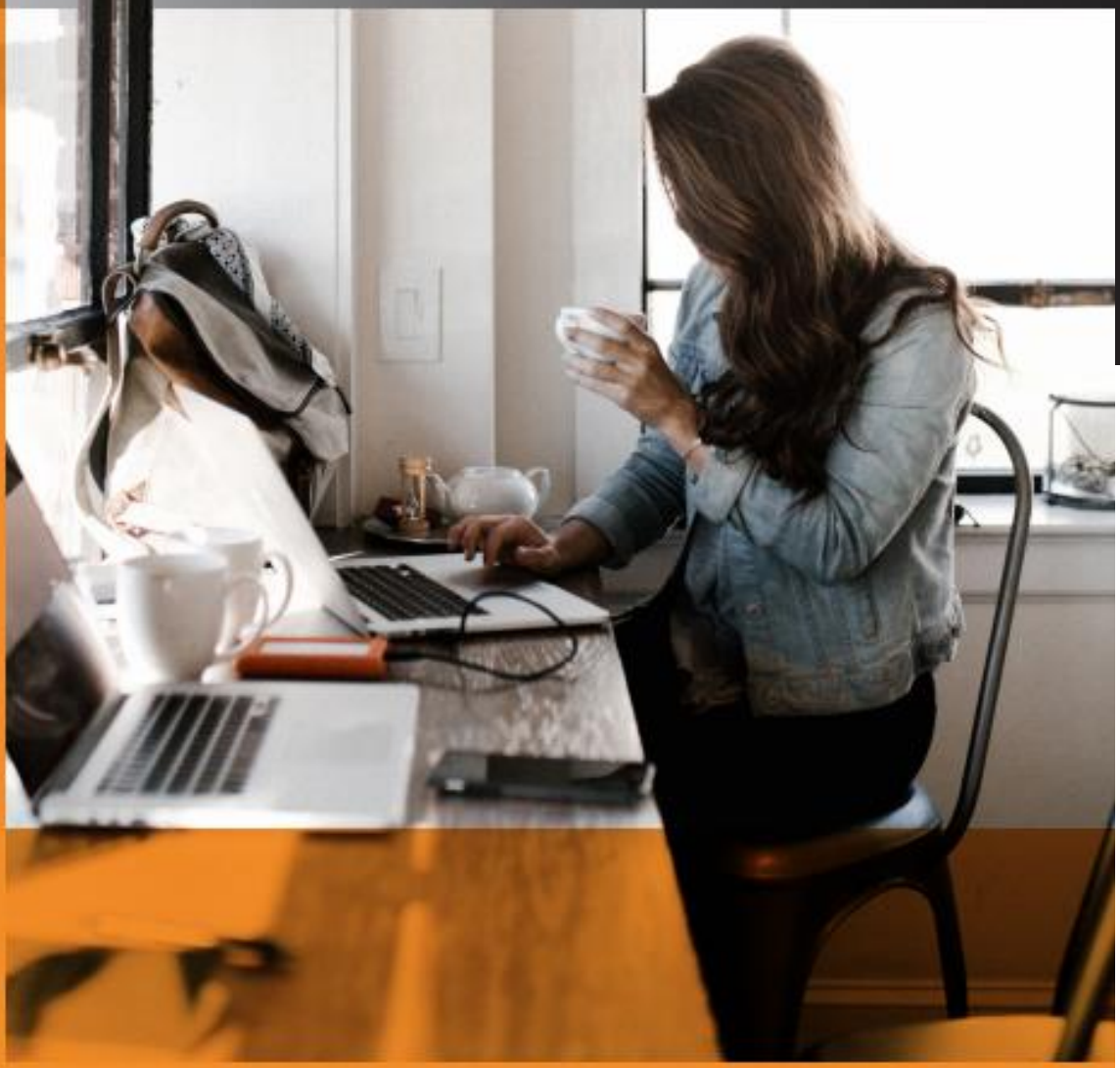
4.1. Members of the Board are asked to note the work of the recruitment team and course teams in achieving an increase in year 1 student numbers for academic year 2019-20.

4.2. Members of the Board are asked to note the engagement with the Annual Student Survey 2018-19 and the increased student satisfaction.

Brian Rock
Director of Education & Training/ Dean of Postgraduate Studies
November 2019

NHS
The Tavistock and Portman
NHS Foundation Trust

Tavistock and Portman
Annual Student Survey 2018-19
OVERVIEW REPORT



Your opinion matters

See taviport.co/studentsurvey

Innovation in mind

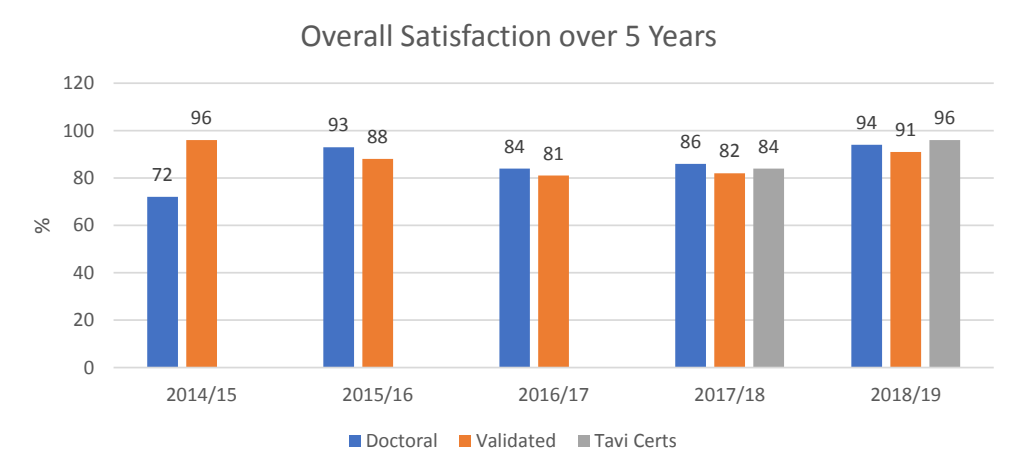
Contents

1. Executive Summary

1.1 Highlights

Over a 5-year period, overall satisfaction has retained relative stability. There was a dip in 2016/17 and 2017/18 but has picked back up to 92% overall in the 2018/19 academic year.

Figure 1: Overall Satisfaction of 5 years by type of delivery



Qualitative comments in response to the question 'Please comment on one thing that has been the most enjoyable or interesting on your course':

> *Impossible to choose just one thing! Meeting like minded people, having ideas challenged, learning and understanding more about working with children, feeling more competent in my work, discovering new ideas...*

1.2 Best performing sections

- Learning and Teaching: 95% (84% last year)
- Library Resources: 90% (82% last year)
- Professional Doc; thesis research and supervision: 85% (77% last year)
- Professional Doctorates (general): 82% (67% last year)
- Ethics: 82% (72% last year)
- Assessment and Marking: 80% (75% last year)

1.3 Sections for further consideration:

The sections which will be focussed on in section 5 of this report broadly fall into the following areas:

Student Experience (encompassing Communication; Organisation and Management; and Engagement)

This area is already identified for review. A project proposal was approved by Executive Training Committee in September 2019, to be led by the new Operations Director.

- Timetabling and room scheduling: 54%
- IT & Moodle Resources: 73% (In particular, Moodle: 68%)
- Organisation and Management: 73% (in particular, communication: 70%)
- *My Institution values and responds to my feedback* (62% (53% last year))

Student support

A significant body of work was carried out over the preceding year in relation to supporting Disabled Students, which is in the process of bedding down. The wider support network for students needs to be considered in the context of student support

- Student Support & Wellbeing: 62% (This is broken down into Student Wellbeing: 75%; English Language support: 40% ; and Disabled student support: 48%).
- Masters Dissertation: 72% (In particular, dissertation support: 60%)
- Advice and guidance for placements (65%)
- Support on placements (73% (64% last year))
- I am encouraged to discuss my future career development/options (59%)

Other outliers

- I have progressed in my career as a result of attending training here (59%)
- Wider research community (doctorates) (51% (40% last year))

Equality, Diversity and Inclusion
This is touched upon under Student Support, but there will be a separate report into this section of the survey.

1.4 Summary of Recommendations

Recommendation 1: Reduce the length of the survey

Recommendation 2: Identify areas of good practice in Organisation and Management, and Communication, to implement across the Trust as part of the Learning and Teaching Student Experience workstream and the communications project.

Recommendation 3: Find areas of good practice in Student Support (such as the library) to look at ways of incorporating this into the rest of the Trust.

Recommendation 4: Set up groups (akin to BAME and LGBTQ+ groups) for Disabled students, those on placements, and international students. Ensure that the skills training in the library is highlighted to those who are second-language-English speakers and those who are coming into Higher Education (HE) for the first time or after a long time out of HE.

Recommendation 5: Review or remove the question '*I have progressed in my career as a result of attending training here'* in the 2019/20 survey.

Recommendation 6: The Learning and Teaching Working Group for Research should continue their work on improving the research culture for doctoral students at the Trust (across all sites of delivery).

2. Introduction

2.1 Background

The Trust has run an annual internal survey in various forms since 2004. For this academic year (2018/19), the questions were largely based on the Postgraduate Taught Experience Survey (PTES) and the Postgraduate Research Experience Survey (PRES), both run nationally by Advance HE (formerly Higher Education Academy), to enable national benchmarking. In order to capture the unique nature of the Trust's programmes and their integral link to NHS clinical training, additional questions were included.

There is potentially a national postgraduate student survey, akin to the National Student Survey (NSS) being rolled out for all institutions registered with OfS, which is currently in consultation. The themes and content areas of the proposed survey were also considered as part of the consultation on the questions, a separate section on Information which draws together existing questions has been identified.

2.2 Survey questions

The full survey questions may be found in Appendix 1

Although there were minimal changes to the questions asked in the previous survey published in the 2017-18 academic year, to allow for analysis of trends, there have been some additional questions with new sections added; and some questions have been moved to different sections or had branching added.

Figure 2: student Survey sections 2018-19

Section	Number of questions	Type of questions
Equalities (Ethos) [NEW]	4	
Equalities (Harassment & Bullying) [NEW]	5	
Equalities (Protected Characteristics) [NEW]	6	
Room Timetabling [NEW]	3	
Learning and Teaching	5	Branching questions
Engagement	5	
Assessment and Feedback	4	Branching questions
Information [NEW]	3	
Knowledge Transfer and Employability	4	
Resources and Services	5	
Support Services: Disabilities	2	Branching questions
Support Services: English Language	1	Branching questions

Student Support and Wellbeing: All students	2	Branching questions
Dissertations	4	Branching questions
Organisation and Management	5	
Professional Doctorates	9	Branching questions
Prof Docs: Thesis, Research & Supervision	12	Branching questions
Ethical Approval	3	Branching questions
Placements	2	Branching questions
Observations	2	Branching questions
Overall Satisfaction	4	
Reasons for survey completion	1	

2.2.3 As depicted in the table above, most of the categories have branching questions so that students who have not experienced that aspect of the learning experience (for example placements) will not be asked questions relating to it.

2.2.4 Most questions are in the form of a statement, and students are asked to tick 'definitely agree', 'mostly agree', 'neither agree nor disagree', 'mostly disagree', 'definitely disagree', and 'not applicable' in response to each statement (the Likert scale). In addition, students were asked optional qualitative comments and a number of multiple-choice questions (for example, their course title).

2.2.5 Apart from the branching questions and qualitative comments, all questions were compulsory.

2.3 Analysis Methodology

2.3.1 In line with standard practice (National Student Survey, PTES and PRES), 'definitely agree' and 'mostly agree' responses are combined to calculate an overall positive (or 'agree') response to each statement. These calculations remove any non-responders and N/A answers.

2.3.2 In line with the previous year, partial responses which were completed up to the end of the Engagement section were included in the quantitative analysis. Qualitative data from these responses are not included as the students did not formally submit the survey.

3. Response Rate and Distribution

3.1 Response Rate

Figure 3: Response Rates over 5 years, Tavistock & Portman Surveys

2013/14	2014/15		2015/16	2016/17	2017/18	2018/19
Internal Survey	Postgraduate Research Experience Survey	Internal Survey	Internal Survey	Internal Survey	Internal Survey	Internal Survey
Hard copy	Online	Hard copy	Online	Online	Online	Online
59%	53%	57%	26%	49%	59%	63%

3.1.1 Factors which are likely to adversely affect the response rate are the length of the survey and the timing of the survey, being over the assessment submission period. Due to the design of the courses, assessments all tend to be due at the same time in the Summer Term. In order to get the best feedback, the survey must also fall in the summer term to enable students to comment on their entire year.

3.1.2 Both anecdotal evidence, and written comments in the report support the fact that the survey is too long. In the NSS survey, there are 23 core questions and then a number of additional questions which are chosen by the institution.

