The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 28th January 2020

Please refer to the agenda for timings.

Board Room 3rd 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, 28th JANUARY 2020, 1.30pm – 4.00pm
BOARD ROOM 3RD 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 26th November 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 (Q3)	Medical and Quality Director	2.05pm	4
3 Items for decision or approval				
3.1	Annual Quality Priorities	Medical and Quality Director	2.25pm	5
3.2	Integrated Governance Committee Terms of Reference	Medical and Quality Director	2.35pm	6
3.3	Equality, Diversity and Inclusion Committee Terms of Reference	Director of HR & Corporate Governance	2.40pm	7
4 Items for discussion				
4.1	Strategic Objectives – 2020/21	Chief Executive	2.45pm	8
4.2	Governance Flows of Assurance	Director of HR & Corporate Governance	2.55pm	9

5 Items for information				
5.1	Serious Incidents Quarterly Report (Q3)	Medical and Quality Director	3.05pm	10
5.2	Guardian of Safe Working Report (Q3)	Medical and Quality Director	3.10pm	11 – Late
5.3	Emergency Preparedness, Response & Recovery (EPRR) Annual Plan	Medical and Quality Director	3.15pm	12
5.4	Annual Equality, Diversity & Inclusion Report	Director of HR & Corporate Governance	3.20pm	13
5.5	Flu Self-Assessment Assurance Reporting	Director of HR & Corporate Governance	3.25pm	14
6. Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.30pm	15
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.35pm	16
7 Any other matters				
7.1	Questions from Public Observers	Trust Chair	3.40pm	
7.2	Any other business	All	3.55pm	
8 Date of Next Meeting				
	3rd March 2020, 1.30pm – 5.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			

The Tavistock and Portman NHS Foundation Trust

Board of Directors Meeting Minutes (Part 1)
26 November 2019, 1.30pm – 4.35pm

Present:			
Paul Burstow Trust Chair	David Holt Senior Independent Director	David Levenson Non-Executive Director	Dinesh Bhugra Non-Executive Director
Deborah Colson Non-Executive Director	Helen Farrow Non-Executive Director	Celestine Keise Associate Non-Executive Director	Paul Jenkins Chief Executive
Terry Noys Deputy Chief Executive / Finance Director	Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Sally Hodges Clinical Chief Operating Officer	Dinesh Sinha Medical and Quality Director
Rachel James Divisional Director – CYAF	Rachel Surtees Director of Strategy	Craig de Sousa Director of Human Resources and Corporate Governance	
Attendees:			
Fiona Fernandes Corporate Governance Business Manager	Nell Nicholson Head Teacher (Item 5.6)	David Wyndham Lewis Director of Technology and Transformation (Item 5.8)	
Apologies:			
Chris Caldwell, Ailsa Swarbrick, Tim Kent			

AP	Item	Action to be taken	Resp	By
1	1.3.1	Amendments to the minutes of the previous meeting	CdS	Immed
2	4.2.5	Update on progress of the GIDS action plan to be presented the board of directors	PJ	Mar 20
3	5.1.5	Board seminar topic to be scheduled surrounding risk management and capacity of managers below board level to handle this.	CdS	Feb
4	5.3.3	Schedule of learning lessons and suicide prevention events to be sent to the board of directors	DS	Immed

1. Administrative matters

1.1 Welcome and apologies

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

1.2 Declarations of interest

1.2.1 There were no declarations of interest for items noted on the agenda.

1.3 Minutes of the previous meeting

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

1.4 Matters arising and action points

1.4.1 All the actions were noted as completed.

1.4.2 There were no matters arising which were not covered by the agenda.

2. Operational items

2.1 Chair and non-executives' reports

2.1.1 Prof Burstow delivered an oral report and highlighted:

- The non-executive director service links had been reviewed and a paper was tabled providing the detail.
- He had taken chair's action to change of name of the clinical, quality, safety and governance committee to the integrated governance committee, on recommendation from medical and quality director.
- That he had attended the refugee team, Camden looked after children service, the north and south Camden child and adolescent mental health service (CAMHS) teams.
- On 27 November 2019 he would be attending a King's Fund conference and would be presenting on integrated care systems.

2.1.2 Dr Colson reported that she had attended the October Gloucester House steering committee away day and that Ms Keise was also present. She reported that there had been an increase in incidents at the school.

2.1.3 Mr Levenson reported that he had completed three days of locally arranged induction meetings; attended a Healthcare Financial Management Association (HFMA) course on audit; and, had attended the NHS Providers two day non-executive director induction. He highlighted that he had picked up through the latter about the mental health investment standard.

2.1.4 Dr Bhugra reported that he had been approached by the National Institute of Mental Health and Neuro-Sciences who had enquired whether the Trust would engage with a two day conference in the near future. He also emphasised that he had been involved in a piece of work to survey medical students across twelve countries on the subject of burnout. Responding to Dr Bhugra, Dr Sinha noted the Trust's General Medical Council (GMC) trainee experience report showed a 35% satisfaction rate and that work was in hand with the director of medical education and directorate of education and training about how to further improve on training opportunities for the junior doctors.

2.1.5 The board of directors noted the reports.

2.2 Chief executive's report

2.2.1 Mr Jenkins presented the report and highlighted:

- Work continued to implement the gender identity development service (GIDS) action plan. He emphasised:
    - New clinical protocols were being developed and signed off by the Trust's operational service delivery board.
    - Further work was progressing to define referral criteria.
    - A wider report would be produced in the Spring on what has been achieved against the action plan.
- He and Prof Burstow had attended the black, asian and minority ethnic (BAME) staff network.
- That he and Prof Burstow hosted a meeting with John Brouder, the former chief executive from North East London NHS Foundation Trust, who is leading a Pan London programme of work on the workforce race equality standard (WRES).
- That the London top leaders network, a meeting of NHS chief executives, had taken place and focussed on wellbeing and he led a presentation about workplace resilience.
- Mr Wyndham Lewis, the Trust's technology and transformation director, would be leaving in early 2020 to take up a promotional role with Atos.

2.2.2 The board of directors noted the report and expressed their congratulations on Mr Wyndham Lewis' appointment and thanked him for his significant contributions.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- At month six the Trust had achieved a small surplus.
- Income was below budget as a result of new business not being achieved.
- The forecast reflected assumptions surrounding income and expenditure patterns within the Charing Cross gender identity clinic and the gender identity development service.
- A reconciliation of purchase orders had been undertaken and were reflected in the report.
- Cash flow position was better than plan.

2.3.2 Responding to Mr Holt, Dr Hodges noted that an activity recovery plan had been established was being monitored through the clinical service delivery board.

2.3.3 The board of directors noted the report.

2.4 Quality dashboard

2.4.1 Dr Sinha presented the report and particularly highlighted:

- There was variable performance across the divisions surrounding waiting times, specifically:
    - The children, young adults and family services had seen compliance for first attendances reduce but performance for second appointments improve.
    - Wait times within adult and forensic services for both first and second attendances had reduced.
    - The gender services division has a high level of referrals which is resulting in longer than planned wait times and work continued in this area.
- Patient non-attendance rates was improving and the reported figure was 9.43%.
- Compliance with the mental health service dataset was continuing to improve.
- Serious incidents are presented on the dashboard and provides and overview of the overall trend.
- Complaint data demonstrates a steady trend with maintained compliance of the response targets.
- There continued to be a high level of adverse media coverage reported.
- Experience of service questionnaires continue to demonstrate positive results.
- There had been a notable drop in mandatory training compliance within the quarter.

2.4.2 Responding to Mr Levenson, Dr Sinha noted that the Trust tracks first and second attendances as these relate to the time gap between initial assessments and, ordinarily, the commencement of treatment.

2.4.3 Reflecting on a challenge from Dr Colson, Dr Sinha noted that the increase adolescent wait times was the result of high staff turnover during the summer.

2.4.4 In response to a challenge from Mr Holt, Dr Hodges noted that there had been an increased level of staff receiving adverse attention via social media, she emphasised the Trust was working hard to support staff where this happens. Mr de

Sousa noted that the Trust's communications team were working on guidance regarding this but there was a national guideline and each professional regulatory body has guidance also for clinical practitioners.

2.4.5 Responding to Ms Keise, Dr Sinha noted that there were no specific guidelines in place for patients regarding social media use.

2.4.6 Dr James noted that the Trust was working with its local commissioners to understand the challenges of capturing outcome measures and what information would be clinically appropriate and useful. Dr Colson emphasised it was important to be able to obtain measures that demonstrate practice and innovation.

2.4.7 Reflecting on a challenge from Mr Holt, Dr Sinha noted that he would discuss further the reporting format of the quality priorities and how best to detail a trajectory.

2.4.8 The board of directors noted the report.

3. Items for decision

3.1 Audit committee terms of reference

3.1.1 Mr Noys presented the terms of reference and noted that they had undergone their annual review with no substantive amendments being proposed.

3.1.2 The board of directors approved the terms of reference.

3.2 NHS pledge on the reduction of single use plastics

3.2.1 Mr Jenkins presented the paper and emphasised:

- The paper reflected a wider NHS commitment to improving organisational sustainability.
- He had engaged with staff at the latest chief executive's forum on steps the organisation can take to address environmental issues.
- It was proposed that the Trust's adopts the pledge to eradicate single use plastic consumables within the organisation.
- The organisation establishes a forum where staff can develop ideas and programmes to improve on the Trust's environmental impact.

3.2.2 Dr Hodges noted that the Trust previously had facilitated a 'green group' with a similar remit.

3.2.3 The board of directors noted the paper, accepted the recommendations made within the paper and approved the adoption of the pledge.

4. Items for discussion

4.1 Trust centenary update

4.1.1 Ms Lyons was in attendance for this item and presented the paper. She highlighted:

- Planning was ongoing and preparations where coming together to establish a range of talks and programmes to mark the centenary year.

- A conference was being planned to take place on 24 September 2020 to be held at King's Place.

- Work was ongoing with the Tavistock Institute of Human Relations to digitise both organisations' archives.

- A family day was being co-ordinated to take place on 25 September 2020 for staff.

- During the centenary year it was anticipated that the Tavistock Charitable Fund and the Tavistock Clinic Foundation would merge and relaunch as a new entity hosting a gala drinks events on 11 June 2020.

4.1.2 Responding to Prof Bhugra, Ms Lyon noted that some ex-staff had been involved and consulted on the centenary preparations.

4.1.3 In response to a questions from Prof Burstow and Ms Keise, Ms Lyon noted that the overarching narrative for the centenary year was to celebrate the past but to have a forward facing approach for the next 100 years.

4.1.4 The board of directors noted the update.

4.2 Data security incident

4.2.1 Mr de Sousa presented the report and noted:

- A data breach had occurred on 06 September 2019 and had affected one of the Trust's clinical services.

- That 1,777 patient records were involved by the incident.

- He had undertaken a full serious incident investigation and had prepared a detailed chronology of the events.

- There had been a notable level of candour from those that were involved in the investigative process.

- The incident was as a result of human error and a number of systemic process factors which caused the incident.

- The immediate response following the incident occurring was robust and comprehensive.

- An action plan had been developed, with the technology and transformation director.

- The incident had been promptly reported to the Information Commissioner's Office and the Trust's commissioners via the strategic executive incident solution (StEIS).

4.2.2 Responding to Mr Levenson, Mr Noys noted that the new maximum number of recipients a member of staff could send an email to had been implemented and the limit was set to 50.

4.2.3 In response to a question from Ms Farrow, Mr de Sousa noted that Chelsea and Westminster NHS Foundation Trust was involved with a similar breach and received a fine from the Information Commissioner's Office. He particularly noted, that the fine was a result of the organisation being involved in the same type of error more than once.

4.2.4 Reflecting on a challenge from Dr Colson, Mr de Sousa noted that he would consult with Mr Wyndham Lewis whether there was any learning from the incident which could inform how other risks can be mitigated within the information management and technology service.

4.2.5 Mr Jenkins noted that the action plan would be implemented and a further report would be brought to the board of directors in March 2020 updating on progress [AP2].

4.2.6 The board of directors noted the report.

5. Items for information

5.1 Board assurances framework

5.1.1 Mr Jenkins presented the report and noted that the framework had been reviewed by the executive management team prior to its submission to the board of directors.

5.1.2 Responding to Mr Holt, Mr Jenkins noted that the executive management team would reconsider the risk appetite reflecting the fact that framework demonstrates a lower risk tolerance being accepted at present.

5.1.3 In response to a question from Mr Levenson, Mr Noys noted that the risk module of the quality portal's development was being slowed down to address a number of issues before its roll out.

5.1.4 Responding to Ms Farrow, Dr Hodges noted that risk six reflects a challenge of getting staff engaged with quality improvement and specifically having time to attend the training. She emphasised that this was being addressed.

5.1.5 Prof Burstow noted that it would be beneficial to use one of the board seminars to explore further management capacity, below board level, to assess and manage risk [AP3].

5.2 Operational risk register

5.2.1 Mr Noys presented the risk register and emphasised:

- A new risk had been added which related to CareNotes.
- Risk 129 related to the family nurse partnership service, which would be transferring out to Public Health England on 01 April 2020. He emphasised

that service had withdrawn funds from the Tavistock Clinic Foundation to procure a solution.

5.2.2 The board of directors noted the report.

5.3 Serious incidents quarterly report

5.3.1 Dr Sinha presented the report and highlighted:

- An analysis of the serious incidents had been undertaken and there was a noted theme surrounding gang related violence.
- The Trust has in place suicide prevention events.
- Workplace violence continues to be a focus area in the Trust and an organisation wide survey had been launched to seek staff opinion on options to improve the Tavistock Centre's access and security.
- The Trust's adult safeguarding lead would be leaving the Trust and recruitment had commenced.

5.3.2 Responding to Dr Colson, Dr Sinha noted that the data surrounding incidents and serious incidents would be triangulated through the assurance processes that feed in to the integrated governance committee.

5.3.3 Reflecting on a further comment from Dr Colson, Dr Sinha noted that the dates of future learning lessons events would be circulated to the members of the board of directors [AP4].

5.3.4 In response to a challenge from Prof Burstow, Dr Sinha noted that the board of directors receives a summary of thematic incidents and for serious incidents and the detail is reported to the integrated governance committee.

5.3.5 The board of directors noted the report.

5.4 Guardian of safe working report

5.4.1 Dr Sinha presented the report and noted that the Trust provides one on-call rota. He emphasised the junior doctors provide senior input to the emergency and paediatric departments at the Royal Free Hospital, University College London Hospital and Whittington Hospital.

5.4.2 Dr Sinha further noted that the guardian of safe working would be coming to the end of their tenure and recruitment would be shortly starting.

5.4.3 The board of directors noted the report.

5.5 CQC action plan update

5.5.1 Dr Sinha presented the report and highlighted:

- Good progress was being made against the action plan.

- The action plan is reviewed monthly by the executive management team.
- The plan is further reviewed by the integrated governance committee.

5.5.2 Responding to Mr Holt, Dr Sinha noted that there were no matters of serious concern to highlight to the board and that whilst there were some actions behind their target dates he was assured that work was progressing in these areas.

5.6 Gloucester House annual report

5.6.1 Ms Nicholson was in attendance for this item and presented the report, she particularly highlighted:

- The school had hosted its fifty year anniversary with the celebrations involving ex-staff, ex-parents and ex-pupils. She noted her thanks to the Trust charity which had supported the event.
- Collaborative working with Challenge Partners continued.
- There had been a high focus on staff wellbeing and investment had been made in leadership development.
- The school continued to provide its outreach service working with various schools including the introduction of a telephone advice service.

5.6.2 Responding to Ms Farrow, Ms Nicholson noted that the school had experienced difficulty with recruiting a band 7 clinical nurse specialist but this has been resolved and a person had been recruited. She reflected further and noted that there was a high level of turnover for band 4 support workers and the reason for this was that the post holders acquire valuable experience at the school and then progress on to band 5 roles within improving access to psychological therapy services.

5.6.3 In response to a challenge from Mr Levenson, Ms Nicholson noted that the staff to pupil ratio is 2:1. Ms Keise noted that the school provided services which were for children who needed more support than a pupil referral unit.

5.6.4 Responding to a challenge from Dr Colson, Ms Nicholson noted that with the departure of the deputy head, the leadership of the school would be reconfigured and two senior teacher positions would be established.

5.6.5 Mr Jenkins noted that the school was an integrated part of the Trust and the service had launched its own Twitter social media account which is managed by one of the leadership team.

5.6.6 The board of directors noted the report.

5.7 Student survey and academic year 2019 student recruitment

5.7.1 Mr Rock presented the report and highlighted:

- Student recruitment for the 2019/20 academic year was exceptionally positive seeing 13% growth.

- Work was underway to plan how further growth might be achieved.
- The student recruitment report excluded 15 students who had been enrolled on a new programme which was initially being delivered by the University of Hertfordshire.
- The student survey had seen an increase in participation and it was pleasing to report that satisfaction levels ranked at 60%.
- The survey highlighted that the directorate needs to take forward further work to improving experience and notably address issues that students with disabilities face.
- The Trust's scheduling solution had successfully timetabled the academic programme with a small number of issues marking a major improvement on the previous year.

5.7.2 Mr Holt noted that the directorate had achieved impressive recruitment figures and congratulated Mr Rock and his staff for this.

5.7.3 Mr Jenkins noted there had been significant work by the student recruitment team to achieve the number of students enrolled.

5.7.4 Prof Burstow noted that the report highlighted a significant evolution of the organisation and echoed Mr Holt's thanks.

5.7.5 The board of directors noted the report.

5.8 Technology and transformation report

5.8.1 Mr Wyndham Lewis was in attendance for this item and presented the report. He highlighted:

- The board of directors approved an information management and technology strategy in 2016.
- The key deliverables within the strategy had been achieved.
- Capital expenditure had been invested in to the function which had facilitated a number of the achievements.
- Project and programme management methodologies had been formalised and established as a core part of the directorate.

5.8.2 Responding to Mr Levenson, Mr Wyndham Lewis noted that the Trust had undertaken a number of pieces of working surrounding cyber security. He emphasised that the Trust had not achieved the cyber security essentials standard.

5.8.3 Reflecting on a question from Prof Burstow, Mr Wyndham Lewis noted that the Trust is participating on a footprint wide piece of work to establish a health information exchange within north central London. He noted that the data solution was solely for locally commissioned services.

5.8.4 On behalf of the board of directors, Prof Burstow expressed its thanks to Mr Wyndham Lewis for his contribution to the organisation.

5.8.5 The board of directors noted the report.

5.9 People strategy report

5.9.1 Mr de Sousa presented the report and highlighted:

- The people strategy was in its final year and there continued to be on target progress against the strategic delivery plan.
- The health and wellbeing component of the delivery plan was behind target owing to the change in occupational health provider.
- The workforce metrics continued to show a stable picture across the key monitoring areas.
- Statutory and mandatory training compliance had declined owing to a number of staff becoming non-compliant in the quarter but the position would remediate following a training event which had taken place in the month.
- Child safeguarding level three training compliance had declined as a result of the trainer taking an unplanned absence.
- Adult safeguarding training levels two and three were improving in compliance and owing to the new intercollegiate guidance full compliance was not expected until at least August 2020.

5.9.2 Responding to Mr Holt, Mr de Sousa noted that the named professional for safeguarding children had scheduled additional training sessions to improve the compliance position.

5.9.3 Reflecting on a comment from Mr Levenson, Mr de Sousa noted that sickness absence levels were low on a rolling basis but due to the small denominators it was important to keep a watch on the spot month figures.

5.9.4 The board of directors noted the report.

6. Board committee reports

6.1 Audit committee

6.1.1 Mr Holt presented the summary and noted that the committee had requested that the integrated governance committee undertake a deep dive in to data security assurance.

6.1.2 The board of directors noted the report.

6.2 Equality, diversity and inclusion report

6.2.1 Mr de Sousa reported that the November committee meeting was used to undertake a planning session for the long term strategic priorities.

6.2.2 The board of directors noted the report.

6.3 Integrated governance committee report

6.3.1 Dr Sinha presented the report and noted that the committee had considered a revised draft of the terms of reference amongst normal business.

6.3.2 The board of directors noted the report.

6.4 Education and training committee report

6.4.1 Mr Rock presented the report and noted that work with the Tavistock Society of Psychotherapists had been taken forward. Prof Burstow noted that there had been an extensive discussion at the committee about this matter.

6.4.2 The board of directors noted the report.

7. Any other matters

7.1 Questions from the public

7.1.1 There were no members of public in attendance.

7.2 Any other business

7.2.1 There was no other business to discuss and the meeting closed at 4.35pm.

Report to	Date
Board of Directors	28 January 2019

Chief Executive's Report

Executive Summary

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

Covered within this paper includes updates on:

- Executive Management Team changes
- GIDS Action Plan
- Freedom to Speak Up Guardian

Recommendation to the Board

Members of the Board of Directors are asked to note this report

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. EMT change

1.1 As I highlighted at the November Board, David Wyndham-Lewis, our Director of Technology and Transformation has now left the Trust to take up a new role. David made a very substantial contribution to the work of the Trust over the last couple of years.

1.2 I am very pleased to announce that Jon Rex, an experienced IT Director has started as our interim Director.

1.3 As part of these changes Rachel Surtees is extending her role to take a wider responsibility for transformation in the Trust including the responsibility for the Programme Management Office.

2. GIDS Action Plan

2.1 Work has been continuing to progress the implementation of the GIDS Action Plan. By the end of the month we will be back on track with the completion of key milestones. Recent developments include:

- A review and update of Trust wide policy and procedures relating to raising concerns.
- A Standard Operating Procedure for the capturing and documentation of Consent, which responds to each related task in the Action Plan, will be distributed to the team shortly.
- The induction and training project is moving forward with collating existing materials and testing Moodle to explore an e-learning offer.
- Work is being taken forward on pathways and referral criteria.

2.2 We are meeting regularly with NHS England to review progress and our intention is to publish a full annual progress update in the Spring.

2.3 Ailsa Swarbrick and I have now completed a series of meetings with the Regional teams in the GIDS service. This has been very helpful in discussing some of the issues they are facing.

3. Freedom to Speak up Guardian

3.1 Gill Rushbridger has now completed her term as the Trust's Freedom to Speak up Guardian. I would like to put on record my appreciation for the leadership Gill has shown in carrying out this important roll.

3.2 Following interviews we have appointed Dan Sumpton, a clinician working in the TAP service as the Trust's new Freedom to Speak up Guardian.

Paul Jenkins
Chief Executive
20th January 2020

The Tavistock and Portman NHS Foundation Trust

Report to	Date
EMT Board	21 January 2020 28 January 2020

Finance and Performance Report – December 2019

Executive Summary

The Finance and Performance Report for the 9 months ending December 2019 is attached.
This shows a net YTD surplus of £235k, versus a Budget deficit of £(413)k, a positive variance of £649k.
All Directorates are ahead of Budget except for AFS which is £166k adverse to Budget.
Income is £1.5m below Budget reflecting: lower than Budget new business income; lower DET income (Portfolios, Child Psychotherapy trainees and Tavistock Consulting); lower CYAF income (Camden CAMHS and Complex Needs); lower AFS income (notably TAP and lower Adult / Complex Needs due to reduced Named Patient Agreements).
GIDS / GIC income is shown at budgeted levels, which assumes that for the full year activity levels are on target.
Staff costs are £1.8m below budget reflecting lower than Budget new business income and the fact that some Budget staff costs are now reflected in non-staffing (consultancy) costs.
Non-staff costs are below Budget reflecting, in particular, delayed office moves.
The Control Total for the year is £141k (after STF monies of £700k). In addition, the Trust has committed (to the NCL STP) to try and surpass its Control Total by £143k.
The Trust is still in on-going discussions with the Trust's external auditors – Mazars – regarding the accounting treatment for relocation costs.

Recommendation to EMT

EMT Board / is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Udey Chowdhury, Director of Financial Operations	Terry Noys, Deputy CEO and Director of Finance

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 9 **Dec-19**

Section

MONTHLY FINANCE AND PERFORMANCE REPORT **Section 1**

Period 9
31 December 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	39,741	**42,646**	44,129	(1,483)	**(3)%**
Staff costs	(28,200)	**(30,906)**	(32,718)	1,812	**6%**
Non-staff costs	(9,101)	**(9,998)**	(10,124)	126	**(1)%**
Operational costs	(37,301)	**(40,904)**	(42,842)	1,938	**5%**
EBITDA	2,440	**1,742**	1,287	**455**	**35%**
- Margin	6%	**4%**	3%		
Interest receivable	25	42	27	15	56%
Interest payable	(21)	(29)	(37)	8	(22)%
Depreciation / amortisation	(894)	(1,033)	(1,202)	170	(14)%
Public Dividend Capital	(485)	(487)	(487)	0	(0)%
Restructuring costs	(25)	0	0	0	
Net surplus	1,040	**235**	(413)	**649**	**157%**
- Margin	3%	**1%**	(1)%		

COMMENTARY
The Trust surplus is £235k, which is £649k above budget.

Revenue is £1,483k worse than budget due mainly to reduced bursary receipts and Practice Supervisor income in DET, reduced new business and complex needs revenue in CYAF and reduced levels of NPAs in AFS Complex Needs

Pay costs are £1,812k less than budget reflecting, in particular, lower level of new business income.

Non pay costs are £126k less than budget due mainly to underspends as a result of reduced activity delayed office moves, reduced bursary payments and lower costs in Practice Supervisors

FINANCE AND PERFORMANCE REPORT **Section 2**
Period 9
31 December 2019

	Prior Year End £'000	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	155	155	118	113			
Land and buildings	19,577	19,771	20,052	20,396	20,573	20,761	20,830	21,018			
IT equipment	3,383	3,479	3,487	3,471	3,472	3,521	2,849	2,813			
Other		0	0	0	0	0	0	0			
Property, Plant & Equipment	22,959	23,249	23,538	23,867	24,045	24,282	23,679	23,831	0	0	0
Total non-current assets	23,115	23,405	23,694	24,022	24,201	24,437	23,797	23,944	0	0	0
Trade and other receivables	5,901	3,291	6,677	5,257	7,796	6,203	6,463	8,396			
Accrued Income and prepayments	3,896	6,336	3,456	3,290	3,833	4,917	4,264	4,300			
Cash / equivalents	8,569	7,426	9,866	9,768	8,537	6,866	7,609	7,873			
Total current assets	18,366	17,053	19,999	18,315	20,167	17,986	18,335	20,569	0	0	0
Trade and other payables	(3,685)	(2,552)	(2,528)	(2,413)	(2,861)	(2,965)	(2,411)	(2,346)			
Accruals	(2,075)	(4,216)	(4,017)	(5,159)	(4,416)	(4,077)	(3,988)	(3,747)			
Deferred income	(4,513)	(2,890)	(6,006)	(3,831)	(6,154)	(4,549)	(4,794)	(7,336)			
Provisions	(212)	(120)	(118)	(74)	(78)	(76)	(76)	(76)			
Total current liabilities	(10,485)	(9,778)	(12,669)	(11,477)	(13,509)	(11,667)	(11,270)	(13,505)	0	0	0
Total assets less current liabilities	30,995	30,680	31,024	30,860	30,858	30,756	30,862	31,008	0	0	0
Non-current provisions	(248)	(248)	(248)	(248)	(248)	(248)	(248)	(248)			
Long term loans	(4,000)	(4,000)	(4,000)	(3,760)	(3,778)	(3,778)	(3,778)	(3,778)			
Total assets employed	26,748	26,432	26,776	26,852	26,833	26,730	26,837	26,982	0	0	0
Public dividend capital	3,474	3,474	3,474	3,474	3,474	3,474	3,474	3,474			
Revaluation reserve	12,621	12,621	12,621	12,621	12,621	12,621	12,621	12,621			
I&E reserve	10,653	10,338	10,682	10,758	10,739	10,636	10,743	10,888			
Total taxpayers equity	26,747	26,433	26,776	26,852	26,833	26,731	26,837	26,983	0	0	0

MONTHLY FINANCE AND PERFORMANCE REPORT FUNDS FLOW **Section 3**

Period 9

31 December 2019

	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	**YTD Act £'000**
Net Surplus	(315)	343	77	(20)	(103)	107	145	**235**
Depreciation / amortisation	401	134	132	135	134	(19)	117	**1,034**
PDC dividend paid	163	54	54	54	54	54	54	**487**
Net Interest paid	(1)	(1)	(6)	0	(2)	(1)	(2)	**(13)**
(Increase) / Decrease in receivables	170	(506)	1,586	(3,083)	510	394	(1,970)	**(2,899)**
Increase / (Decrease) in liabilities	(616)	2,893	(1,148)	2,028	(1,840)	(398)	2,236	**3,156**
Increase / (Decrease) in provisions	(92)	(2)	(44)	4	(2)	0	0	**(136)**
Other working capital movements	(563)	(184)	(383)	370	(270)	878	(346)	**(498)**
Net operating cash flow	(853)	2,732	269	(512)	(1,519)	1,016	234	**1,366**
Interest received		18	5	6	5	4	4	**42**
Interest paid				(18)				**(18)**
PDC dividend paid				(291)				**(291)**
Restructuring costs								**0**
Cash flow available for investment	(853)	2,750	274	(815)	(1,514)	1,020	237	**1,099**
Purchase of property, plant & equipment	(290)	(310)	(150)	(415)	(158)	(276)	(263)	**(1,862)**
Capital accruals							290	**290**
Purchase of property, plant & equipment- cash	(290)	(310)	(150)	(415)	(158)	(276)	27	**(1,572)**
Net cash flow before financing	(1,143)	2,440	124	(1,230)	(1,672)	744	264	**(473)**
Repayment of debt facilities	0		(222)					**(222)**
Net increase / (decrease) in cash	**(1,143)**	**2,440**	**(98)**	**(1,230)**	**(1,672)**	**744**	**264**	**(695)**
Opening Cash	8,569	7,426	9,866	9,768	8,536	6,866	7,609	**8,569**
Closing cash	**7,426**	**9,866**	**9,768**	**8,536**	**6,865**	**7,610**	**7,873**	**7,873**

Capital Expenditure **Section 4** 9

Period 9

Dec-19	ANNUAL				Y.T.D		
9	£000 Fcst	£000 Budget	£000 Var		£000 Actual	£000 Budget	£000 Var
SITS Phase 2	(0)	-	0		(0)	-	0
Microsoft Office 365 E-Mail Migration	-	-	-		-	-	-
Robotic Process Automation - Scheduling	-	-	-		-	-	-
Endpoint Replacement 2019/20	259	259	1		220	115	(105)
Endpoint Procure/Config/Compliance/Monitor	174	167	(7)		87	167	80
Patient-Level Individual Costing System (PLICS)	-	-	-		-	-	-
e-Referrals System Implementation	53	54	1		42	54	12
Programme & PMO Development	-	-	-		-	-	-
Tavistock Centre Data Centres Power Provision	64	65	1		-	65	65
IMT Service Improvement	15	30	15		15	30	15
SMS Appointment Reminders	-	-	-		-	-	-
Digital Dictation, Transcription, & Hybrid Mail	-	-	-		-	-	-
Cyber Essentials	12	16	4		-	16	16
Data Warehouse Optimisation & Dashboards	-	-	-		-	-	-
Care Notes Renewal	(17)	-	17		(17)	-	17
Health Information Exchange	300	15	(285)		162	8	(154)
MyTap Annual Upgrade 2019/20	199	41	(158)		157	41	(116)
Health & Social Care Network	28	33	4		-	33	33
Endpoint Replacement 2018/19	13	-	(13)		13	-	(13)
DET Record Management System	(3)	-	3		(3)	-	3
Scheduling & Robotic Process Automation	305	404	100		215	227	12
Data Warehouse & Dashboard	-	-	-		-	-	-
Network Replacement	47	-	(47)		17	-	(17)
Default	-	-	-		-	-	-
STP FUNDING	(250)	-	250		-	-	-
IT	**1,200**	**1,085**	**(115)**	-	**908**	**756**	**(152)**
Ventilation	72	59	(13)		26	56	30
Security	40	-	(40)		-	-	-
Safety	30	31	1		-	31	31
Pumps	30	29	(1)		-	29	29
Water	62	68	6		-	62	62
Electrics	54	66	12		-	60	60
PC Compliance	9	9	-		-	9	9
TC Compliance	54	54	-		-	54	54
Access	-	-	-		-	-	-
Agile Working	8	33	26		8	33	26
Miscellaneous / Contingency	-	-	-		-	-	-
LH - 67 Belsize Lane	48	18	(30)		48	18	(30)
Clapham Junction Re-fit	26	28	1		26	28	1
Finchley Road	201	-	(201)		161	-	(161)
Tavistock Centre - Phase 1	-	-	-		-	-	-
ESTATES	**634**	**396**	**(238)**	-	**269**	**381**	**112**
FNP Database - COST	880	-	(880)		75	-	(75)
FNP Database - FUNDING	(880)	-	880		-	-	-
F.N.P DATABASE	**(0)**	**-**	**0**		**75**	**75**	**0**
RELOCATION	**1,255**	**1,322**	**66**		**608**	**895**	**287**
DIGITAL ACADEMY	170	505	335		1	235	234
TOTAL	**3,259**	**3,307**	**48**		**1,861**	**2,343**	**481**

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: January 2020

Report to	Date
Board of Directors	January 2020

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q3 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 on page 1, which was a new addition to the report in November, continues to show an increase in referrals Trust wide, and specifically for Camden CAMHS. Smaller increases were noted in TAP, C&H and Adult services. GIC saw a decrease in referrals.
- Whilst most AFS and CYAF services saw slight increases in the number of patient contacts in Q3, overall the Trust saw the lowest number of patient contacts in the last 4 quarters. Decreases were most noticeable in Gender services.
- Waiting times improvements are noted for the Portman and most of CYAF service lines, especially for second appointments target. The exception is TAP which saw an increase in waiting times for first appointment primarily due to a 30% cut in resources.
- Overall Trust DNA rates continue to perform over target although TAP and GIC services remain above 10% with a significant increase in GIC this quarter. GIC rates are related to an issue with the SMS reminder functionality now resolved.
- Q3 MHSDS collection rates show a small decrease in the three areas where we have been showing consistently poor data – ethnicity; employment status (adults) and accommodation status (adults). Actions completed during Q3 to improve compliance will show in the March NHS Digital report and be included in Q4. The most recent DQMI is for September 2019 with compliance at 93.4%.
- Q3 saw a decrease in complaints received from 60 in Q2 to 30 in Q3 due to significant a drop in GIC complaints from 51 to 18.
- Among our outcome measures, CORE improvement rates dropped in Q3 but are still above target at 73%. Time 1 Goal Based Measure completion rates further increased in Q3 from Q2, however, Time 2 completion dipped to 35%. The QI project in Camden North and South continues to work on improving these.
- The CGAS completion rates have increased for both Time 1 and Time 2.
- HR mandatory training rate has increased from 63% in Q2 to 82% in Q3 as a result of an INSET day being held.