Qualitative comment from the student survey:

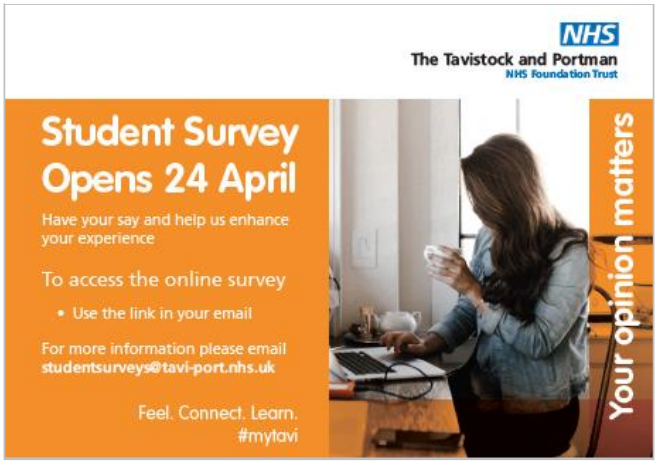
When will this survey end? Too long but will try and stay with it!?

3.1.2.1 The Tavistock survey has 10 core sections (Equalities, Learning & Teaching, Engagement, Assessment & Feedback, Information, Career, Resources & Services, Support & Wellbeing, Organisation & Management, and Overall Satisfaction). There are also several sections that only apply to certain groups of students and therefore only some students are asked questions in these sections: Room Timetabling, Masters Dissertation, Disability and English Language Support, Professional Doctorates (2 sections), Ethical Approval, Placements and Observations.

Recommendation 1: Reduce the length of the survey.

3.2 Marketing

Figure 4: Example of Collateral from Student Survey Marketing Campaign (Postcard)



3.2.1 A communication strategy was put in place as part of the survey planning. The following was put in place:

- Banners and Posters were put up around the building and provided electronically to national centres;
- Postcards put out in the Academic Hub, Café, Library and common rooms
- Weekly emails targeted at those students who had not completed the survey
- E-mail footers sent to all DET staff to add to their signatures
- Course packs were created with guidance for course leads on increasing response rates, a copy of the survey and postcards to hand out in classes
- A prize draw was also set up for students who completed the survey – for one of five £25 Amazon vouchers. Winners were drawn out of a tub by the Dean of Postgraduate Studies on the 10/09/2019 and vouchers emailed to winners.

3.3 Distribution

3.3.1 The survey ran for 10 weeks from the 24 April 2019 to the 5th July 2019. It was distributed online via *Smart Survey.* The survey was moved from *Survey Monkey* as *Smart Survey* was GDPR compliant and enabled tracking and targeted email campaigns meaning that solely students who had not completed the survey could be targeted.

3.3.2 All students who were on Tavistock Certificate courses (of at least one year in duration), and all validated course provision were invited to complete the survey. Students were invited to complete one survey for each course they were on.

4. Overall Satisfaction Analysis

4.1 Overall satisfaction

Qualitative comments in response to the question 'Please comment on one thing that has been the most enjoyable or interesting on your course':

Inclusive, positive and calming environment that stimulates reflection

Everything has been useful and interesting but the infant observation has been a unique experience that has taught me a great deal

The quality of the teaching is in all respects outstanding.

Very happy with the quality of teaching and resources at the Tavi. It is outstanding.

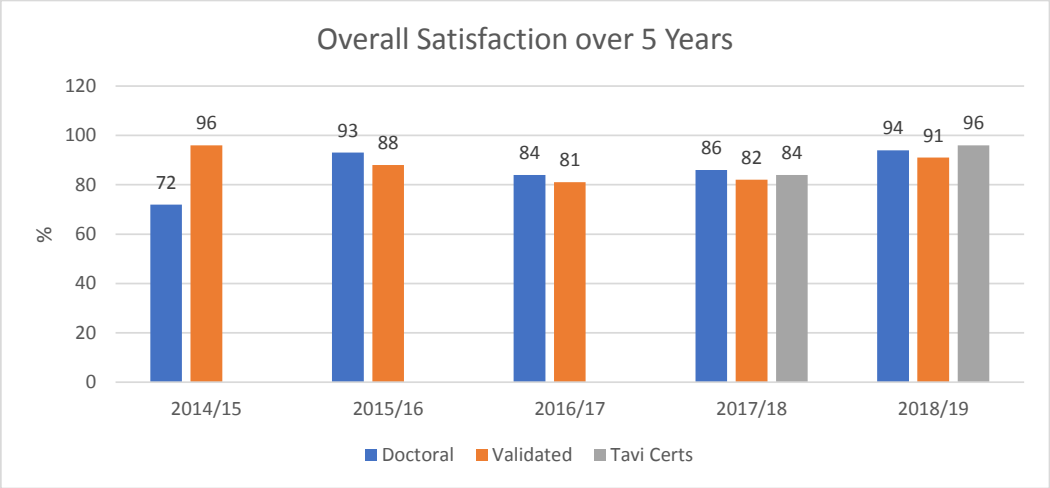
Provoking, interesting, integrated, just a fantastic experience.

4.1.1 In line with national surveys, the overall satisfaction is based on the 'agree' responses to the statement 'Overall, I am satisfied with the quality of the course' This question has remained consistent across previous Taught Postgraduate surveys and so direct comparison can be taken.

4.1.2 The headline overall satisfaction score of 92% breaks down into 94% for doctoral (research) students, 91% for level 6 and 7 (taught) students on validated programmes, and 96% for Tavistock Certificate courses (non-validated). Even though Doctoral and Tavistock Certificates achieve 94% and 96% respectively, because there are fewer students on these courses the overall satisfaction across all courses is 92%.

4.1.3 The satisfaction scores show a significant increase in comparison with last year. This is against a higher rate of participation compared to the previous year. It could be surmised that a higher response rate equals a higher satisfaction rate – the hypothesis being that content students are the least likely to complete the survey. It is true that in the first week of the survey, overall satisfaction was at 89%. However, the rate of satisfaction remained relatively stable in the low 90's in the last three weeks of the survey. In addition, in 2015/16 when the survey experienced a significant drop in response rate (26%) due to becoming solely online for the first time, the overall satisfaction for that year are still broadly in line with previous years.

Figure 5: Overall Satisfaction over 5 Years



4.1.4 The satisfaction rates over 5 years remain relatively stable – with a dip in 2016/17 and 2017/18. The other interesting thing to note is that the satisfaction across the different types of delivery (Tavistock certificates, validated and professional doctorates) are roughly consistent with one another. Doctoral students consistently display slightly higher satisfaction, apart from 2014/15 when doctoral students experienced significant issues regarding registration requirements and completion timelines. However, this is not statistically significant due to the difference in sample size between doctoral students and students across all courses.

4.1.5 For comparison with the wider sector, the Postgraduate Taught Experience Survey (PTES) gave 80% satisfaction, published October 2018, and the Postgraduate Research Experience Survey (PRES) gave 80% satisfaction, published October 2018. The National Student Survey (NSS) satisfaction (England) is 85% for part-time students.

4.2 Satisfaction by Section

4.2.1 Satisfaction by section is calculated by taking the mean average of all the responses which are on the Likert scale within each section (for example, the average of all responses to learning and teaching questions) (**Figure 6**).

4.2.2 The average of all the sections together is 78%. We can therefore take a general figure of 75% as a way of internally benchmarking performance across the sections of the survey.

4.2.2 Compared to the national benchmarks for these sections, the Trust performs well (**Figure 7**). This is using the latest dataset from the Postgraduate Taught Experience Survey (PTES).

4.2.2.1 In Learning and Teaching, the Trust performs significantly better (95% vs 82%), and in Assessment moderately better (80% vs 74%). Engagement, Organisation and Management, Resources and Services, and Information, are all the same as the sector averages or within a 3% tolerance. The dissertation section falls below the sector average at 72% vs 79%.

4.2.2.2 In the Dissertation section, there is one question statement which pulls the average for that section down. This question is:

> *I am happy with the support I have received for planning my dissertation from academic staff (topic selection, project outline, literature search etc)*

The satisfaction to this statement is 60%. Without it, the average for this section would be 76% which would be within the 3% tolerance margin when compared with the national benchmark, and would also be above the internal Trust benchmark of 75%. This question/statement is being reviewed in more detail under Section 5 this report.