- SNOMED report now available which permits monitoring. SNOMED codes have been added to the EPR system with Trust assessment of CQUIN compliance.

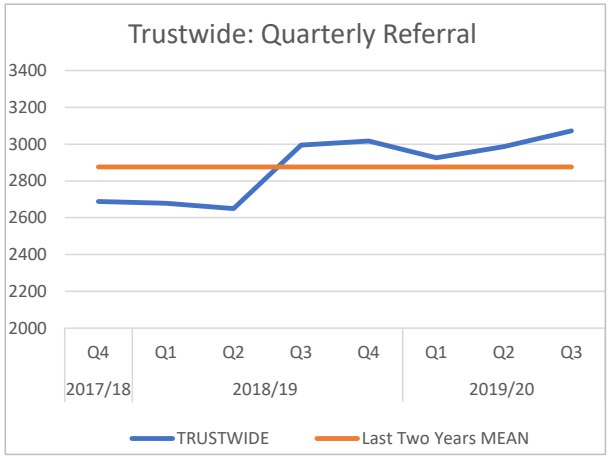
There are also details of continuing **Challenges**:

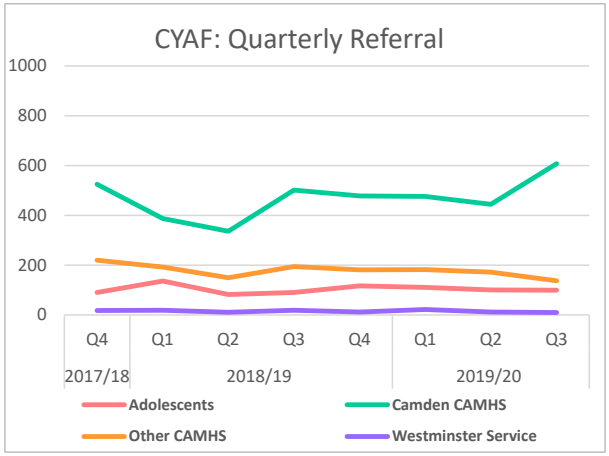
- These include the ongoing waiting times for Gender Services, Adult Complex Needs and TAP.
- A plan for the mitigation of patient contact issues identified continues to be implemented.
- GBM and CGAS collection rates under target, though there continue to be improvements compared to Q1
- CORE low collection 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.

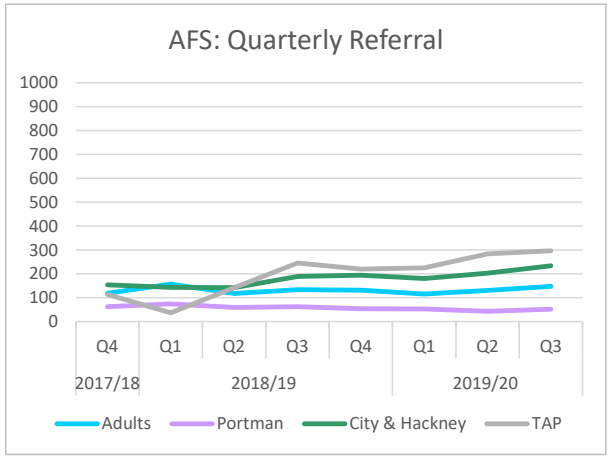
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.
Trust strategic objectives supported by this paper
Finance and Governance

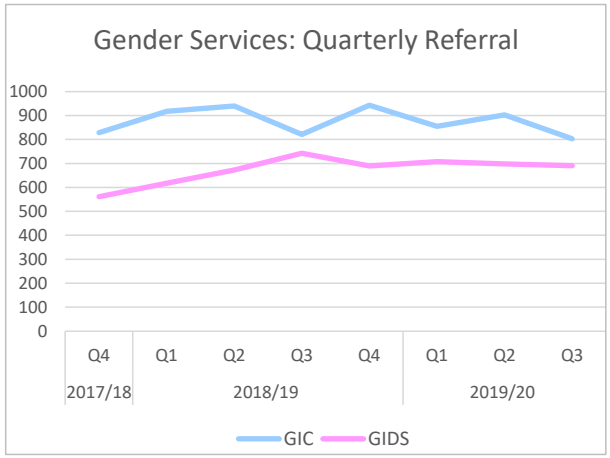
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q3 2019/20: Trust Reach – Access









Data source: 09/01/2020 SRRS (Internal Reporting System) Reported by the Quality Team

Number of Referrals Received:

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

We noticed an increase in the number of referrals during Q3 with 2846 received referrals Trust-wide, significantly higher number that the last two years average.

Adolescent : in Q3 received 99 referrals, the average of referrals over the last 4 quarters is 106 and in the previous 4 quarters it was 99.

Camden CAMHS: in Q3 there was an increase in the number of referrals, reaching 607 – the highest figure over the last two years.

Other CAMHS: in Q3 received 137 referrals, the lowest number over the last two years. The average of referrals over the last 4 quarters was 168 and in the previous 4 quarters it was 188.

Westminster service: the number of referrals slightly dropped in Q3, receiving only 9 referrals compared to the 11 received in Q2

Adults Complex needs: has experienced an increase in referrals, receiving 147 in Q3 – the highest number over the last 6 quarters.

Portman: in Q3 experienced an increase, with 51 referrals. But when comparing the average of referrals over the last 4 quarters is 50 and in the previous 4 quarters was 64 - we can see a slight decrease.

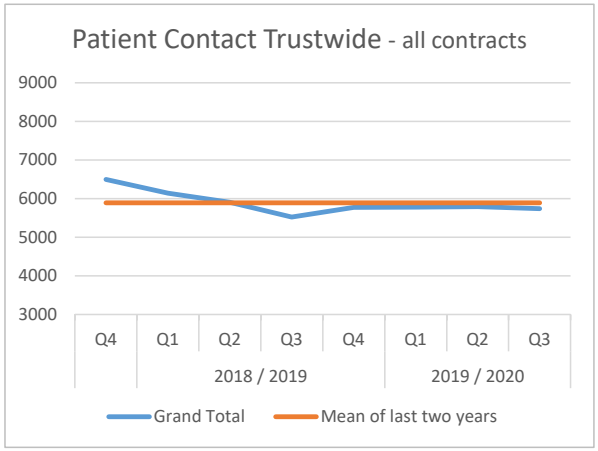
C&H PCPS: has had an increase in the number of referrals received, reaching 233 in Q3 - the highest figure over the last two years.

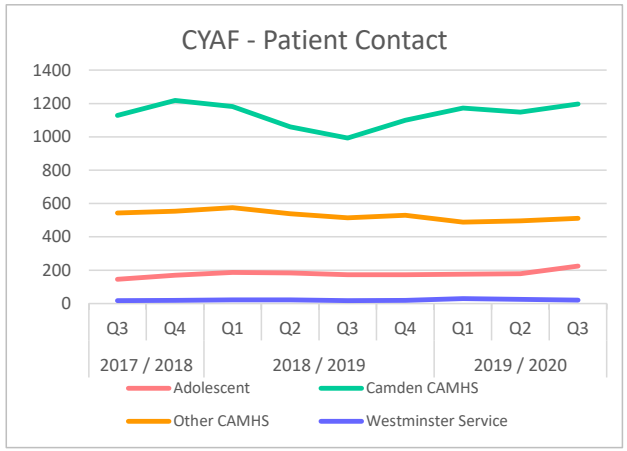
TAP: in Q3 experienced a rise on the number of referrals with 496, compared to the 283 received in Q2.

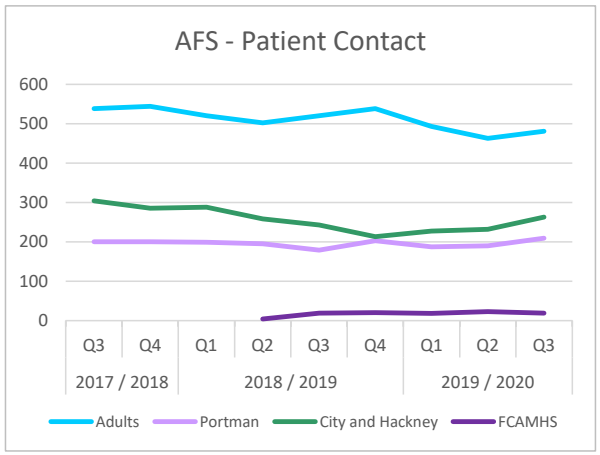
GIDS: in Q3 GIDS received 8 referrals fewer than in Q2. This could mean that the major increase in demand over the last few years is reaching its peak.

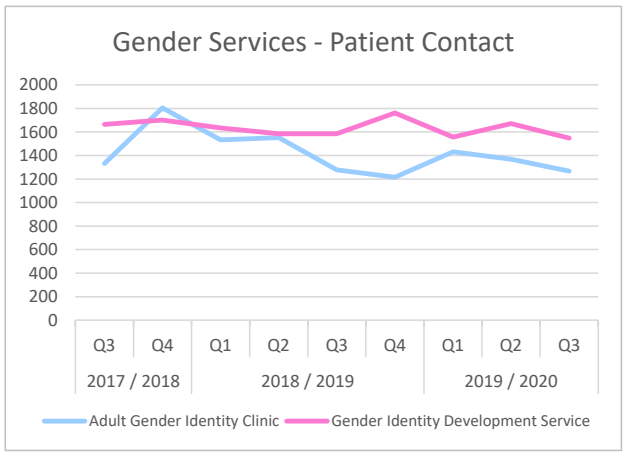
GIC: this service line receives the highest number of referrals Trust-wide. The average of referrals received other the last 4 quarters is 876 and in the previous 4 quarter we had 876, so the number remains stable.

Q3 2019/20: Trust Reach – Access









Data source: Data warehouse, informatics team 08/01/2020
Note: Telephone appointments are listed as an appointment where there is significant work done with the patient

Individual patients in contact with our services

The number of individual patients in contact with our services report includes all contracts, excluding EIS and Mosaic. We include all individual patients who have contact with our services. They are reported only once per quarter. This includes 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 5770 but in the previous four quarters was 6013. In Q3 we were in contact with 5740 patients, the lowest figure in the last 4 quarters.

Adolescent : the average number of contacts over the last two years has been stable, but in Q3 we noticed an increase, reaching 224 patients contacted compared to 178 in Q2.

Camden CAMHS: saw 1197 patients in Q3 – the highest number since Q1 18/19.

Other CAMHS: in Q3 they experienced a rise from 495 in Q2 to 511 in Q3; but when comparing the average of referrals over the last 4 quarters it is 50 and in the previous 4 quarters it was 545, so we can see a slight decrease.

Westminster: this team actually experienced a slight increase in contacts. Going from 25 in Q2 to 20 in Q3, this is second quarter where contact has dropped.

Adults Complex Needs: in Q3 saw a rise in the number of contacts, reaching 481, while in Q2 they had 463. When comparing the average of contacts over the last 4 quarters, 494, and the previous 4 quarters, 521, we still see an activity decrease.

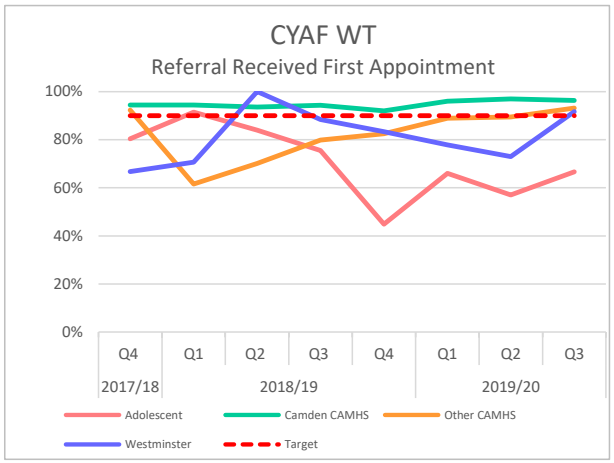
Portman: in Q3 they increased the number of contacts to 209, the highest since Q2 in 2017/18.

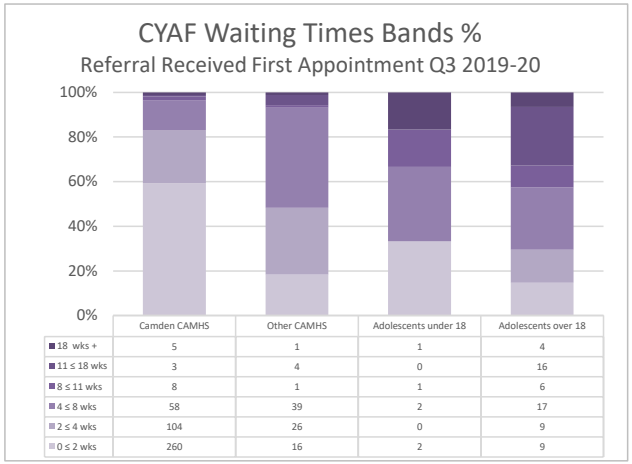
C&H PCPCS: in Q3 they saw 263 patients, this is the third quarter this figure has increased.

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

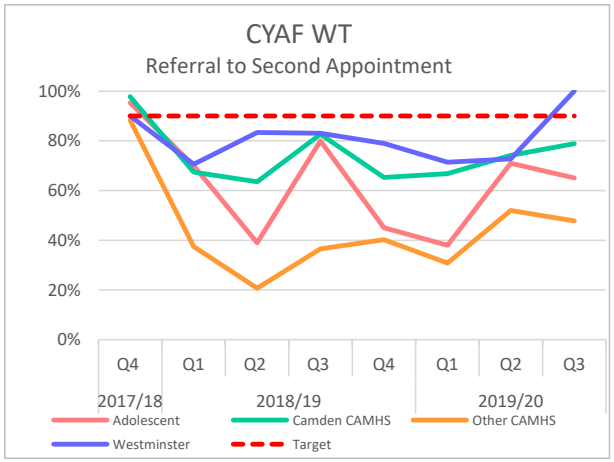
GIC: in Q3 had 1267 contacts, lower number than in Q2. We noticed a reduction, with an average of 1320 over the last four quarters and 1542 previously.

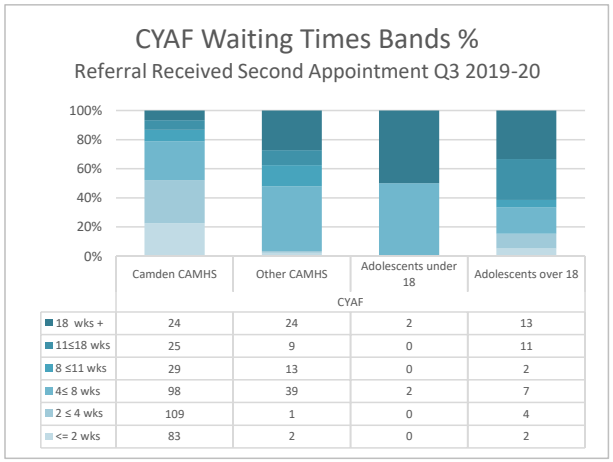
Q3 2019/20: Quality Responsive – Access





	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	5	1	1	4
11 ≤ 18 wks	3	4	0	16
8 ≤ 11 wks	8	1	1	6
4 ≤ 8 wks	58	39	2	17
2 ≤ 4 wks	104	26	0	9
0 ≤ 2 wks	260	16	2	9





CYAF	Camden CAMHS	Other CAMHS	Adolescents under 18	Adolescents over 18
18 wks +	24	24	2	13
11≤18 wks	25	9	0	11
8 ≤11 wks	29	13	0	2
4≤ 8 wks	98	39	2	7
2 ≤ 4 wks	109	1	0	4
<= 2 wks	83	2	0	2

Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/01/2020

CYAF Waiting Times :

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

First appointment: In Q2 CYAF saw 79% of patients within the contractual waiting times. In Q3 this compliance increased to 93%
Second appointment: In Q2 CYAF saw 54% of patients within the contractual waiting times. In Q3 this compliance increased to 70%

Adolescent services have reduced the length of psychotherapy assessment and improved some data quality recording issues.
Referral to 1st appointment – in Q3 the whole service line had a slight improvement in compliance, reaching 65% compared to 72% in Q2.
➢ Adolescents under 18 - **67%** ➢ Adolescents over 18 - **67%**
Referral to 2nd appointment – it has been brought to our attention that the calculations for second appointment for adolescents over 18 were not accurate. We have re run the data from Q1 this year (beginning of the splitting the service lined under age brackets). Q3 the whole service line reached 65% compared to the 71% in Q2.
➢ Adolescents under 18 - **50%** ➢ Adolescents over 18 - **67%**

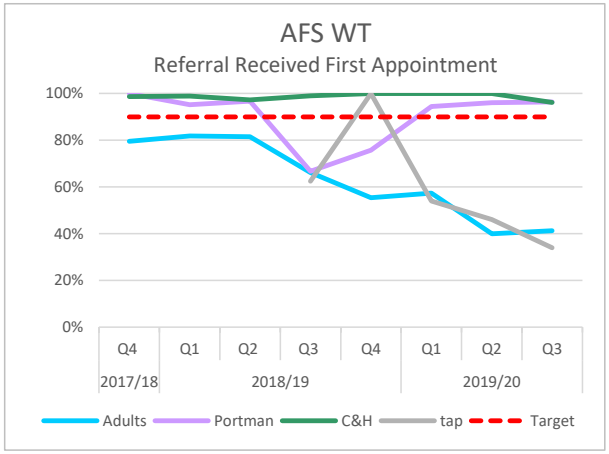
Camden CAMHS.
Referral to 1st appointment – has consistently done well since 2017/18 in Q3. The compliance rate is 96%, only one percentage lower than in Q2.
Referral to 2nd appointment – 79% % of the patients had an appointment within 8 weeks. This is the third consecutive quarter of improvement. 74% in Q2.

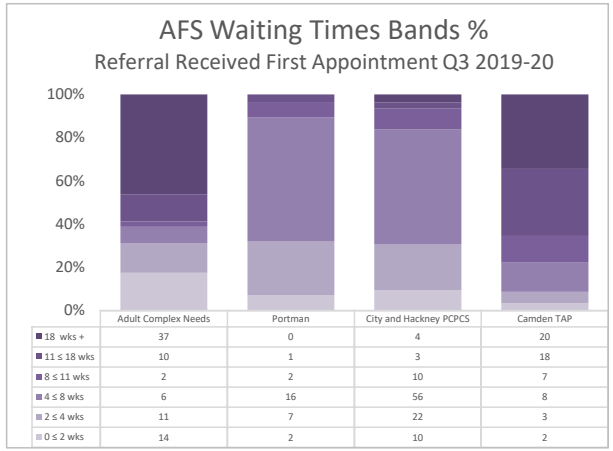
Other CAMHS
Referral to 1st appointment – In Q2 they achieved 89.47% compliance and we are pleased to see that in Q3 they achieved 93%, this is the first time they met the target since the end of 17/18.
Referral to 2nd appointment – in Q3 we noticed a slight decrease in patients seen on time with 48% compliance, compared to the 51% in Q2. Please note that this is still above the average amount of time taken last financial year.

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

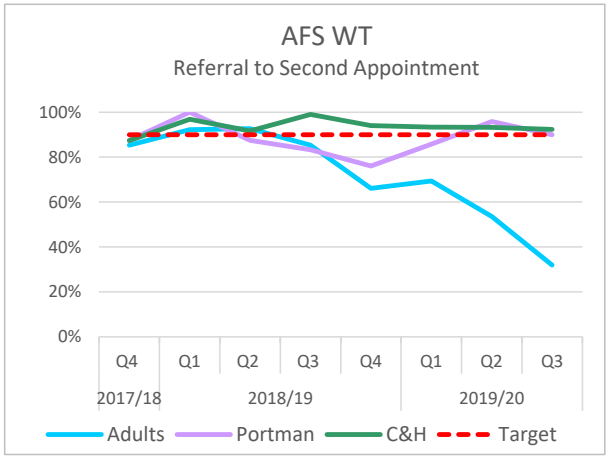
For further comments from service leads please see the commentary part of the report Page 19

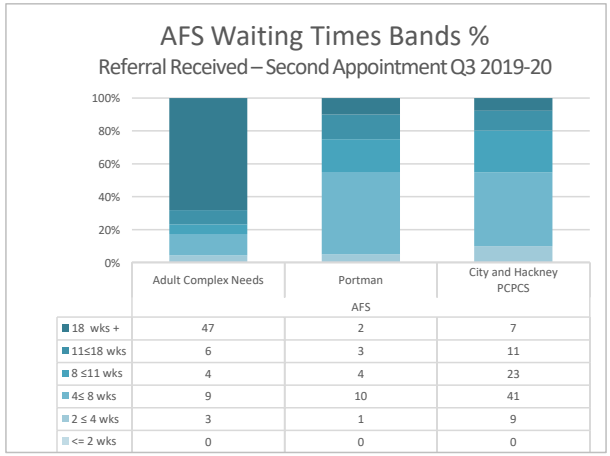
Q3 2019/20: Quality Responsive – Access





	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
18 wks +	37	0	4	20
11 ≤ 18 wks	10	1	3	18
8 ≤ 11 wks	2	2	10	7
4 ≤ 8 wks	6	16	56	8
2 ≤ 4 wks	11	7	22	3
0 ≤ 2 wks	14	2	10	2





AFS	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	47	2	7
11≤18 wks	6	3	11
8 ≤11 wks	4	4	23
4≤ 8 wks	9	10	41
2 ≤ 4 wks	3	1	9
<= 2 wks	0	0	0

Data run and validated 08/01/2020
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

AFS Waiting Times :

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

Referral to 1st appointment: In Q2 AFS saw 68%. of patients within the contractual waiting times. In Q3 this compliance increased to 64%
Referral to 2nd appointment: In Q2 AFS saw 81%. of patients within the contractual waiting times. In Q3 this compliance decreased to 69%

Adult Complex Needs are aware of the decrease on WT compliance, mainly due to work force issues; successful recruiting of temporary staff took place, new post advertised
Referral to 1st appointment –in Q3 they had 41% compliance, a 40% slight increase compared to Q2.
Referral to 2nd appointment – in Q3 they had 32% compliance, a 54% decrease compared to Q2.

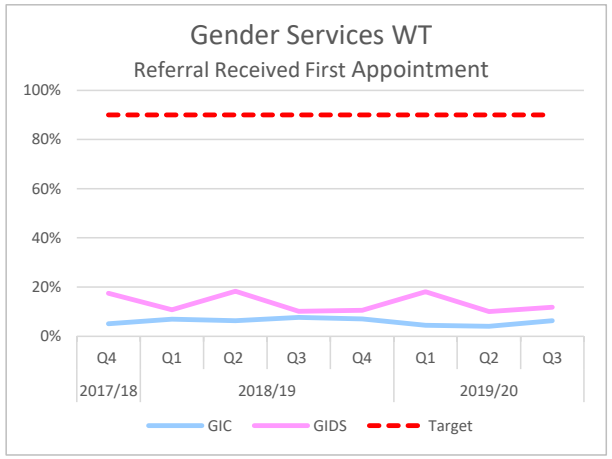
Portman They have met both targets for the last two quarter- they have reviewed the intake system and allocation process to assessing clinicians.
Referral to 1st appointment – has consistently improved for three consecutive quarters and met the target since Q1 and in Q3 with 96% compliance.
Referral to 2nd appointment – in Q3 they had 90% compliance, a slight decrease compared 96% in Q2 but still within target.

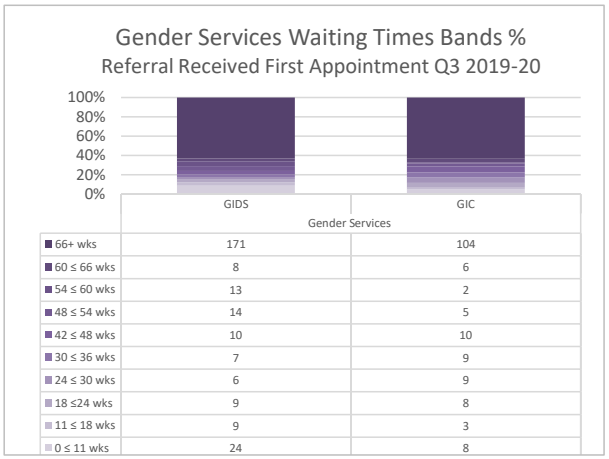
C&H PCPS have met the targets consistently over the last two years
Referral to 1st appointment – in Q3 they achieved 96%, and slight decrease from the 100% achieved last quarter
Referral to 2nd appointment – in Q3 they achieved 92% a very similar performance to the one achieved over the last year.

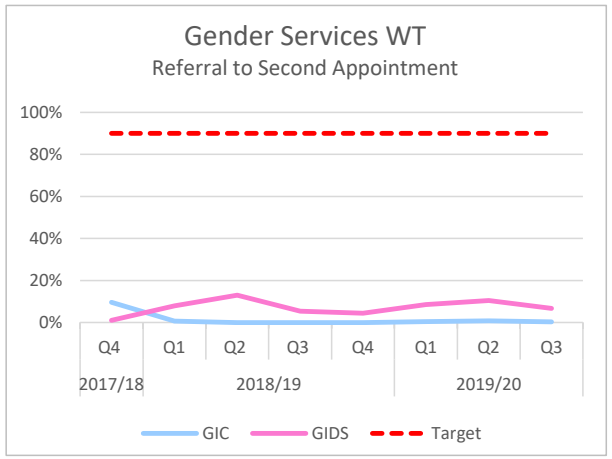
TAP
This quarter we were informed that the patients seen within 8 ≤ 11 weeks by TAP should have been counted as seen within contractual hours – unfortunately where previously calculating them as breached - hence percentages have been updated from Q1
Referral to 1st appointment –in Q3 the percentage of patients seen on time lowered to 34%, in Q2 they achieved 46% compliance.
Referral to 2nd appointment – this service does not report on second appointments as their system (EMIS) is not able to provide the data.

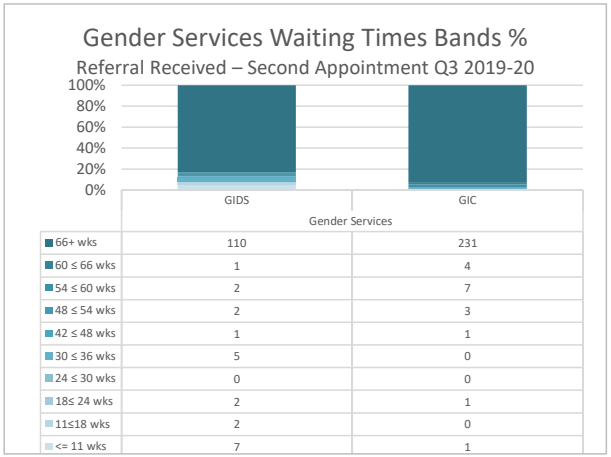
For further comments from service leads please see the commentary part of the report Page 20

Q3 2019/20: Quality Responsive – Access









Data run and validated: 08/01/2020
Data source: SRRS (Internal Reporting System) Reported by the Quality Team

Gender Services Waiting Times :

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

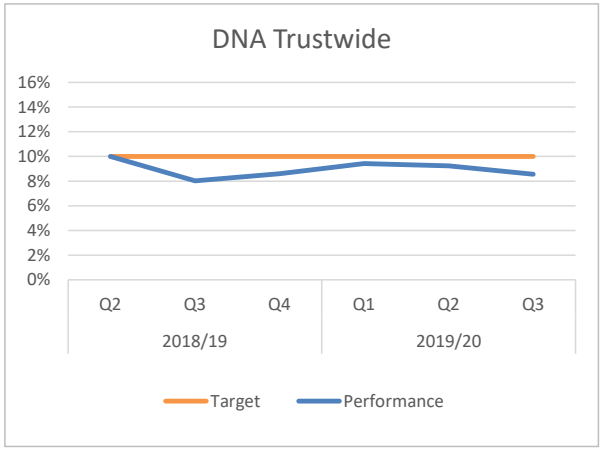
First appointment. Gender Services Directorate saw in Q3 10% of patients within the contractual waiting times.
Second appointment. Gender Services Directorate in Q3 3% of patients within the contractual waiting times.

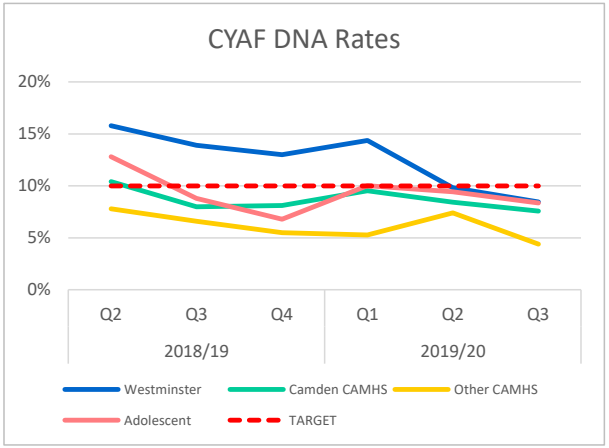
GIDS as measure of awareness the GIDS website raises awareness of the WT issue; the current waiting time is advise on the website to young people and referrers and explained that they currently see young people who are referred 22-26 months ago.
Referral to 1st appointment – in Q3 achieved 12% compliance an slight increment from 10% in Q2.
Referral to 2nd appointment –in Q3 achieved 7% compliance an decrease increment from 11% in Q2%.

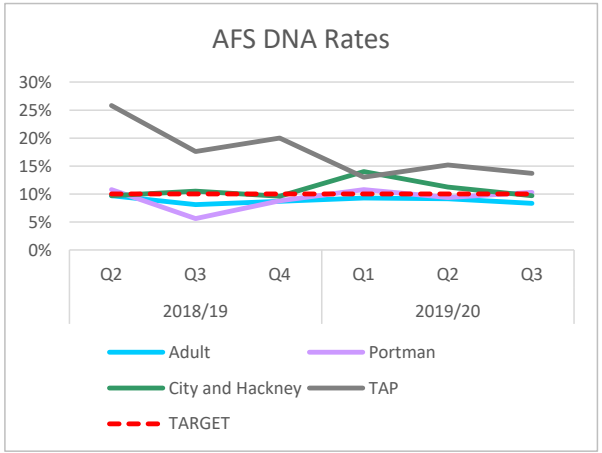
GIC The Gender Identity Clinic in London continues to have extremely high number of referrals which is challenging within the current clinic parameters. The Trust is hopeful that we will have a positive outcome to procurement and there will be more resources coming into the clinic in order to address this nation-wide issue.
Referral to 1st appointment – in Q3 achieved 6% compliance an slight increase from 4% in Q2%.
Referral to 2nd appointment –in Q3 achieved 0.4% compliance an slight decrease from 0.8% in Q2%.

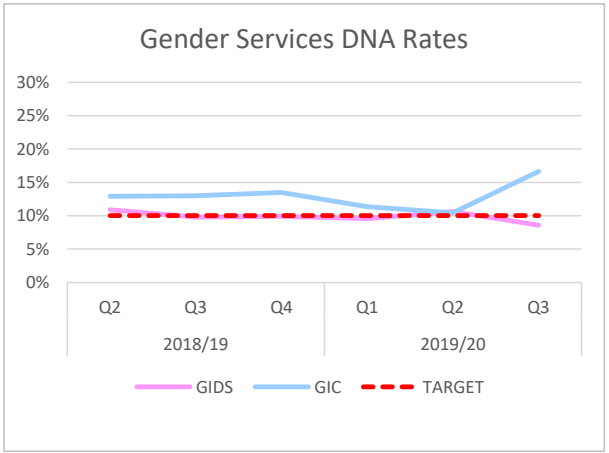
For further comments from service leads please see the commentary part of the report Page 21

Q3 2019/20: Quality Effective – Access









Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/01/2020
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 data. DNA rates are expected to be no higher than 10%. The current Trustwide rate is 9% which it is within the contractual target. This quarter rate has improved in relation to last quarter.

Adolescents had a DNA rate of 8.35% in Q3 – this is a improvement compared to 9.4% in Q2 and 10% in Q1. Target met every quarter for the last year.

Camden CAMHS improved the DNA rate reaching 7.58% in Q3, this service has met the target for the last five quarters.

Other CAMHS had the lowest DNA rate Trustwide reaching a 4.39%.

Westminster saw a significant decrease in Q2 and again Q3, reaching 8.46% 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 8.35% in Q3.

Portman saw an very slight increase on DNAs in Q3, resulting in 10.28% rate DNA rate just above the target – this could be related to appointments before the Christmas break – which can be a difficult time and affect motivation.

C&H PCPS have reduced the DNA rate reaching 9.69%, just under target. In Q1 started some groups for patients difficult to engage causing a DNA increase, those groups are now settled into the middle period of their runtime.

TAP: had a slight decrease in DNA rates reaching an 13.7%, compared to 15.2% in Q2.

GIC had a unexpected increase with a rate of 16.7%. This is directly related to a glitch noticed in the SMS reminder functionality. As this issue was resolved in early December, it is expect that the DNA rate will reduce in Q4.

GIDS in Q3 we have seen an decrease, with a rate of 8.59%. The cause for this drop is a new and clarified DNA policy and the increase of SMS reminders.

For further comments from service leads please see the commentary part of the report Page 22, 23 & 24

Q3 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 (QAM) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved. The Quality Assurance Meeting (QAM) has been defining and implementing operational changes in all service lines to accommodate the new requirements: increased percentage expected for Ethnicity, Primary reason for Referral, Care Professional Service or Team Type Association and the Ex-British armed forces indicator. The most recent published DQMI is for September 2019 and the compliance achieved is 93.4%. The actions completed during Q3 to improve compliance will show in March's NHS Digital publication, hence it will be included in Q4 report.

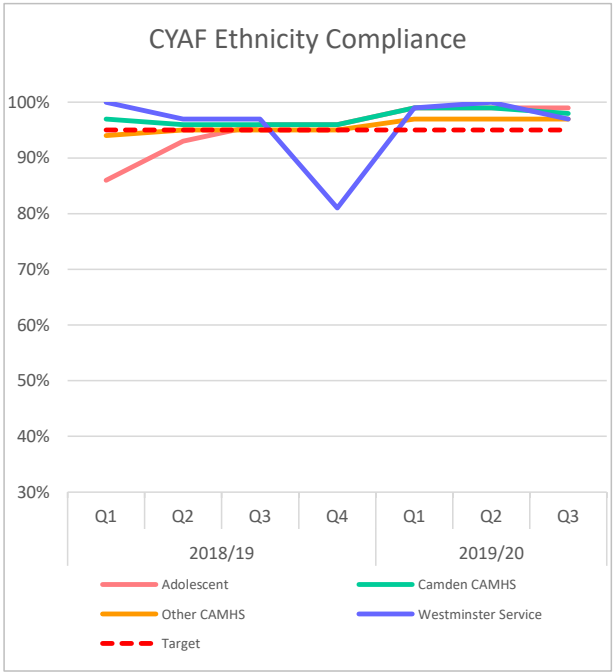
	Target	Month 7 October 2017/18	Month 10 January 2017/18	Month 1 April 2018/19	Month 4 July 2018/19	Month 7 October 2018/19	Month 10 January 2018/19	Month 1 April 2019/20	Month 4 July 2019/20	Month 7 October 2019/20
Valid NHS number	95%	99.10%	98.60%	98.60%	98.70%	98.90%	98.90%	99.00%	98.99%	98.95%
Valid Postcode	95%	99.80%	99.70%	99.80%	99.80%	99.80%	99.80%	99.70%	100%	100%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.50%	99.10%	99.00%	99.20%	99.00%	99.00%	99.20%	99.21%	99.15%
Valid Organisation code GP Practice	95%	99.20%	98.20%	97.80%	98%	98.10%	98.20%	98.90%	98.88%	98.78%
Valid Gender	95%	99.80%	99.80%	99.80%	99.70%	99.40%	99.40%	99.40%	99.44%	99.47%
Ethnicity	85%	79.60%	78.40%	77.30%	76%	75.80%	76.10%	80.60%	81.88%	78.76%
Employment Status (for adults)	85%	36.90%	43.40%	49.10%	50.50%	51.60%	54.00%	59.30%	59.79%	57.94%
Accommodation status (for adults)	85%	36.60%	42.90%	48.50%	49.90%	51.00%	53.20%	58.30%	58.78%	56.90%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%
DQMI -Data Quality Maturity Index	95%	The DQMI is not published in the same intervals. The October's data has not been published yet. **The most recent score is from Sep 2019 when we achieved 93.4%**						89%	91%	NA

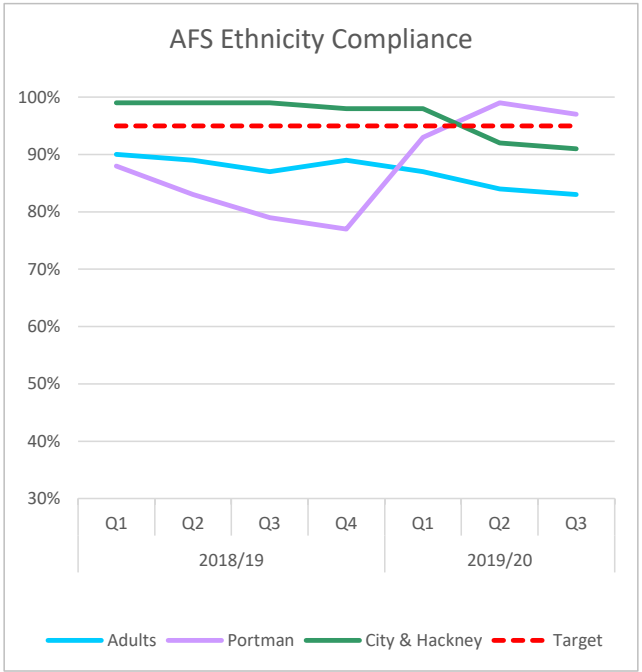
Data source: Data warehouse, informatics team 08/01/2020

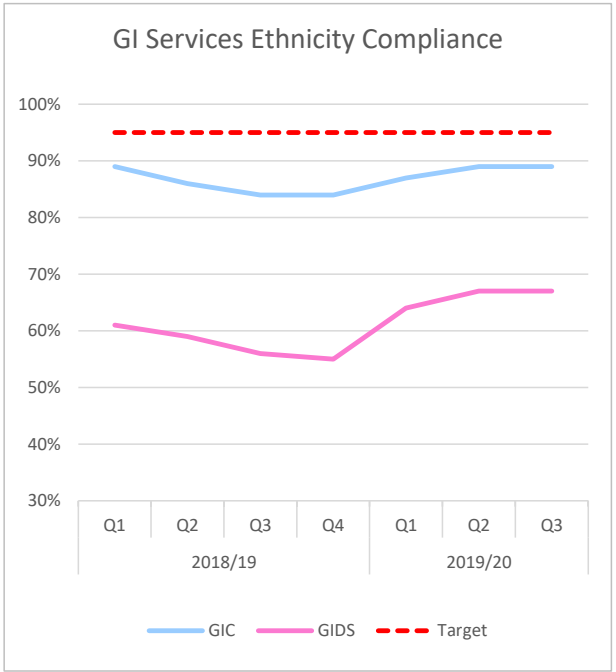
Q3 2019/20: Single Oversight Framework – Access

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.. 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 published by NHS Digital is: 80% compliance 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. The Quality Assurance Department continue to work with teams in the Quality Assurance Meeting, meeting regularly to improve this data further. QAD will work with C&H and ACN analysing and addressing the drop in rate in Q3.

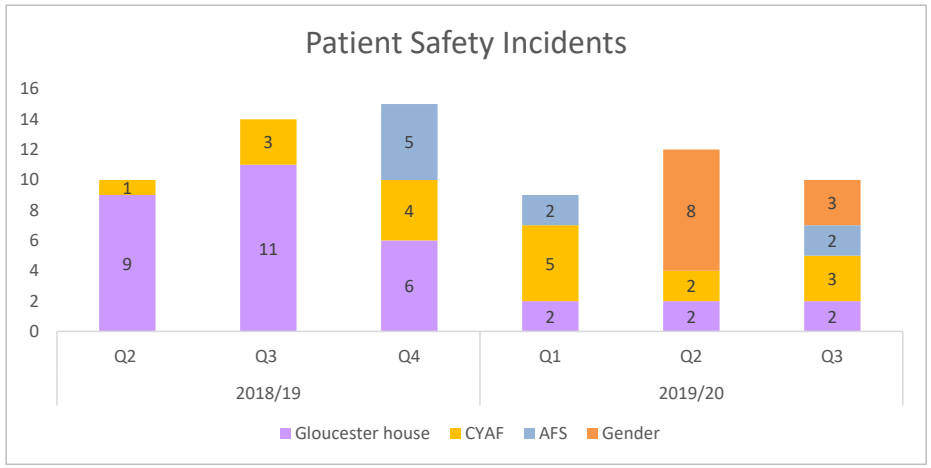






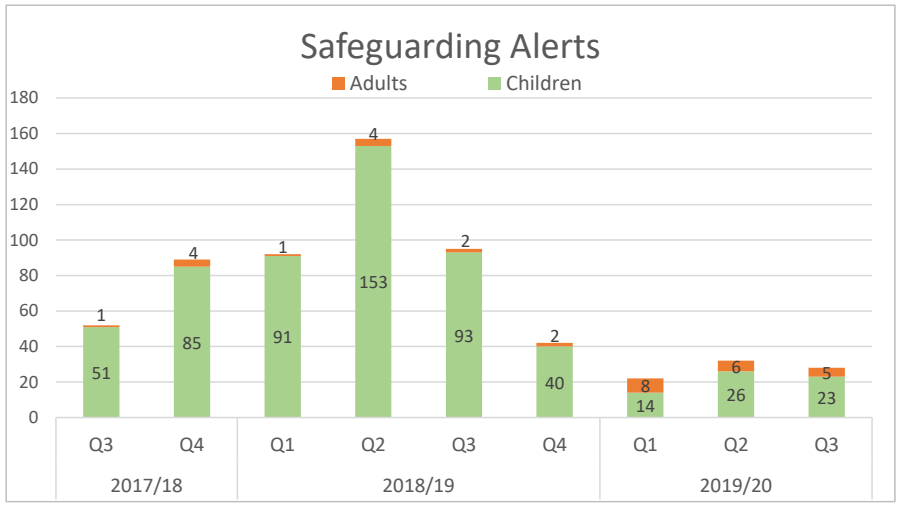
Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/01/2020

Q3 2019/20: Quality Safety – Care



NRLS reportable incidents;
We have had 3 suspected suicides , two from GIC and one from the Portman, all will be investigated by senior clinicians. We continue to monitor all incidents via the Incident panel every month which is chaired by the Medical Director.

Health and Safety Manager 14/01/2020



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

Data & commentary source: *Clinical Governance 10/01/2020*

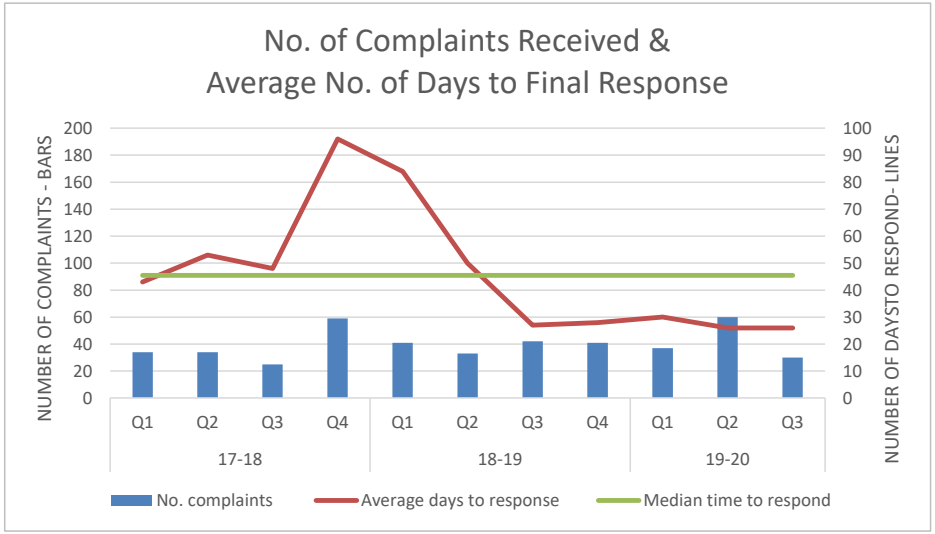
Incidents Reported by Risk Level – Trust wide	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3
1-4	81	119	88	100	65	69
5-8	42	35	22	28	28	38
9-12	7	3	9	3	13	11
15+	0	1	0	0	1	0
Total	130	158	119	131	107	118

There has been a rise in abusive or aggressive telephone and email messages to the Gender services, this is being monitored by senior staff and the communications team.

Health and Safety Manager 14/01/2020

Data & commentary source: Health & Safety Department 14/01/2020

Q3 2019/20: Quality Responsive – Care



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

During quarter 3 a total 30 complaints were received. 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 a decrease in complaints from the last quarter by 30. The quarter 2 increase related to a data breach IG incident.

Of the 30 complaints, this quarter, 18 have been responded to, 6 have been upheld, 1 has been partially upheld and 11 complaints have not been upheld, the remaining 12 remain open. Some complaint responses have taken longer than the anticipated 25 working days. This is partly due to annual leave over the Christmas period, but also pressure of work. The complainants have been informed that their responses will be delayed. All complaints are acknowledged within 3 working days.

Total PALS enquiries 01/10/2019 to 31/12/2019

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

Top PALS enquiries for Q3 2019/20:

- Communications
- Access to Treatment or Drugs
- Appointments

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

Data & commentary source: Complaints Department 10/01/2020

Q3 2019/20: Quality Responsive – Care

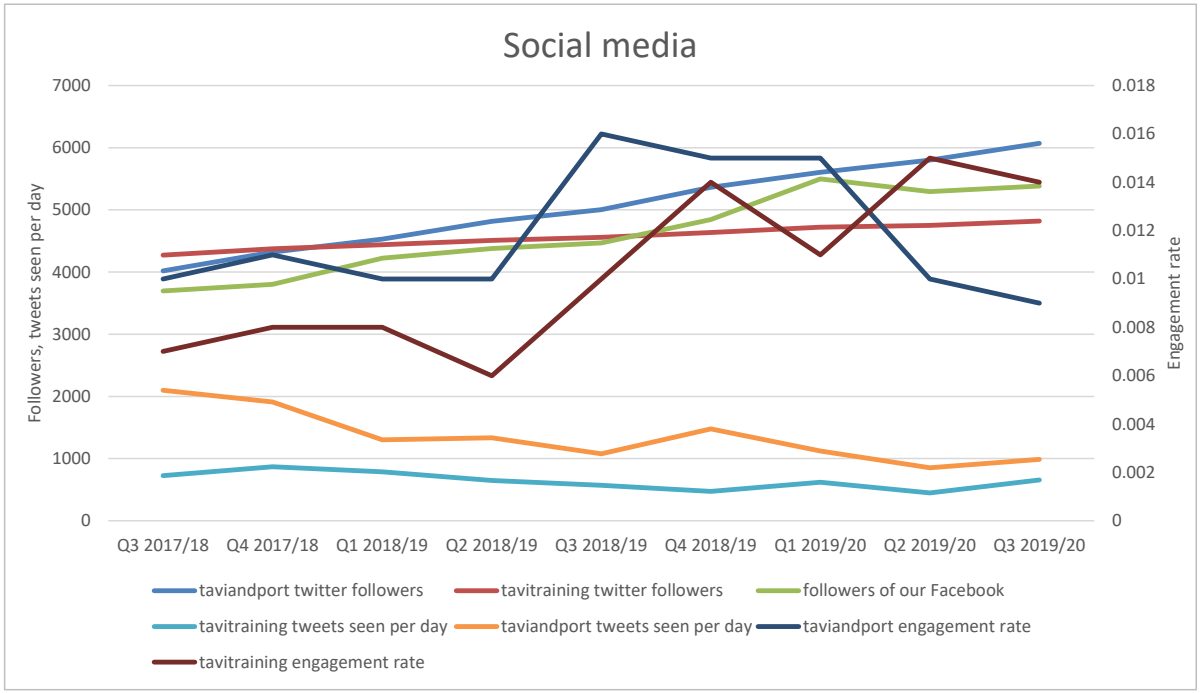
KPI London contracts			Q3 17/18			Q4 18/19			Q1 19/20			Q2 19/20			Q3 19/20		
Question number and description	Monitoring	Target	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%	d (123)	n (12)	%
Q4 from ESQ 'Views and worries were taken seriously'	Quarterly	n/a	127	121	**99%**	180	178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

ESQ Rates

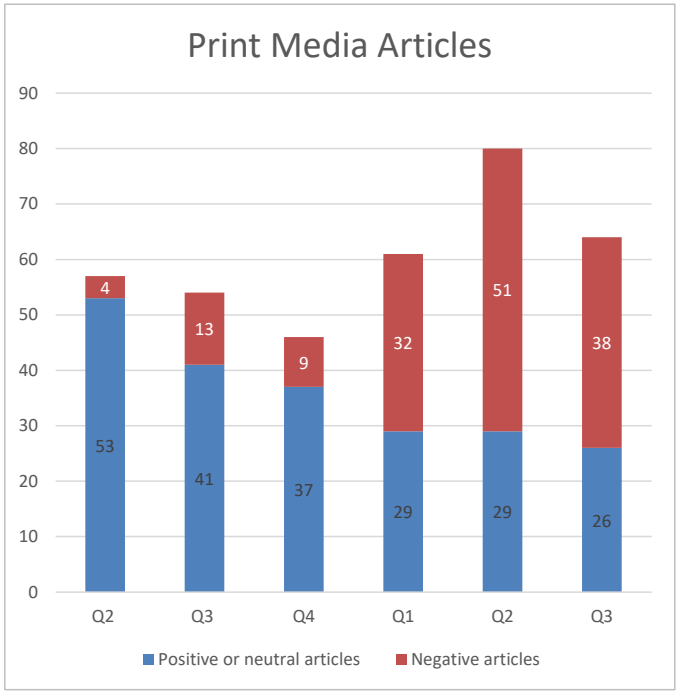
Traditionally the responses and feedback from our patients are very positive and we are very pleased with the comments and scores received. But we feel that the number of forms returned could be higher. The trust has piloted a new shorter form which aims to improve the collection rates and next month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

Data source: SRRS (Internal Reporting System) Reported by the Quality Team 08/01/20

Q3 2019/20: Media – Care



We had slightly more users and sessions this quarter compared to the same quarter in 2018/19, but slightly fewer pages per session.
Our social audiences are increasing in size. The amount of social posting we are doing remains low due to the contested nature of our work in those spaces.
About half of all website traffic goes to our course pages, half goes to the whole of the rest of the site. Stories around GIDS are our most popular news items cumulatively, although the video for emotionally unstable personality disorder remains the number one item.

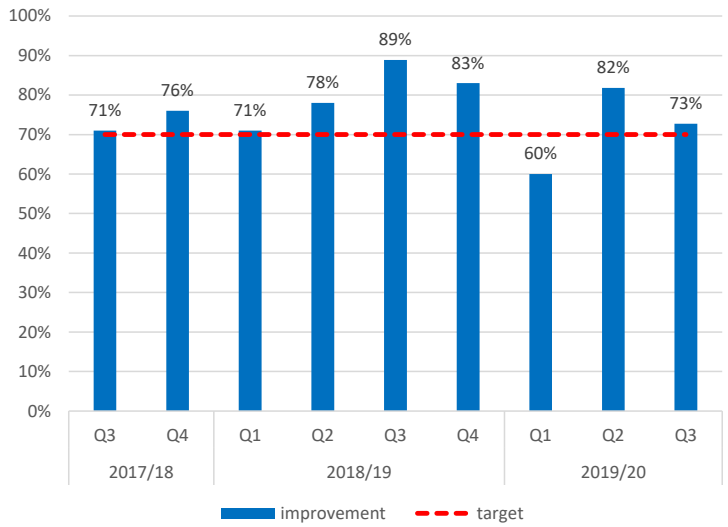


This is a lower volume of overall coverage compared to Q2, a slightly lower proportion of GIDS related coverage, and a small increase in sentiment: 40% positive or neutral coverage, compared to 36% positive or neutral in Q2, and 52% in Q1 of 19/20.

Data & commentary source: Communications Department 10/01/2020

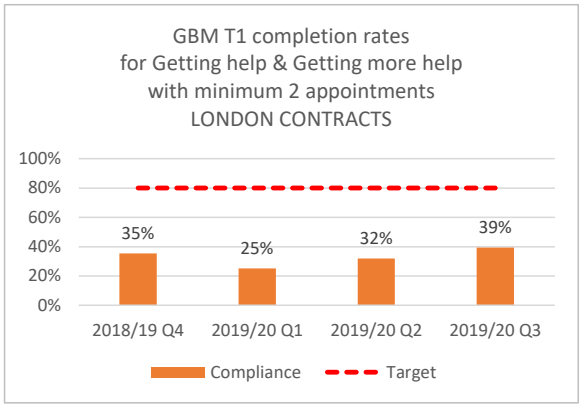
Q3 2019/20: Quality Effective – Outcomes

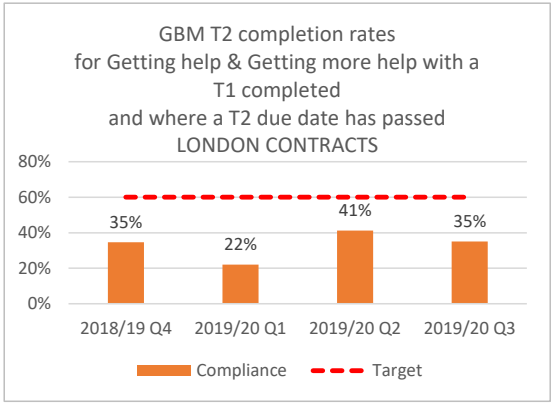
A F S and over 18 Adolescents

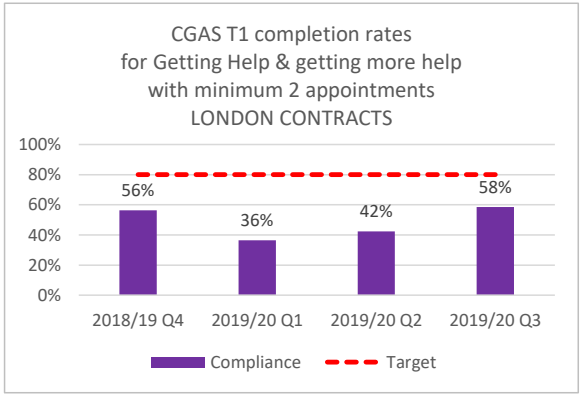


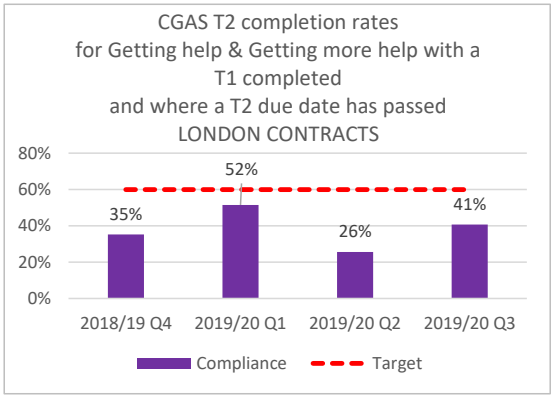
To calculate the CORE improvement rates **we compared patients with a Pre-Assessment and an End of Treatment score** (EOT) . The number of cases within these parameters is very low, but we are pleased to see an increase in the number of collected forms over the last two quarters. The End of Treatment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

C Y A F





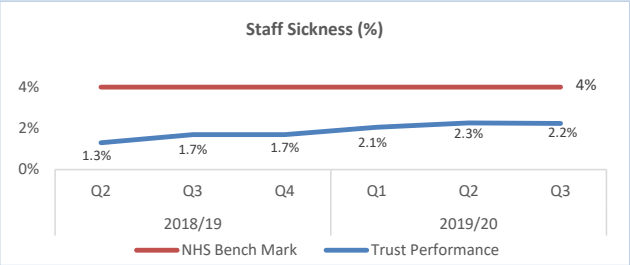


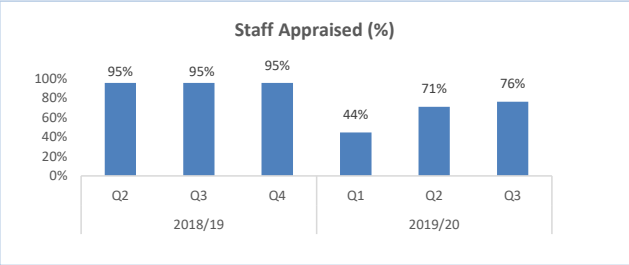


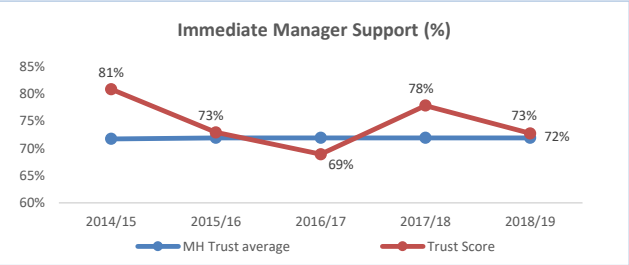
The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: we are pleased to see that GBM T1 has increased over the last two quarters, reaching 39% compliance. GBM T2 has decreased - this is linked to some restrictions generating T2, a solution is going to be implemented next month.
-CGAS rates: increases in T1 of 16% and in T2 of 15% are encouraging changes, we hope this trend will continue next quarter.

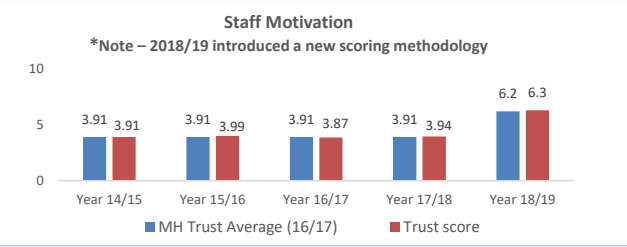
Data source: SRRS (Internal Reporting System) Reported by the Quality Team 09/01/2020

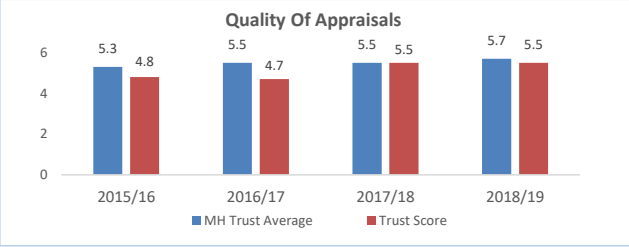
Q3 2019/20: Quality Well-Led

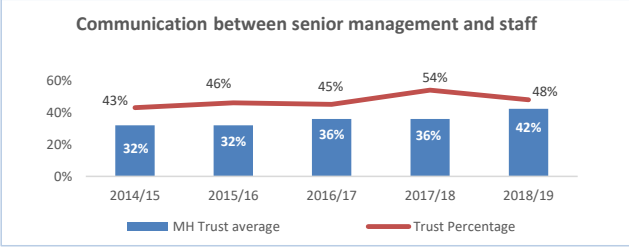


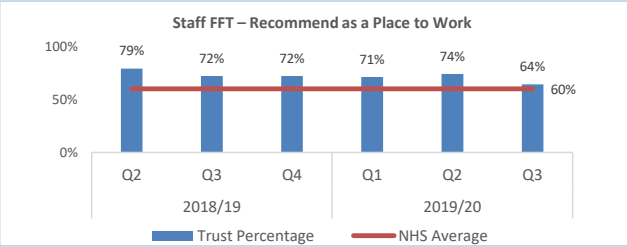


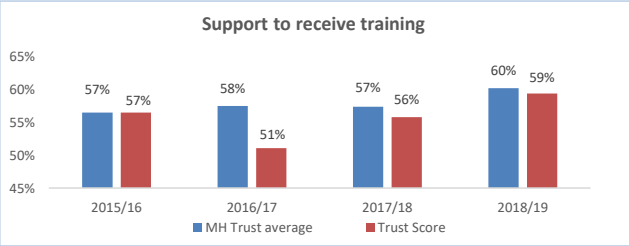


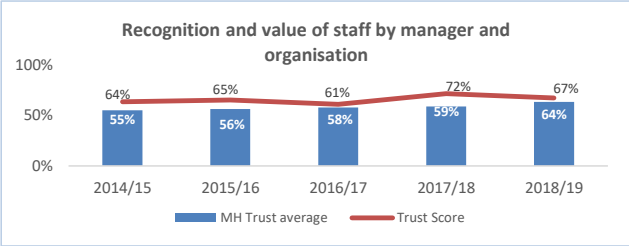


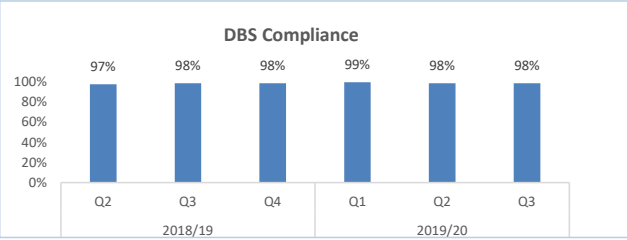


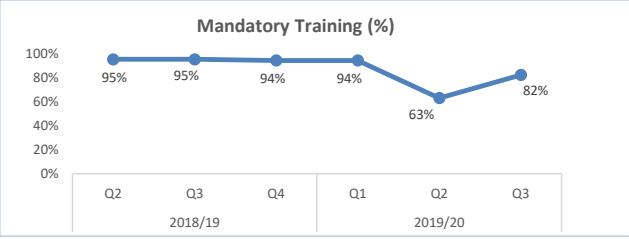








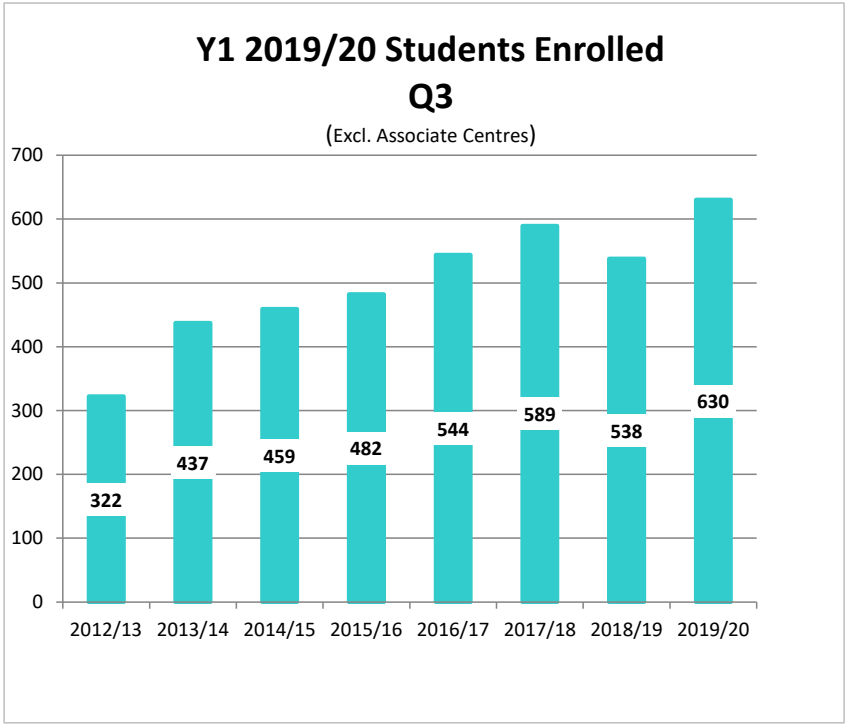




Mandatory training compliance has improved in Q3 as a result of an INSET day being held. The level of compliance now reaches the internal reporting rating of amber as it is within an 80 – 85% range. The Trust has rolled out the ability to achieve compliance via e-learning and those who are not compliant are being chased to address this deficit. Appraisal compliance has improved by 5% during the quarter and work continues to chasing managers and directors to ensure paperwork for the 2019 appraisal round is returned.