Figure 6: Changing Satisfaction over 3 Years by Section

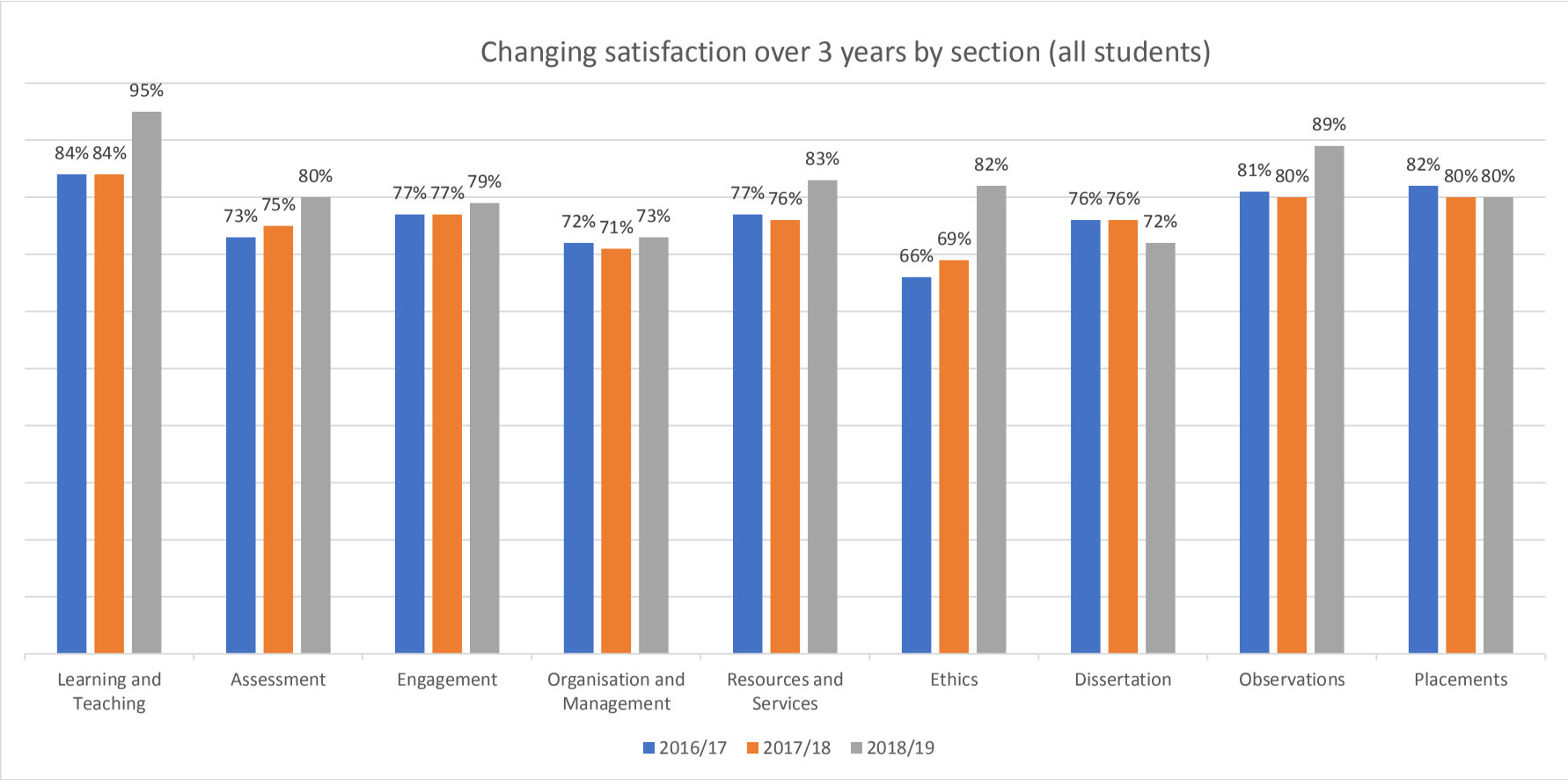
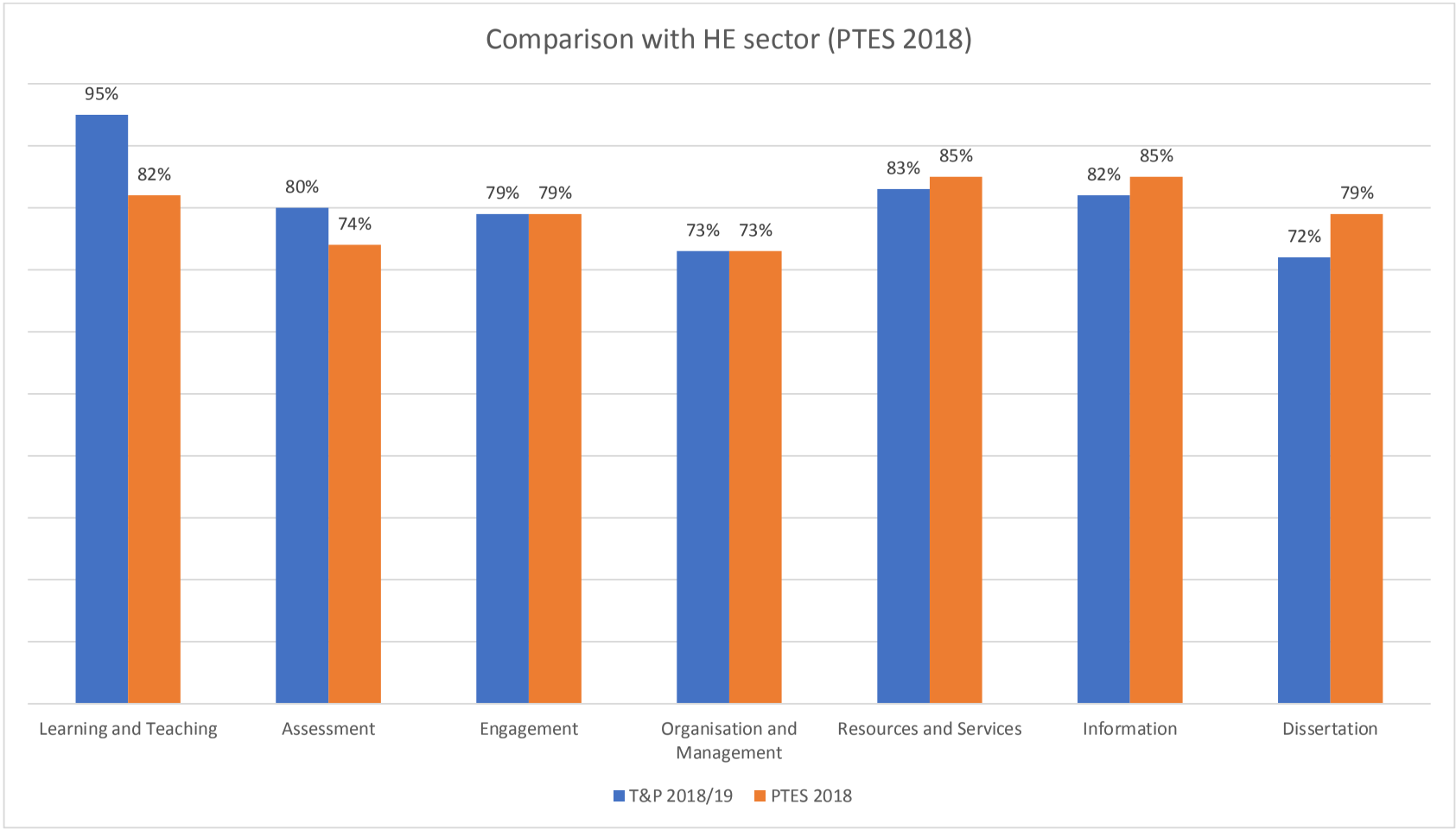
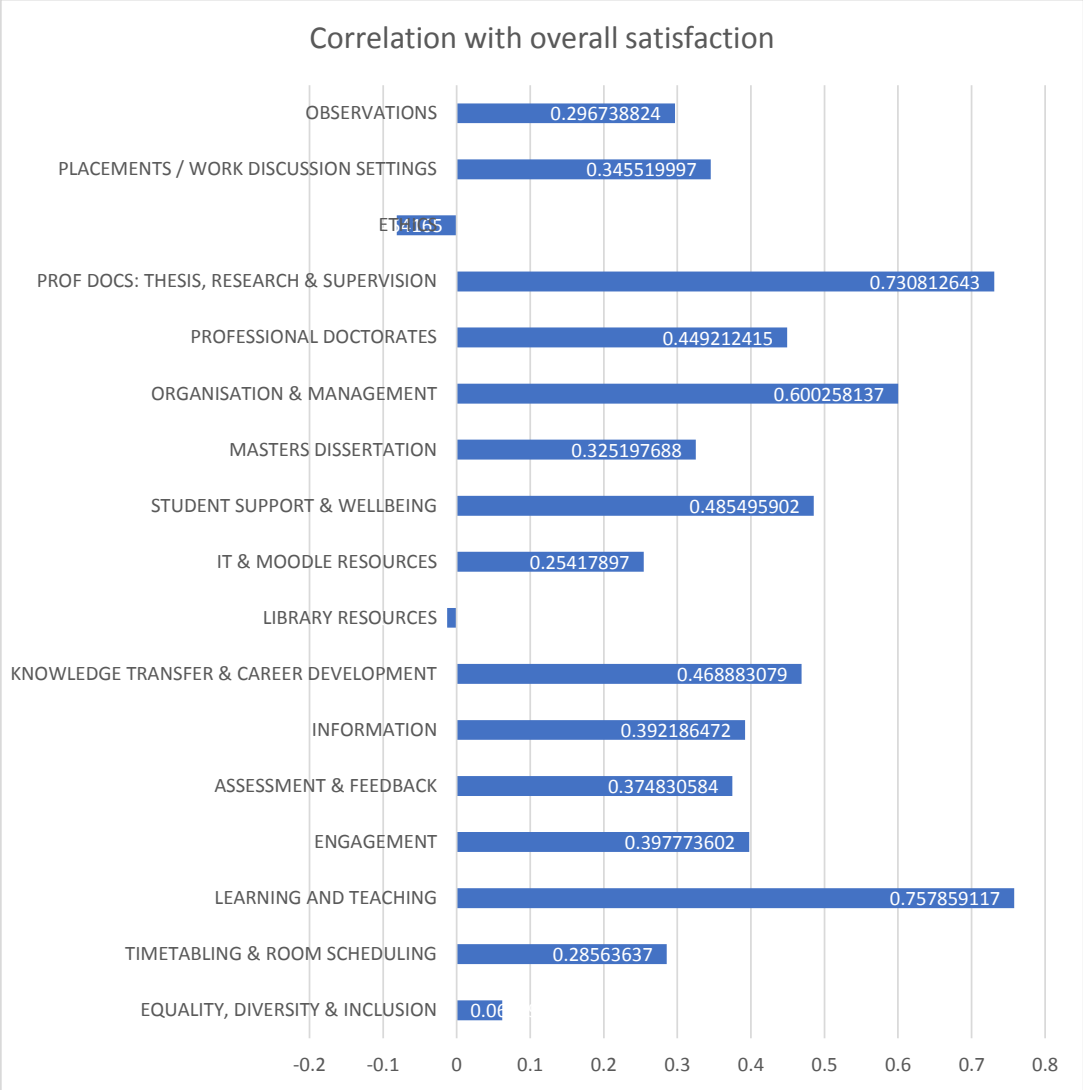


Figure 7: Comparison Between PTES (2018) Sections and T&P (2019) Sections



4.2.3 It is also worth comparing satisfaction by section and overall satisfaction, to see which sections have the biggest influence on overall satisfaction. This correlation scale is from 0 (no correlation) to 1 (perfect correlation):

Figure 8: Correlation Between Overall Satisfaction and Each Section



Anything below 0.3 is a weak correlation, and above 0.7 is a strong correlation. There are many flaws with correlations and they should not be taken too literally as the picture is a lot more complex than this allows, but it gives some indication of the areas which matter most to students, which are:

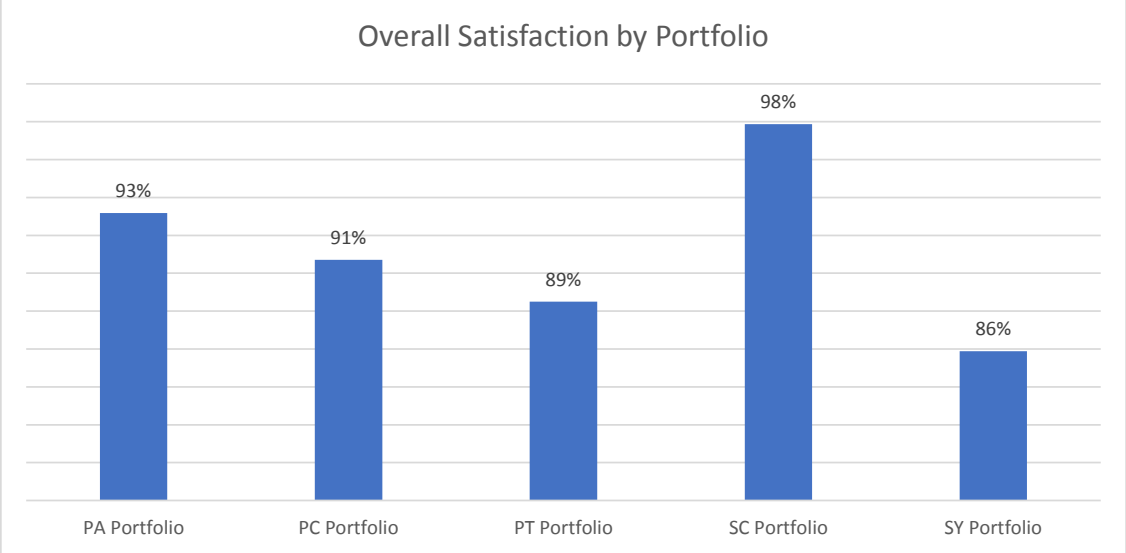
1) Learning and Teaching (0.75);
2) Organisation and Management (0.6);

3) Student Support and Wellbeing (0.48);
4) Knowledge Transfer and Career Development (0.47);
5) Engagement (0.4);
6) Information (0.39); and
7) Assessment and Feedback (0.37).

4.3 Satisfaction by Portfolio

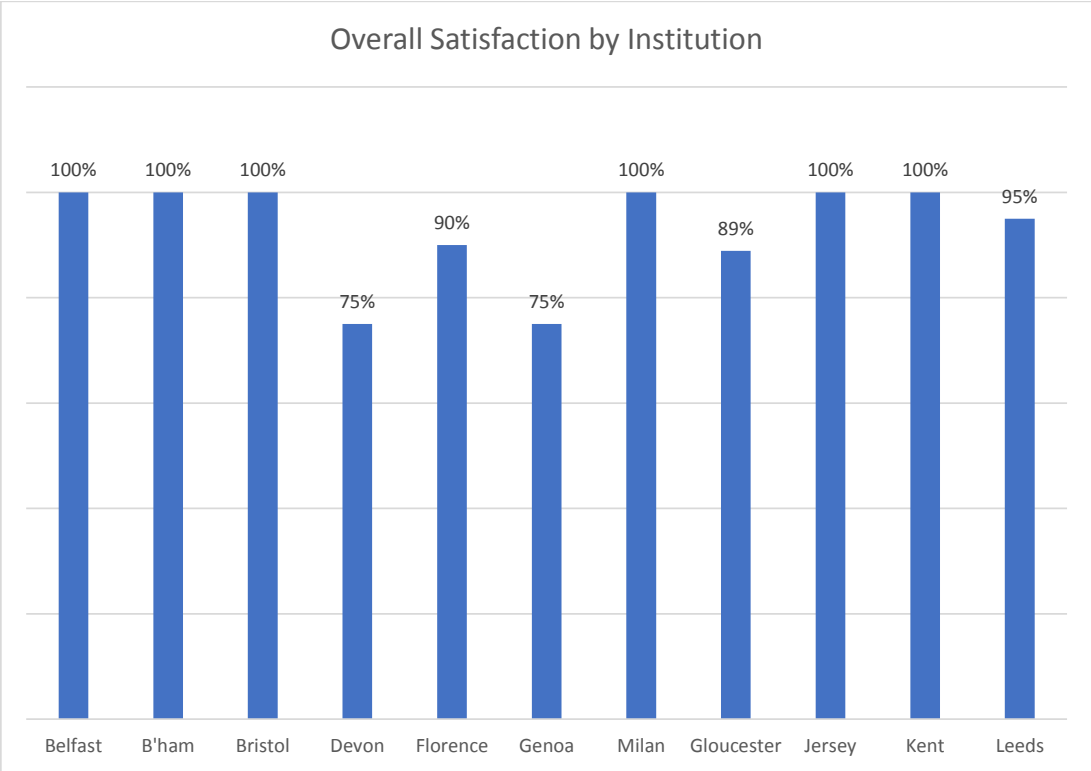
4.3.1 Across the portfolios, satisfaction is broadly similar across Psychoanalytic Applied, Psychoanalytic Clinical and Psychological Therapies, with the most significant difference being between the Social Care portfolio scoring a significantly higher satisfaction of 98% than the average of 92%; and the Systemic Portfolio at 86% falling short by the same margin. Course level statistics are reviewed in section 5 of this report.

Figure 9: 2018/19 Survey Overall Satisfaction by Portfolio



4.4 By Institution

4.1.1 The below chart shows the overall satisfaction rates by Centre of delivery. However, because the number of returns (and indeed the number of students studying at these centres) is much lower than that of the Trust it is difficult to reach robust conclusions based on this data.