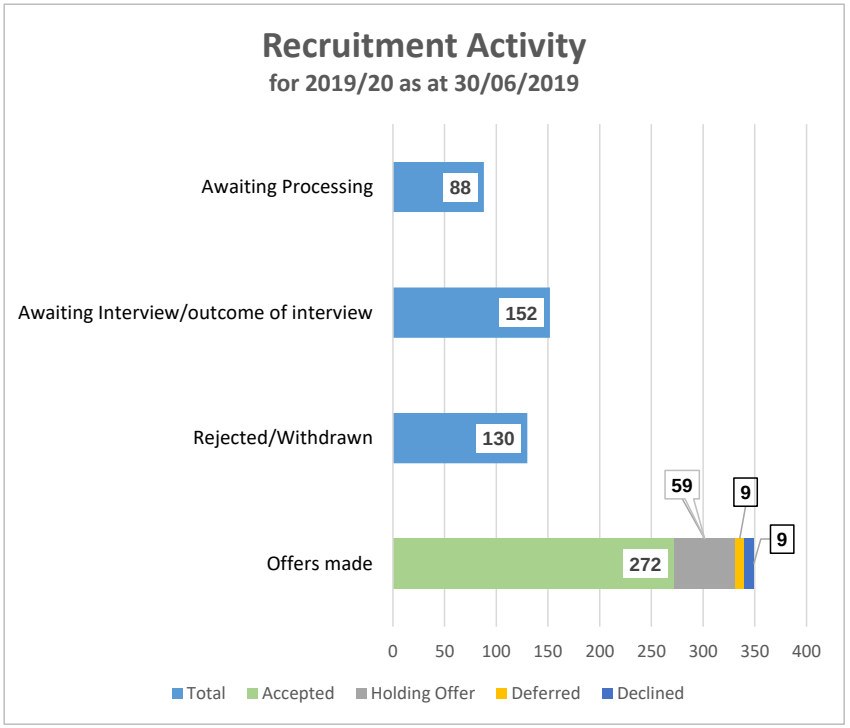
Data & commentary source: Human resources

Q3 2019/20: Directorate of Education and Training (DET) – Access



An increase in enrolled Y1 figures of 14.6% compared to 2018/19. The enrolled student number includes those who have reached both pre-enrolment (i.e. PE - fees paid and awaiting clearance of DBS checks) and full enrolment (C) stages, but excludes Associate Centres.

Data & commentary source: DET 10/01/2020



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

Q3 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	81
	Bespoke work	14	18	10	38	45	33	66
	Visitors Programme / international					23	14	6
	HEE additional in year funding						6	8
Students	**Attendee/Student Nos**	2079	2738	2063	2279	2300	2193	2429
								Identified Income to Date
Income	**Income**	501,917	556,261	493,090	£692,710	£854,710	£1,271,641	£1,272,518
	Income growth on previous year	35%	16%	-11%	40%	23%	49%	0%
	Contribution	160,769	158,104	123,616	£197,122	£527,123	£645,292	**£611,324 * (predicted)**
						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 2019-20

Data source: DET 10/01/2020

Q3 2019/20: Directorate of Education and Training (DET) - Outcomes

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

Student Experience and Outcomes

Satisfaction: "Overall, I am satisfied with the quality of the course"	Benchmark	Tavistock	Change from previous year
2014	87.0%	93.0%	
2015	83.0%	94.0%	↑
2016	86.0%	90.0%	↓
2017	84.0%	81.0%	↓
2018	83.0%	83.0%	↑
2019	83.5%	92.0%	↑

Personal Development /Prepared: "As a result of the course I feel better prepared for my future career"	Benchmark	Tavistock	Change from previous year
2014	77.9%	86.2%	
2015	81.0%	91.0%	↑
2016	82.0%	89.0%	↓
2017	78.0%	86.0%	↓
2018	78.0%	84.0%	↓
2019	*82.0%	90.0%	↑

Effectiveness ""Attending the course has improved my approach to my job"	Benchmark	Tavistock	Change from previous year
2014	77.0%	81.3%	
2015	78.0%	87.0%	↑
2016	80.0%	96.0%	↑
2017	81.0%	87.0%	↓
2018	80.0%	86.0%	↓
2019	**83.0%	*97.0%	↑

Notes for 2019:

Benchmark data from National Student Survey (NSS) 2019

"Q27: Overall satisfaction"

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

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

Benchmark Question from NSS 2019

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

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

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

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

Benchmark Question from NSS 2019

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

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

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

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

Data & commentary source: DET 10/01/2020

Quarterly Quality Report Commentary Q3 2019/20

Introduction

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

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

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

The following metrics are summarised below:

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

Waiting Times feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q3	Objective / plan for next Quarter	Lead
Adolescent /AYAS	AYAS continue to work hard to manage the large number of referrals to the service. We have a number of interventions to ensure patients are being offered an initial introductory session within the required time frames. From previous report regarding interventions to manage the waiting times to ensure that patients remain safe whilst waiting for a psychotherapy assessment: We have implemented a number of measures to address the wait for assessment, this has included reducing the length of psychotherapy assessment for the most straight forward assessments. As this was not resulting in significant improvements in timeliness in seeing patients we have started offering appointments to patients prior to them being invited for a formal therapy assessment. The aim of this is to gain an understanding of the young people waiting to be seen and managing any risks or needs they may have whilst waiting. However, it does not solve the problem of increased referrals per se'.	AYAS will continue to implement the current plan to manage first assessment appointments and we will start evaluating patients experience of the new introductory structures towards the end of the next quarter. Reminder of interventions from previous quarterly report: As a service we are working hard to ensure that our patients are being seen in a timely manner to ensure that they feel contained, we are able to manage any risk presentations and the patients have an understanding of the waits currently being experienced in the service and how to access support in the meantime. We are rolling out the concept of introductory appointments for those who appear from referral to be keen to engage in a psychotherapy assessment and pre assessment consultations (PAC's) for those where there is a need for more clarity from them as to whether they would like to engage in the types of treatment available in AYAS more widely.	*Consultant child and Adolescent Psychiatrist and YAS Clinical Service Manager*
Camden CAMHS	Waiting times remain low in Camden and we are pleased that we have maintained this in spite of a significant increase in schools referrals over this financial year.	Continue to maintain waiting times and monitor this with the teams.	*CYAF service Manager*
Other CAMHS	We are pleased that we have achieved the target on waiting times this quarter in other CAMHS. This demonstrates a consistent improvement in waiting times over the last 18 months	Continue to achieve waiting time target through careful monitoring of waiting lists	*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 Q3	Objective / plan for next Quarter	Lead
Adult Complex Needs	We are aware that we have not managed the target for the waiting time for the first appointment by far for the last two quarters due to the lack of resources by sick leave, maternity leave of members of staff and recruitment difficulties. Even though three posts of medical training for psychotherapy in North London were advertised in Spring last year no appropriate applicants applied for them. One of those posts would have been allocated to the Tavistock team. Those three posts they were re-advertised in Autumn and successfully recruited as fixed term contracts for 0.6 WTE in total goes till the end of March next year. Those posts have been allocated to see new patients. We hope we become able to meet the target in the next quarter.	We also expect we will be able to recruit a couple of clinicians permanently by that time so that we can keep the target for assessments Secondly, we advertised 0.9 WTE training post for 4 years last November. We had 11 applicants none of whom had had enough experience in psychotherapy. We are going to re-advertise the post soon.	*Consultant Psychiatrist in Psychotherapy Head of Adult Complex Needs Service*
Portman	As is visible from the data, our waiting time for first and second appointment has been in target for the last three quarters. We have an efficient intake system, and smooth allocation process to assessing clinicians.	To continue with the system that is in place.	*Clinical Governance Lead for Portman Clinic*
City and Hackney PCPCS	PCPCS are pleased with our Q3 waiting times figures. As in Q1 and Q2, most patients were seen within 8 weeks, and only 4 patients waited longer than 18 weeks, meaning a large majority patients and referrers received care and support from the service within a good time frame. 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.	Q1 and Q2 contained zero breaches, whereas in Q3 we had 4. We will look into those particular cases so as to understand what happened and try to course-correct from there. We will continue the expedient processing of referrals, intake, and initial appointment booking. We have recently lost 2 members of full-time staff, so are under capacity again going into Q4. We aim to recruit to both posts as soon as we possibly can.	*Service Lead Primary Care and Consultant Psychotherapist and Social Worker*
TAP	A primary factor was the 30% cut in resources leaving the trust and TAP having to re-organise the service through a formal staff consultation in order to reduce overall costs whilst trying to maintain a viable service and model. The model and its clinical offer is important to the trust as part of a local (NCL) partnership project with C&I NHSFT, MIND and Hillside Clubhouse. It also forms one part of the Tavistock's contribution to the NHSE Forward View of community services in Camden. The cuts put staff posts 'at risk' and consultation had a direct impact on working patterns and continuity of treatments because staff did not know whether they would continue to have a job in the service beyond three months' time, this then limited options for how quickly or realistically certain patients could be booked in for treatments (which could have been jeopardised if staff had to leave the service prematurely. The second significant factor was a new member of staff an some training difficulties this led to some quite serious delays, errors, complaints and missing data all of which had an impact on waiting times due to booking not happening in an efficient and timely way.	Part of our aim for the next months is to use the outcomes from an external evaluation to argue for a re-evaluation of funding relative to the wider impact of TAP work on the health economy and local systems of care. Also critical to the next 3-6 months will be the successful negotiation of a contract size i.e. a realistic caseload number relative to the team's capacity. To do this we have held a series of meetings with Camden and Islington NHSFT with support from our T&P CCOO and contracts lead, both of whom are committed to having an upper limit or 'cap' of capacity which the team considers absolutely necessary to safely limit unrealistic and unsafe clinical pressures as well as supporting staff morale and mental health when facing overwhelming demand relative to the services capacity. This issue relates equally to waiting times because capacity mapping also effects waiting lists / times.	*TAP Service Manager*

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

Waiting Times feedback and action plan from Service Leads – Gender Services			
Service line	Commentary Q3	Objective / plan for next Quarter	Lead
GIC	The Gender Identity Clinic in London continues to have extremely high number of referrals with no additional resources to accommodate these patients. The Trust is hopeful that we will have a positive outcome to procurement and there will be more resources coming into the clinic in order to address this nation-wide issue.	The Gender Identity Clinics in the UK are in a procurement process and should know the outcome in Q4 2019-20. Once there is confirmation of the outcome, the clinic will be able to plan for the future.	*GIC Service Manager*
GIDS	The Gender Identity Clinic in London continues to have extremely high number of referrals which is challenging within the current clinic parameters. The Trust is hopeful that we will have a positive outcome to procurement and there will be more resources coming into the clinic in order to address this nation-wide issue.	The Gender Identity Clinics in the UK are in a procurement process and should know the outcome in Q4 2019-20. Once there is confirmation of the outcome, the clinic will be able to plan for the future.	*GIDS Service Manager*

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

DNAs Feedback and action plan from Service Leads – CYAF Services			
Service line	Commentary Q3 2019-20	Objective / plan for next Quarter	Lead
Adolescent /AYAS	AYAS DNA rate continues to be below the 10% level.	AYAS will continue to implement the strategies devised to ensure that patients attend appointments or cancel appointments if they are not able to attend.	*Consultant child and Adolescent Psychiatrist and AYAS Service Manager*
Camden CAMHS	DNA rates continue to fall in Camden CAMHS and we continue to engage patients and manage attendance	Maintain a low DNA rate across the service line	*CYAF service Manager*
Other CAMHS	The DNA rate in Other CAMHS is consistently below target and we are pleased that it has fallen again this quarter. We continue to try and engage patients and manage attendance	Maintain a low DNA rate across the service line	*Divisional Director CYAF*

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

DNAs feedback and action plan from Service Leads – AFS Services			
Service line	Commentary Q3 2019-20	Objective / plan for next Quarter	Lead
Adult Complex Needs	DNA rate remains under 10 % which is below the target.	We continue to sustain the low percentage of DNA rates by continual clinical discussions in each team meeting.	*Head of Adult Complex Needs Service*
Portman:	As is visible from the data, our DNA rate was slightly above the target range in Q3. Although we cannot know for sure, this may have been related to the fact that patients sometimes do not attend appointments in the sessions before the Christmas break – which can be a difficult time for them and mean that their motivation for treatment diminishes.	To continue to monitor DNA rates on an ongoing basis.	*Clinical Governance Lead for Portman Clinic*
City and Hackney PCPS	PCPCS are pleased to see our DNA rate fall back below the 10% target set by the Trust. Following the rise in Q1, we found that group appointments were having a disproportionately large negative impact on our DNA rates. As the groups are now settled into the middle period of their runtime, the fall in DNAs can been as evidence that patient engagement is generally strong within PCPCS. Our service'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 maintain a similarly low rate in Q4, and continue to use letters, SMS text reminders, and phone calls to sustain patient engagement in their treatment. We firmly believe that patients relate to the whole institution -- not just their allocated clinician – so encourage all members of the team to communicate clearly and in a straightforward manner when in contact with patients.	*Service Lead Primary Care and Consultant Psychotherapist and Social Worker*
TAP	TAP are very pleased to have consistently reduced the DNA rates for the last 4 quarters. This has been possible due to a concerted effort by the team to analyse the factors thought to have greatest variability in our hypothesis ; clinical, electronic, human error and/or procedural. Our Governance and QI leads have progressed a Quality Improvement project, running 4 different PDSA cycles i.e. trialling 4 different interventions over time. This has allowed us to pinpoint where the different interventions had greatest effect whilst also determining which where the system was failing. The results are striking! Below are the median DNA rates per quarter last year. We started the QI project in April, hence the initial drop from 19.5 to 13.2%: - Jan-Mar 19.5% - Apr-Jun 13.2% - July- Sep 12.0% - Oct-Dec 11.1% The DNA rate in December was 10.8%, which is the lowest DNA rate we've had and happened after the introduction of our 4th PDSA cycle. Our aim for the QI project was to get to 10%.	Our aim is to continue this good work as part of our goal to optimise efficiencies in treatment and governance with a much reduced size of team. We will look at the data at the end of January and decide then if we need to introduce a further intervention to get the DNA rate consistently down to the 10% mark for the future. We are very pleased with the outcome and the work of our QI and Governance team.	*TAP Service Manager*

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

DNAs Feedback and action plan from Service Leads – Gender Services			
Service line	Commentary Q3 2019-20	Objective / plan for next Quarter	Lead
GIC	In Q3 there was a glitch noticed in the SMS reminder functionality. The SMS reminders, which normally are sent 6 weeks, 1 week and 1 day before a patient's appointment, if they have consented to be contacted, were turned off from mid-September to early December when the issue had been identified and rectified. This will certainly be part of the problem with the rise in DNAs in Q3. As this issue was resolved in early December, it is hoped that the DNA rate will reduce in Q4. With the introduction of the appointments team in late August we are now better able to track DNAs and communicate with those patients. We are also operating a stricter policy whereby if a patient has DNAed one appointment, they are contacted and if they would like another appointment it is explained that a second DNA will result in being discharged. This is all done with clinical input to ensure that more vulnerable	From Q4, patient' appointment will be scheduled and sent their appointments 6-8 weeks before their appointment. The clinic is hopeful that this will cut down on the number of appointments which are rescheduled by the clinic. There is also a hope that this will reduce the number of DNAs.	*GIC Service Manager*
GIDS	We are very pleased that DNA rates have reduced in quarter from 10.61% to 8.52%. We attribute that to two key changes which we have been implementing in stages over the last year, namely a new and clarified DNA policy (which communicates to patients and staff the fact that we discharge patients if they repeatedly do not engage with the service); as well as the increase of SMS reminders regarding appointments from one to two, for those who opt in to the service. We have evaluated the positive impact of SMS reminders, and are thinking about next steps – and we are planning to evaluate the impact of the revised DNA policy in the coming months.	We are planning to continue the positive work undertaken so far – and continue evaluation of the initiatives we have put in place. Next steps might include further increase of SMS reminders, or further changes based on any shortfalls in the current DNA policy.	*GIDS Service Manager*

3. **Quality Priorities**

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

Quality Priority	1. Improve identification and management of high-risk patients	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
Establish a "train the trainers" risk assessment and management toolkit and deliver the training to identified clinicians across the Trust.	Risk assessment material is available for clinicians to access on the ESR. In addition, there is a quarterly risk assessment skills workshop open to all clinicians. Risk assessment and risk management are also considered where appropriate at the monthly incident panel and at the Trust wide Learning Lessons Forum held x5/year. Where there are risk concerns i.e. risks to self, risk to others and risk from others. Discussions about individual cases take place in team meetings and in individual and peer supervisions. Care plans which are copied to GPs/referrers include information about risk assessment and risk management where indicated.	On Target
Ensure all CYAF crisis plans have been regularly reviewed and updated. The frequency will need to be decided on a case by case basis but minimally once every 3 months.	Case notes audit completed in Q2. In addition, two CYAF clinical teams have undertaken their own case notes audit. The standard of completion of crisis plans is good overall but needs to be reviewed regularly.	On Target
Continue to audit recording of clinical risk assessments and actions taken	Ongoing	On Target

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 3 Narrative Updates**	**RAG Rating**
Further consultation with the Quality Advisory Group before completing and testing the new forms	No Q3 updates required as workstream completed during Q2.	Complete
Test streamlined forms in one service initially and review and evaluate effectiveness	Due to first phase of the trial falling over the summer period (Jul-Sept '19), and with this summer period having a reduced rate of attendance, the trial of YOS collection within CAMHS has been extended to the end of October 2019 to maximise the amount of forms collected. Early analysis of collection rates (comparing monthly collection rates in 2018 with the same months in 2019) indicates an increased amount of patients/parents completing forms as well as an increased amount of qualitative feedback being provided. Positive clinician feedback on YOS also received.	Complete
Test streamlined forms in second service building on evaluation of first service	Additional service for second phase of YOS trial identified as City & Hackney PCPCS, within the Adults Directorate. YOS trial beginning in Jan '20, with evaluation to be undertaken at the end of Q4.	On Target
Evaluate and review second test and adjust with a view to rollout across the directorates	No Q3 update possible as form not yet trialled within second service. Plans made for second trial to begin within City & Hackney PCPCS in January 2020 so an update will be provided on this at end of Q4 prior to Trust wide rollout.	On Target

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

Quality Priority	3. Improve patient and carer involvement in care planning in CYAF teams	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
Improve quality of patient and / or carer involvement in the development of care plans	This data was not shared in Q3, there has been a need to balance priorities and increasing the production of care plans has been our focus. We will agree a plan to bring this back to our attention in Q4	
Increase the quality of data recorded of care plans shared with patients and referrers	In Q3 we audited 20 Care Plans and found that they were largely complete and with good quality information. There were some one off issues identified that were raised with the clinicians involved and satisfactory explanations given. In Q4 we will share examples of good practice with staff. The number of assessment summaries had the box to send a care plan has been checked has increased from 78 in Q2 to 147 in Q3 which is positive improvement we can hopefully further improve	On Target
Increase the percentage of care plans shared with patients and referrers	The number of care plans completed is increasing as is the number of assessment summaries with the two closely linked. We are glad to see this improvement which is largely a result of accurate reporting and being able to follow up with clinicians more quickly. This will continue in Q4 We note the numbers are different to those submitted in Q2 and this is down to greater clarity in reporting	On Target

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

Quality Priority	4. Provide Effective Sleep Management Information	
Key Workstreams	**Quarter 3 Narrative Updates**	**RAG Rating**
Establish an adolescent only group for patients experiencing sleep difficulties (those aged 14 – 18)	We ran a successful adolescent group this quarter with 2 patients. Though the group was small, both patients completed treatment successfully.	Complete
Develop information guide on sleep hygiene for adolescents with patient, carer and patient representative input	The sleep hygiene guidance is sitting with the PPI group and is awaiting feedback	On Target
Develop and disseminate information for clinicians on sleep in adolescence	This guide is in its final stages of completion and will be published on the intranet by Q4	On Target
Share sleep information more widely with other external agencies	As stated in Q1. This will be completed by Q4.	On Target

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 3 Narrative Updates**	**RAG Rating**
Reduce the number and % of patients dropping out between end of assessment and first treatment episode	Drop-out rate assessed at end of Q2 and was lower than initially expected. Based on the low number and % of patients dropping out the focus for this target has been amended to put plans put to identify patients who started their therapy during Q3 and to obtain feedback on their experience of being on the waiting list for treatment. This will be covered in the target below.	Complete
Obtain feedback from service users on their experience of the gap period	We are now gathering the information of those patients who have started regular therapy during Q3. We have begun to agree questions to ask patients in order to improve their experience on the waiting list. Feedback will be provided in Q4.	On Target
Review reasons for drop out and patient experience to improve the service for both patients and staff	Proposals for improving the experience of patients on the treatment waiting list will be made once feedback has been obtained in Q4.	On Target

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 3 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.	**89 out of 226 due GBM T1's completed during Q3 - 39% compliance** We are pleased that the compliance for GBMs continues to improve though acknowledge we remain some way off the target. Focus for improvement is through a QI project being undertaken in one of our Camden teams. Feedback from clinicians are that they often do not feel ready to set goals at the beginning of treatment as they are focusing on engagement. Clinicians are being encouraged to set general goals that can then be revised to SMART goals at a later date.	
	128 out of 219 due CGAS T1's completed during Q3 – 58% compliance Compliance for CGAS has improved significantly this quarter. We have also improved our reporting removing under 4's from the data as CGAS is not measure recognised for use in this patient group. In Q4 we are looking at the "logic" for the creation of CGAS as we believe there is some variation in teams that we need to address. As outlined above with GBMs we will also be issuing more reminders this quarter.	
Obtain service user feedback on the use of outcome measures to feedback on progress.	This project has yet to start. The clinicians who will work on the project have been identified but at time line and work plan needs to be developed	
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	**39 out of 111 due GBM T2's completed during Q3 – 35% compliance** Before Christmas a change was agreed on the "logic" of generating GBMs in our EPR, it is hoped by making the forms available earlier more staff will take this up. In Q4 we are bringing in reminders for completion of OM – while until now we have asked clinical staff to monitor their own compliance admin will now be sending fortnightly reminders to try and improve completion further.	
	46 out of 113 due CGAS T2's completed in Q3 – 41% compliance As with time 1 we are pleased that rates of completion for CGAS continue to improve. We have received feedback from some clinicians that they do not find the CGAS a relevant or reliable measure of change, despite the fact this is a recognised CORC measure. This has opened up a debate that in an ideal world we would use whatever outcome measure we thought was most relevant for a CYP and be able to report on all the measures in one data return though this is challenging for reporting and for showing an improvement at T1 and T2	
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.	This project has yet to start. The clinicians who will work on the project have been identified but at time line and work plan needs to be developed	

4.1 **CQUINS**

CQUIN CCG2: Increasing Flu Vaccination Uptake Amongst Frontline Staff				
Quarter 3 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**Workforce Plan for Next Quarter**	**RAG Rating**
Achieve an 80% uptake of Flu Vaccinations by frontline clinical staff	The flu vaccination programme started later than anticipated for 2019 due to the change of Occupational Health Providers in September. Therefore from 29th October to date we have vaccinated 38.5% frontline staff (207/538 staff).	Due to the shortage of the main flu vaccine we only received 120, however contacting the Immunisation Commissioner NHS England, the Trust was able to purchase a different vaccine brand. The Trust also purchased Flu Vouchers to address the shortfall.	The Trust has signed up to do peer to peer vaccinations for the remainder of the Flu Campaign. This will enhance the number of staff being vaccinated. Dates have been circulated via the Daily Digest. The Trust will be writing to all frontline workers who have not had their vaccination done via the different options provided by the Trust this year to let us know if they have had it done elsewhere. Flu Vaccination season will end in March 2020.	

4.2 **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 minimum of 90% and a maximum 95% DQMI score	The DQMI is published with a three-month delay and we have now received September's DQMI where we achieved **93.4%.** We are pleased to confirm that we have passed the lower payment threshold of 90%. The actions completed during Q3 to improve compliance will show in the data published at the end of March 2020, hence it will be included in Q4 report. During Q3 we made the 'Referral Closure Reason' field mandatory - this change was active from October 2019 and will have an impact on the DQMI published in 20 January 2020. For Clinical Response Type and Activity Location Code, we corrected background codes not linked properly from Care Notes to the MHSDS code. In both parameters we have now achieved 100%. Similarly, with primary Source of Referral we have now achieved 99%	**Hour Care Contact, Referral Receive Time and Indirect Activity Time** are currently parameters in our DQMI. The Trust Contracts Department are questioning this with the Commissioners as these are penalising us for having too many appointments on the hour. This is a problem for us as at least 60% of our services now running operate clinic models where the appointments are an hour long, so they would finish on the hour. QAD feels that if these parameters are not removed, we might not achieve the 95% target in Q4.	To carry on monitoring compliance and identifying areas for improvement. We have dropped ethnicity recording by 1% and we will be liaising with admin leads to improve our performance in this area. Despite the slight drop we have had an overall good performance in this area as most of the uncoded ethnicities are due to the high number of patients waiting to be seen at the Gender Services. This is a regular item in the Quality Assurance Meeting.	

4.3 **CQUINS**

CQUIN CCG5b: Mental Health Data Quality: Interventions (London Contracts)				
Quarter 3 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**Workforce Plan for Next Quarter**	**RAG Rating**
70% intervention target by Q3	London Contracts 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 Oct 2019 – Dec 2019, there were 609 cases in the cohort, among which 573 cases had SNOMED code present – which makes the intervention measurement to be approx. 94.09 % Please note the figure above is calculated from our internal reports. The official NHS digital/MHSDS figures for November 19 have not as yet been published.	The Future NHS digital is published with 3 to 4 months delay. Data will be verified then official figures are published.	Appointment activity has been analysed over the past 12 months. Event types where no SNOMED codes have been recorded in the clinical EPR system have been shared with the services. Services have provided SNOMED codes for some events which have been added to the EPR system. An updated list of active events which have no SNOMED code recorded will be shared with the services. 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.	According to our internal reports. Data will be verified when December's data (Q3) get published

4.4 **CQUINS**

CQUIN CCG5b: Mental Health Data Quality: Interventions (NHSE Specialist Contracts)				
Quarter 3 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	Contracts included: NHS England Specialist Commissioning (008-GIDS,065-Portman,178-GIC,215-FCAMHS). For period Oct 2019 – Dec 2019, there were 396 cases in the cohort, among which 377 cases had SNOMED code present – which makes the intervention measurement to be approx. 95.2%. Please note the figure above is calculated from our internal reports. The official NHS digital/MHSDS figures for November 19 have not as yet been published for Q3.	The Future NHS digital is published with 3 to 4 months delay. Data will be verified then official figures are published	Informatics and the Data Quality Team have analysed the appointment activity over the past 12 months. Appointment Event types used within the last 12 months which have no SNOMED code recorded have been highlighted and shared with the services. Previously all Event types for GIC had no SNOMED codes mapped to their appointments. GIC have supplied the SNOMED Codes for the most used Event types and they have been added to the clinical EPR system. Also GIC requested for a number of event types to be made inactive as they were no longer required – this has been actioned on the EPR system. An updated list of active events which have no SNOMED code recorded will be shared with the services. 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.	According to our internal reports. Data will be verified when December's data (Q3) get published

4.5 **CQUINS**

Local CQUIN: Anxiety Disorders and RCADS Outcome Measurement			
Quarter 3 Targets	**Quarterly Performance Against Targets**	**Associated Issues / Risks**	**RAG Rating**
Quarterly report : RCADS T1	Completions monthly rates during Q3: Oct 54%, Nov 42% and Dec 55% - baseline set at 32% We remain above the baseline for RCADS completion though we are yet to see a consistent trend in improvement As with other measures the logic of these forms has been a complex issue to resolve and attempts to make the forms easier to use by automatically generating were hampered by software updates that have not yet happened. This has now been corrected but the RCADS form has had to be put back in the CYPIAPT appointment form which is less accessible		
Quarterly report : RCADS T2	Completions monthly rates during Q3: Oct 42%, Nov 26% and Dec 38% - baseline set at 26% Please see above.	It is noted that If an anxiety disorder or depression is found on the RCADS Time 1 there is a logic to completing a follow up. If there is no indication of an anxiety disorder or depression at Time 1 then there would is no logic to repeating it.	

4.6 **CQUINS**

Local CQUIN: Telemedicine / Virtual Patient Sessions		
Quarter 3 Targets	**Quarterly Performance Against Targets**	**RAG Rating**
Acquire and implement the technology required to facilitate Telemedicine	GIDS has acquired and configured its own instance of Refero and has progressed some testing across a number of operating systems, devices and modes of connection (hard wire, wifi, 4G). Testing continues and we are working with the supplier to identify changes at server and network level that will improve issues arising from latency. Full procurement is dependent upon the results of forthcoming testing following these system modifications. Given the above, the service has on a limited number of occasions and with the support of the Trust's IG Manager, used Skype for Business to facilitate network meetings with professionals in Adult Services in Newcastle and Leeds and CAMHS services in Slough and London and with a small number of service users in Ireland.	
Trust and third party provider CINOS to train clinicians in use of new platform	Because testing of Refero continues, we have not yet requested that Cinos provide training to clinicians.	
Test the new videoconferencing platform in meetings with external professionals	This has happened to a limited extent with Skype for Business thus far with plans to increase the numbers of sessions using the platform to work towards the specified number of sessions (100) by the end of March 2020 to enable robust analysis	
Obtain experience survey data from GIDS clinicians and external professionals	This is currently being collected.	
If system has proven robust and consistent, begin telemedicine sessions with carefully selected, low-risk young people and families in treatment	Although Refero has not been used, a limited number of Skype for Business sessions have been held with carefully selected young people and parents in the Republic of Ireland.	
Provide a milestone report	Given the delays occasioned by the need for system modifications and continued testing, completion of a full milestone report has not been possible; however, evidence is being currently gathered from all sessions that are being conducted using Skype for Business.	

2019/20 CQUIN Performance Tracker

CQUIN: Anxiety Disorders and RCADS Outcome Measuring				
Description	The Revised Children's Anxiety and Depression Scale (RCADS) and the RCADS - Parent Version (RCADS-P) are questionnaires that measure the reported frequency of various symptoms of anxiety and low mood. The CQUIN will put into place the systems and processes to enable the data to be collected across CAMHS services, build new reports to enable use of the 'current view' form of patient record to be monitored and paired scores to be reported			
Target	Payment based on results at end of each quarter against quarterly milestones			
	Quarter 1	*Quarter 2*	*Quarter 3*	*Quarter 4*
Quarterly Targets	1. *Agree list of 'Anxiety Disorders'* 2. *Confirm use of 'Current View' and RCADS with Clinicians* 3. *Amend RCADS form link to be available for all CAMHS services* ***25% Weighting***	1. *Build new reports to enable establishment of baseline for RCADS use* 2. *Set trigger on Carenotes for completion of RCADS form* 3. *Set up visual workflow for RCADS Time 1 & 2* 4. *Baseline RCADS use* ***25% Weighting***	1. *Quarterly report to be provided looking at data obtained from patients with time 1 and time 2 scores recorded* ***25% Weighting***	1. *Quarterly reports to be provided looking at data obtained from patients with time 1 and time 2 scores recorded* 2. *Comparison report looking at improvements in RCADS completion rates between baseline rate established in Q2* ***25% Weighting***
Quarterly Performance Overview	1. *List of anxiety disorders agreed* 2. *Plan in place for use of Carenotes to measure this CQUIN* 3. *Change proposal agreed by CYAF senior team. Work ongoing with informatics to adjust associated logic*	1. *Reports are now in use* 2. *Carenotes triggers calibrated* 3. *Visual workflow produced* 4. *RCADS use baseline established*	1. *Quarterly report for Q3 shows month-on-month improvements against baseline*	
Trust Perspective (RAG)				
CCG Perspective				

CQUIN CCG2: Increasing Flu Vaccination Uptake Amongst Frontline Staff				
Description	CQUIN measuring increase in uptake of flu vaccinations amongst frontline healthcare workers			
Target	To achieve an 80% uptake of the flu vaccination by frontline clinical staff			
	Quarter 1	*Quarter 2*	*Quarter 3*	*Quarter 4*
Quarterly Targets	*Achieving an 80% uptake of flu vaccinations by frontline clinical staff.*	*Achieving an 80% uptake of flu vaccinations by frontline clinical staff.*	*Achieving an 80% uptake of flu vaccinations by frontline clinical staff.*	*Achieving an 80% uptake of flu vaccinations by frontline clinical staff.*
Quarterly Performance	Planning for September is ongoing	Communication plan finalised and four all-day flu-vaccination clinics organised over a two-week period at end of October 2019	38.5% of frontline staff received flu vaccine during Q3. More work to be undertaken during Q4 to increase this figure.	
Trust Perspective (RAG)				
CCG Perspective				

CQUIN CCG5a: MHSDS DQMI - Maturity Index (50% of total **CCG5** weighting)				
Description	Improving the quality and breadth of data submitted to the Mental Health Services Dataset (MHSDS). The MHSDS Data Quality Maturity Index (DQMI) score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS			
Target	To achieve a MHSDS DQMI score of between 90-95% during Quarters 2 to 4			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quarterly Targets	No Targets for Q1	Achieve an MHSDS Maturity Index Score of 90%-95%	Achieve an MHSDS Maturity Index Score of 90%-95%	Achieve an MHSDS Maturity Index Score of 90%-95%
Quarterly Performance	• Action Plan devised on Quality Portal • MHSDS Completeness data already shared with teams • Missing data requests circulated	Most recent official DQMI score for the trust was 88.9%, which corresponds to June 2019. Since then a lot of work has been carried out with clinical teams at the front-end, and with IT at the back-end to ensure that we will have achieved 90% when the official scores for Q2 are published	Latest official DQMI score is 93.4% - within target range. Work will continue during Q4 to make improvements to increase this score where possible.	
Trust Perspective (RAG)				
CCG Perspective				

CQUIN CCG5b: Mental Health Data Interventions *(50% of total **CCG5** weighting)-*				
Description	The denominator for this CQUIN is the number of referrals that receive their second attended contact during Quarters 3 & 4 2019/20 Of this denominator, the CQUIN is measuring the referrals with at least one SNOMED CT Procedure Code recorded between the referral start date and the end of the reporting period Completion rates provided by NHS Digital will be Trustwide data based on MHSDS submissions.			
Target				
	Quarter 1	*Quarter 2*	*Quarter 3*	*Quarter 4*
Quarterly Targets	*No targets during Q1*	*No targets during Q2*	*Evidence between 15-70% of referrals during this quarter having had a SNOMED CT procedure code recorded between referral start date and the end of the reporting period* ***50% weighting***	*Evidence between 15-70% of referrals during this quarter having had a SNOMED CT procedure code recorded between referral start date and the end of the reporting period* ***50% weighting***
Quarterly Performance	● All Contract / CCGs were considered ● Found that for period APR2019-JUN2019, there were around 981 cases in the cohort, among which 737 cases had SNOMED code present – which makes the intervention measurement to be more than 70%	Internal reports created for monitoring progress against targets. Work carried out by Informatics mapping codes and ensuring activity is linked to SNOMED codes to ensure achievement of targets by next quarter	According to our internal reporting, across both London and Specialist contracts – there were 1005 eligible referrals with a second attended contact; 950 of which had a SNOMED code present. Giving compliance of 94.5% Additional coding work has been undertaken within informatics that should see this score increase over Q4.	
Trust Perspective (RAG)				
CCG Perspective				

CQUIN: Telemedicine / Virtual Patient Sessions				
Description	Telemedicine is a methodology used by the NHS to support accessibility of services whenever there are geographical barriers to patients. The GIDS is a highly specialist national service and hence accessibility is a key issue for those patients who may have to travel long distances or do not have the means to do so. Offering Telemedicine appointments would enable the service offer to be more flexible and inclusive and reduce barriers to access for patients.			
Target	The target for this CQUIN is to initially test and enable remote participation in professional meetings involving GIDS clinicians and to then use this development to offer greater flexibility across the GIDS service to enhance patient experience.			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quarterly Targets	No targets during Q1	• *Update documentation/guides* • *Create additional ESQ survey* • *Identify clinicians for Project Team* • *Identify professionals for Project Team* ***25% weighting***	*1. Implement telemedicine technology* *2. Clinicians to be trained in new platform* *3. Test videoconferencing at meetings* *4. Obtain feedback* *5. If system proves robust, begin telemedicine sessions with carefully selected patients* *6. Provide milestone report* ***50% weighting***	• *Continue to offer telemedicine* • *Analysis of feedback re: clinical efficacy* • *Collect data on no. of sessions offered/taken up* • *Provide milestone report* • *Complete final report* ***25% weighting***
Quarterly Performance	• IM&T Steering group confirmed central departmental support for this project • Discussion with Clinical Lead at Leeds site re: selecting appropriate patients etc…	• Guides/documentation updated • ESQ survey created • Clinicians to become involved once video-conferencing software is proven to be up and running to avoid reducing clinical capacity unnecessarily • Clinicians identified for future involvement	1. Telemedicine capabilities acquired, testing still underway 2. As testing still underway, no training provided 3. Limited testing undertaken 4. Feedback currently being collected 5. Limited no. sessions undertaken 6. Milestone report underway	
Trust Perspective (RAG)				
CCG Perspective				

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: January 2020

Report to	Date
Board of Directors	28 January 2020

Quality Priorities 2020/21

Executive Summary

The purpose of this report is to provide an update on the proposed quality priorities for 2020/21. This information will be included within the Annual Quality Accounts.

The anticipated Quality Accounts letter, Detailed Requirements for Assurance for Quality Reports had not been published at the time of this report. However, central guidance is that there will be few, if any changes from 2019/20. The requirement in previous years' is for at least three priorities to be agreed by the Board of Directors.

The priorities have been chosen to reflect the main messages from wide consultation.

This report has been reviewed by the following Committees:
EMT, 28/1/2020

Recommendation to the Board of Directors

The Board of Directors is asked to approve the priorities for 2020/21

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
Marion Shipman, Associate Director Quality and Governance	Dr Dinesh Sinha, Director of Quality

1.0 Introduction

'Priorities for Improvement' are included as a section in the annual Quality Accounts. NHS Improvement Guidance has previously confirmed that Trusts are required to include at least three priorities indicating the relationship, if any, between the identification and the reviews of data relating to quality of care.

The rationale for the selection of the priorities and whether / how the views of patients, the wider public and staff were taken into account must be included in the report. In addition, information on how individual priority progress will be monitored, measured and reported must be stated.

The priorities must be agreed by the Board of Directors for NHS Foundation Trusts'.

The Quality Accounts will include progress made against each of our four 2019/20 priorities.

2.0 Current Priorities

There were six priorities agreed for 2019/20 which are reported quarterly to Board in the Quality and Commentary report. These are below. Progress has been made on all priorities.

Patient Safety		
Priority 1	Improve identification and management of high risk patients	This built on a 2018/19 Quality priority
Patient Experience		
Priority 2	Experience of Service Questionnaire Review	This was new priority in 2019/20
Clinical Effectiveness & Patient Experience		
Priority 3	Improve patient and carer involvement in care planning in children, young adult and family services	This built on a 2018/19 Quality priority
Clinical Effectiveness		
Priority 4	Provide effective sleep management information and support to adolescent patients and carers of those with sleep disorders (aged 14-18)	This built on a 2018/19 Quality priority
Priority 5	Improve waiting time experience form end of assessment to first treatment session in the generic Adult Complex Needs Service	This was new priority in 2019/20
Priority 6	Embed meaningful use of outcome measures in services	This built on a 2018/19 Quality priority

3.0 Choosing priorities for 2020/21

Priority topics for 2020/21 were developed following discussions with a number of service users, non executive directors, staff, management and commissioners and a review of current Trust Quality Priorities, service challenges, key performance issues and quality data reviewed and presented to Board over the past year. As a result we have chosen four priorities which reflect the main messages from these consultations.

Patient Safety		
Priority 1	Standardise the use of Carenotes Alerts to enhance patient safety and communications.	Our ambition in this priority is to include consistent Carenotes Alert information in careplans, letters and crisis plans. Currently there is different practice across the Trust in the use of the Carenotes Alert field. This priority will agree a consistent standard to support the implementation of the Health Information Exchange (HIE) and Accessible Information Standards (AIS). The AIS targets will include the sharing of information about people's information and communication needs with other teams, services, agencies and providers and taking steps to ensure that people receive information in the way they have requested, with the support they require.
Patient Experience		
Priority 2	Experience of Service Questionnaire (ESQ) Implementation	This will build on the 2019/20 Quality priority and include further testing and implementation of the updated ESQ across the Trust.
Clinical Effectiveness		
Priority 3	Reduce waiting times across the Trust.	This builds on waiting time issues across the organisation, recognising the impact that long waiting times have on patient experience. The priority will target the implementation of job planning and accurate capacity planning to improve waiting times.
Priority 4	Embed meaningful use of outcome measures in services across the Trust	This priority will build on work undertaken in Children, Adults and Young Families (CYAF) during 2019/20 and will also include Adult & Forensic Services and Gender Services.

3.0 Summary

Detailed measurable targets are currently being confirmed for each priority. Where appropriate we will use Quality Improvement methodology as the tool of preference for undertaking the work.

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 January 2020

Integrated Governance Committee – Terms of Reference

Executive Summary

Over the last nine months a comprehensive review of the integrated governance committee has been undertaken by the medical director and supported by the director of HR and corporate governance.

A draft set of revised terms of reference have been developed and are based on the model version contained within the NHS Providers' compendium of good governance.

The committee has carefully considered the terms of reference and asks for the board to formally consider these for adoption.

In doing so, members of the board should note that the terms of reference reflect a recommendation from the audit committee to assess the suitability of the membership and mandatory attendees in order to obtain assurance on all matters within its remit.

Recommendation to the Board

Members of the Board are asked to approve the terms of reference

Trust strategic objectives supported by this paper

All strategic objectives

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

The Tavistock and Portman NHS Foundation Trust

Integrated Governance Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	
Name of originator/author:	Director of HR & Corporate Governance / Medical Director
Name of responsible committee / individual:	Medical Director
Previous Name of Committee:	Clinical, Quality, Safety and Governance Committee
Date issued:	
Review date:	

Integrated Governance Committee

Terms of Reference

1. Overview, Authority and Purpose

1.1 The integrated governance committee is constituted as a standing committee of the trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings.

1.2 The committee is authorised by the board of directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by the committee.

1.3 The committee is authorised by the board of directors to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4 The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Scope

2.1 To enable the board to obtain assurance that high standards of care are provided by the trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the trust to:

2.1.1 promote the safety and excellence in patient care;

2.1.2 identify, prioritise and manage risk arising from clinical care;

2.1.3 ensure the effective and efficient use of resources through evidence-based clinical practise;

2.1.4 protect the health and safety of trust employees; and

2.1.5 ensure compliance with legal, regulatory and other obligations.

3. Membership

3.1 The following will be members of the Committee:

- Two non-executive directors;
- Chief Executive;
- Medical and Quality Director; and
- Clinical Chief Operating Officer.

3.2 The following will be in attendance

- Two Governor representatives;
- Deputy Chief Executive and Finance Director;
- Director of Human Resources and Corporate Governance;
- Director of Technology and Transformation;
- Director of Research and Development;
- Divisional Directors;
- Associate Director of Quality and Governance;

- Associate Medical Director
- Divisional Heads of Clinical Governance; and
- Clinical Governance and Quality Manager.

3.3 At the discretion of the Chair, other persons may be invited to attend and participate in Committee meetings. However, only Committee members have the authority to vote and determine decisions.

Quorum

3.4 The committee will be deemed quorate to the extent that the following members are present:

3.4.1 Medical Director;

3.4.2 Clinical Chief Operating Officer; and

3.4.3 At least one non-executive director.

3.5 In addition to the above, the committee will also need sufficient mandatory attendees present to be able to conduct its business.

4. Frequency of meetings

4.1 Meetings shall be held quarterly.

4.2 Additional meetings may be held on an exceptional basis at the request of the chair or any three members of the committee.

5. Duties

5.1 In particular, in respect of general governance arrangements:

5.1.1 ensure that all statutory elements of clinical governance are adhered to within the trust.

5.1.2 approve trust-wide clinical governance priorities and give direction to the clinical governance activities of the trust's service lines and directorates, not least by reviewing and approving each service's and division's annual quality plan;

5.1.3 review and approve the trust's annual quality report before submission to the board;

5.1.4 approve the terms of reference and membership of its reporting sub-committees (as may be varied from time to time at the discretion of the committee) and oversee the work of those sub-committees, receiving reports from them as specified by the committee in the sub-committee's terms of reference for consideration and action as necessary;

5.1.5 consider matters referred to the committee by the board;

5.1.6 consider matters referred to the committee by its sub-commitees;

5.1.7 review and recommend for approval by the board the annual clinical audit programme;

5.1.8 obtain assurance that the trust's policies and procedures with respect to the use of clinical data and patient identifiable information are compliant with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 2018;

5.1.9 make recommendations to the audit committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;

5.1.10 seek assurance on the implementation of policies and procedures, including but not limited to:

- infection prevention and control annual report and programme
- health and safety policies and procedures
- complaints policy
- claims policy
- incident reporting policy
- consent policy
- safeguarding children policy
- safeguarding adults policy

5.1.11 foster quality links with primary care and other stakeholders including patient forum members.

5.2 In respect of safety and excellence in patient care, in particular:

5.2.1 agree the annual safety plan and monitor progress;

5.2.2 ensure that internal standards are set and monitored, including (without limitation):

5.2.3 commission the setting of standards by the board (e.g. in trust policies), and ensure that a mechanism exists for these standards to be monitored;

5.2.4 ensure the standards outlined in national service frameworks are implemented and monitored;

5.2.5 ensure the standards outlined in relevant national service frameworks are implemented and monitored;

5.2.6 ensure the trust complies with NHS Litigation Authority standards;

5.2.7 ensure the registration criteria of the Care Quality Commission continue to be met;

5.2.8 implement an engagement programme with the leaders of clinical service lines to ensure regular and constructive scrutiny of activities;

5.2.9 support the board to promote within the trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy;

5.2.10 ensure that robust arrangements are in place for the review of patient safety incidents (including near-misses, complaints, claims reports from HM Coroner) from within the trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;

5.2.11 ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed;

5.2.12 identify areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/ PALS and ensure appropriate action is taken;

5.2.13 oversee the system within the trust for obtaining and maintaining any licences relevant to clinical activity in the trust receiving such reports as the committee considers necessary;

5.2.14 monitor the trust's compliance with the relevant national standards of quality and safety of the Care Quality Commission, and NHS Improvement's licence conditions that are relevant to the

committee's area of responsibility, in order to provide relevant assurance to the board so that the board may approve the trust's annual declaration of compliance and corporate governance statement;

5.2.15 ensure that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation:

5.2.16 review the trust's risk management strategy prior to its presentation to the board of directors for approval'

5.2.17 ensure that processes are in place to ensure the escalation of risks from local and clinical service line risk registers to the corporate risk register and receive reports from the trust's Associate Director of Quality and Governance;

5.2.18 identify areas of significant risk, set priorities and place actions using the assurance framework;

5.2.19 ensure the trust incorporates the recommendations from external bodies e.g. the National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery;

5.2.20 maintain and monitor the trust's risk management policy;

5.2.21 ensure those areas of risk within the trust are regularly monitored and that effective disaster recovery plans are in place;

5.2.22 ensure implementation of the National Learning and Reporting system;

5.2.23 assure that there are processes in place that safeguard children and adults within the trust; and

5.2.24 escalate to the executive management team and/or audit committee and/or board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant threats to the operation, resources or reputation of the trust;

5.2.25 agree the annual patient experience plan and monitor progress;

5.2.26 assure that the trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, so as to identify areas for improvements and ensure that these improvements are effected.

5.3 In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

5.3.1 review and recommend for approval by the board the annual quality plan and to monitor progress;

5.3.2 review proposals for cost improvement programmes and other significant service changes and to monitor their impact on the trust's quality of care (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the board of directors;

5.3.3 ensure that care is based on evidence of best practice/national guidance;

5.3.4 assure that procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council, Nursing and Midwifery Council and the Health and Care Professions Council) are in place and performed to a satisfactory standard;

5.3.5 ensure that there is an appropriate process in place to monitor and promote compliance across the trust with relevant clinical

standards and guidelines including but not limited to NICE guidance;

5.3.6 assure the implementation of all new procedures and technologies according to trust policies;

5.3.7 review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them;

5.3.8 monitor trends in complaints received by the trust and commission actions in response to adverse trends where appropriate;

5.3.9 monitor the development of quality indicators throughout the trust;

5.3.10 generally monitor the extent to which the trust meets the requirements of commissioners and external regulators;

5.3.11 identify and monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties;

5.3.12 ensure the research programme and governance framework is implemented and monitored;

5.3.13 ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);

5.3.14 ensure that where the practice is of high quality, that practice is recognised and propagated across the trust; and

5.3.15 ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

6. Reporting

6.1 The minutes of all meetings of the quality committee shall be formally recorded.

6.2 The committee will report to the board after each meeting.

6.3 The following reports will also be made available by the committee:

6.3.1 exception reports from the executive management team and its sub-committees (via major issues report and minutes as appropriate);

6.3.2 major issues reports covering all elements of quality;

6.3.3 quality dashboard;

6.3.4 annual quality report including highlighting areas for improvement;

6.3.5 quarterly updates of compliance with CQC national standards; and

6.4 The following sub-committees shall report to the committee:

6.4.1 Clinical, Quality and Patient Experience Sub-Committee;

6.4.2 Risk and Safety Sub-Committee;

6.4.3 Information Governance Sub-Committee;

6.4.4 Estates and Facilities Sub-Committee;

6.4.5 Organisational Development and People Sub-Committee;

6.4.6 Research and Development Sub-Committee; and

6.4.7 Divisional Clinical Governance Committees.

7. Review

7.1 The terms of reference should be reviewed by the board at regular intervals but as a minimum annually.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	28 January 2020

Equality Diversity and Inclusion Committee: Terms of Reference

Executive Summary

The terms of reference have undergone their annual review and are presented the board of directors for approval.

Minor changes have been made which include:

- An update to the membership
- Confirming the status as a specialist interest committee
- The reporting after each committee has been amended to the reflect the current practice of presenting a summary of the meeting to the board of directors.

Recommendation to the Board

Members of the board of directors are asked to approve the revised terms of reference

Trust strategic objectives supported by this paper

People

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

The Tavistock and Portman NHS Foundation Trust

Equality, Diversity and Inclusion Committee

Ratified by:	Board of Directors
Date ratified:	TBA
Name of originator/author:	Director of HR & Corporate Governance
Name of responsible committee/individual:	Equality, Diversity and Inclusion Committee Chair
Date issued:	TBA

Equality, Diversity and Inclusion Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Specialist Interest Committee to be known as the Equality, Diversity and Inclusion Committee ("the Committee").

1.2 This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a non-executive director.

2. Membership

2.1 Membership of the Committee shall be as follows:

2.1.1 A non-executive director (who will chair to Committee)

2.1.2 Director of human resources and corporate governance (who act as the executive lead)

2.1.3 A divisional director

2.1.4 Associate dean, learning and teaching

2.1.5 Trust race diversity champion

2.1.6 Trust LGBTQI+ champion

2.1.7 An adult and forensic services division representative

2.1.8 A children, young adults and family services division representative

2.1.9 A gender services division representative

2.1.10 An HR representative

2.1.11 A communications representative

2.1.12 A trade union representative

2.1.13 Patient and public involvement representative

2.2 At the discretion of the Committee Chair, other persons may be invited to attend and participate in Committee meetings. However, only members have the authority to vote and determine decisions on behalf of the Committee.

2.3 Appointments to the Committee shall be for a period of up to three years, which may be extended for one further three-year period.

3. Quorum

3.1 This shall be a minimum of 6 members including the Committee Chair.

4. Frequency of meetings.

The committee shall meet bi-monthly

5. Agenda & Papers

5.1 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.

5.2 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.

6. Minutes of the Meeting

6.1 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.

6.2 Approved minutes will be forwarded to the Board of Directors for noting.

7. Authority

7.1 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.

7.2 The Committee is authorised to obtain outside legal advice or other professional advice at the Trust's expense, and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Duties

8.1 The Committee will provide an advisory role to help ensure that the Trust better supports and considers equality, diversity and inclusion as an employer, as a system leader in education and training and as a provider of clinical services.

8.2 The Committee will help to provide independent assurance of the Trust's responsibilities under the Equality Act 2010 and advancing equality.

8.3 The Committee will provide a safe place for discussion on equality, diversity, and inclusion issues relating to clinical service delivery, education, training and workforce development for the Trust.

8.4 The Committee will be responsible for working with a range of partners to advance equality, diversity and inclusion and influence equality principles relating to clinical service delivery and education and training.

8.5 The Committee will empower Trust staff to achieve an organisation where 'everyone counts' and support improving performance on equality, diversity and inclusion, the Committee will follow the principles outlined in the NHS Constitution for England.

8.6 The Committee will establish working groups as and when required to ensure that the objectives of the Committee are taken forward and implemented in a timely manner.

8.7 The Committee will highlight areas of good practice and share information across the Trust.

8.8 The Committee will monitor the equality, diversity and inclusion programme budget and where necessary support the business planning process to attain programme funding.

9. Other Matters

9.1 At least once a year the Committee shall 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.

10. Sources of Information

10.1 The Committee will receive and consider sources of information from any relevant individual or department.

11. Reporting

11.1 The Committee shall report formally to the Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities.

11.2 A summary of the minutes 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.

11.3 The Committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit or where action or improvement is needed.

11.4 11The Committee will report its activities at least once a year to the Trust Board to fulfil the requirements set out in the Equality Act 2010 (Specific Duties) Regulations 2011.

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

11.6 The Committee Chair shall make a statement in the Trust's Annual Report about the activities of the Committee, the process used to make appointments, and explain if external advice or open advertising was not used.

11.7 The Committee shall make itself available to the Nominations Committee should that Committee require its input whenever any discussion of the re-appointment of a non-executive director or the Trust chair takes place.

12. Support

12.1 The Committee will be supported by a secretary.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 January 2020

Draft Trust Objectives

Executive Summary

In the coming year, the Trust aims to build on its position as a distinctive provider of quality mental health services and training and education including taking the opportunity to expand its activities into new areas of work in and outside the NHS, where aligned with our Mission and Values.

This paper sets out a draft set of strategic objectives.

Recommendation to the Board

Members of the Board of directors are asked to discuss the draft objectives

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
All Executive Directors	Chief Executive

The Tavistock and Portman NHS Foundation Trust

Tavistock and Portman NHS Foundation Trust
Draft Trust Objectives – 2020/21

In the coming year, the Trust aims to build on its position as a distinctive provider of quality mental health services and training and education including taking the opportunity to expand its activities into new areas of work in and outside the NHS, where aligned with our Mission and Values.

The Trust's objectives are focused on the quadruple aim of:

- *Delivering better health outcomes to the populations we serve*
- *Continuously improving the experience of those who use our services*
- *Improving and enhancing the wellbeing of those who work for us*
- *Ensuring we always use our financial resources wisely*

This will be done through a focus on:

- *People*
- *Services*
- *Growth*
- *Finance and Governance*

Objective	Lead Director
1. Increase the pace of progress in achieving equality of opportunity across the organisation including a particular focus on race equality and disability.	Director of HR & Corporate Governance
2. Strengthen the engagement with the Trust's workforce addressing issues highlighted in the 2019 staff survey.	Chief Executive
3. Develop an updated People Strategy for the Trust with a focus on future workforce needs and addressing staff welfare and morale.	Director of HR & Corporate Governance
4. In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Clinic site.	Deputy Chief Executive
5. Develop and operationalise a strategic plan for high quality and financially sustainable clinical and educational services.	Chief Clinical Operating Officer Director of Education and Training

Objective	Lead Director
6. Contribute actively to the development of models of integrated care in Camden and across North Central London.	Chief Executive
7. Complete implementation of the recommendations of the GIDS Review and any wider lessons from the Review for the Trust's services.	Chief Clinical Operating Officer
8. Progress the Trust's longer-term priorities for new service development and meet the target for new growth in 2020/21.	Director of Strategy
9. Increase the reach of the Trust's training and educational work including delivery of new long course programmes and initial rollout of the Trust's Digital Academy.	Director of Education and Training
10. Further establish the Trust's external reputation as a voice on workforce development and wellbeing including the rollout of the ADD Wellbeing Programme and related initiatives.	Director of Nursing
11. Develop as part of the Centenary Year, a strategic narrative for the role of the Trust's work and expertise in the 21st Century.	Director of Strategy

Objective	Lead Director
12. Meet the Trust's requirements with its national regulators.	Medical Director
13. Meet the Trust's budget and control total for 2020/21	Deputy Chief Executive

Report to	Date
Board of Directors	28 January 2020

Flows of Assurance

Executive Summary

The Care Quality Commission (CQC) conducted its well-led review in September 2018. The inspection team noted that the Trust has in place good oversight mechanisms but it should reflect on how to further improve these to ensure that the organisation does not lose sight of important matters which could have adverse consequences.

This paper presents a view of the flows of assurance and is intended to open a discussion about whether this is an accurate representation.

Recommendation to the Board

Members of board of directors are asked to note and discuss this paper.

Trust strategic objectives supported by this paper

Finance and Governance

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

Flows of Assurance

1. Introduction

1.1. The Care Quality Commission (CQC) conducted its well-led review in September 2018. The inspection team noted that the Trust has in place good oversight mechanisms but it should reflect on how to further improve these to ensure that the organisation does not lose sight of important matters which could have adverse consequences.

1.2. Following the restructure of the Trust's clinical services and the creation of new operational oversight functions has given an opportune moment to remap the flows of assurance.

2. General points

2.1. Within all NHS organisations assurance flows through three layers which are:

- Operational service delivery;
- Oversight through the chief executive who will delegate their powers to directors to execute functions on their behalf; and
- Scrutiny, challenge and assurance sought through the board of directors or a standing committee established to fulfil a specific function.

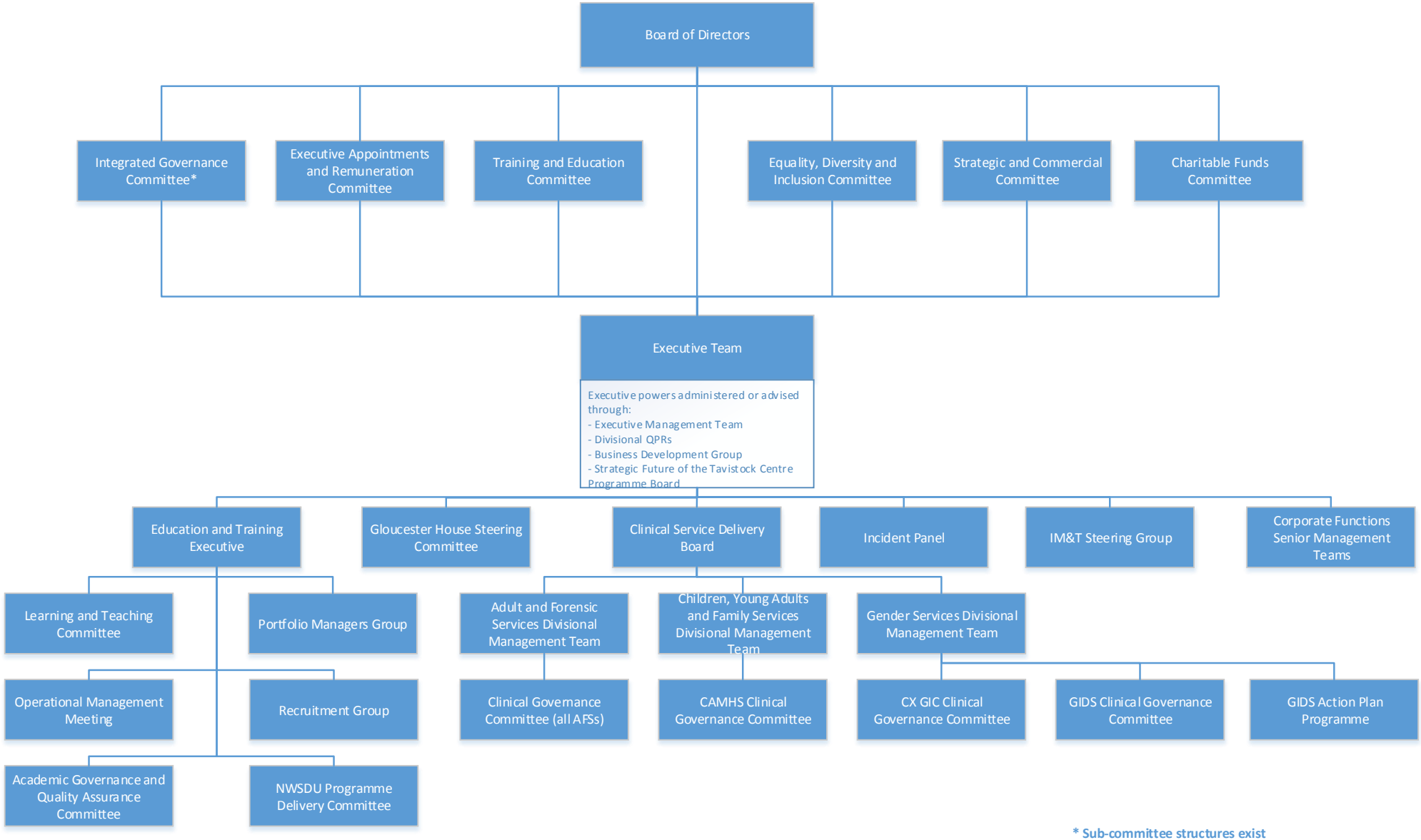
2.2. As part of the legislation that sets out how foundation trusts are constituted each organisation must have, as a minimum, the following standing committees of the board of directors:

- A nominations and remuneration committee to fulfil the purposes of appointing and removing executive and non-executive directors; and,
- An audit committee to seek assurance on matters of corporate governance and risk on behalf of the board.

2.3. Whilst not mandatory, it is recommended that each organisation has a quality committee.

3. The flows of assurance

3.1. The chart below, sets out an initial view point of the organisation's flows of assurance.



* Sub-committee structures exist

4. Conclusions and Recommendations

4.1. This paper is presented, having been considered by the executive management team, to open a discussion within the board of directors about the construct of the flows of governance.

Craig de Sousa
Director of HR & Corporate Governance

January 2020

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	16th January 2020

Serious Incidents – Quarterly Report – Q3 2019/20

Executive Summary

This quarterly serious incident summary report for the Board covers Q3 2019-20.

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

There were 5 serious incidents logged externally on StEIS in Q3, and sadly 4 of them were patient deaths. There was a patient death in the North Camden services of a historical patient who took their life. The service had not seen the patient since 2017 so we were not involved officially in any investigation into this death, which is a suspected suicide.

There was a death in the Portman service of a patient who had been discharged earlier in 2019. We received the coroner's report confirming the cause of death was suicide; multiple injuries sustained from jumping in front of a train. A concise internal report has been submitted to the January Incident Panel for review.

There were two deaths reported in the adult gender services both of which were suspected suicides and one of which actually happened during Q2 but the Trust was only notified of it in Q3. Concise internal reports were completed and will be reviewed at the January Incident Panel.

The final externally reported incident was a gang related shooting of a patient in the South Camden service. Thankfully this was not a fatal shooting but it did highlight an emerging theme of growing gang violence for some of our patients. After discussion at Incident Panel and with our commissioners, it was decided the Trust would undertake a thematic review of three recent gang related incidents to complete a deep dive into the circumstances and outcomes. The review has already begun and is due for completion within 4 months. The commissioners have agreed to halt all further investigations into these chosen incidents until the thematic review is completed and reported on.

Action plans from previous serious incident investigations continue to be monitored via the monthly Incident panel to identify any gaps for learning opportunities and to ensure completion.

The Trust wide lessons learned events continue to be relatively well attended and are open to all staff with a Trust contract, due to the nature of the discussions.

The Adult Safeguarding Lead role has now been amalgamated with the Prevent Lead role and is now 2 sessions. This new role has been advertised internally and externally with interviews due to take place on 11th February 2020. Both roles are currently being covered by staff on a temporary basis.

Recommendation to the Board

The Board of Directors is asked to note this paper

Trust strategic objectives supported by this paper

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

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Trust Board	16th January 2020

Guardian of Safer Working Hours 2019-2020 Quarter 3

Executive Summary

The number of exception reports over this quarter remain low however the number of hours worked above the expected amount has increased. 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. A process has been put in place to manage fine disbursement.

Recommendation to the Board

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

People

Author	Responsible Executive Director
Guardian of Safe Working	Medical and Quality Director

Guardian of Safe working hours Q3 report

1. Introduction

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

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
October	5	0	4	1
November	9	4	3	2
December	6	2	2	2
Totals	20	6	9	5 (25%)

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

2.2 Work schedule reviews

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

2.3 Vacancies

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

2.4 Locum

The NROC is currently being staffed by Trainees.

	Number of shifts	Number Covered	Number Vacant	Clinicians
October	1	1	0	Sprs
November	0	0	0	
December	2	2	0	

It is likely that for the next quarter the number of locum shifts available will increase as a number of trainees are on maternity leave and 2 trainees are leaving the rotation as they have achieved their CCT's.

2.5 Fines

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
October	20.25	4.5	£2340.68	£ 877.71	£1462.97
November	6	1.5	£ 713.76	£ 267.66	£ 446.10
December	5.5	4.5	£1204.00	£ 451.50	£ 752.50
Totals	28		£4258.44	£1596.81	£2661.57

The fines accrued are more hours than usual. In December this was due to staff issues at the Whittington

Fines accrued 2018-2019

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

Fines accrued 2019 – 2020

Total	Total hours	Total fines	Total paid to trainees	Amount accrued
Q1	21	£2122.96	£766.09	£1326.85
Q2	14.5	£1991.99	£746.98	£1245.01
Q3	28	£4258.44	£1596.81	£2661.57

3. Junior Doctors Forum (JDF)

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

Fine Disbursement:

£560.67 fine released for texts books for trainees offices.

4. Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC on 20th January 2020

5. Conclusions and Recommendations

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

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

5.3 This is likely to be my final report to the board in my capacity as GOSWH as I step back from the role after 3 years on post. I would like to thank you for receiving my reports with interest and over the year appropriate concern and support where needed.

S. Habel

Dr Sheva Habel

Guardian of Safer Working Hours

Report to	Date
Board of Directors	28th January 2020

Emergency Preparedness , Response and Recovery (EPRR)
Assurance and Action plan for 2019-2020

Executive Summary

All healthcare provider organisations are obliged to undertake an annual EPRR assessment against NHS England core standards and to secure agreement from the Board to the submitted Level of Compliance and approve the Action plan.