Overall Satisfaction by Institution
100%
100%
100%
75%
90%
75%
100%
89%
100%
100%
95%
Belfast
B'ham
Bristol
Devon
Florence
Genoa
Milan
Gloucester
Jersey
Kent
Leeds

5. In focus

5.1 Introduction

5.1.1 In this section, areas of the survey that have performed lower than the Trust average of 75% have been pulled out into themes for consideration. They broadly fall under the two themes of Student Experience and Student Support, with a few outliers.

5.2 Student Experience

Qualitative comment in response to the question 'Please comment on one thing that has been the most enjoyable or interesting on your course'. This is representative of many students' views:

The teaching and the discussion has been excellent, as has the supervision. The administrative and communication has been very challenging as a course, and has impacted on the experience and student feelings, but I would still have chosen to do this course

5.2.1 As noted in 4.2.3, Organisation and management has the second strongest correlation with overall satisfaction (after Learning and Teaching) – meaning that this is likely to be one of the biggest influencing factors on students' overall satisfaction.

5.2.2 Organisation and Management, and particularly Communication, is an area that has been under increasing scrutiny over the last few years within the Trust. This is in response to both the Student Survey and from other arenas for student feedback such as the Dean's Student Forum. As a result of this student feedback, the Trust is setting up a group led by the new Operations Director (DET) to tackle communication and look for ways of improving communication across the piece.

5.2.3 The following questions, or sections of the survey, are performing below the Trust's average benchmark of 75%:

- The timetabling and room scheduling section (54%)
- The question *Moodle and other learning technologies are used well by tutors in the delivery of my course* (68%)
- The section Organisation and Management (73%), and particularly the question *Any changes in the course or teaching have been communicated effectively* (70%)

- The question *My institution values and responds to my feedback* (62%) (53% last year)

5.2.4 There has been a significant commitment to resolving timetabling issues, and although improvements are ongoing, the start of the 2019/20 term has been much more positive for students. This project will continue to run until room timetabling issues are resolved and the new system is working optimally.

5.2.1 Moodle continues to be a source of dissatisfaction in students' qualitative comments. These generally centre around requests for more information (such as slides being put on in a timely manner) on Moodle; and navigation of Moodle. Some do state that it is a useful and helpful resource, but generally the feeling is that it is 'difficult to navigate', is poorly utilised by some (but not all) course team, and its potential is not being realised at present.

A sample of qualitative comments relating to Moodle:

moodle is a great resource

I have found moodle a little hard to navigate - sometimes seems overcomplicated.

moodle is counter intuitive to use and I can never find what I need or want.

moodle is not intuitive to navigate, so finding resources and information is not always easy or clear

moodle can be very confusing and a lot of follow up has been needed to make sure all information is clear. Again previous experience at UCL was much better.

moodle is not used appropriately. The material is not placed under appropriate labels but just on the front page.

Tutor use of moodle variable - none seem to use it much and some not at all.

My tutor never seems to know where anything is on moodle! My supervisors have no need of it.

moodle resources are fantastic once located. The separate tutorials on different topics are very helpful

5.2.1.1 Possibilities for improving user experience is the introduction of a Moodle app, which Technology Enhanced Learning (TEL) have been exploring for the last year. In addition, a simpler template for the Course Pages is being proposed and will be considered over the coming months. User engagement continues to be a key activity for TEL, to encourage and motivate course teams to develop Moodle into a true 'learning environment' rather than an information repository and assignment delivery platform. A report from TEL, which will be presented to Academic Governance and Quality Assurance Committee and Learning and Teaching Committee in December, will address these issues in more detail.

5.2.2 Although the scores for Organisation and Management are not below the sector average, which is some achievement given the resources of the bigger Universities that the Trust is competing with, the qualitative comments reveal an underlying frustration and irritation with these systems and processes, particularly in relation to communication, which could lead to unnecessary stress and anxiety for students. This is supported by comments from students at Dean's Student Fora that took place in 2018/19.

Qualitative comments on Organisation and Management:

Communication and resources is still limited in comparison to other training institutions.

there seemed to some inefficiency in communication between admin staff and lecturers.

Despite the efforts of some excellent individuals, administration and organisation is very poor. It is rare to receive an answer to an email or phone call.

Emails about changes are sometimes sent very late, and I don't look at my emails constantly

I think that there could be more information provided in terms of knowing what to expect re. workload and how this is distributed across the academic year.

I think communication could be better, it can be hard to communicate with the Tavistock directly when required.

5.2.3 Below the comments are paraphrased and condensed down into a few common themes, which are:

- The administrative staff being too busy to attend to needs effectively (reoccurring terms such as 'short-staffed' 'helpful but too busy' 'unresponsive' appear).
- Differing sources of information (particularly around assessment and timetables given verbally and on Moodle and other printed materials).
- Communication between course teams
- Working full-time meaning they have limited time to find out the information which is often difficult to access/find

5.2.4 There are also a significant number of positive comments relating to administration and course organisation which must not be overlooked. Two course administrators are named as being particularly excellent in their support and administration of their students, and the same can be said of the comments around organisation and management by course leads.

Example of a positive comment relating to organisation and management and use of Moodle:

The course is well organised and Moodle is used effectively, with lecture materials and reading lists being available in advance of taught sessions (M4)

The course rep meetings are a good forum for discussing issues and the management seem to take on board what is said and respond appropriately. There have been some staff replacements in admin but the impact of this was minimal in my opinion.

5.2.5 It is important to identify courses that perform particularly well in the area of Organisation and Management to learn what good practice might be identified and

put in place across all courses. Notably, the following courses who have at least 10 respondents all have high scores for organisation and management:

- D24 (89%) – Psychological Therapies Portfolio;
- EC1 (92%) – Psychoanalytic Applied Portfolio;
- M10 (85%) – Systemic Portfolio;
- M80 (82%) – Psychoanalytic Clinical and Forensic Portfolio;
- D12 (88%) – Psychoanalytic Applied Portfolio; and
- D59C (84%) – Psychoanalytic Clinical and Forensic Portfolio.

5.2.6 Although there is still improvements to make in terms of student engagement, and students feeling that their feedback is being listened to and addressed, there has been significant improvement on the previous year. The introduction of a mid-year 'flash' survey, which will enable the Trust to make quick improvements mid-year; additional Dean's Student Fora; and additional information and support for Student Reps will hopefully continue to improve satisfaction in this area.

Recommendation 2: Identify areas of good practice to implement across the Trust as part of the Learning and Teaching Student Experience workstream and the communications project.

5.3 Student Support and Wellbeing

5.3.1 The following sections and questions all relate to the provision of support to students on their courses:

- Student Support & Wellbeing: 62% (This is broken down into Student Wellbeing: 75%; English Language support: 40% ; and Disabled student support: 48%).
- Masters Dissertation: 72% (In particular, dissertation support: 60%)
- Advice and guidance for placements (65%)
- Support on placements (73% (64% last year))
- I am encouraged to discuss my future career development/options (59%)

5.3.2 The Student Support section was expanded in this survey to include questions around Student Wellbeing, in response to the *NHS Staff and Learners' Mental Wellbeing Commission Report* (Pearson et al., 2018). The Trust achieved 75% for the wellbeing section of the survey. This is on the threshold in relation to the 75% benchmark for all sections of the survey. This deserves further exploration over the coming year and is likely to be positively affected by improvements in communication and student support.

5.3.3 It is interesting to note that the library support achieves significantly higher satisfaction than the rest of the support provided within DET, and worthy of further exploration:

- The Tavistock and Portman's library staff are knowledgeable and supportive (93%)
- The information skills training has helped me to locate relevant resources for my studies (82%)

5.3.4 In relation to disability support, a significant body of work has been carried out over the last academic year, including re-writing the Policy and Procedure, Standard Operating Procedures and accompanying guidance for disabled students. This has helped to clarify the processes, and will hopefully lead to higher satisfaction in this area as it beds in over the course of the year. The results of the survey in the 2019/20 academic year will be crucial in perceiving initial success in this area.

5.3.5 The qualitative comments from students largely overlap with the communication and organisation comments from students. Mostly, that it is difficult to find and access information, and that administrative and course teams can be hard to reach. Several students mention the academic hub being not fit for purpose because the staff are unable to help and/or that it is not open at times that they can come.

Sample of qualitative comments in relation to student support:

> *Sometimes I am not clear what I can discuss with my tutor. The role of the personal tutor on D10 course could be better described, as some students do not authorize themselves to discuss things beyond essays*
>
> *Overall it has been positive*
>
> *I had excellent support and advice in regard to my development personally and educational needs*
>
> *Academic writing skills seminars and library tutorials were helpful in preparation for the course. During induction, some information was unavailable which would have helped ease anxieties (e.g. placements; assignment dates / numbers ; availability of handbook; access to UoE emails to register for council tax exemption, travelcards etc.)*

I think the student support mechanisms are not clearly signposted or identified for students and this could be improved

5.3.6 In relation to placements advice and guidance (65%), there is a Placements Project underway to create a consistent understanding of placement requirements across long courses within DET and to improve the support, communication and data across the piece.

5.3.7 Student wellbeing and support is a crucial area of the student experience, which increasingly gains more interest and attention across the sector. Support encompasses many areas of the student experience, including study skills, emotional support, support for vulnerable groups such as international students, those who are second-language-English speakers, LGBTQI and BAME communities, and supporting students who are going through disciplinary procedures such as fitness to practice or academic misconduct. Most Universities have both a Students' Union and a dedicated team of staff who provide support for students across these areas. Support for students who are going through difficulties should be easy to find and access.

Recommendation 3: Find areas of good practice (such as the library) to look at ways of incorporating this into the rest of the Trust.

Recommendation 4: Set up groups (akin to BAME and LGBTQ+ groups) for Disabled students, those on placements, and international students. Ensure that the skills training in the library is highlighted to those who are second-language-English speakers and those who are coming into HE for the first time.

5.4 Other areas for consideration

5.4.1 The following questions also attracted lower than average scores on the survey:

5.4.2 *I have progressed in my career as a result of attending training here* (59%)

5.4.2.1 This question is somewhat premature, given that the students have not completed the course yet. The national benchmark for this is found in the DLHE (Destination of Leavers of Higher Education) which tracks Undergraduate students 5 years after they graduate. Of course, the Trust's courses are not typical of the sector in terms of career progression; nor are they undergraduate. However, the issue still stands that if the students have not yet finished the course, it is unlikely to have had a significant impact on their progression in their career.

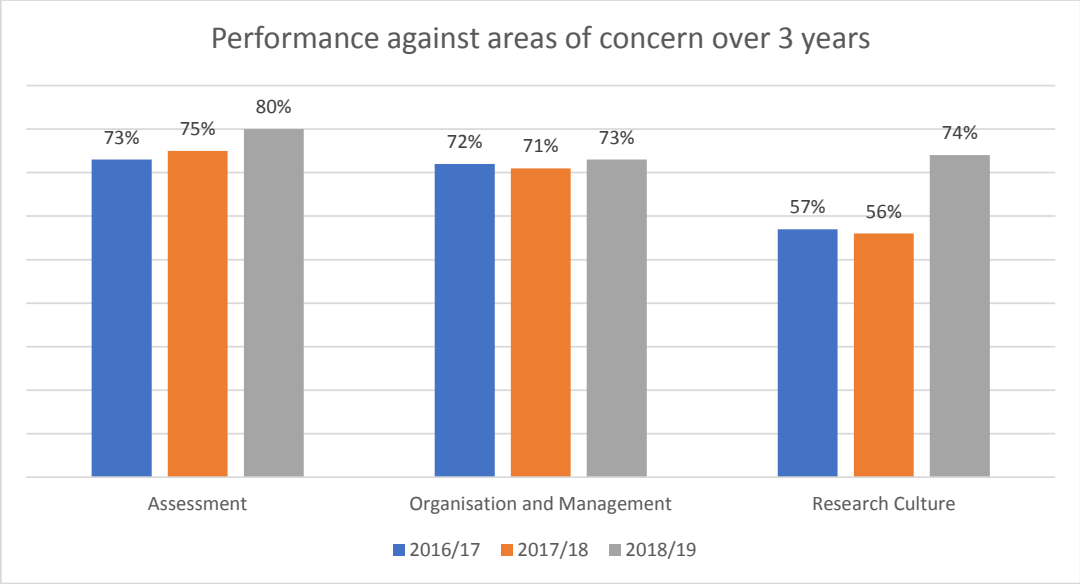
Recommendation 5: Review or remove the question in the 2019/20 survey.

5.4.3 *I have opportunities to become involved in the wider research community, beyond my course* (51%). This forms a question in the Professional Doctorate part of the survey. It formed an area that was identified for action in the previous (2017/18) survey. Although it is a low score, it also represents significant improvement on the previous year where the same question achieved 40% satisfaction. There has been a working group in the Learning and Teaching Committee looking at this area, and this working group is continuing over the current academic (2019/20) academic year.

Recommendation 6: The Learning and Teaching Working Group for Research should continue their work on improving the research culture for doctoral students at the Trust (across all sites of delivery).

5.5 The 2017/18 Survey

5.5.1 The areas which presented the lowest satisfaction from students in last year's survey were assessment feedback, operational aspects of course delivery and communications, and the research culture on professional doctorate courses.



5.5.2 There is an upward trend of satisfaction on Assessment. Organisation and Management which, considering the room timetabling issues faced, has remained stable at 73%. These generally fall slightly below satisfaction on other sections on this survey, which achieve between 75% and 85%. However, Assessment compares favourably with the national benchmark from the 2018 PTES survey who publish a

satisfaction score of 74% for Assessment; and Organisation and Management is comparable at 73% on the PTES survey.

5.5.3 Research culture has shown a significantly bigger increase in student satisfaction, although this overall score hides a variability in individual answers of between 51% (*I have opportunities to become involved in the wider research community*) and 89% (M*y department provides a good seminar programme*). This compares to a national benchmark from the 2018 PRES survey of 63% for Research Culture.

6 Performance by Course

6.1 Introduction

6.1.1 Course Teams have been provided with their individual survey results as part of the Annual Review of Courses (ARC), where they report on their course performance. The ARC reports are based on feedback from various sources (including the student survey, external examiner comments and course committees) and create an action plan for the year. These are reviewed by the Portfolio manager and presented at the Quality Review meeting of the ARCs. The Quality Review panel members will be looking to ensure that all survey results that are lower than the Trust average have been addressed and considered by the course team.

6.1.2 Students have the opportunity to feed into the Annual Review of Courses process through the Course Committees, where the draft reports are presented.

6.1.3 Below is a summary by course of performance against each section of the survey, presented as 'heat maps' which provide a quick visual representation of the range of results. The heat maps from the previous year are included for comparison.

6.2 Postgraduate Taught

6.2.1 The number of responses on some of the smaller courses inhibits a fair analysis of the results.

6.2.2 Four of the courses achieve a 100% satisfaction, and all except one achieve a result of 79% or above overall satisfaction.

6.2.3 The AFT re-accreditation of D4F required in-year changes to the course which may have impacted on the satisfaction on this course. The Annual Review of Courses report will provide more detail about the issues which may have a bearing on these results.

2018/19

Figure 10: Heat map of 2018/19 Level 6&7 (Postgraduate Taught) Tavistock-based courses by section

	D24	D24A	D4F	D4I	M6	D10	EC1	M7	M9	M16	M34	D58	Tavi (all)	PGT Lvl 6+7
n of respondents	16	5	23	15	34	37	30	70	2	15	31	52	752	484
Response rate (%)	53	56	66	83	68	63	91	68	100	63	74	85	65	72
EQUALITY, DIVERSITY & INCLUSION (%)	86	96	78	88	75	66	91	74	60	74	66	65	**76**	**78**
HARRASSMENT & BULLYING (%)	81	53	52	77	62	59	80	40	50	37	68	53	**68**	**66**
TIMETABLING & ROOM SCHEDULING	81	100	63	65	38	76	77	52	75	54	55	38	**54**	**58**
LEARNING AND TEACHING (%)	100	100	83	91	93	92	96	93	100	87	95	91	**95**	**94**
ENGAGEMENT (%)	92	100	76	90	73	63	87	74	75	67	82	74	**79**	**79**
ASSESSMENT & FEEDBACK (%)	91	100	60	73	85	72	85	78	NA	56	76	60	**80**	**77**
INFORMATION (%)	88	100	64	69	86	82	91	82	100	76	75	73	**82**	**81**
EMPLOYABILITY (%)	76	78	69	72	73	66	77	74	60	49	74	59	**75**	**72**
LIBRARY RESOURCES (%)	95	100	76	78	93	83	86	95	100	83	98	91	**90**	**89**
IT & MOODLE RESOURCES (%)	89	100	41	68	63	53	78	79	100	58	74	63	**73**	**70**
STUDENT SUPPORT & WELLBEING (%)	70	88	49	68	41	59	67	64	NA	63	75	58	**54**	**52**
MASTERS DISSERTATION (%)	NA	NA	NA	NA	78	39	NA	93	NA	80	66	0	**72**	**71**
ORGANISATION & MANAGEMENT (%)	89	95	50	69	61	74	92	69	90	49	70	50	**73**	**72**
ETHICS (%)	NA	NA	NA	NA	78	90	NA	100	NA	100	NA	NA	**82**	**89**
PLACEMENTS / WORK DISCUSSION SETTINGS (%)	67	100	65	81	73	64	88	85	100	100	68	71	**80**	**75**
OBSERVATIONS (%)	87	92	NA	67	NA	93	90	89	83	83	100	83	**89**	**91**
Q127. 1. Overall, I am satisfied with the quality of the course **(%)**	100	100	72	86	80	100	96	89	100	79	83	81	**92**	**90**

NB The shaded headings are new or revised sections that cannot be directly compared with the previous year.

2017/18

Figure 11: Heat map of 2017/18 Level 6&7 (Postgraduate Taught) survey results by section

	D24/D24A	D4	M6	D10	EC1	M7	M9	M16	M34	D58	Average of PGT	Overall Average
Learning and teaching	88	81	85	78	86	85	86	74	81	78	82	84
Engagement	81	76	81	70	79	75	82	69	76	73	76	77
Assessment	81	64	81	70	80	75	78	75	79	68	75	75
Assessment feedback	77	68	74	61	79	74	83	78	78	68	74	74
Employability	82	78	82	75	82	81	80	69	79	74	78	80
Resources and services	76	72	81	73	81	74	77	71	80	76	76	76
Equality and student support	78	74	78	73	80	72	80	77	79	71	76	75
Dissertation	NA	NA	74	65	NA	82	94	83	78	76	79	75
Organisation and management	75	59	69	71	78	70	86	66	67	61	70	71
Placements	83	78	76	77	83	80	NA	73	76	83	79	80
Observation modules	81	NA	NA	NA	82	86	83	78	NA	NA	82	81
Overall satisfaction	86	73	81	83	86	84	94	73	83	77	82	83
Number of respondents	46	34	37	50	18	114	8	18	30	68		

6.2 Doctorates

2018/19

Figure 12: Heat map of 2018/19 Level 8 (Doctorate) courses by section

Questions	M5	M4	D10D	M80 (all)	M10	D55	D50_D60	Tavi (all)	Doctorates
n of respondents	2	33	11	85	17	11	7	752	166
Response rate (%)	25	72	73	63	85	69	47	65	65
EQUALITY, DIVERSITY & INCLUSION (%)	**90**	**72**	**80**	**71**	**93**	**85**	**82**	**76**	**76**
HARRASSMENT & BULLYING (%)	**50**	**76**	**77**	**77**	**71**	**59**	**93**	**68**	**75**
TIMETABLING & ROOM SCHEDULING (%)	**0**	**24**	**55**	**42**	**59**	**62**	**43**	**54**	**42**
LEARNING AND TEACHING (%)	**90**	**98**	**96**	**98**	**100**	**93**	**97**	**95**	**98**
ENGAGEMENT (%)	**88**	**78**	**95**	**74**	**90**	**80**	**88**	**79**	**79**
ASSESSMENT & FEEDBACK (%)	**50**	**83**	**93**	**84**	**97**	**98**	**96**	**80**	**87**
INFORMATION (%)	**83**	**74**	**63**	**87**	**87**	**91**	**83**	**82**	**83**
KNOWLEDGE TRANSFER & CAREER DEVELOPMENT (%)	**80**	**91**	**88**	**86**	**80**	**71**	**93**	**75**	**87**
LIBRARY RESOURCES (%)	**100**	**97**	**89**	**96**	**98**	**97**	**83**	**90**	**95**
IT & MOODLE RESOURCES (%)	**50**	**72**	**56**	**84**	**66**	**85**	**100**	**73**	**78**
STUDENT SUPPORT & WELLBEING (%)	**90**	**67**	**100**	**90**	**91**	**90**	**100**	**54**	**66**
MASTERS DISSERTATION (%)	**NA**	**NA**	**NA**	**100**	**NA**	**NA**	**NA**	**72**	**NA**
ORGANISATION & MANAGEMENT (%)	**50**	**64**	**65**	**82**	**85**	**80**	**84**	**73**	**77**
PROFESSIONAL DOCTORATES (%)	**100**	**87**	**89**	**79**	**80**	**78**	**97**	**82**	**82**
PROF DOCS: THESIS, RESEARCH & SUPERVISION (%)	**100**	**86**	**92**	**85**	**100**	**83**	**90**	**85**	**85**
ETHICS (%)	**100**	**66**	**70**	**85**	**50**	**100**	**100**	**82**	**76**
PLACEMENTS / WORK DISCUSSION SETTINGS (%)	**100**	**89**	**100**	**89**	**NA**	**100**	**100**	**80**	**89**
OBSERVATIONS (%)	**100**	**79**	**NA**	**100**	**50**	**NA**	**NA**	**89**	**78**
Q127. 1. Overall, I am satisfied with the quality of the course (%)	100	87	100	94	100	90	100	92	94

2017/18

Figure 13: Heat map of 2017/18 Level 8 (Doctorate) courses by section

	M4/M5	M10	D10D	M80	D55	D50/D60	Average of PGR	Overall Average
Learning and teaching	85	89	82	87	91	90	87	84
Engagement	75	85	68	77	89	87	80	77
Assessment	78	81	71	81	91	0*	80	75
Assessment feedback	70	88	75	78	83	0*	79	74
Employability	86	82	82	86	87	93	86	80
Resources and services	76	81	74	77	89	86	81	76
Equality and student support	79	84	70	76	88	91	81	75
Organisation and management	68	84	60	75	87	85	77	71
Research - general	79	86	71	72	83	84	79	77
Thesis	72	80	73	69	0†	82	75	73
Research supervision	76	97	84	73	0†	91	84	81
Research culture	57	60	59	54	0†	59	58	56
Research skills	80	87	88	75	87	92	85	80
Ethical approval	64	80	67	62	0†	70	69	72
Placements	86	60	0	85	70	0*	60	80
Observation modules	77	NA	NA	NA	68	0*	73	81
Overall satisfaction	84	95	82	84	95	94	89	83
Number of respondents	29	11	11	70	12	7		

* Students on research phase and no longer doing assessments

†Students on taught phase and not yet doing research

6.3 Tavistock Certificate (Non-Validated) Courses

Figure 14: : Heat map of 2018/19 Tavistock Certificate courses by section

	D12	M21	D18	D58	D59C	D59F	D59I	D59L	D65	M1	M14	D10C	Tavi (all)	Tavi Certs
n of responses	31	5	6	6	10	2	18	2	4	15	2	1	752	102
Response rate (%)	63	50	100	100	111	18	62	25	57	52	25	14	65	57
EQUALITY, DIVERSITY & INCLUSION (%)	82	76	56	73	70	60	76	90	60	55	60	60	76	72%
HARRASSMENT & BULLYING (%)	66	80	42	75	60	50	72	75	25	57	100	50	68	64%
TIMETABLING & ROOM SCHEDULING (%)	75	80	83	50	55	100	31	25	88	35	25	0	54	58%
LEARNING AND TEACHING (%)	91	96	93	100	98	100	97	100	100	91	100	100	95	94%
ENGAGEMENT (%)	86	65	95	83	93	63	71	100	100	70	75	75	79	81%
ASSESSMENT & FEEDBACK (%)	89	80	92	63	93	50	85	88	50	51	100	100	80	83%
INFORMATION (%)	95	73	87	72	97	83	82	83	78	64	50	67	82	83%
KNOWLEDGE TRANSFER & CAREER DEVELOPMENT (%)	73	84	61	83	75	70	70	90	70	67	100	80	75	72%
LIBRARY RESOURCES (%)	89	73	100	72	88	100	91	83	67	71	100	0	90	84%
IT & MOODLE RESOURCES (%)	93	60	88	45	94	50	75	50	67	70	100	0	73	78%
STUDENT SUPPORT & WELLBEING (%)	60	80	80	80	78	75	59	100	67	57	25	100	54	49%
ORGANISATION & MANAGEMENT (%)	88	80	81	83	84	50	60	100	93	44	70	40	73	73%
PLACEMENTS / WORK DISCUSSION SETTINGS (%)	81	100	100	69	91	100	82	38	75	81	100	NA	80	80%
OBSERVATIONS (%)	78	NA	NA	NA	NA	NA	90	100	NA	39	100	NA	89	84%
Q127. 1. Overall, I am satisfied with the quality of the course **(%)**	100	100	100	100	100	100	88	100	100	87	100	100	92	96%

Figure 15: Heat map of 2017/18 Tavistock Certificate courses by section

	D12	M1	D59	Average of non-validated	Overall Average
Learning and teaching	83	89	83	85	84
Engagement	77	81	73	77	77
Assessment	73	60	56	63	75
Assessment feedback	79	67	71	72	74
Employability	76	84	77	79	80
Resources and services	77	78	73	76	76
Equality and student support	75	69	72	72	75
Organisation and management	72	71	65	69	71
Placements	74	83	81	79	80
Observation modules	67	95	76	79	81
Overall satisfaction	84	91	81	85	83
Number of respondents	39	14	41		