The Tavistock and Portman NHS FT EPRR Assurance feedback report was reviewed by the Trust Accountable Executive Officer (AEO) for
Emergency Planning, Dr Dinesh Sinha, and an action plan in response to the report submitted to NHS England in The Board of Directors is asked to:
- Review the 2019-2020 EPRR Assurances Report from EPRR NHS England
- Confirm the Level of Compliance
- Approve the action plan that has been put in place to address the issues raised.

The Action plan will be reported to and monitored by the Corporate Governance and Risk Work stream and reported to the Integral Governance Committee.

Appendix 1 is the 2019 EPRR Assurance Report from NHSE

Recommendation to the [Board / Committee]

The Board is asked to approve this document

Trust strategic objectives supported by this paper

EPRR Policy, Business Continuity Plan, Major Incident Plan,
Pandemic Flu Plan, Severe Weather Response Plan.

Author	Responsible Executive Director
Lisa Tucker Health and Safety and Risk Manager , Emergency Planning Liaison Officer (EPLO)	Dr Dinesh Sinha Medical Director Accountable Emergency Officer (AEO)

1. Introduction

NHS England (London) uses an annual EPRR assurance process to assure themselves that all NHS organisations in London are prepared to respond to an emergency, and have plans and the resilience in place to continue to provide safe patient care during a Major Incident (MI) or Business Continuity (BC) event.

2. Assurance compliance

Our assurance self-assessment papers and relevant plans and policies were submitted in September and then reviewed with NHSE EPRR leads at our assurance review meeting attended by Dr Sinha on 17th of October 2019.

From the panel review of our assurance it was agreed that the Tavistock and Portman level of EPRR compliance is; **SUBSTANTIALL**

'The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months'.

3. Summary

This is a great improvement and mainly due to;
Executive involvement,
The establishment of the Director on Call,
The Trust wide table top exercise on a cyber-attack away day in July 2019,
Completion on Local Business Continuity Plans.

We will continue to review plans with staff involvement on a biannual basis, where senior staff will meet as an EPRR working group.

4. Conclusion from NHSE EPRR

'The Trust has made very good progress this year to maintain and improve its EPRR arrangements, this was evident in the Trust's assurance submission which provided reasonable commentary and included the required evidence. The Trust originally highlighted seven 'Amber' ratings, however, following the discussions at the assurance meeting it was agreed that the Trust had successfully completed its outstanding actions thus achieving 'Green' ratings. The Trust's post assurance rating is reflective of the discussions'.

5. Action Plan

Action	Plan	Lead	Deadline
The Trust is to determine whether they adopt a bi-annual approach to reviewing their plans	EPRR Working Group will be the main replacement of an Executive Management Team meeting, inviting the four Directorate Leads; DET , CYAF , AFS and Gender and the EPLO before March 2020	EPLO to coordinate with CEO office	March 2020 and then biannually
The Trust agreed to deliver a live exercise by September 2022	Further table top exercise in 2020 Q1 or Q2 Live exercise can be utilised from report of a Major Incident declaration.	EPLO to coordinate with Deputy CEO	June 2020
The Trust will look at organising Strategic Leadership in a Crisis training for their strategic and tactical responders at a later date	Director on Call / Silver Command training to be refreshed. Any dates and location to be disseminated by NHSE if arranged by them.	EPLO liaising with CandI and other MH / CH services across London	June 2020
The Trust will look to increase the number of trained Loggist with assistance from GOSH trainer	8 Staff have been identified from across the Trust	EPLO to continue to liaise with GOSH	April 2020
NHSE&I to check whether the LHRP Specialist Trust Rep is engaged with the AEO and provides them with updates	To be confirmed with NHSE EPRR.	EPLO, AEO and NHSE&I	April 2020

Author Lisa Tucker, Health and Safety Manager, EPLO for EPRR
9th December 2019

Approved by Dr Dinesh Sinha, Medical Director, AEO for EPRR
10th December 2019

2019 EPRR Assurance Report

Tavistock and Portman NHS Foundation Trust

Version number: 1.1

First published: November 2019

Prepared by: Liz Rogers, NHS England and Improvement (London);
Roshan Abdool-Raheem, NHS England and Improvement (London).

Classification: OFFICIAL

Contents

1 2019-20 Assurance review summary

The 2019-20 annual EPRR assurance process is used to be assured that NHS Organisations in London are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

The process this year is similar to that followed in 2018-19; however, where possible it incorporates learning from feedback received through the post assurance debrief process.

To support NHS organisations in preparing their assurance returns additional guidance was prepared and circulated to each NHS organisation.

Within North East and North Central London, the NHS England and Improvement (London) patch team undertook an assurance review process with the following organisation types:

- Acute hospital service providers
- Community service provider (this includes NHS Trusts, Foundation Trusts and social enterprises)
- Mental health service providers
- Specialist health service providers
- NHS 111 service providers
- Clinical Commissioning Groups

For acute Trusts additional site visits were arranged to review specific requirements regarding Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe).

All organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR which would provide the framework for the assurance review meetings furthermore the review meetings would also have a broader oversight and ensure that plans and arrangements were being updated with relevant learning and guidance.

At the review meeting the Trust advised that progress had been made against the Trusts workplan for 2018-19. The Trust was able to deliver a BC exercise in May 2019, a post Exercise Report was signed off in July 2019. The organisation has gone through structural changes which will result in three directorates. The Trust ran an exercise and as a result implemented a single number to contact the director on -call in an incident, previously there were different numbers for directors when on-call.

It is also important to mention that the AEO is very supportive in providing a level of oversight and direction on EPRR related work impacting on the Trust as a whole.

2 Assurance review process

The assurance process for Tavistock and Portman NHS Foundation Trust (TAVI) was conducted as follows:

Assurance Meeting	Date of Visit	Assurance Review attendance
Main Assurance Meeting	17th October 2019	**NHS England and Improvement (London):** Roshan Abdool-Raheem (Chair), Liz Rogers, Camilla McBrearty (Peer Reviewer) **TAVI:** Lisa Tucker (EPLO), Dinesh Sinha (AEO)

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2019-20 Assurance Process Letter (9th July 2019), the overall level of compliance is based on the total percentage of amber and red ratings.

In respect of Tavistock and Portman NHS Foundation Trust for Core Standards 1 – 69, it was agreed that the Trust assessed level of compliance is **SUBSTANTIAL**.

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

Amber ratings were received for the following core standards:

- Core Standard 33 - Loggist

Red ratings were received for the following core standards:

- None

The assurance review meeting agreed RAG ratings and discussion points can be found in appendix A

4.1.2 Deep dive outcomes – Severe Weather Response

Amber ratings were received for the following core standards:

- None

Red ratings were received for the following core standards:

- None

4.2 Assurance review meeting agreed actions

NHS England and NHS Improvement (London) EPRR / Panel-agreed actions as follows:

1. The Trust is to determine whether they adopt a bi-annual approach to reviewing their plans (Core Standard 2, 12, 13, 14 and 51).
2. The Trust agreed to deliver a live exercise by September 2022 (Core Standard 27).
3. The Trust will look at organising Strategic Leadership in a Crisis training for their strategic and tactical responders at a later date (Core Standard 28).
4. The Trust will look to increase the number of trained loggists with assistance from GOSH (Core Standard 33).
5. NHSE&I to check whether the LHRP Specialist Trust Rep is engaged with the AEO and provides them with updates (Core Standard 40).

5 Next Steps: Action Plans and Governance

Tavistock and Portman NHS Foundation Trust is required to submit, within two weeks of the date of this report the following documentation to england.london-assurance@nhs.net:

- The Trusts EPRR workplan which sets out clear actions, timescales and leads and includes areas where the organisation scored Red or Amber
- A signed declaration of the overall level of compliance achieved from the AEO

5.1 Identified key priorities

The Trust is advised to prepare a robust work plan for the next twelve months which will include any actions set out in section 4.2, the reviews of plans, policies and the testing and exercising of plans.

6 Conclusion

The Trust has made very good progress this year to maintain and improve its EPRR arrangements, this was evident in the Trust's assurance submission which provided reasonable commentary and included the required evidence. The Trust originally highlighted seven 'Amber' ratings, however, following the discussions at the assurance meeting it was agreed that the Trust had successfully completed its outstanding actions thus achieving 'Green' ratings. The Trust's post assurance rating is reflective of the discussions.

As the outcome of the deep dive response did not affect the overall Trust compliance level, it was agreed that a number of the deep dive standards (Deep Dive 16 – 20) were not directly related to EPRR and also not within the remit of the EPLO. Therefore, it was concluded that any actions pertaining to these would be the Trust's decision to include in their annual EPRR workplan.

Finally, on behalf of the NHS England and Improvement (London) NENC EPRR Team, thank you to all colleagues involved in this assurance process.

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

EPRR Core Standards					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG rating**	**Agreed 2019 RAG rating**	**RAG rating rationale and review meeting comments**
Governance					
1	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. The AEO is engaged and attended the Regional EPRR Business Continuity Conference.
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. The Trust should update EPLO's from other Trusts they reference, remove actions cards as this would be best served in Trust Major Incident Plan. Any response related information should be moved to the Major Incident Plan.
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. This was signed-off with statement of compliance. The Quality Account and Board report is available on internet for public viewing.
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. EPRR Resource is adequate and EPLO is supported by AEO.
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Supported by NENC London EPRR representative.
Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.

8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Duty to maintain plans					
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. EPLO meets (quarterly) with Pan London MH and CH Trusts Completion of local and overarching BCPs are confirmed and reported to CCG / CSU quarterly.
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Additional comments were noted by the panel and have been shared so that they can be incorporated in the next version.
13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
16	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. In line with the latest guidance.

		arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.			
18	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. No bed availability on site.
20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Evacuation of all the Trusts Estate buildings take place annually. The clinical staff take responsibility for the safety of their patients; all services are outpatient clinics. Health and Safety Site Risk assessments have evacuation plans confirmed. All Trust premises have automated front doors with CCTV (all have one access) controlled by the Front of House Staff.
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Health and Safety Site Risk assessments have lockdown and fire safety plans confirmed.
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Command & Control					
24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
25	**Trained on call staff**	On-call staff are trained and competent to perform their role and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. The Trust advised that the Management team were present at the Table top exercise in June 2019 and tested the actions cards for the Gold, Silver and Bronze. There are between 6-8 on-call directors.

		The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.			
Training & exercising					
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept demonstrating this.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. The Trust has identified that an SLC refresher is needed for senior staff.
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Data Breach incident in September 2019, which allowed the Trust ti establish a Command Post to manage incident. Communication exercises take place monthly. **Action: Trust agreed to deliver live exercise by September 2022.**
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Following a recent table top exercise in June 2019 and a major Incident being declared in August when the Trust had an IT outage for over a 24-hour period. **Action: The Trust will look to organise this training at a later date.**
Response					
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.

		are fit for purpose and supported with documentation for its activation and operation.			
31	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. All Policies and Procedures are on the Trusts website, local BCPs are on shared file and hard copies within each team.
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
33	**Loggist**	The organisation has 24-hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	**Partially compliant**	**Partially compliant**	The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate. There are currently two trained loggists with a further five who are due to take the course, this will be delivered by GOSH's EPLO. **Action: The Trust will look to increase the number of trained loggists with assistance from GOSH.**
34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Warning & Informing					
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to trained media spokespeople able to represent the organisation to the media at all times.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Cooperation					
40	**LHRP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. **Action: NHSE&I to check whether the LHRP Specialist Trust Rep is engaged with the AEO and provides them with updates.**
41	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.

		Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.			
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Business Continuity					
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Local BCPs have relocation / working from home / telephone consultation / home visits for riskier patients if a service has a loss of facilities.
52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.

54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
CBRN					
56	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating. The Trust has Action cards on reception - numbers for decontamination services, laminate information card of hazardous-material-incident-guidance-for-primary-and-community-care.pdf, on reception and used in training.
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.

Deep dive					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG**	**Agreed 2019 RAG rating**	**Assurance review meeting comments**
Severe Weather Response					
1	**Overheating**	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Volunteer service supports distribution of water.
2	**Overheating**	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
3	**Staffing**	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
4	**Service provision**	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
5	**Discharge**	The organisations arrangements include how to deal with discharges or transfers of care into non-health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating. N/A to our services, all 'discharged' patients are referred back to GPs or onto other providers, If in crisis, a patient is sent to A&E in an ambulance (rapid transfer procedure)
6	**Access**	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisation's boundaries. When snow / ice occurs, there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third-party gritting or snow clearance service.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
7	**Assessment**	The organisations arrangements are clear in how it will assess all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
8	**Flood prevention**	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. Following a recent flooding incident, the Trust is in the process of reviewing its flood plan.

9	**Flood response**	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating. The Trust is reviewing the information available to on-call/response staff as part of the overall redraft of its flood plan.
10	**Warning and informing**	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
11	**Flood response**	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site-specific arrangements for flood response, for known key high-risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate. No identified risk of flooding, only underground car park at the Tavistock. Flood is included as a risk in local BCPs - unavailability of building is included
12	**Risk assess**	The organisation has documented the severe weather risks on its risk register and has appropriate plans to address these.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
13	**Supply chain**	The organisation has a documented process of seeking risk-based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintained the organisation has alternative documented mitigating arrangements in place.	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
14	**Exercising**	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
15	**ICT BC**	The organisations arrangements include the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	**Fully compliant**	**Fully compliant**	The Panel agreed that the self-assessed compliance rating as being appropriate.
Long Term Adaptation Planning					
16	**Risk assess**	Evidence that the there is an entry in the organisations risk register detailing climate change risk and any mitigating actions	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
17	**Overheating risk**	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
18	**Building adaptations**	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.

					EPLO aware of Environmental considerations with Estates, major projects and relocation plans. ERIC returns completed for 2019
19	**Flooding**	Areas are identified in the organisation's adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.
20	**New build**	The organisation has relevant documentation that it is including adaptation plans for all new builds	**Partially compliant**	**Fully compliant**	The Panel considered the evidence and additional information offered by the Trust at the assurance meeting to reach an agreement and revise this rating.

The Tavistock and Portman NHS
NHS Foundation Trust

Emergency Planning Response and Recovery (EPRR) Policy

Version:	2.1
Bodies consulted:	WMT
Approved by:	Board
Date Approved:	April 2019
Lead Manager:	Health and Safety Manager as EPLO
Lead Director:	Medical Director as AEO
Date issued:	July 2016
Review date:	April 2020

Version Control Sheet

Version	Date	Author	Status	Comments
V 1	July 2016	Lisa J Tucker	EPLO	New Policy - Guidance for all staff
V 1.2	August 2017	Lisa J Tucker	EPLO	Section 4.1 page 6 Defined the EPRR group as the WMT 'Duties'
V 1.2	August 2017	Lisa J Tucker	EPLO	Section 6.2 page 11 Quarterly reports and Governance of the SS BCPs,
V.2	September 2018	Lisa J Tucker	EPLO	Replaced contact details of EPLOs across London with Mutual Aid protocol (inc contact details)
V.2	September 2018	Lisa J Tucker	EPLO	Replaced Local Business Continuity Plans template
V 2.1	April 2019	Lisa J Tucker	EPLO	EPRR Group 4.1 Additional Stakeholders in the event of Major Incident
V 2.1	April 2019	Lisa J Tucker	EPLO	Relevant Policies and Procedures 5.1 Infectious Diseases Plan (with in the Infection prevention and Control Procedure)
V 2.1	April 2019	Lisa J Tucker	EPLO	BCPs 5.1 page 11 Business Impact Assessment's
V 2.1	April 2019	Lisa J Tucker	EPLO	Major Incidents 5.5 Information Sharing and Lessons Learnt
V 2.1	April 2019	Lisa J Tucker	EPLO	CBRNE training for all Front of House staff. Appendix 2 Training Needs Analysis

Contents

Introduction

It is the policy of The Tavistock and Portman NHS Foundation Trust that Emergency Preparedness, Resilience and Response (EPRR) arrangements are in place to enable the effective response and management of any incident impacting upon the Trusts main and subsidiary sites, effecting the population served by the Trust and the wider community.

This policy will ensure that the Trust is carrying out its statutory duties as a Category 2 responder under the Civil Contingencies Act 2004, Care Quality Commission outcomes and contractual duties required by our Commissioners. The Trust will ensure that all plans comply with national EPRR Guidance, notably the NHS England core standards for EPRR. The Trust will also align its Business Continuity Plans with ISO22301.

1.0 Aims and objectives

1.1 Aim:

To provide a framework within which the Trust will prepare, respond and recover from any emergency or incident which threatens or causes disruption to either the health of the community in which the Tavistock and Portman operate or the delivery of community services.

1.2 Objectives:

- To ensure the Trust has in place adequate emergency and business continuity plans
- To ensure risks identified by the assessment of borough, regional and national risk registers are considered and addressed
- To ensure appropriate management oversight of the EPRR programme and clarify roles and responsibilities
- To set standards for the development of emergency plans, training, exercising and procedures

2.0 Definitions and explanation of any terms used.

AEO	Accountable Emergency Officer
BRF	Borough Resilience Forum: within London these are the local multi-agency groups which bring together all the category 1 and 2 responders within a police force area for the purpose of facilitating co-operation in fulfilment of their duties under the Civil Contingencies Act. Outside London these are known as a Local Resilience Forum.
BCP / M **Business Continuity Plan / Management**	A management process that helps manage risks to the smooth running of an organisation or delivery of a service, ensuring that it can operate to the extent required in the event of a disruption

Category 1 Responder	A person or body listed in Part 1 of Schedule 1 to the Civil Contingencies Act. These bodies are likely to be at the core of the response to most emergencies. As such, they are subject to the full range of civil protection duties in the Act.
Category 2 Responder	Co-operating and sharing relevant information with other Category 1 and 2 responders. Due to the nature of our services the Tavistock and Portman is classified as a Cat 2 responder
CBRNE	A term used to describe Chemical, Biological, Radiological, Nuclear and Explosive materials. CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent.
Civil Contingencies Act (2004)	Act of 2004 which established a single framework for Civil Protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for Local Responders; Part 2 of the Act establishes emergency powers.
CC - Command and Control	The exercise of vested authority through means of communications and the management of available assets and capabilities, in order to achieve defined objectives.
Emergency	An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or the security of the UK or of a place in the UK.
Management Team	Executive Management Team – made up of the CEO and the Clinical and Corporate Directors and the Dean Education and Learning. The Management Team includes the wider group - Directors of HR, IMT and Communications.
EPLO	Emergency Planning Liaison Officer; responsible for supporting services and sites in devising local BPCs and the MIP and the overarching BCP. Facilitates the annual Table top exercise for the Management Team, and responsible for submitting the Annual EPRR Assurance to NHS England. Represents the Trust at BRF and receives and responds to all EPRR communications
EPRR	Emergency Preparedness, Resilience and Response. A programme of work within the health community whereby incidents are planned for, responded to, and recovered from under the auspices of the Civil Contingencies Act.

HazMat	Abbreviation for Hazardous Materials although it is commonly used in relation to procedures, PPE equipment and incidents involving hazardous materials.
MIP - Major Incident Plan	The response plans for specific scenarios of a Major Incident, including action cards for the Gold Silver and Bronze Commands and the team around incident, including Communications, Loggist and CBRN action cards.
Major Incident	*In the NHS a Major Incident is defined as:* Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations
Mutual Aid	Staff transference to support a critical service or site with Staffing issues on an emergency basis only. Also between Trusts in the event of Major Incident (i.e.; Medical Staff) *See Appendix 4 for contacts*
Situation Report (SitReps)	Report produced by an officer or body, outlining the current state and potential development of an incident and the response to it.
Strategic **(also known as Gold Command)**	The strategic level of command and control (above Silver level and Bronze level) at which policy, strategy and the overall response framework are established and managed for individual responder agencies. In Tavistock and Portman this role is fulfilled by the Medical Director or on-call Director for the Directorate.
Tactical **(Silver Command)**	Level (below strategic level and above operational level) at which the response to an emergency is managed.
Operational **(Bronze)**	The level (below tactical level) at which the management of 'hands-on' work is undertaken at the incident site(s) or associated areas, equating for single agencies to Bronze level.

3.0 Duties

The following section depicts a list of the roles connected with the EPRR Management Framework and its application. Roles defined here do not include any role in the response to incidents – these can be found in the Trust's Major Incident Plan and Business Continuity Plans.

3.1 THE EPRR Group

The EPRR group consists of the members of the Wider Management Team and including;

Chief Executive
Finance Director & Deputy CEO
Medical Director (As AEO)
Dean of Post-Graduate Education, Director of DET
Director of Children Young Adults & Families
Director of Adult and Forensic
Director of Nursing
Director of Human Resources
Director of Information Technology and Transformation
Director of Communications and Marketing
Estates Consultant
Head of Estates and Facilities
Director of Quality and Patient Experience
Health and Safety Manager

In the case of a Major Incident / BCP this will also include relevant senior staff and representatives of the stakeholders (e.g.: LA, CCG, CSU) of the Tavistock and Portman services effected.

3.2 Accountable Executive Officer (AEO)

The AEO is appointed by the Chief Executive Officer to be responsible for establishing the strategic direction of the Trust with regard to EPRR. In the Trust this is the Medical Director.

Responsibilities:

- Ensure the Executive Team is updated annually regarding the level of preparedness relating to EPRR
- Maintain oversight of the EPRR Management Framework
- Maintain oversight of the risks associated with the EPRR programme
- To ensure the EPRR Group is aware of the status of plans mentioned in this framework
- To understand the role of the AEO as set out by NHS England
- To allocate appropriate resource to EPRR to meet the Trust's statutory obligations.

3.3 Emergency Planning Liaison Officer (EPLO)

Appointed by the AEO to ensure management of the processes under the framework, note that the EPLO is responsible for the day to day delivery of the EPRR agenda. In the Trust this is the Health and Safety Manager.

Responsibilities:

- Development of plans, templates, exercises and audits for the execution of the EPRR Framework
- Advise in the development of emergency procedures at service and site level
- Ensure that emergency plans are relevant and reflect changes to guidance and internal changes within the Trust
- Monitor and report on the status of all plans and documents within this framework
- Ensure the completion of corrective and preventative actions required in action plans
- Monitor and ensure compliance with document controls on all documents falling under the EPRR Framework
- Present the status of this framework and documents under it to the Executive Management Team.
- Conduct training needs analysis for all staff in this framework and those that have specific roles in response and where necessary provide training or suggest appropriate external training courses
- Where required provide specialist advice to ensure projects and service changes take into account Emergency Planning and Business Continuity measures
- Ensure risks identified under the Borough Risk Register are assessed for potential impact on the Trust and planned for appropriately
- Ensure central emergency planning resources (BCP / MIP etc.) remain fit for purpose and available for use at short notice, reporting gaps to the AEO.

3.4 Directors

Responsibilities:

- To ensure all services under their supervision have adequate emergency procedures where required in conjunction with the Resilience plans
- Provide support in the development of plans for all services they manage
- To ensure plans for their Service lines and Directorate are cross linked where possible to prevent immediate draws on central resources and enable Mutual Aid across the Trust and externally in the event of a Major Incident
- To facilitate cross directorate plan development where necessary
- To ensure risks are appropriately reported, added to the Operational Risk Register, addressed or tolerated.

3.5 Service line Managers

As the lead for their services these individuals will assist in the development of emergency plans and procedures. This work will be supported by team leads.

Responsibilities:

- Creation and completion of local emergency plans and procedures for their service(s)
- Development of resilience within their service(s)
- To advise of projects and changes to the service which impact on service resilience
- Ensure staff entering their service in an emergency are briefed appropriately
- Escalation of EPRR risks within their service to the Operational Risk Register
- Communication of service continuity arrangements to all staff within the service
- Help facilitate debriefs following an incident

3.6 Director of Estates & Facilities and external Facilities Manager/s

Including Local Facilities Managers (sites not owned or managed by the Tavistock and Portman Trust). From an E&F perspective these individuals should assist in the development of emergency plans and procedures as specialists for their sites. This should be supported by the local Estates &Facilities, or Health and Safety Managers.

Responsibilities:

- Creation and completion of local emergency plans and procedures for sites
- Development of resilience within sites
- To advise of projects and changes to sites which impact on resilience
- Ensure staff entering their site in an emergency are briefed appropriately
- Escalation of EPRR risks within their sites to the corporate risk register

- Communication of site continuity arrangements to all relevant staff
- Help facilitate debriefs following an incident.

4.0 All Staff

Responsibilities:

- To ensure that risks and disruptions are escalated to their Service Line manager, site Estates and Facilities Manager or other appropriate authority
- Act in accordance with the emergency planning and business continuity arrangements of the service/site and Trust as required
- Follow emergency instructions given to maintain safety of patients, staff and visitors
- Report any Near Misses or Incidents that could cause any interruption to service via the QP for Incident reporting and include senior staff responsible for action plans.

5.0 Governance for EPRR

5.1 Emergency & Business Continuity Plans (BCPs)

The Trust will put in place a series of emergency plans and procedures to ensure that the Trust is fully prepared for incidents impacting itself and on the population it serves. An overarching Trust Business Continuity Plan and Major Incident Plan will be created to ensure the Trust's command and control structure is standardised for the response to all incidents, whilst also allowing the response to be adapted to the incident occurring. The Trust wide plans will be supported by threat specific response plans where arrangements differ due to the nature of the incident, as well as service, team and site specific Business Continuity Plans. (See Appendix 2)

Minimum standards for plans:

- Management of the incident
- Communication methods and channels
- List of services primarily involved in response, or required changes to services
- Identification of the impact to health of incidents to allow potential impacts to be assessed (where applicable)
- Resources required and actions to ensure an adequate response to the planning assumptions, relocation of services, alternative sites and staffing
- Specific roles required to respond
- Links to other plans and procedures
- Version control

Plans will be maintained with full version control. This will include a version number and the disposal of past copies of plans. Where expired versions are to be kept they should be marked as such. All plans and documents under the EPRR Policy will have a version number, month and year placed upon them. Where a plan is replaced the version number will be increased by 0.1 for a minor change and 1.0 for a major change.

The plans that the Trust will put in place are:

- Major Incident Plan

- Trust Business Continuity Plan
- Heatwave Plan (where necessary with vulnerable patients) included in the MIP
- Cold Weather Plan (where necessary with vulnerable patients) included in the MIP
- Pandemic Influenza Plan
- Infectious Diseases Plan (with in the Infection prevention and Control Procedure)
- Team / Service Specific BCPs, including outreach services

This list is not exhaustive and other procedures and plans will be put in place as required. The plans listed above will be subject to annual review, but where required ad hoc changes will be made more frequently.

5.2 Business Continuity

It is the policy of Tavistock and Portman that it will continue to deliver services (as defined in the Trust Business Continuity Plan) in the event of disruption through robust business continuity arrangements.

Business Continuity plans will be put in place at service level with a Trust Business Continuity plan to enable a co-ordinated response in the event of an incident disrupting multiple services.

5.3 Business Impact Assessment

The Trust annually reviews and assesses their BCP to ensure all staff are aware of the Maximum Time Period of Disruption (MTPoD) of the Tavistock and Portman Trust Estate buildings which is covered in the BCP. The timescale provided in the Recovery Time Objectives are measured in increments of hours days and weeks. Any incident that would need further recovery time up to and more than 3 weeks would involve an NHSE notification of a Major Incident and reported to our NHS Commissioners.

5.4 Responsibility for reviewing BCPs

Service level business continuity plans are the responsibility of the relevant Associate Director.

Team level business continuity plans are the responsibility of the Services leads and team leads if at multiple sites

All teams should be included in their local BCP if in a building not owned or managed by the Trust, i.e. contact details in the case of an emergency or closure of a building.

5.5 Incident Control Room

The Trust will ensure that an Incident Control Room (ICR) is available at all times to enable an effective response to be coordinated from a central point. It is the policy of the Trust that the Trust's ICR will meet the requirements of the NHS Commissioning Board Command and Control Framework 2013. Overarching this will be in the Tavistock Centre, either the SR4 or the Board Room or off site at the Monroe Centre, individual services or sites will identify local arrangements.
See Major Incident Plan for Incident Control Room Action Card

5.6 Training

Training frequency will be determined by the likelihood of risk and the need to ensure that a role for specific staff i.e. Medical Staff, or the Trust as a whole can be carried out effectively when needed, and the level of expertise required of carrying out the task. All training will be included on an EPRR Training Needs Analysis (TNA) -*see Appendix 3*, which is updated whenever relevant training is delivered.

All EPRR related training, including lessons learnt from a 'Live' event or incidents, will be evaluated through a short debrief and report. An evaluation report assessing the training, and if the objectives have been reached will be submitted by the training coordinator. Any updates are submitted in the quarterly report to the Corporate Governance and Risk Work stream, meetings held quarterly. Any feedback from these reports and debriefs will be collated and used to improve future training.

5.7 Exercising

The Trust has in place an exercise schedule to test response plans and procedures with elements of threat specific plans tested with these arrangements. All exercises carried out by the Trust will:

- have defined aims and objectives
- be consistent with the scope in the EPRR Policy
- be reviewed and debriefed
- be planned so an incident being caused as a result of the exercise is minimized
- have clear guidance on the suspension and rules of any exercise

Annually; the Management Team will review the exercising needs of the Trust against the previous exercises carried out, requirements of EPRR core standards and the NHS England EPRR Framework.

Exercises will be evaluated by the participants against the aims and objectives, this will be done at the end of the exercise in an exercise debrief. The exercise will also be followed up with an evaluation sheet to record any learning. Following an exercise the EPLO will produce an exercise debrief report, this report will include an action plan to address any concerns and preventative actions required to improve response plans and framework.

5.8 Information Sharing and Lessons Learnt

Any incidents that trigger the local or overarching BCP will be reported as an incident with 48 hours. If this is a serious incident (see Serious Incident Procedures) this must be reported to the relevant CCG / CSU, Information Commissioners Office or Health and Safety Executive. In the event of 'harm' (service with drawn or unavailable) to patients then onto STEiS .There will be a request for a concise report from Director of IT and Transformation or the Medical Director. This will be reviewed at the monthly Incident panel and then sent onto relevant stakeholders. The Concise Report will include any lessons learnt, highlighting what went well and the action plan or any further actions. Any BCP incidents and reports are shared with the meetings associated with the incident, e.g.; Corporate Governance and Risk and the Estates and Facilities workstreams and relevant and team or service line meetings.

6.0 Governance

6.1 Governance and Version Control

All documents created and maintained as part of the EPRR programme will be subject to the Trust's governance arrangements, including the requirements for document control, audit and oversight.

6.2 Authorisation and sign off of BCPs

Service procedures and plans will be agreed between service leads, the Directors and the AEO and EPLO, the service line managers will review submitted plans to ensure that they are complete and have enough detail to fulfil the requirements of the response they are written for. Where plans lack sufficient detail, feedback will be provided to ensure the plan is improved before it is considered complete. Once a plan is agreed it will be signed off by the relevant Director and the EPLO. Where a new plan is written, or amendments are made it will be signed off by the Management Team prior to publication.

6.3 Reporting process through to the Board

The Health and Safety Manager will provide a quarterly report to the Corporate Governance and Risk work stream and then onto the Clinical Quality Safety and Governance Committee chaired by the Medical Director (Trust AEO and Gold Command) In that report there will be an update on site vests, including updates on the Service Specific BCPS and report any best practise, concerns and risks to be escalated to the Risk Register.

6.4 NHS Assurance and Board report on Compliance and Action Plan.

To ensure that the Trust is complying with its EPRR obligations NHS England (London) will undertake an annual assurance process with updated policies, procedures and training requirements. The Board will received a report on the Assurance compliance and the Action Plan for the next year.

7.0 Consultation Process

The following stakeholders were consulted in the creation of this policy and comments incorporated as appropriate:

- Executive Management Team for the Tavistock and Portman
- Board of Directors for the Tavistock and Portman
- NHS England (London)

8.0 Approval and Ratification Process

The initial draft of this procedural document is to be sent to the Management Team in September 2016 and reviewed annually.

9.0 Dissemination and Implementation

This document will be submitted to the intranet and the website by the EPLO and AEO

It will be therefore be available to all staff via the Tavistock and Portman NHS Trust intranet. Furthermore the local / service line BCPs document will be circulated to all managers who will be required to cascade the information to members of their teams. They will confirm receipt of the procedure and destruction of previous procedures/policies which this supersedes. Managers will ensure that all staff are briefed on its contents and on what it means for them.
This policy will also be made directly available to all members of the Trust's Management Team.

10.0 Training

In line with national guidance is committed to deliver as a minimum; one live exercise every three years, a table-top exercise every year and a test of communications cascades every six months with the Wider Management Team and relevant specialists. This will be organised and facilitated by the EPLO and supported by the AEO.

For training requirements please refer to the Trust's Training Needs Analysis **Appendix 2**

11.0 Archiving

The AEO and EPLO will undertake the archiving arrangements.