6.4 National Centres

Figure 16: Heat map of 2018/19 National Centre courses by section

	Belfast		B'ham	Bristol	Devon	Flrnce	Genoa	Milan	Gl'str	Jersey	Kent	Leeds		
Questions	**M7N**	**M9N**	**M7B**	**M7K**	**M7 D**	**M7F**	**M7G**	**M7M**	**D24/ A G**	**D4FJ**	**D4IK**	**D58L**	**M8N**	**All NC**
n of completions	11	8	9	15	4	13	5	8	10	2	2	12	8	109
EQUALITY, DIVERSITY & INCLUSION	89	87	82	73	80	88	72	98	78	100	100	79	71	**83**
HARRASSMENT & BULLYING	82	69	78	70	63	58	70	88	85	75	75	83	88	**76**
LEARNING AND TEACHING	98	100	98	99	90	97	72	100	100	100	100	92	93	**96**
ENGAGEMENT	95	91	97	86	81	88	40	100	73	100	100	85	78	**85**
ASSESSMENT & FEEDBACK	83	92	87	86	100	80	73	73	78	100	75	67	93	**82**
INFORMATION	94	92	85	89	83	92	67	83	83	100	100	75	96	**87**
KNOWLEDGE TRANSFER & CAREER DEVELOPMENT	83	90	77	71	70	75	80	95	61	60	70	86	77	**78**
LIBRARY RESOURCES	83	87	72	82	92	86	92	81	79	83	100	83	95	**84**
IT & MOODLE RESOURCES	72	100	83	40	38	50	63	56	61	100	75	68	81	**66**
STUDENT SUPPORT & WELLBEING	98	87	41	85	50	69	42	75	53	100	75	100	85	**71**
MASTERS DISSERTATION	100	NA	NA	83	NA	100	NA	75	NA	NA	NA	NA	100	**78**
ORGANISATION & MANAGEMENT	98	97	87	92	80	66	40	90	71	100	90	76	94	**83**
PROFESSIONAL DOCTORATES	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	79	**79**
PROF DOCS: THESIS, RESEARCH & SUPERVISION	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	85	**79**
ETHICS	100	NA	100	NA	NA	88	100	100	NA	NA	NA	NA	NA	**95**
PLACEMENTS / WORK DISCUSSION SETTINGS	100	75	100	100	100	88	75	100	71	NA	88	73	90	**82**
OBSERVATIONS	88	90	96	94	92	100	100	100	71	NA	NA	NA	NA	**92**
Q127. 1. Overall, I am satisfied with the quality of the course	100	100	100	100	75	90	75	100	89	100	100	100	88	**95**

Figure 17: Heat map of 2017/18 National Centres by section

	Leeds	Belfast	Birmingahm	Bristol	Devon	Liverpool	Manchester	Oxford	Stroud	Sussex	Florence	Genoa	Average of centres	Overall Average
Learning and teaching	87	88	85	96	89	97	93	80	89	78	81	70	86	84
Engagement	80	80	82	84	89	87	84	75	79	73	77	62	79	77
Assessment	82	74	74	85	83	70	70	50	81	60	79	59	72	75
Assessment feedback	83	82	91	67	75	51	88	0	83	67	81	67	70	74
Employability	83	83	81	86	86	79	87	87	83	67	86	72	82	80
Resources and services	73	68	71	70	73	56	64	72	65	59	69	69	67	76
Equality and student support	75	80	66	73	76	63	73	70	78	58	73	58	70	75
Dissertation	85	85	NA	98	NA	NA	NA	90	NA	NA	93	70	87	75
Organisation and management	76	87	73	82	82	59	77	68	73	48	74	52	71	71
Placements	86	NA	80	100	NA	NA	93	NA	85	60	80	50	79	80
Observation modules	80	82	87	87	88	87	NA	100	83	NA	94	80	87	81
Overall satisfaction	87	96	83	90	85	87	92	93	91	60	80	60	84	83
PGR														
Research - general	76													77
Thesis	72													73
Research supervision	85													81
Research culture	56													56
Research skills	81													80
Ethical approval	67													72
Number of respondents	37	14	7	6	4	3	5	3	9	3	11	10		

7 Conclusions and Recommendations

7.1 Conclusions

The Trust has achieved a very good overall satisfaction of 92%. In key areas such as Learning and Teaching and Assessment, the Trust has also performed above the sector average.

At a course level, the Annual Review of Courses is picking up lower performing areas of the survey, so the recommendations in this report are centred around what can be effectively done at an institutional level to improve the student experience.

There is already a large amount of activity and resources centred around the timetabling issues. A project proposal to improve communication has received endorsement by Education and Training Executive Committee, and will be led by the new Operations Director. This should help address some of the issues relating to organisation and management, communication and Moodle.

The two areas that can be usefully considered at an institutional level are issues around student support

7.2 Recommendations

Recommendation 1: Reduce the length of the survey

Recommendation 2: Identify areas of good practice to implement across the Trust as part of the Learning and Teaching Student Experience workstream and the communications project.

Recommendation 3: Find areas of good practice (such as the library) to look at ways of incorporating this into the rest of the Trust.

Recommendation 4: Set up groups (akin to BAME and LGBTQ+ groups) for Disabled students, those on placements, and international students. Ensure that the skills training in the library is highlighted to those who are second-language-English speakers and those who are coming into HE for the first time.

Recommendation 5: Review or remove the question '*I have progressed in my career as a result of attending training here'* in the 2019/20 survey.

Recommendation 6: The Learning and Teaching Working Group for Research should continue their work on improving the research culture for doctoral students at the Trust (across all sites of delivery)

Rebecca Bouckley
Senior Quality Officer
1st November 2019

Report to	Date
Board of Directors	26 November 2019

People Strategy Report

Executive Summary

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

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

Recommendation the Board

Members of the board are asked to note this report.

Trust strategic objectives supported by this paper

People

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

Organisational Development and People Strategy Assurance Report Quarter 2 – 2019/20

1. Introduction

The organisational development and people strategy was launched in April 2017 and set a direction of travel for the next three years.

This paper provides an overview of a number of programmes of work which have been undertaken to achieve the strategy's delivery plan. It also identifies the key workforce indicators during the period.

2. Quarter two strategy delivery plan summary

The key actions which have been taken forward in the second quarter include:

- The Trust has completed its diagnostic activities against the talent management e-tool.

- The procurement activity for the middle management development programme has concluded and a supplier has been selected. Throughout quarter three, work will be undertaken to develop the programme up ready for launch in the final quarter of the year.

- Our new occupational health provider commenced providing services to the organisation and the transition has been seamless with no issues to report.

- The diversity champions' line management transferred to the director of HR and corporate governance in the quarter and their priorities have been set following their performance appraisals / objective setting sessions.

Unfortunately, no health and wellbeing plan has been produced which builds on the previous years. A remediation plan has been put in place to increase

the efforts to develop this and to use the expertise that our new occupational health and wellbeing provider brings to us.

3. Work programmes not featured on the strategy

Throughout the quarter, a number of other programmes of work have been progress which do not directly feature on the strategy which are worth of noting.

NHS staff survey – 2019

Preparations for the 2019 survey were completed in the quarter including the re-procurement activity of the provider that administers the process on the Trust's behalf. The Picker Institute have been awarded a three year contract through a framework agreement to provide these services.

An engaging marketing campaign to raise awareness and importance of the survey was developed and will launch at the beginning of the surveying period.

Flu campaign

The Trust's HR function have worked with the new occupational health provider to deliver a similar programme to the previous year. Owing to the cut over periods between the two providers this has meant that planning has been somewhat fragmented compared to previous years.

Management handbook and induction

To complement the launch of the management development programme, a handbook is being developed by the senior HR team. The intended purpose is to provide simple and easy access to key information managers need to know.

It will be launched in January 2020 to coincide with the beginning of the programme and will be an online resource which maximises the potential that the Trust's intranet offers.

Oracle learning manager

The learning and development function have now migrated the historic training database on to the national HR / payroll solution to enable reporting to occur through the system as opposed to manual generation.

With any system migration, there needs to be further validation work completed to ensure that all of the data has made its way in to the new solution.

For the purposes of this assurance report, the mandatory training data has been validated against both ESR and the historic database to ensure an accurate set of compliance data is provided.

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

The following table presents the 2018/19 element of the organisational development and people strategy delivery plan and details that planned delivery dates and what progress is being made against each of the areas.

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

			2019/20			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Recruit, attract and retain talent	Succession panning	Undertake the NHS Leadership Academy talent management diagnostics	X	X		
		Report on findings from the regional diagnostic			X	
		Develop and implement an action plan to further develop our talent management approaches			X	X

			2019/20			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Develop, promote, reward, recognise and support our existing staff;	Leadership development	Commission and deliver the aspiring leaders programme			X	X
	Management development	Commence procurement activities for a management development programme for middle managers	X	X		
		Award, recruit and promote the management development programme			X	
		Management development programme to commence			X	X
	Leadership and management development	Evaluation of career progression for participants engaged on the Trust leadership programmes (3 years)				X
		Refresh the executive and senior leadership team succession plan				X
	Robust performance and appraisal system	Conduct a review of the Trust's appraisal process			X	
	Health and wellbeing group	Develop the 2019/20 annual plan	X			

			2019/20			
Strategy Theme	Specific priorities	Action required	Q1	Q2	Q3	Q4
Protect the physical and mental health and wellbeing of our staff.	Promote health lifestyles	Conclude occupational health service transition.		X		
		Commence active promotion with Team Prevent UK Ltd			X	
		Plan and implement a health and wellbeing event.				X
Respect and value diversity.	Diversity champions	Agree annual priorities with the diversity champions.	X			
	Create cultural change	Expand the requirement for diversity representatives to be on all selection panels.		X	X	
		Launch a second round of conversations about sexuality in clinical settings training			X	
		Develop an equality and diversity strategy to align with our PSED requirements.			X	
		Seek approval for the new strategy.				X

5. Workforce indicators

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

Period: April 2019 - September 2019									
Report Title	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sep**	**Q2**	**Trajectory**
Staff in Post									
Full Time Equivalent Staff in Post (FTE)	654.95	650.02	652.42	652.46	655.17	657.37	662.62	658.39	↔
Headcount	787	780	786	784.33	787	787	797	790.33	↔
Vacancy Rate	5.66%	6.37%	6.02%	6.02%	5.63%	5.31%	4.55%	5.16%	↔
Turnover	17.73%	17.33%	16.52%	17.19%	15.46%	16.11%	16.74%	16.10%	↔
Stability Index	82.21%	82.21%	82.99%	82.47%	81.47%	82.58%	81.60%	81.88%	↔
Health, wellbeing and morale									
Sickness Absence Spot Month	2.31%	2.47%	3.63%	2.80%	2.11%	2.17%	2.24%	2.17%	↓
Sickness Absence 12 month rolling average	1.77%	1.82%	2.05%	1.88%	2.08%	2.17%	2.24%	2.16%	↑
Training and compliance									
DBS Compliance	99%	99%	99%	99%	99%	99%	99%	99%	↔
Appraisal Compliance	95%	45%	45%	62%	49%	54%	71%	58%	↑
Establishment FTE (From Finance)	**694.24**	**694.24**	**694.24**		**694.24**	**694.24**	**694.24**		

6. Mandatory Training Compliance

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

Compliance with the mandatory and statutory training that applies to all staff remains has decline in the quarter. This is as a result of a number of staff becoming not compliant towards the latter portion of September 2019. A mandatory training update day is scheduled for 28 November 2019 which should result in this indicator improving in quarter three.

Description	Quarter 1 2019/20	Quarter 2 2019/20
Mandatory Training Compliance INSET and Induction Attendance	94%	72%
Local Induction Checklists Completed	100%	98%

The table below provides an overview of role specific mandatory and statutory training. There are a number of areas with low compliance which are expanded on in the narrative following the table.

Description	Quarter 1 2019/20	Quarter 2 2019/20
Basic Life Support - First Aiders	100%	100%
Basic Life Support - Medical & Nursing	96%	98%
Conflict Resolution Training	100%	100%
Data Security Awareness	95%	95%
Ladder Safety	67%	95%
Manual Handling	67%	95%
Safeguarding Adults - Level 2	3.28%	5.59%
Safeguarding Adults - Level 3	20%	33%

Description	Quarter 1 2019/20	Quarter 2 2019/20
Safeguarding Children – Level 3	71%	72%
WRAP (PREVENT L3)	81%	80%

In the quarter, the remediation plan for safeguarding children training was enacted but as other individuals have become non-compliant during the period this has resulted in a net compliance rate of limited change. Concerted and focused effort remains in place to bring this back in to an acceptable level of compliance.

Adult safeguarding training continues to increase in compliance rates and this is continuing to be monitored by the Trust's medical director.

The Trust has appointed a new prevent lead, work will be progressed with the new post holder about how best to increase compliance with the level three workshop requirement.

7. Conclusions and recommendations

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

Craig de Sousa
Director of HR & Corporate Governance
October 2019

Report to	Date
Board of Directors	26 November 2019

Report on Audit Committee Meeting – 10 October 2019

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 10 October 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 10 OCTOBER 2019

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 10 October 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 15 May 2019 and 18 September 2019.

2.2 The Committee heard that CQSGC was performing well and that the recent structural changes had bedded in. It was noted that the revised terms of reference (TOR) for CQSGC had still to be agreed.

2.3 The Committee heard that the Care Quality Commission had attended the meeting of 18 September and had provided positive feedback.

2.4 There was a discussion around the reporting of Information Governance and how the Board was assured on this subject. As a result, the Deputy Chair of CQSGC, who is also a member of the Committee, took away an action to ensure that future CQSGC minutes better reflected this issue.

3. BOARD ASSURANCE FRAMEWORK ("BAF")

Deep Dive

3.1 Dr Sally Hodges (Clinical Chief Operating Officer) gave a presentation to the Committee regarding risk 9 on the BAF, relating to the impact of external events on the morale and activity within the GIDS service. The BAF risk relates to the reputational risks associated with failing to complete the agreed action plan and the impact of the external environment which could reduce capacity in the service.

3.2 Dr Hodges provided the Committee with a detailed explanation of how the risk had arisen and the thinking that went into its scoring.

3.3 There was an extensive exploration of the subject with it being noted, in particular, that the GIDS action plan would take some time to implement and that external factors outside of the control of the Trust meant that it was difficult to reduce the Target Risk Rating below 9.

3.4 In the view of Dr Hodges, as the action plan was implemented further staff losses were possible, however, it was imperative to implement the action plan in order to better secure the service and the wellbeing of the wider staff group. It is

recognised that the impact of the changes being introduced is more pronounced on the senior staff group, however, early feedback from more junior staff is that they welcome the clarity the action plan changes bring.

3.5 It was decided that consideration be given to rephrase the risk narrative so that it better reflected the nature of the risk, that is, that external pressures / noise was leading to lower staff morale and thus impacting, negatively, on performance.

Third Party Assurances

3.6 Some work carried out by RSM on assurances from third parties was noted. The Committee noted that tracking of any action points relating to these third parties fell to other elements of the governance structure within the Trust, notably the Executive Management Team and the Estates and Facilities work stream of CQSGC.

4. INTERNAL AUDIT PROGRESS REPORT

4.1 Reports on the Scheduling Project and Learning From Incidents were discussed.

4.2 In reviewing the benchmarking report produced by RSM, the Committee was pleased to note the progress the Trust had made year on year and its performance compared with other providers.

5. EXTERNAL AUDIT

5.1 Management responses to the recommendations made by Deloitte's in their ISA 260 report were discussed and noted.

5.2 The Trust's new external auditors – Mazars LLP – were formally introduced to the Committee.

6. LOCAL COUNTER FRAUD

6.1 The Committee noted that the fraud relating to estates time sheets had been closed and that a second attempted fraud relating to trade marks was due for closure.

6.2 The Committee discussed, in depth, the recent fraud relating to the use of a Trust credit card. The Committee, noting that the size of the Trust meant that resources were limited, raised the challenge to the Director of Finance whether or not there was a need for the Trust / Finance function to refocus on basic internal controls and / or increase the resources in this area.

6.3 The Director of Finance noted that he was constantly evaluating the balance of risk and reward in terms of his allocation of resources and that whilst he would like more resource dedicated to some of the more basic financial control issues this could only be done by directing resources from more valuable areas of the Trust's work. It was agreed, however, that any lessons learnt resulting from the current investigation would be implemented quickly.

Terry Noys
Finance Director
15 October 2019

Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 14 November 2019

Key items to note

The November committee meeting took place and was used as a developmental session to inform the thinking for the emerging equality, diversity and inclusion strategy which will be brought forward for approval in early 2020.

The session was well attended and has resulted in the creation of:

- A strategic ambition statement
- Actions required to deliver a comprehensive strategy
- A reflection of what works well in the organisation, less well and areas where we should start taking more action.

Actions required of the Board of Directors

None

Report from	Prof Dinesh Bhugra, Committee Chair
Report author	Craig de Sousa, Director of HR and Corporate Governance
Date of next meeting	16 January 2020

Report to	Date
Board of Directors	14th November 2019

Clinical, Quality, Safety and Governance Committee Minutes Q2 Board Report

Executive Summary

This report provides the minutes from the Q2 September Clinical Quality, Safety and Governance Committee. All work streams have reported good progress and four of the six work streams were rated as green. The Patient Safety and Clinical Risk and Information Governance work streams have been rated as amber, as although there are plans in place to reach compliance, there is still some work to do before the work stream leads recommend a green rating.

There were some significant changes agreed in relation to the committee structure during Q2. It was agreed to change to this committee's name to; Integrated Governance Committee (IGC). To avoid any confusion and to incorporate the additional data security reporting, it was also agreed to change the name of the IG work stream to Data Security.

It was also agreed to invite the new three clinical divisional directors to attend the committee. They will not be required to provide update reports to the committee, the intention is for them to hear the areas and issues discussed at committee which will assist them in managing their divisions.

All of the above changes to the committee will be incorporated into the committee Terms of Reference, which is due for final agreement at the November committee.

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

Clinical Quality, Safety and Governance Committee (CQSGC)

Minutes of the committee held on Wednesday, 18th September 2019

Members	Present?
Dinesh Sinha, Medical Director (& CQSGC Chair) (DS)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	N
George Wilkinson, Public Governor (GW)	Y
Dinesh Bhugra, Non-Executive Director (DB)	N
Debbie Colson, Non-Executive Director (DC)	Y
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
Sally Hodges, Director of CYAF (SH)	Y
David Wyndham Lewis, Director of Technology & Transformation (DWL)	Y
Caroline McKenna, Associate Medical Director (CMK)	Y
Chris Caldwell, Director of Nursing covering Quality and Patient Experience (CC)	N
Tim Kent, Director of Adult and Forensic Services (TK)	N
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	N
Craig da Sousa, Director of HR (CdS)	Y
Liz Searle, Consultant Child Psychiatrist & Clinical Governance Lead for Children, Young Adults and Families (CYAF) (LS)	Y
Ian Garlington, Estates Consultant (IG)	Y
Eilis Kennedy, Director of Research and Development (EK)	Y
Natalie Austin-Parsons, CQC (NAP)	Y
Kamalpreet Singh, CQC (KS)	Y
Irene Henderson, Clinical Governance & Quality Manager & CQSGC Secretary (IH)	Y

SUMMARY OF ACTION POINTS				
AP	Item	Action	By	Due

	3	CQSGC ToR to be completed for approval at the November CQSGC.	CdS	Nov 2019
	3	Invite the 3 clinical divisional directors to all future CQSGC meetings.	IH	Sept 2019
	6.5	DS to initiate a review of internal support for staff involved in producing serious investigation reports and attending inquests which will include input from the new divisional directors.	DS & Div. Directors	Feb 2020
	6.6	Provide the Lessons Learned event topics to NEDs regularly going forward	CdS	Ongoing

1		**Chair's opening remarks** DS opened the meeting and welcomed our CQC colleagues, NAP and KS and confirmed that the reports being considered were for the Q1 2019/20. DS acknowledged that the committee had started slightly later than planned due to the room change.	
2		**Attendance** Apologies were received from Paul Burstow, Dinesh Bhugra, Elisa Reyes-Simpson, Terry Noys and Chris Caldwell.	
3		**Notes from the last meeting** The notes from the last meeting were accepted as accurate with the following amendment: Item 7. 2 Toza have been asked to provide information to NHSE regarding their excellent work in introducing healthy eating options. DS confirmed all previous actions had been completed except the action regarding the CQSGC Terms of Reference (ToR). There was some discussion around whether the new divisional directors should be invited to attend this committee and all felt it would be beneficial to have them in attendance and IH agreed to send invitations to all future committees. DS asked the	IH

		committee to forward any further comments on the ToR directly to CdS. CdS confirmed the updated ToR will be presented at the November committee for final approval.	CdS
4		**Matters Arising** DS confirmed all previous actions have been completed except the action regarding the CQSGC Terms of Reference (ToR). There was some discussion around whether the new divisional directors should be invited to attend this committee and all felt it would be beneficial to have them in attendance. DS asked the committee to forward any further comments on the ToR directly to CdS. CdS confirmed the updated ToR will be presented at the November committee for final approval.	
		WORK STREAM REPORTS	
5		**Information Governance** David Wyndham-Lewis, Director of Technology & Transformation *(on behalf of Terry Noys, Director of Finance and Trust SIRO)*	
	5.1 5.2	DWL introduced his report and highlighting the following 3 areas: **DSPT** This year's assertion toolkit has evolved considerably as expected introducing more significant technical trust requirements and the IG work stream is currently reviewing all the new requirements and informing assertion owners of changes for this year's toolkit. **Freedom of Information Requests (FOIs)**	

	5.3	FOIs continue to increase both in number and complexity which has led to concerns about the cumulative impact of stress on individuals who needed to respond to FOIs and the need for more sustainable support. In Q1 19/20 we received 15 (4 GIC and 11 GIDS) FOIs related to gender services. **Business Continuity Planning (BCP)** The trust delivered a desktop exercise this summer which received good feedback from all staff in attendance. An action plan was drawn up after the day to identify and address the required changes and lessons learned and this is being tracked through the IG work stream. DWL confirmed we be seeking to ensure consistency across teams and will carry out internal audits on local BCPs.	
	5.4	DS confirmed the desktop exercise had gone well and had contributed to the EPPR NHSE who will be visiting next month with the next event planned in February 2020. **Information Commissioners Office (ICO)** DWL confirmed there were no notable incidents reported to the ICO during Q1 but that there had been a significant breach early in Q2 in which a staff team had wrongly disclosed just under 2000 email addresses as part of a PPI promotion working with the GIC service. DWL outlined the action being taken noting the trust had responded swiftly the incident had happened at 2pm and then reported to IT at 2:08pm. The team who sent the email tried to recall it unsuccessfully, as the recall function does not work for external emails. Consent to use personal email addresses has been sought and received from around 5000 GIC patients and the team involved had split this group into batches of 1000 emails each to send. After sending the second batch they realised they had used the copy field instead	

		of the blind copy field, meaning all email addresses were visible to all recipients. The IT team then sent individual emails to each recipient apologising for the disclosure in error and explained a serious investigation had been launched and the IG breach had been reported externally to the ICO. DWL confirmed the current and further mitigating action taken to address this incident: a) introducing technical controls in the form of a direct marketing tool. b) limit the number of external recipients to 50 c) ensure individual emails are sent instead of group emails d) reported the incidents at the same day to the ICO who have provided us with some questions to respond to by next Wednesday e) CdS has been confirmed as the investigating officer on the serious investigation which is to be completed within the next two weeks f) internal comms was sent to all staff regarding the email policy and top tips and guidance DWL confirmed there are likely to be further action is expected after the conclusion of the serious investigation and also following the ICO investigation. DC commented that in 6.1 clear protocols for sending patient letters are noted and asked if this has been extended further than patients. DWL confirmed this has now been extended to all patients, staff and students. DWL also confirmed the Department of Education and Training (DET) are already using this marketing tool and with the disclosure in error category of is IG incidents going up, which we feel is in part related to improved reporting facilities this tool will be an essential addition to negate a repeat of incidents of this kind.	