12.0 Monitoring and Auditing Compliance with the Procedural Document

Compliance with this policy will be monitored by the Management Team. An annual EPRR board report will be submitted which will include:

- Details of all plans in place
- The outcome of the annual NHS England (London) assurance process
- Progress made on action plans
- Details of training and exercises undertaken or participated in

13.0 Review arrangements

This procedural document will be reviewed every 3 years, or annually post Annual Assurance for NHS England. It will be reviewed by the AEO and EPLO and the EMT

14.0 Associated Documentation

Tavistock and Portman BCP
Tavistock and Portman MIP
Influenza Plan
Business Continuity Plans

15.0 References

- NHS Commissioning Board Emergency Preparedness Framework 2013
- NHS England Core Standards for Emergency Preparedness, Resilience and Response 2015
- Civil Contingencies Act 2004
- Camden Risk Register 2017

Appendix 1; Equalities Statement

Completed by	Lisa J Tucker
Position	Health and Safety Manager, EPLO
Date	April 2019

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources.

Appendix 2: Training Needs Analysis for EPRR and Business Continuity Planning

Training Topic	Local Induction (start)	Induction (within 6 months of start date)	INSET (every 2 years)	6 months	Annually (site visits)	3 years	Front Line Staff (Receptions, Front of House and General Office)	Admin & Managers	Service line Managers	Executive Management Team	Wider Management Team
CBRNe Please see MIP for specific training											
Fire Safety and Lockdown											
Business Continuity Planning											
Internal Communications testing											
Emergency Planning- Table top Exercise											
Emergency Planning- Live Exercise											

Appendix 3: Local Business Continuity Planning

The Tavistock and Portman NHS
NHS Foundation Trust

Team / Service Name

Local Business Continuity Plan

& Action Cards

Version:	1.0
Bodies consulted:	Management Team
Approved by:	
Date approved:	
Service manager:	
Service director:	
Date issued:	
Review date: (annual)	

Audit Trail		
Date	**Updates**	**Author**

Staff Contact details

In the case of an emergency please ensure all relevant parties are contacted.

Start with contacting staff who will be affected using a 'Cascade' or Telephone tree.

Please ensure all staff have colleagues contact information in their phones and that the managers have key personal details 'In Case of Emergency' (ICE) contact. All staff have a responsibility to ensure they have notified the caller they have received the call or message.

Role	Name	Contact Number	ICE contact

Site Details

This service operates from the following sites.

Site Details for Service Line - Please ensure all relevant contact names and numbers are here.		
Site(s) Address		
Telephone		
Service opening days/ hours		
Other services provided within the site		
Landlord / Estates		
Number of rooms		
Number of floors		
Number of T&P staff at this site		
Utility suppliers		
T&P Estates Manager		Tel / email
Estates Personnel		Tel / email
Key Holder(s)		Tel / email
Do you have access to alternative sites?	Address	Contact *

**Please ensure the services in the alternative accommodation are aware that they're nominated in your plan.*

Roles and Responsibilities

Below is a list of roles performed within the service and the priority of this role during an incident that is disrupting the service.

Role	**Level** Essential / Desirable	**No. staff performing this role currently?**	**Minimum no. staff needed in this role during an incident to maintain service**

Business Continuity Plan - Action Cards

Incident Level	Description	Example	BCP Actions	Escalation
Low level	**Local Incident** This level would consist of routine issues which and will not impact upon any critical activities/services.	Leaks, or generic maintenance issues. IT or Utility outage that can be rectified within **3 hours.** **10% of staff** off of work due to infection disease outbreak	Communicate to all staff on the issues and expected timescales. Ensure paper records for Care notes Monitor staff sickness and infection control measures	Escalation should stay within local limits of building users and site managers to ensure 'Business As Usual' capabilities are met.

Additional Actions *(EXAMPLES – This is the basis of your BCP)*	**Staff responsible for Action**
Do you have up to date contact details for all staff and key external staff and stakeholders?	
Are there paper versions of any Care notes templates kept on site?	
How many staff have shared skills i.e.; reception / telephone	
Do you have access to portable heaters?	

Incident Level	Description	Example	BCP Actions	Escalation
Moderate level	**Serious Incident** Loss of non-critical activities/services due to a minor disruption or incident which is and will not impact on critical activities/services.	Local flooding, local IT failure, telecoms disruption, not expected to last more than the **3 days.** localised infection disease outbreak affecting **35% of staff**	The Local Service Business Continuity Plan activated Set up a Control room and notify Gold Command (Strategic) Contact all staff and patients. Consideration and arrangements ; Service relocation Staff working from home or rescheduling appointments and meetings. Home visits to patients if possible.	Decide on a Single Point of Contact responsible for Tactical actions / 'Silver Command' Start log of times and decisions, use SitReps cards for updates Support from IT , Estates and Comms Follow Action Cards Notify Management Team at incidentcontrolroom@tavi-port.nhs.uk ,Gold Command and Director On Call

Additional Actions	Staff responsible
How many staff can work from home or relocate?	
Who will manage and monitor cancellations of appointments/ meetings / groups?	

Incident Level	Description	Example	BCP Actions	Escalation
Significant level	**Major Incident** Loss of critical activities/services due to a disruption or incident which has a potential to last more than acceptable he but will need the co-ordination of a senior manager.	Utility failure, damage to site, restricted access to site, IT Outage or access to Servers for **3 Weeks** Infectious disease outbreak or staff absenteeism of **50% staff**	Activation of overarching BCP or Major Incident Plan for the Trust Set up a Control room and notify Gold Command (Strategic) Senior staff support service lead in their ability to continue their most critical functions	Decide on a Single Point of Contact responsible for Tactical actions / Silver Command Start log of times and decisions Service lead escalates to building users and Senior Managers. Support from IT , Estates and Comms - follow Action Cards Notify Management Team at incidentcontrolroom@tavi-port.nhs.uk ,Gold Command / Director On Call

Additional Actions *(EXAMPLES – This is the basis of your BCP)*	**Staff responsible**
Example; copy of BCP / MIP for the kept on site for additional Action cards	
Ask for resources for extra staff during and after the incident – i.e. updating Care notes	
Can any part of the service be relocated?	
Identify critical services i.e.; court reports	

Incident Level	Description	Example	BCP Actions	Escalation
Extreme level	**Disaster** Loss of critical activities/services due to a disruption or incident which is expected to last more than 3 months and may cause risk to patient and staff safety	Fire resulting in evacuation and restricted access for prolonged period. Severe weather conditions causing damage to site and access for prolonged period. Complete loss or prolonged IT or Utility failure. Prolonged Infectious disease outbreak i.e. Flu Pandemic, tidal outbreaks affecting services, patient population, schools and transport. External Major Incident	This plan will support services in their ability to continue their most critical functions by recovering the sites critical activity within the timescale but with Commissioner level support	Escalate to building users, Service Director and the Management team. NHS England London EPRR and consider national escalation to co-ordinate the response.

Additional Actions	Staff responsible
This is managed by the Trust – but service lines must identify critical services i.e.; court reports	

Action Card –Team Manager

In the event of a Major Incident or Serious Incident ***Call 999*** before continuing with initial actions.

No.	Initial Actions Checklist	Complete
1	Identify the scale of the incident and reason for disruption. Identify an Incident manager – even if that is you.	
2	Start an Incident Log (use Sit Rep template and a Loggist)	
3	Risk assess the estate for safety of staff and patients	
4	Ask Staff to identify Critical Services or Patients at Risk	
5	Liaise with Landlord/Trust Service Leads	
6	Report any disruption of utilities to relevant utility company or UK Power Networks	
7	Escalate identified risks to Incident Manager, communicate the roles and responsibilities of all in involved	
8	Produce information signs for staff and patients where necessary	
9	Attend the Incident Management meeting either in person or by telephone to update on all estates matters arising	
10	Continue to notify and escalate upwards	
11	Continue to liaise with estates staff and service staff on site	
	Insert as appropriate	

Service Manager/Senior Manager on-call

No.	Initial Actions Checklist	Comments
1	Identify the impact on the service(s) and potential contingency needs i.e. Evacuation, relocation, temporary closure of service	
2	Activate **Service Business Continuity Plan**	
3	Risk assess the estate for safety of staff and patients	
4	Start an Incident Log and complete SitReps at regular intervals as required by the Incident Lead	
5	Liaise with Estates Manager/Site Manager	
6	Escalate any identified risks to Service Directors/Directors on-call where necessary ; incidentcontrolroom@tavi-port.nhs.uk	
7	Attend the Incident Management meeting either in person or by telephone to update on all service issues arising	
8	Arrange mutual aid or extra resource if necessary	
9	Continue to notify and escalate upwards	
10	Continue to liaise with estates staff and service staff on site	
	Insert as appropriate	

Director On call Action Card

No	Initial Actions Checklist	Date Time and comments
1	Liaise with Service Manager/Senior Manager on-call to assess the situation	
2	Declare the Major Incident, see the Major Incident Plan for specific incident actions or activate the Trust Business Continuity Plan if it is necessary to support the co-ordination of the response. Inform Communications team, engage a Loggist and ICC room manager.	
3	Call a 'Gold' incident management meeting or group email via incidentcontrolroom@tavi-port.nhs.uk to set the strategic objectives for the response and recovery, decide on timescales for updates.	
4	Agree to a recovery group meeting either in person or arrange a teleconference with appropriate directors & confirm a group Chair.	
5	Declaring a Major Incident - telephone call via Page One on **0844 8222 888** asking for **NHS01.** Just basic information; the incident type, site details, your name and number.(140 characters) NHS E London EPRR On Call Manager will call you back and ask; • The type of Incident • The current and projected impact of the incident • How many casualties / fatalities are involved • The level of media interest, If an internal incident and you need extra media support call **0844 8222 888 and ask for LON01** • Your ability to cope, any additional support or resources that you	

	require, • Which other agencies / partners are involved in the incident • Any other information you feel is relevant.	
6	Inform relevant CCG/CSU of the internal incident and measures being taken to continue services (within working hours)	
7	Agree with the Service Manager/ Manager On-call any mutual aid/resource potentially needed, support or arrange mutual aid or extra resource.	
8	– Ensure Directors contact their Service leads to cascade information – Continue to liaise with estates staff and service staff on site – Continue to notify and escalate upwards – Arrange debrief meetings – Allocate Action cards, including setting up the Control Room , a Loggist and Comms; updates on the Website, Intranet and emails	

Action Card for Service / Incident Manager / Loggist

Sit Rep (Situation Report) for Senior Staff or Stakeholders

Date:	**Time:**

Completed by:		**Department/ Team**	
Notified by:	**Name:**		
	Contact Details:		

What has actually happened or is the anticipated scenario?	
What is the current / possible impact on sites / services / critical activities	

Incident Level:	**1**	**2**	**3**	**4**
Support Required:				
Next Update at :	Date:	Time:		
Authorising Manager				

Appendix 4 Mutual Aid Protocol

The NHS England Emergency Preparedness Framework 2013 states that 'mutual aid can be defined as an agreement between category one and two responders and other organisations not covered by the CCA within the same sector or across sectors and across boundaries to provide assistance with additional resource during an emergency that may overwhelm the resources of a single organisation'.

The Trust has a number of mutual aid agreements already in place which are available one drive, SharePoint and held within the ICCs. However it is recognised that requests for mutual aid may need to be made at the time of the incident. If this is the case the following protocol will be followed.

Criteria

- The requesting organisation must have declared a major incident or invoked their business continuity arrangements in response to an incident.
- The organisation requesting mutual aid can no longer manage the incident with the full deployment of their resources/assets and prioritisation of their services.
- When an organisation or health economy is potentially or actually unable to maintain safe level of health critical services either through lack of physical or human resources.

Types of mutual aid

- Equipment

- Human

- Capacity

- Key Personnel

- Advice

Process

1. Request for mutual aid agreement will be made by the Director on-call or Office in Charge by the originating organisation.
2. The Director on-call from the requesting organisation will make contact with the potential mutual aid provider and identify a point of contact.
3. The Director on-call making the request will complete the mutual aid template as at appendix 1 of this protocol and forward a copy to the intended provider.
4. Any organisation receiving a request for mutual aid may as a consequence consider declaring a major incident. This alone should not be considered a reason to deny the request received.

5. The Director on-call will ensure that NHS England London/Essex and/or commissioners are advised of all mutual aid requests made or received.
6. For requests received the Director on-call will review the request and advise the originating organisation whether all or part of the request will be met or denied.
7. Agree an assembly point/delivery area and or a focal point where incoming resources will be met or received.
8. The responsibility for deploying mutual aid resources rests with the receiving organisation.
9. The receiving organisation is responsible for the command and control of all assets supplied by other organisations under the mutual aid agreements.
10. The receiving organisations should notify the supporting organisations when the need for support ends or can be reduced as soon as it is recognised.
11. All mutual aid requests with response and reason for decision must be logged.
12. The mutual aid requests should be time limited and monitored through the response and recovery to the incident.
13. Any organisation providing mutual aid but no longer able to do so, or only able to do in a limited capacity should notify the receiving organisation and relevant NHS England local area team and commissioner.
14. The cost for mutual aid is normally based on the principle of 'shared risk' recognising the fact that the risk presented in major or business continuity incidents may be equal.
15. Any mutual aid provided between NHS organisations will be on the basis of shared risk and costs lie where they fall. Consequently there is normally no cross charging for mutual aid between organisations. If any NHS organisation wishes to discuss associated costs of supplying mutual aid this should take place after the incident has been stood down.
16. The organisations must ensure that all associated mutual aid costs are tracked and logged.
17. If we receive mutual aid the Director on-call will;
    - Assume initial command for the incoming resources
    - Manage deployment of incoming resources
    - Maintain liaison with the supporting organisation
    - Ensure that staff are appropriately briefed prior to being deployed on specific tasks
    - Arrange hot debriefs for staff of the providing organisation and ensure staff are rotated back to their home organisation.

For large incidents that require a multiagency response it may be necessary for NHS England to coordinate all health mutual aid requests to ensure that the health sector does not become overwhelmed.

Organisations

The following list is for the CH and MH Trusts across London, it is not exhaustive but provides a list of Tavistock and Portman local resilience partners who may be able to supply resources to support our response. All contact details are in the EPRR Policy

Mental Health and Community Health Contacts (as of March 2019)

Barnet Enfield and Haringey

Bryn.shaw@beh-mht.nhs.uk T: 020 8702 6293 M: 0794 3515 810

Camden and Islington MH

John.Griffin@Candi.nhs.uk T: 020 3317 7381 M: 07770 853562

Central and North West London CH/MH

katy.john@nhs.net T: 020 3214 5848 M: 07969640846

Central London Community Health Care

Sam.Biden@clch.nhs.uk T: 020 7798 0898 M: 07799 860913

Hounslow and Richmond Community Health Care

Stuart.Cornish@HRCH.NHS.UK T: 020 8973 3126 M: 07717 727551

North East London CH / MH

Nicky.Mclean@nelft.nhs.uk T: 0300 555 1200 ext. 64492 M: 07946 081114

South East London - Oxleas CH / MH

jenny.seal@oxleas.nhs.uk 01322 625773

South West London and St George (MH)

sam.moffitt@swlstg-tr.nhs.uk T: 020 3513 6185 M: 07927 642 333

Niall.Smyth@swlstg-tr.nhs.uk T: 020 3513 6183 M: 07590 443 688

West London MH

James.Harris@wlmht.nhs.uk Tel: 0208-483-2191

melissa.brackley@nhs.net

Royal Free Hospital, Emergency Planning Lead.

Emergency Mutual Aid Request

Requesting organisation Include contact name and details.	
Date & Time	
Request being made to	
Mutual aid requested This must be explicit including exact quantities, for how long and for what purpose.	
Where the mutual aid is to be sent to Exact location must be included.	
Transport arrangements Will transport be provided or is this being requested as well. If transport has been arranged include details of what is being used – courier, ambulance taxi etc.	
Contact arrangements Remember to include in and out of hours if appropriate	
Signature of Director on-call	

A copy of this mutual aid agreement must be retained.

Report to	Date
Board of Directors	28 January 2020

Annual Report

Executive Summary

Each year in January we take the time to reflect on our endeavours to creating an organisation that diverse and inclusive. It is the point at which we carefully look at the activities that have taken place across the organisation and also what impact they have had.

This report fulfils the Trust's statutory requirements under the Equality Act 2010 (Specific Duties) Regulations 2011.

This report relates to the activities spanning the period January 2019 – December 2019.

Recommendation to the Board

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

Trust strategic objectives supported by this paper

People and Services

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

Equality, Diversity and Inclusion
Annual Report

1. Introduction

Each year in January we take the time to reflect on our endeavours to creating an organisation that diverse and inclusive. It is the point at which we carefully look at the activities that have taken place across the organisation and also what impact they have had.

This report fulfils the Trust's statutory requirements under the Equality Act 2010 (Specific Duties) Regulations 2011.

This report relates to the activities spanning the period January 2019 – December 2019.

2. The work of the equality, diversity and inclusion (EDI) committee

The Trust has an established EDI committee which has continued to exist through 2019 and is chaired by Prof Dinesh Bhugra. The committee reports its activities to the board of directors after each meeting takes place.

Throughout the year, the committee has continued to meet and there have been five formal meetings of the committee and two developmental sessions. The development sessions have provided an opportunity to reflect on the committee's achievements and also to start shaping an emerging strategy.

3. Committee changes in year

In the last year we saw a number of changes to the committee in terms of how it manages its business and the membership. The following summarises the changes to date:

- Louise Lyon stepped down from her board level position in the summer, Craig de Sousa, director of human resources and corporate governance has since taken over the role of executive lead for EDI.

- Karen Tanner retired in the year and her successor was confirmed as Paul Dugmore, associate dean for learning and teaching.

- Tim Kent, divisional director for adult and forensic services joined the committee to add a senior clinical representative to the committee.

- Jos Twist was appointed as LGBTQI+ champion in April and joined the committee.

- Geraldine Crehan, diversity lead for the directorate of education and training has withdrawn from attending the committee.

- The agenda and meeting format was changed in September 2019 introducing standing reports and dedicated time to deep dive in to key areas of focus.

The committee noted the considerable contribution that all of the previous members had made the Trust's EDI agenda.

4. Review of effectiveness

The committee continues to run effectively after each meeting it reports its activities to the board of directors. This link keeps the board sighted on the work being undertaken by the committee and maintain oversight of progress on its plans and challenges that are emerging.

Structurally the agenda was redesigned in September 2019 to create a set of standing items and space for each of the divisional and trust wide leads to be able to feedback on their work.

Attendance at each committee meeting has been good with the committee being quorate at each of its meetings.

Going forward sub-groups or task and finish groups will be established to take forward priority work areas and involve staff who across the organisation. The intention of these planned changes is to increase engagement amongst the wider workforce and to provide greater focus to the committee's work and oversight responsibilities.

5. Notable events

In the last year, there have been a number of notable events which the committee has overseen, these include:

- The appointment of an LGBTQI+ champion;

- The publication of the second year of the gender pay gap data;

- A series of very well planned events to mark black history month, with special thanks going to Irene Henderson, BAME diversity champion who led this work;

- Publication of the first workforce disability equality standard and action plan, led by Karen Merchant, head of HR operations; and

- Continuing development of diversity and inclusion initiatives within the directorate of education and training with each portfolio agreeing local action plans.

6. Forward plans

For the coming year, the committee recommends to the board that a comprehensive EDI strategy is developed and implemented. This will enable the organisation to articulate its vision of equality and a number of steps which will ultimately improve the experience of service users, staff and students.

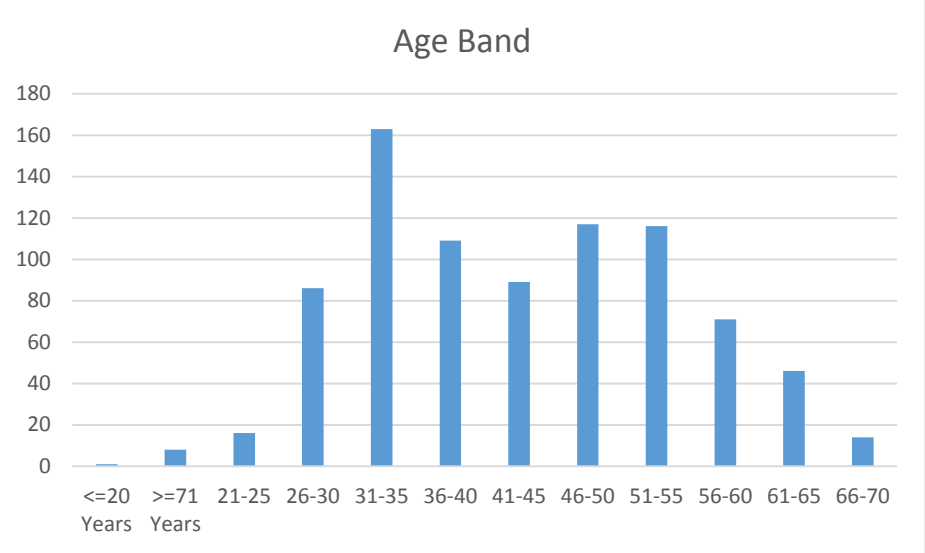
The committee will also place some focus on developing initiatives within our clinical services to better understand areas where health inequalities may exist and how we start to address those. At this stage, it is thought the approach should start small and with locally commissioned services where our patient populations are more clearly known and then scale this up, in due course, to our nationally provided services.

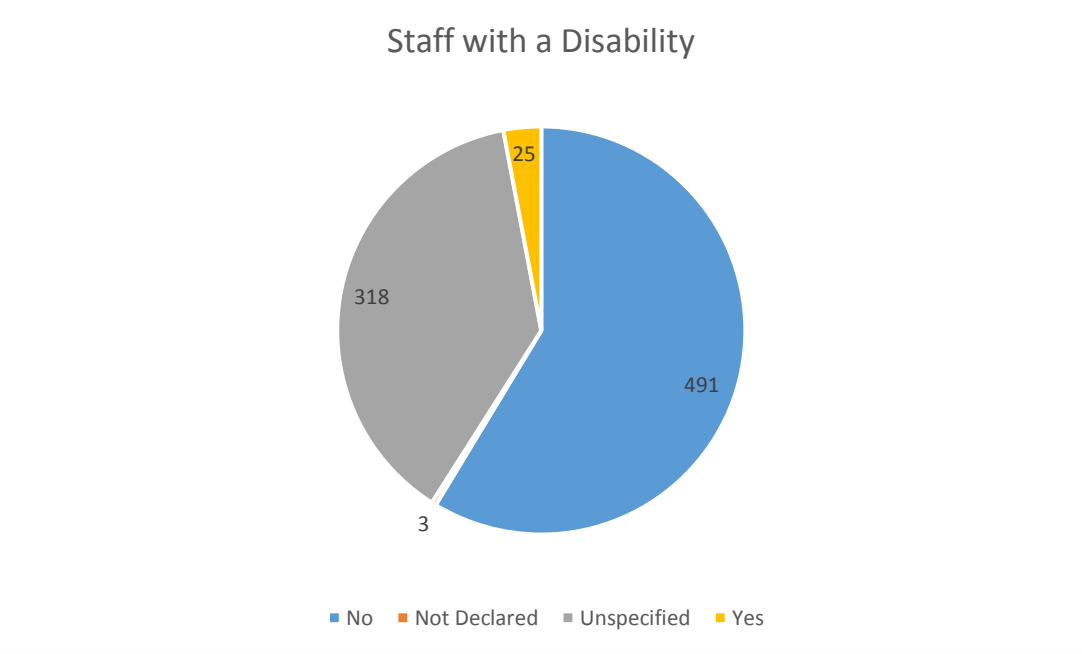
7. Conclusions and recommendations

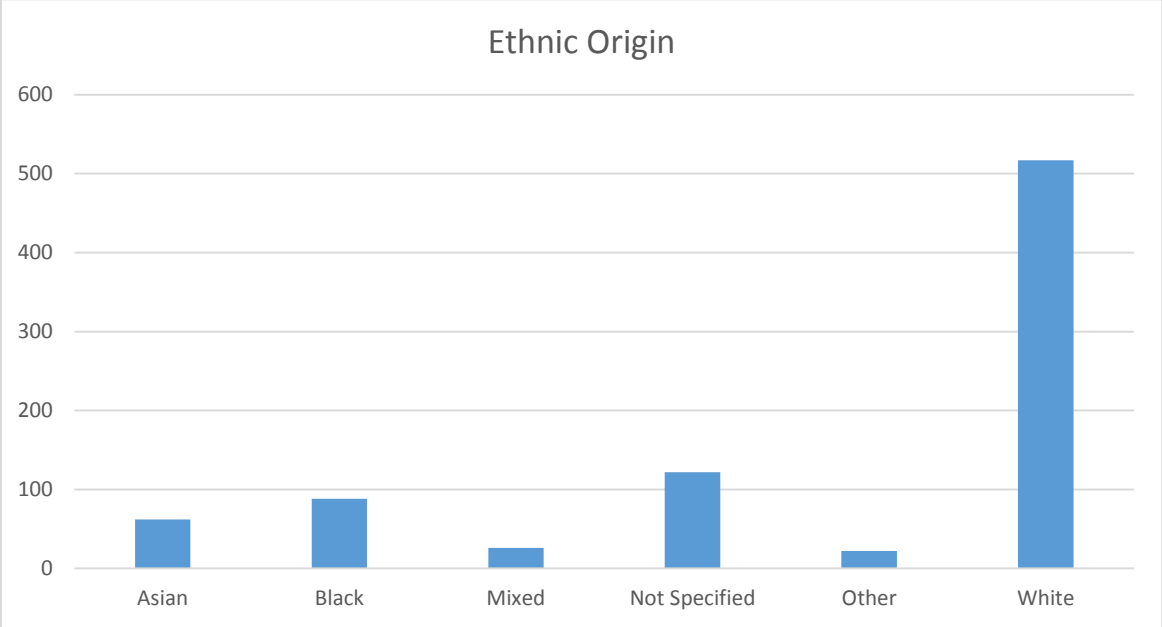
The board of directors is asked to note the contents of this report and provide its endorsement of for the forward plans set out in this paper.

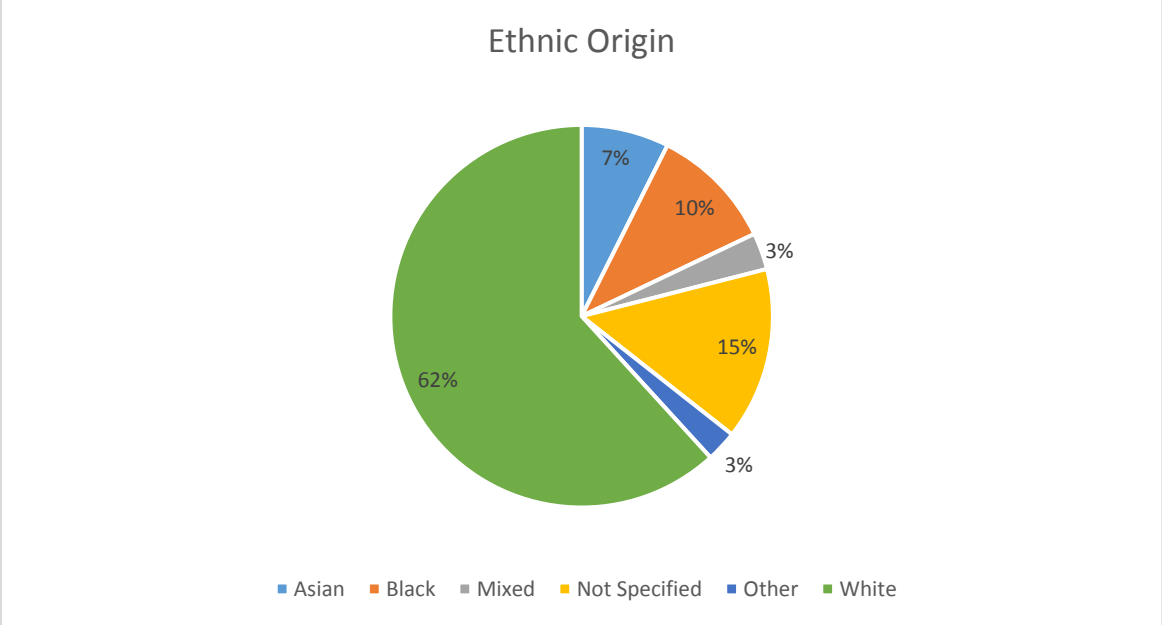
Craig de Sousa
Director of HR & Corporate Governance

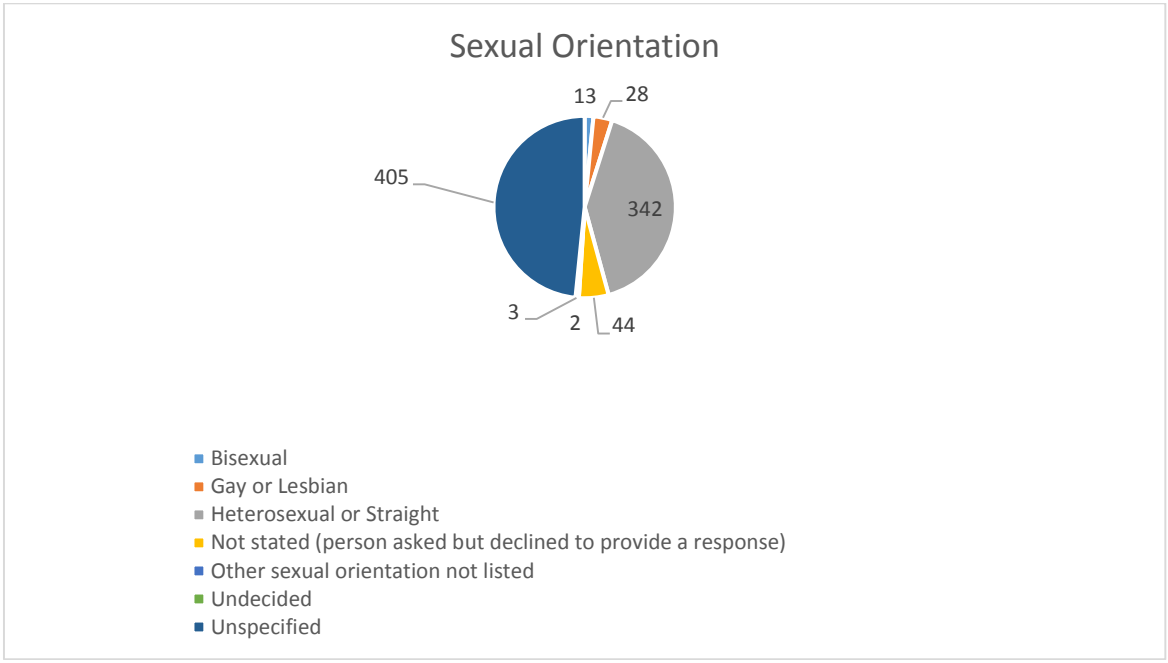
Appendix A – Equality Monitoring Data – Workforce

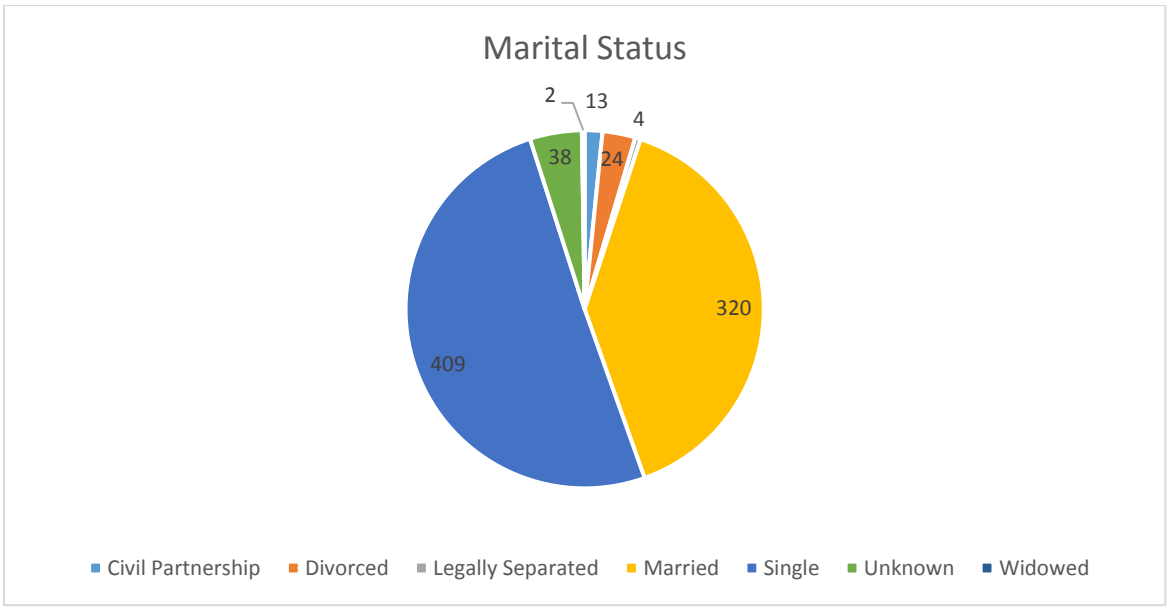


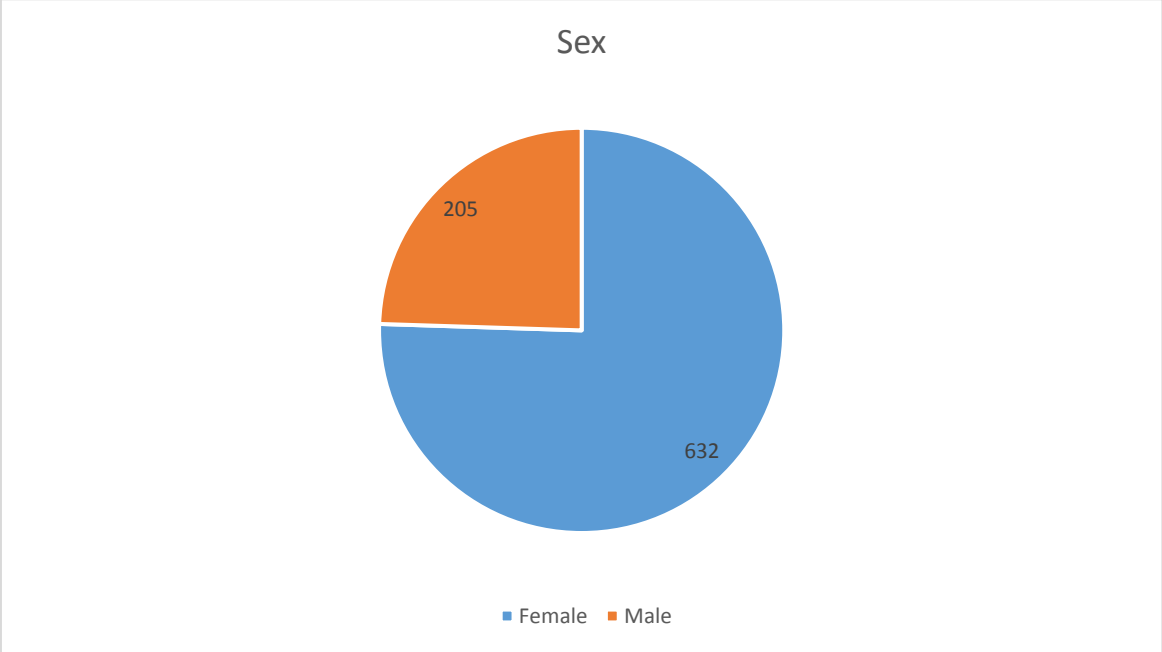



Ethnic Origin
600
500
400
300
200
100
0
Asian
Black
Mixed
Not Specified
Other
White


Ethnic Origin
7%
10%
3%
15%
3%
62%
Asian
Black
Mixed
Not Specified
Other
White


Sexual Orientation
13
28
405
342
3
2
44
Bisexual
Gay or Lesbian
Heterosexual or Straight
Not stated (person asked but declined to provide a response)
Other sexual orientation not listed
Undecided
Unspecified


Marital Status
2
13
4
38
24
320
409
Civil Partnership
Divorced
Legally Separated
Married
Single
Unknown
Widowed


Sex
205
632
Female
Male

Appendix B – Equality Monitoring Data – Clinical Services

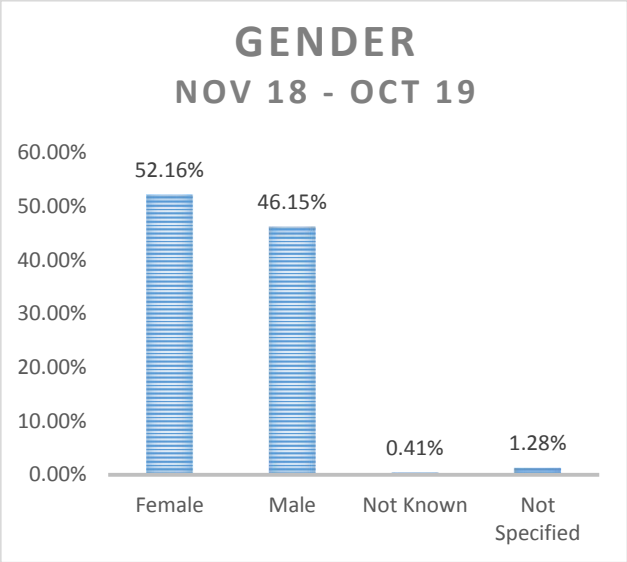
Introduction

To ensure data is collected in a way that complies with NHS guidance and publication timescales we have run the data for November 2018 to October 2019 and also rerun data for November 2017 to October 2018 for comparison. Trustwide actions were taken following previous reports, in order to improve data collection on equalities metrics. It is recognised that this data will help with improving quality of access and treatment for patients. In addition, we have repeated the measures from 2016/17 and 2017/18 to monitor consistency of data collection across the trust and to allow us to benchmark internally and externally.