		DS confirmed the QI project is being set up to look at hybrid mail, which could help prevent inadvertent disclosures. The committee accepted the amber rating for this work stream for Q1.	
6		**Patient Safety and Clinical Risk** ***Caroline McKenna, Patient Safety and Clinical Risk Lead***	
	6.1 6.2 6.3	CMK introduced her report highlighting the following: **Patient Aggression Towards Staff** There has been a notable increase of patient aggression towards staff, with both admin and clinical staff reporting verbal aggression from patients on the phone as well as presenting at reception areas, which many staff feel has become a part of their role which they need to expect and accept. Some services have needed to increase physical security in their services such as entry code access etc. There were also 4 new incidents reported via the Portman Clinic involving patient aggression, which again is a notable increase. To help address this, the main focus of the most recent Lessons Learned event on 17th September 2019 was patient aggression towards staff. **Serious Investigations** There were 4 patient deaths reported in Q1, all of which have been externally reported on StEIS. Following further investigation, one of these SIs has been de-escalated on StEIS as the patient had died following a fall whilst inebriated. The November 2019 Learning Lessons event will focus on these serious incidents as a whole. **Inquests**	

	6.4	2 Trust staff have been involved in a recent inquest, which was also reported in local and national media and which is due to conclude in November 2019. The Trust also took part in a further administrative inquest where we were requested to provide paper work rather than to attend and provide evidence.	
	6.5	**Prevent Lead Safeguarding Role** The Trust has not yet been able to recruit a Prevent Lead and CMK have been covering this safeguarding role in the interim for both children and adults.	
		Complaints There has been no significant change in the number of complaints recorded and again are mostly around our gender services provision including waiting times and types of therapy offered. CMK requested any comments or questions for this report. SH asked if staff attending inquests are provided with support. CMK confirmed this is being looked into now especially as it is clear that staff who completed serious investigations for the Trust will more routinely be requested to attend inquests and although there is support from our legal team, staff will need to be supported more generally during these often difficult events. DS confirmed that the Trust has a relatively low number of inquests to attend it would not be an option for us to have the same system as some larger Trusts which includes a central team responding to inquests, but **it was agreed that staff support should be reviewed and the review should include the new divisional directors.** There was some discussion around the lack of Prevent Lead and it was acknowledged that the role is often seen as a toxic brand. It was confirmed that Prevent was initiated by the Home Office but the process is being devolved to local CCGs. SH suggested we	DS & Divisional Directors

		consider adding this role to the new roles being developed for staff in the Returning Families service. PJ asked about the level of attendance at the recent Learning Lessons event and whether it had been effective. CMK confirmed it was fairly well attended, but noted that it clashed with the CEO Question Time event on climate change, which was a shame but confirmed we will ensure future clashes for such events do not occur. CMK also confirmed there are 6 events spread over the year, and these are open to all staff. The presentations are interactive and it is a forum for thinking about the issues in depth and those in attendance are asked to cascade further within their teams. PJ asked if staff who could not attend in person could attend via a virtual link and CMK and DS confirmed that remote access for those who cannot attend in person has been provided but that the interactive nature of the event did not always lend well to that platform as those joining via streaming can only view rather than comment. DC asked if non-execs could be invited to attend some of these events and DS also confirmed the only exclusion criteria for attendance is that staff must have a Tavistock contract to attend, as the material discussed can often be sensitive patient identifiable information. **CdS agreed to provide the content detail of future lessons learned events to non-execs so they could choose to attend the most appropriate.** DS also highlighted the Trusts' Inter-Professional Event taking place on 16th October 2019 in the Lecture Theatre from 12 – 2pm. The committee accepted the amber rating for this work stream for Q1.	CdS
7.		**Clinical Quality and Patient Experience** ***Chris Caldwell, Director of Nursing covering Quality and Patient Experience***	

	7.1	In CC's absence, MS presented this work stream report noting the following: **Work stream Terms of Reference (ToR)** At the last CQPE work stream meeting CC reviewed the work stream terms of reference with the introduction of the new divisional directors, 2 of which were in attendance. The discussions had focused mainly on the reporting topics within the CQPE report and it was agreed the quality dashboard would no longer be appropriately reported within this work stream. It was noted that the reporting topics were mostly green within this quarter and the committee were invited to ask any questions. DS congratulated the work stream on the green compliance ratings. The committee accepted the green rating for this work stream for Q1.	
8.		**Corporate Governance and Risk** ***Marion Shipman, Associate Director of Quality and Governance***	
	8.1 8.2	MS introduced her report noting the following four areas and invited any questions: **Non-clinical incidents** The number of non-clinical incidents at Gloucester House school are reducing whereas the general reporting of incidents has actually increased across the Trust, which is good. **BCP**	

	8.3	MS confirmed that the business continuity plans are being updated by all relevant teams across the organisations. **Trust Legal Claims** There were no completed claims in Q1. There are however 5 claims in train with another 2 about to be added, one for an individual and one for a group.	
	8.4	There was some discussion around whether the toy cleaning rota is being adhered to and SH confirmed that all clinicians that have toys in their rooms have been written to individually to ensure they are compliant with the toy cleaning rota as many who are listed as non-compliant, do not actually have any toys to clean. **Adult Safeguarding Training** The Trust discussion around the provision of adult safeguarding training and CdS confirmed that level 3 had now been added on a phased approach for all relevant staff. It was noted that compliance was only 44% in July but with an expectation to reach over 90% by the end of Q4. The committee accepted the green rating for this work stream for Q1.	
9.		**Estates and Facilities** ***Ian Garlington, Estates Consultant***	
	9.1	IG introduced his report highlighting the following: **Estates compliance** All areas of statutory and non-statutory compliance have improved and confirmed we now have established a compliance programme with our maintenance provider. Action plans are now in place to enable premises' audit reports to be completed.	

	9.2 9.3	**External sites** The trust is working well with landlords at our external sites and have made good progress but note this is still a work in progress and it is hoped that we can shortly introduced electronic recording to manage this going forward. **Estates Policies** IG confirmed that some policies were in the process of being updated including transport and car parking policies. PJ asked about the general issues of patient incidents in car parks. IG noted this is a problem for many sites and that there have been no CAS alerts, but confirmed there are ligature risks in car parks and currently we have no control on the parking underground in terms of who can access down there. DS agreed we need secure access to all areas within the trust including the car park and asked if staff and students will be consulted in relation to free access to the building and IG confirmed the current arrangement of free access to the building presents problems that will need to be addressed. The committee accepted the green rating for this work stream for Q1.	
10.		Research and Development *Eilis Kennedy, Director of Research and Development*	
	 10.1	EK introduced her report noting the following: This is the second R&D report for this committee with the first reporting covering all studies to give the committee an overall view. This report for Q1 concentrates on all the studies that the Trust is leading on:	

	10.2	**The Personalised Programmes for Children' Study** We have now had confirmation for the 2nd 3 years of the study for the randomised controlled trial for children with conduct problems. We are also applying for excess treatment costs and this is moving in a positive direction.	
	10.3	**Primary Sclerosing Cholangitis Wellbeing Study** This study is small and has been completed. The papers have been published in the PLOS Medicine and BMJ publications. The study has had further coverage and exposure at a national PSC conference and is expected to have an impact on the guidelines.	
	10.4	**NIHR LOGIK Study** EK noted the following studies within this programme: a) Secondary data analysis of clinical data in the UK and Netherlands has begun b) LOGIC Quantitative c) LOGIC Qualitative EK confirmed that the studies were each recruiting, but there are many challenges including a delay in the development of the online study database and often delays or a lack of patients responding to invitation letters to participate. **CRN Funding** EK noted the funding for this year has been confirmed at £58,346, DWL asked if there were likely to be any thematic risks that may result in FOIs connected to the LOGIC study and if there were any opportunities regarding technical opportunities for the research platform for secondary data. There was lots of discussion around the effect of these FOIs and EK confirmed the data held is on 1,050	

		patients, of 13 years and under within the GID service who have lots of issues. EK also confirmed we need to protect the study from unwarranted FOIs and may need to seek legal advice and invoke the research exemption where appropriate. The committee accepted the green rating for this work stream for Q1.	
11.		**Any other business**	
	11.1	DS proposed a change to this committee's title to: Integrated Governance Committee (IGC). There was much discussion about this and it was noted that it would not be confused with the IG work stream title as this was changing to Data Security within the new Terms of Reference. The committee agreed the name change, which will be ratified at the next available EMT.	
	11.2	DS asked the committee if we still needed to retain 2 hours for this committee as the last 2 committee have finished within an hour and a half. After discussion it was agreed to retain the 2 hours, especially with addition of the divisional directors set to join the committee.	
	11.3	MS asked if the new divisional directors will be asked to produce reports to this committee and DS confirmed that they will not be required to provide reports. SH noted that it will be very helpful for them to hear the committee views which will assist them in managing their divisions.	
12.		**Future Meeting Dates:** Wednesdays, 11am – 1pm in the Tavistock Board Room 20th November 2019 19th February 2020 20th May 2020 16th September 2020	

		18th November 2020	
		DS thanked the committee and our CQC colleagues for their attendance and closed the meeting.	

Report to	Board of Directors
Report from	Education and Training Committee – 7th November 2019

Key items to note

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

Student Recruitment

The committee noted the outcome and success of the student recruitment cycle achieving the highest ever level of Y1 student enrolments. Given the level of achievement the committee requested that a separate report is presented to the November Board. Work is being undertaken to understand the diversity of the Trust's student body across all long courses by portfolio.

Scheduling and Timetabling

The committee noted the significant improvement in timetabling and scheduling, and reduction in issues, which are being dealt with by the weekly Change Board as they arise. The committee noted the knock-on impact on our CPD programme, which has created uncertainty in the planning process for CPD. The Continuing Education Development Unit (CEDU) are working with the Scheduling team to identify a process for planning CPD activity alongside scheduling. Some of these issues will be addressed by starting and concluding the work on the AY20/21 timetable earlier than was possible last year. The improvements achieved through a meticulous process including course lead review and sign-off has helped secure this outcome. Special thanks to Isabelle Bratt, Stephanie O'Mahony and members of the scheduling team and project.

International Strategy

The committee noted that an external consultant has been engaged to work with the International Working Group. Initially this is for a four-month period to focus on the following areas: operational improvements in managing the pipeline of activity and on delivery; developing our internal and external communications plan; improving our marketing and relationship building; and developing a platform for more solid growth in our income and contribution targets. The key objective will be to further establish the foundation for development and a baseline for growth.

Digital Academy

The committee noted that the Digital Academy project is entering a transition phase. The project board for phase 1 has been closed, and the phase 2 programme is being established.

Long course development

The committee noted that long course development will be key to our future growth strategy. The committee noted the timeline for the development of a long course with the University of Essex which will go through validation ready for AY20/21. There will be a placeholder in the prospectus for 20/21, and work is being undertaken around how to market the course. The Deputy Director, Education & Training/ Dean of Postgraduate Studies provided assurance around risk mitigation.

Alumni Strategy
The committee noted the operational plan for the Trust Alumni Strategy to achieve our strategic aims for 19/20. The committee noted the synergies between the alumni strategy and Trust Centenary, and the need to identify enablers across the Trust to participate in developing our offer.

Annual Student Survey
The committee noted the high engagement with the survey, and the overall satisfaction of the Trust student body, and a separate paper is being presented to the Board.

Tavistock Society of Psychotherapists
The committee discussed the due diligence undertaken by the Deputy Director, Education & Training/ Associate Dean, Academic Governance and Quality Assurance. The committee recommends to the Board of Directors that they approve the proposal to incorporate the Tavistock Society of Psychotherapists into the Trust.

HESA/HESES
The committee discussed the work undertaken by the Head of Academic Governance & Quality Assurance and Head of Course Administration, Data and Reporting in implementing and progressing the HESA/HESES action plan. The committee noted the improvement in institutional knowledge, with the successful submission of both the HESA and HESES. The committee agreed it would be important to have Standard Operating Procedures in place to have oversight and understanding of the processes involved in these complicated returns.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

The Board of Directors is asked to approve the proposal to incorporate the Tavistock Society of Psychotherapists (TSP) into the Trust.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	06 February 2020

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 26th NOVEMBER 2019, 1.30pm – 4.25pm
LECTURE THEATRE, 5TH FLOOR. THE TAVISTOCK CENTRE,
120 BELSIZE LANE LONDON, NW3 5BA

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	1.30pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 24th September 2019	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	1.40pm	Verbal
2.2	Chief Executive's Report	Chief Executive	1.50pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.00pm	3
2.4	Quality Dashboard (Q2)	Medical and Quality Director	2.05pm	4
3 Items for decision or approval				
3.1	Audit Committee Terms of Reference	Deputy Chief Executive / Director of Finance	2.10pm	5
3.2	NHS Pledge on Reduction of Single Use Plastics	Director of Estates, Facilities and Capital Projects	2.15pm	6
4 Items for discussion				
4.1	Tavistock Centenary	Projects Director	2.25pm	7
4.4	Data Security – Serious Incident Report	Director of HR & Corporate Governance	2.35pm	8
5 Items for information				
5.1	Board Assurance Framework	Chief Executive	2.45pm	9
5.2	Operational Risk Register	Deputy Chief Executive / Finance Director	2.55pm	10

Agenda pullout

		Presenter	Timing	Paper No
5.3	Serious Incidents Quarterly Report (Q2)	Medical and Quality Director	3.00pm	11
5.4	Guardian of Safe Working Report (Q4)	Medical and Quality Director	3.05pm	12
5.5	CQC Action Plan update	Medical and Quality Director	3.10pm	13
5.6	Gloucester House Annual Report	Head Teacher	3.20pm	14
5.7	Student Survey and AY 2019 Student Recruitment	Director of Education & Training/Dean	3.30pm	15
5.8	Technology and Transformation Report	Director of Technology & Transformation	3.40pm	16 – Late
5.9	People Strategy Report	Director of HR & Corporate Governance	3.45pm	17
6. Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.55pm	18
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	4.00pm	19
6.3	Clinical Quality, Safety and Governance Committee	Committee Chair	4.05pm	20
6.4	Education & Training Committee	Committee Chair	4.10pm	21
8 Any other matters				
8.1	Questions from Public Observers	Trust Chair	4.15pm	
8.2	Any other business	All	4.20pm	
9 Date of Next Meeting				
	28th January 2020, 1.30pm – 5.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			