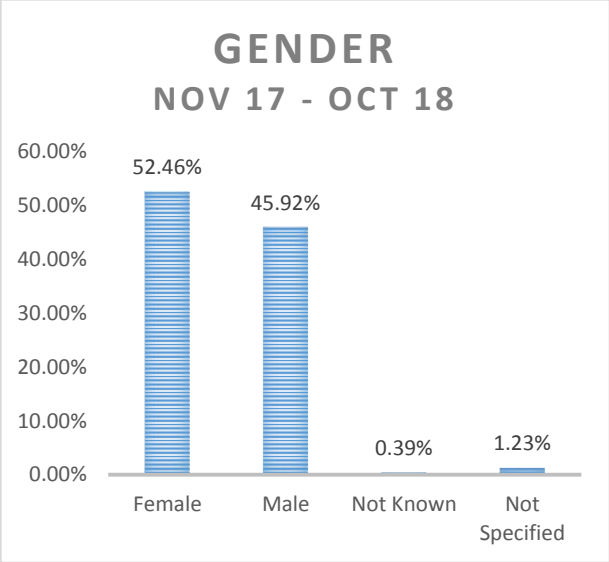
The Mental Health Services Data Set (MHSDS) requires for us to have 95% completeness within patient demographics. The demographics analysed in this report relate closely to those of the MHSDS but specifically cover the 9 protected characteristics of equality. This report shows equality data for patients with open non-rejected referrals in the period and have been seen, at any time.

Gender

November 18 to October 19
Total Patients: 16185



November 17 to October 18
Total Patients: 17442

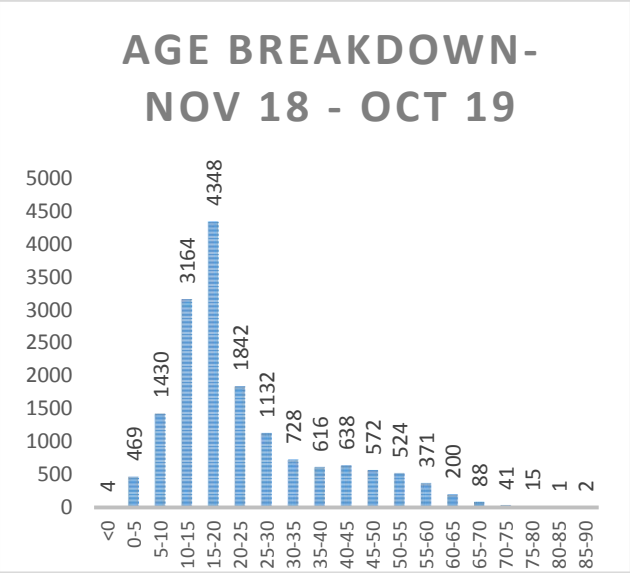


In the period November 18 to October 19 we had 16185 non rejected referrals, 1257 less than from November 17 to October 18, when we had a total of 17442.
In both periods, the percentage of female patients is higher compared to the male representation, but the gap has reduced very slightly. In 18/19, 52.16% of our patients we female, a reduction of 0.3 percent compared to the same period 17/18.
In previous years we have run this report based on financial year rather than October to November, non-the-less when we looked at the data produced for 2016/17, we found a very similar situation where most of the patients seen were female: 56% of patients were female, 44% recorded their gender as male. This corroborates the trend which shows the percentage of male patients increasing.

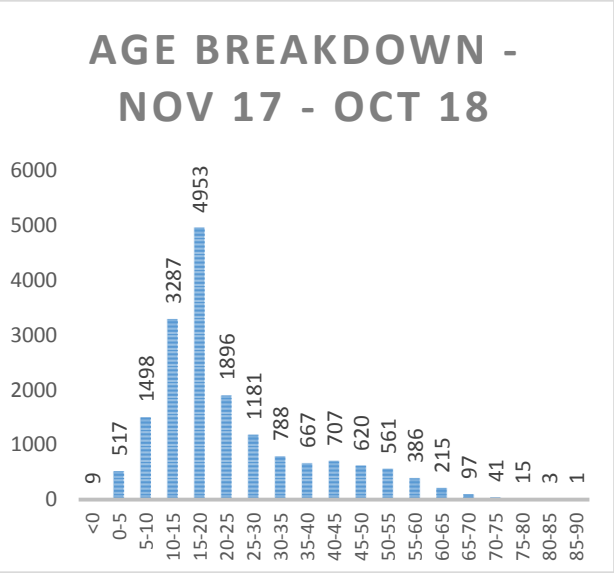
Age

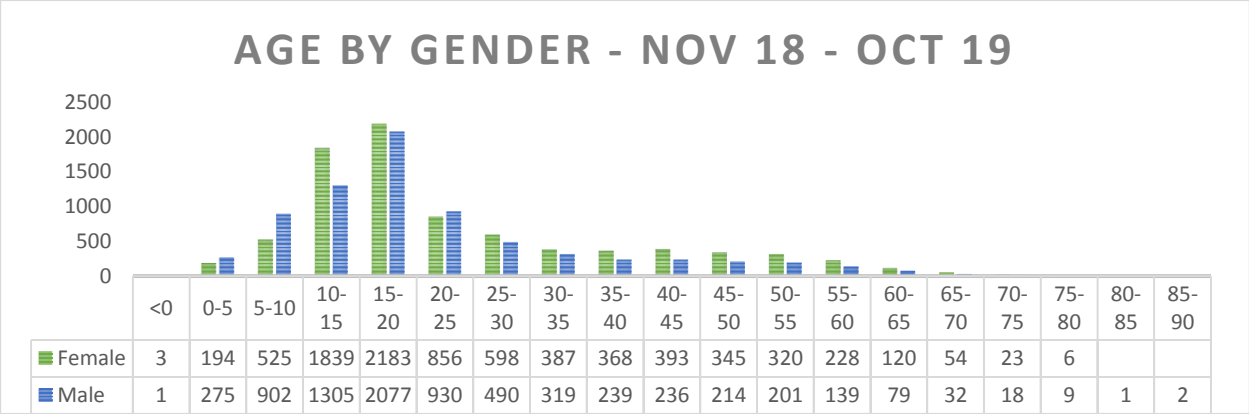
Below we have an age breakdown and a further breakdown by age and gender. The distribution of gender in the age bands are very similar over the two analysed periods. On the other hand, the number of open cases had been reduced by 1257 cases. This would suggest a higher proportion of discharged cases in the last 12 months.

November 18 to October 19

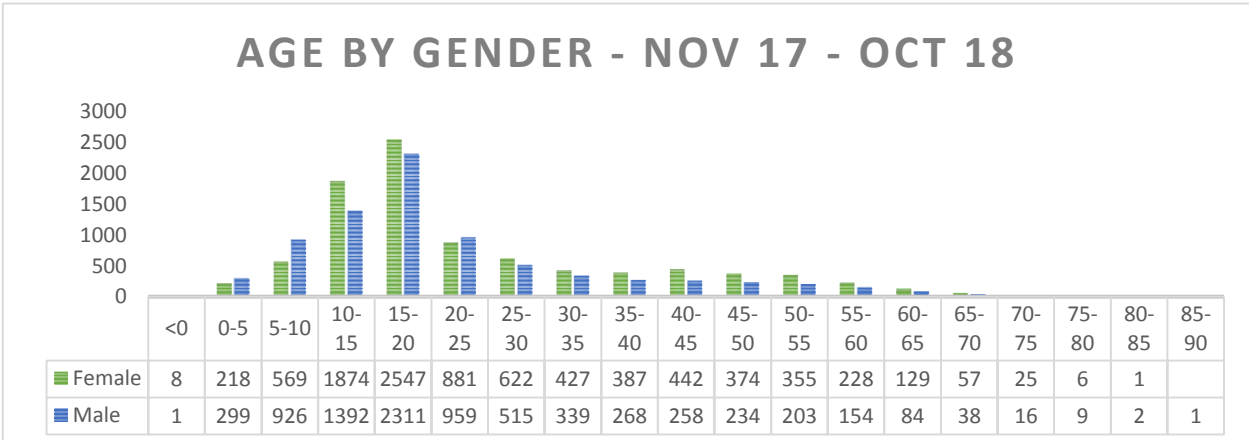


November 17 to October 18





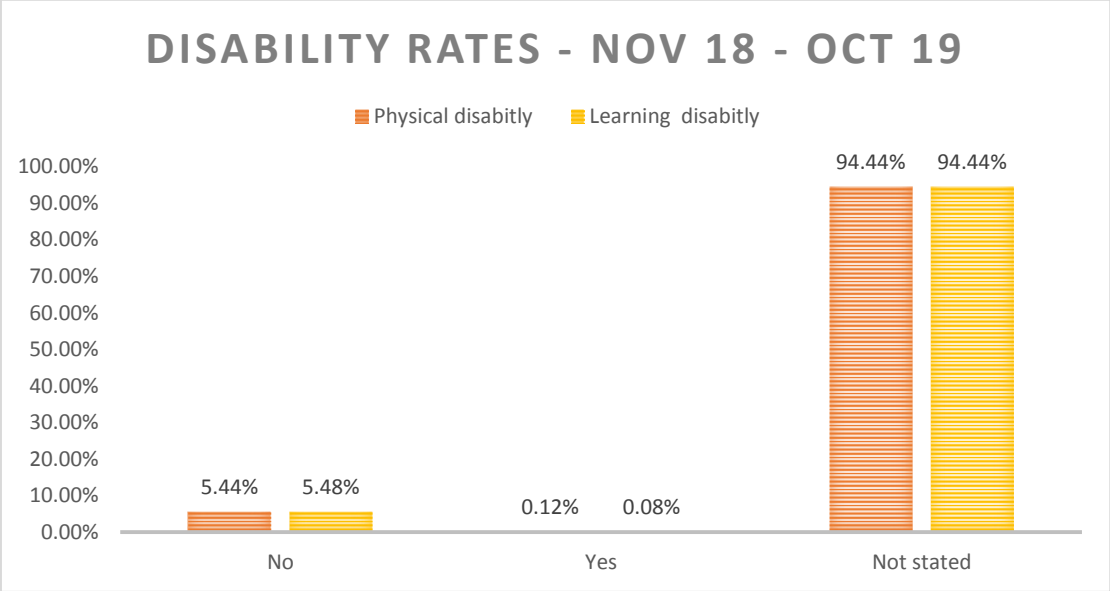
	<0	0-5	5-10	10-15	15-20	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	60-65	65-70	70-75	75-80	80-85	85-90
Female	3	194	525	1839	2183	856	598	387	368	393	345	320	228	120	54	23	6		
Male	1	275	902	1305	2077	930	490	319	239	236	214	201	139	79	32	18	9	1	2

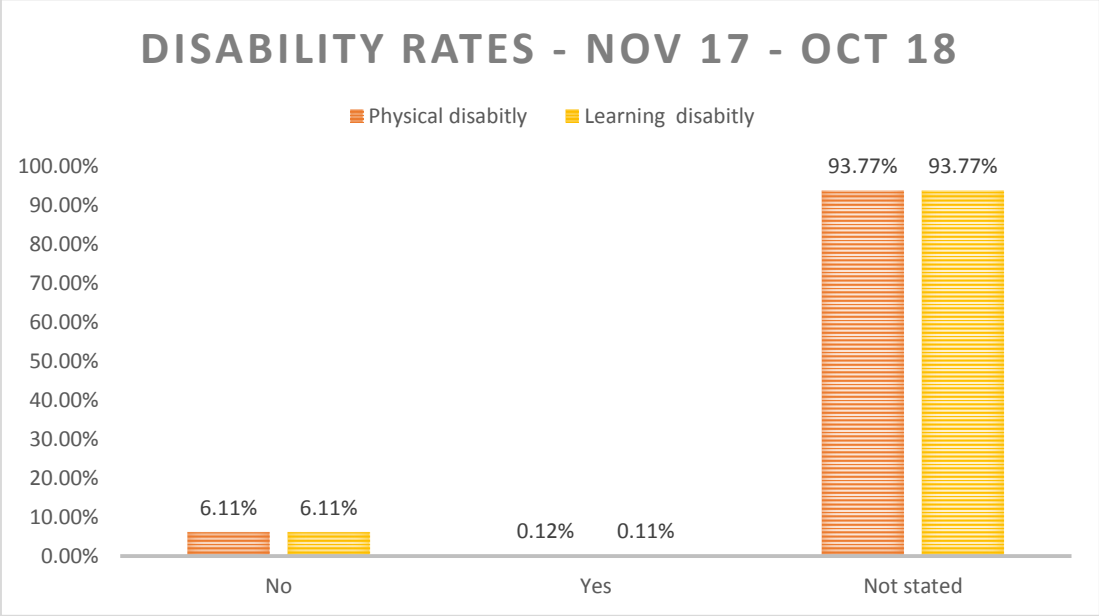


	<0	0-5	5-10	10-15	15-20	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	60-65	65-70	70-75	75-80	80-85	85-90
Female	8	218	569	1874	2547	881	622	427	387	442	374	355	228	129	57	25	6	1	
Male	1	299	926	1392	2311	959	515	339	268	258	234	203	154	84	38	16	9	2	1

Disability

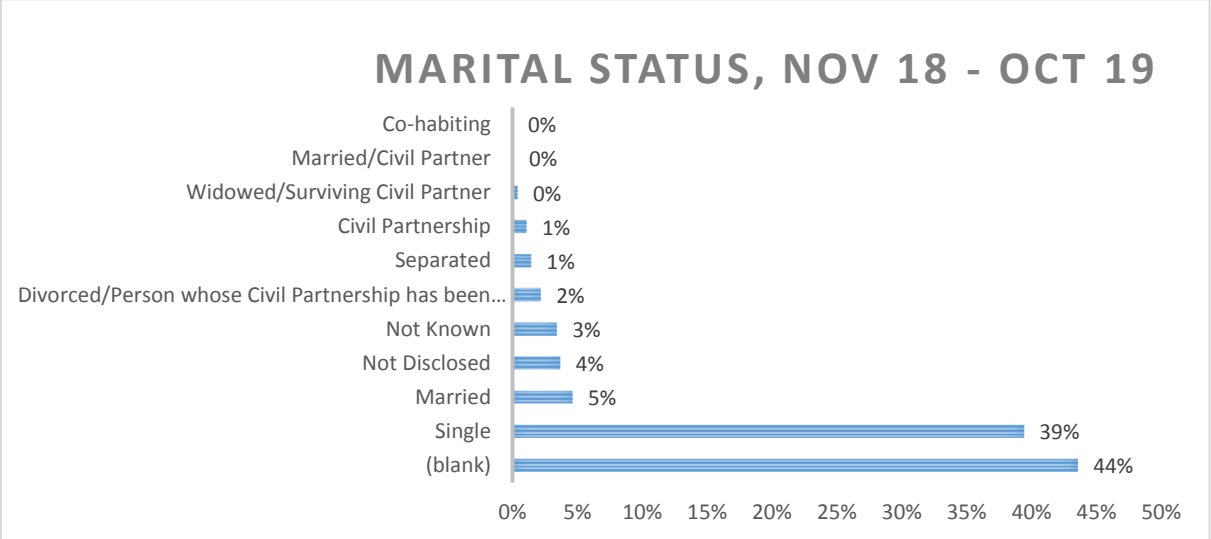
Information on Learning and Physical disability was only stated in 5.44% of patients seen between November 18 – October 19, in the period November 17 – October 18 this was 6.11%. This is a significant fall in collection since 16-17 when we achieved 14.6%. Improving the identification and recording of this data is important to ensure we are providing high quality services for all our patients, including those with learning and physical disabilities.

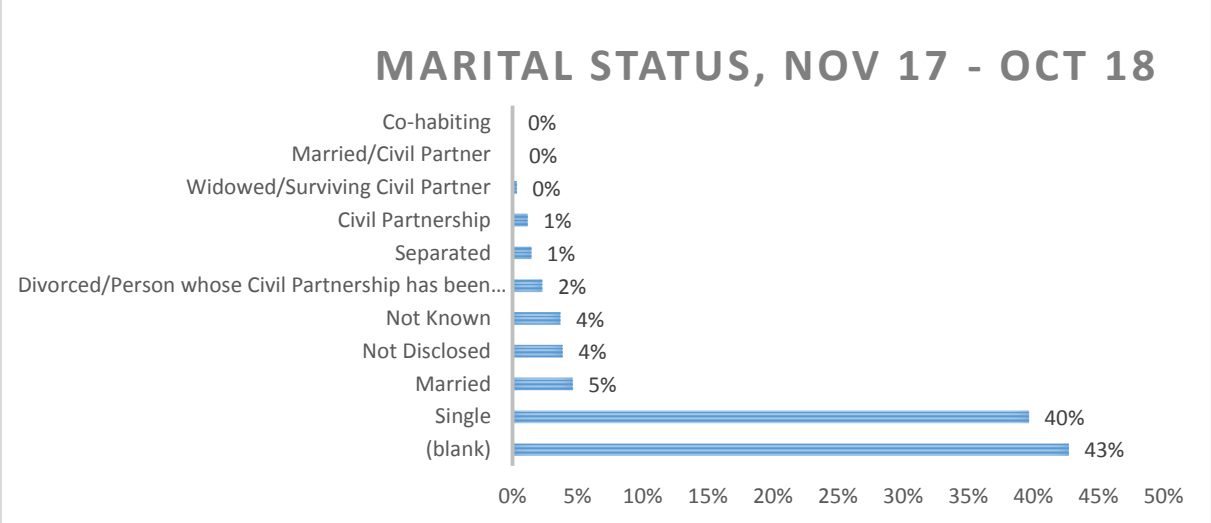




Marital status and civil partnership

The data below depicts marital status recorded data. There has been little change in recording this data with the number of "blank" responses having increased from 43% to 44%.





The Quality Assurance Department have revised the GP referral forms used by all service lines, to support an increase in collection rates. Implementing an action plan to improve the administrative procedures around recording Equalities data is being considered, possibly as a Quality Improvement project.

The Quality Assurance Department is in the process of sharing this data with administration leads and at directorate meetings to ensure all staff are aware of current performance levels.

Religion/Beliefs

Religion is not currently asked of every patient in the trust, however the trust has increased the recordings substantially over the last 3 years.

Looking back at the report produced in 16-17 financial year 81% of patient religion/beliefs data was left black and Christianity was the most commonly recorded religion at 4%.

In the current reporting period from November 18 to October 19 there have been improvements in recording this type of data. Only 50.11% of the fields are left blank Atheists accounted for 11.96% and Christianity 6.6%.

Currently we have record for 97 types of believes/religions; below are listed the 20 options more used and the percentage they represent.

November 18 to October 19

Hindu	0.19%
Spiritualist	0.23%
Free Thinker	0.25%
Catholic Apostolic Church	0.30%
Other Religions	0.37%
Anglican	0.40%
Pagan	0.58%
Buddhist	0.61%
Own Belief System	1.01%
Jewish	1.04%
Roman Catholic	1.14%
Declines to Disclose	1.56%
Agnostic	2.00%
Church of England	2.32%
Muslim	2.64%
Unknown	3.16%
Christian	6.60%
None	11.20%
Atheist	11.96%
(blank)	50.11%

November 17 to October 18

Wicca	0.17%
Spiritualist	0.23%
Free Thinker	0.24%
Other Religions	0.33%
Catholic Apostolic Church	0.33%
Anglican	0.38%
Pagan	0.57%
Buddhist	0.65%
Jewish	0.91%
Own Belief System	0.99%
Roman Catholic	1.13%
Declines to Disclose	1.15%
Agnostic	1.98%
Church of England	2.23%
Muslim	2.63%
Unknown	3.03%
Christian	5.89%
None	11.07%
Atheist	11.80%
(blank)	51.96%

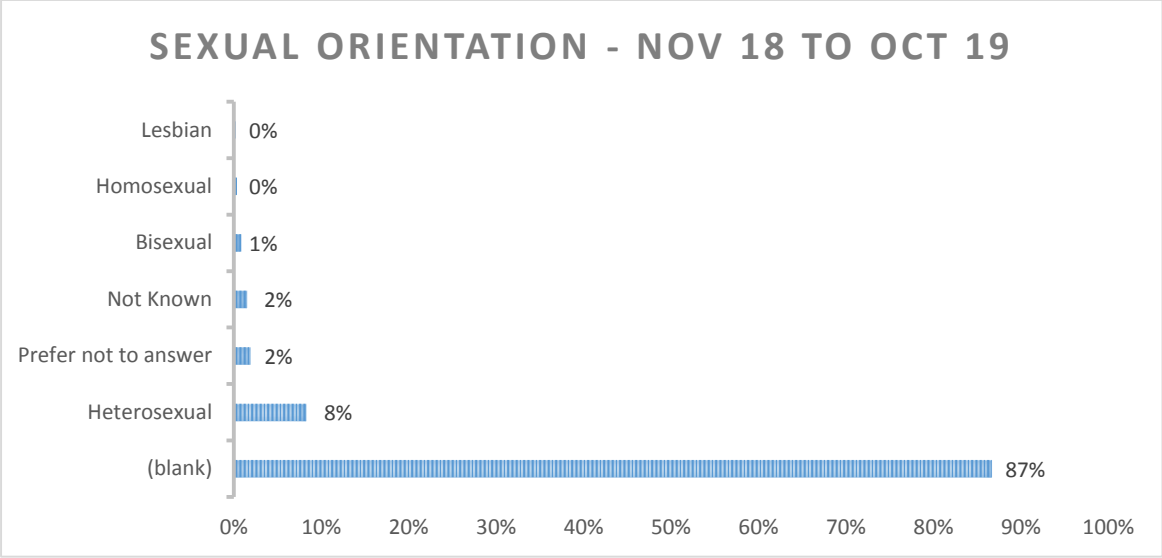
The ten most recorded options for the last two years have remained the same.

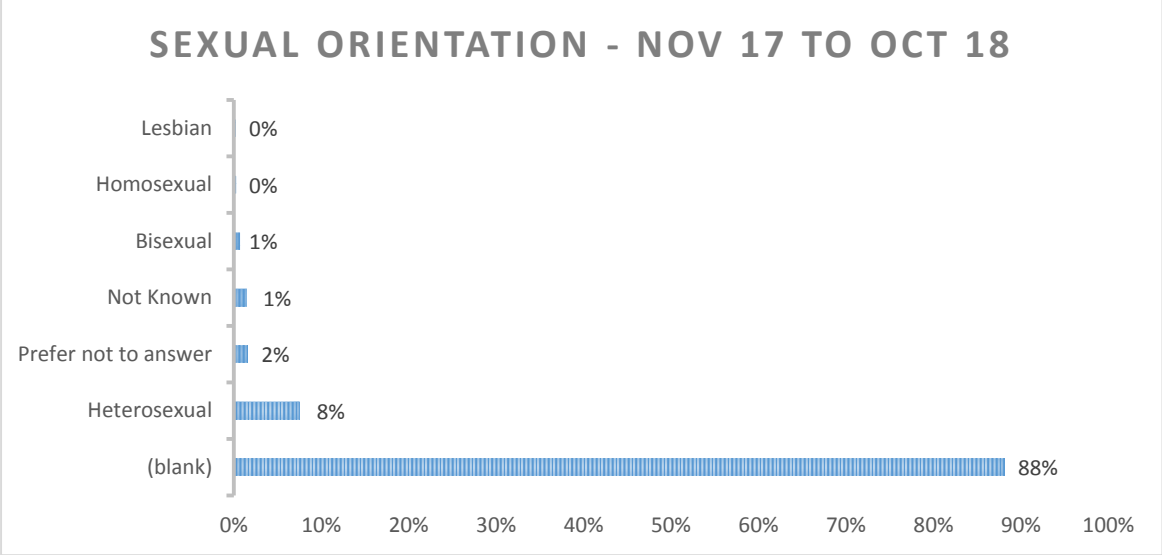
Pregnancy and maternity

We do not collect this data as it is not relevant to service delivery.

Sexual Orientation

We currently collect sexual orientation for those using our services. For some patients in certain services this may be quite an intrusive question however, there is a 'prefer not to answer' option for those who do not wish to disclose on the equalities monitoring form that is currently under development.

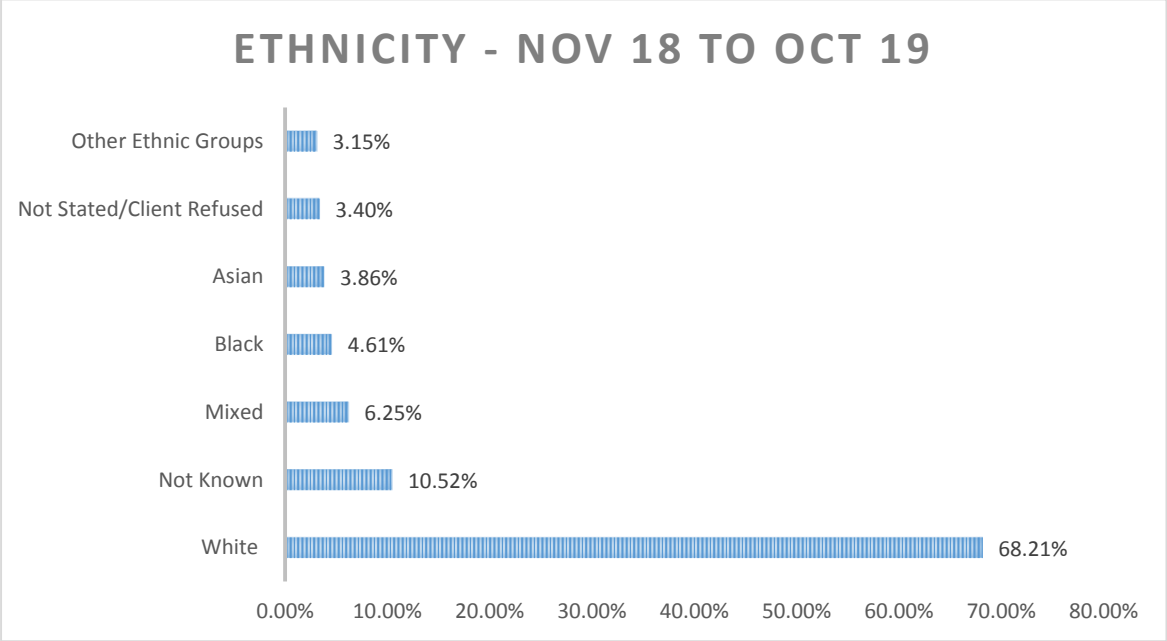


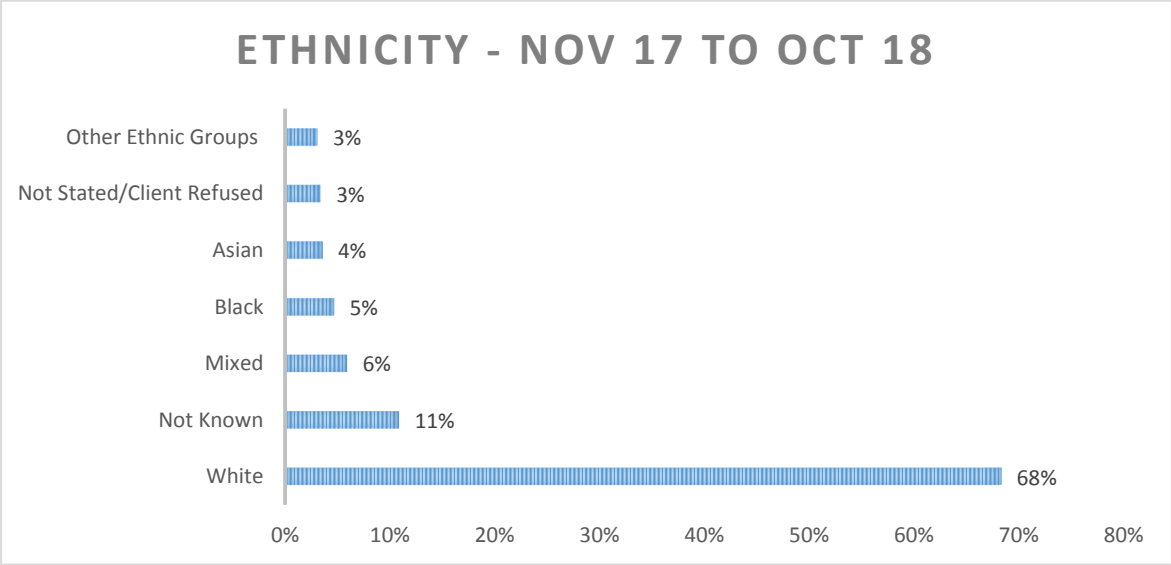


Comparing the last two periods we have reduced the fields left blank by 1%. We expect further improvement over the next year.

Ethnicity

Ethnicity collection rates have remained very similar when comparing November 18 to October 19 and November 17 to October 18. However, the 'not-known' ratio has decreased slightly. The MHSDS ethnicity collections rates has also been increasing over the last two years.

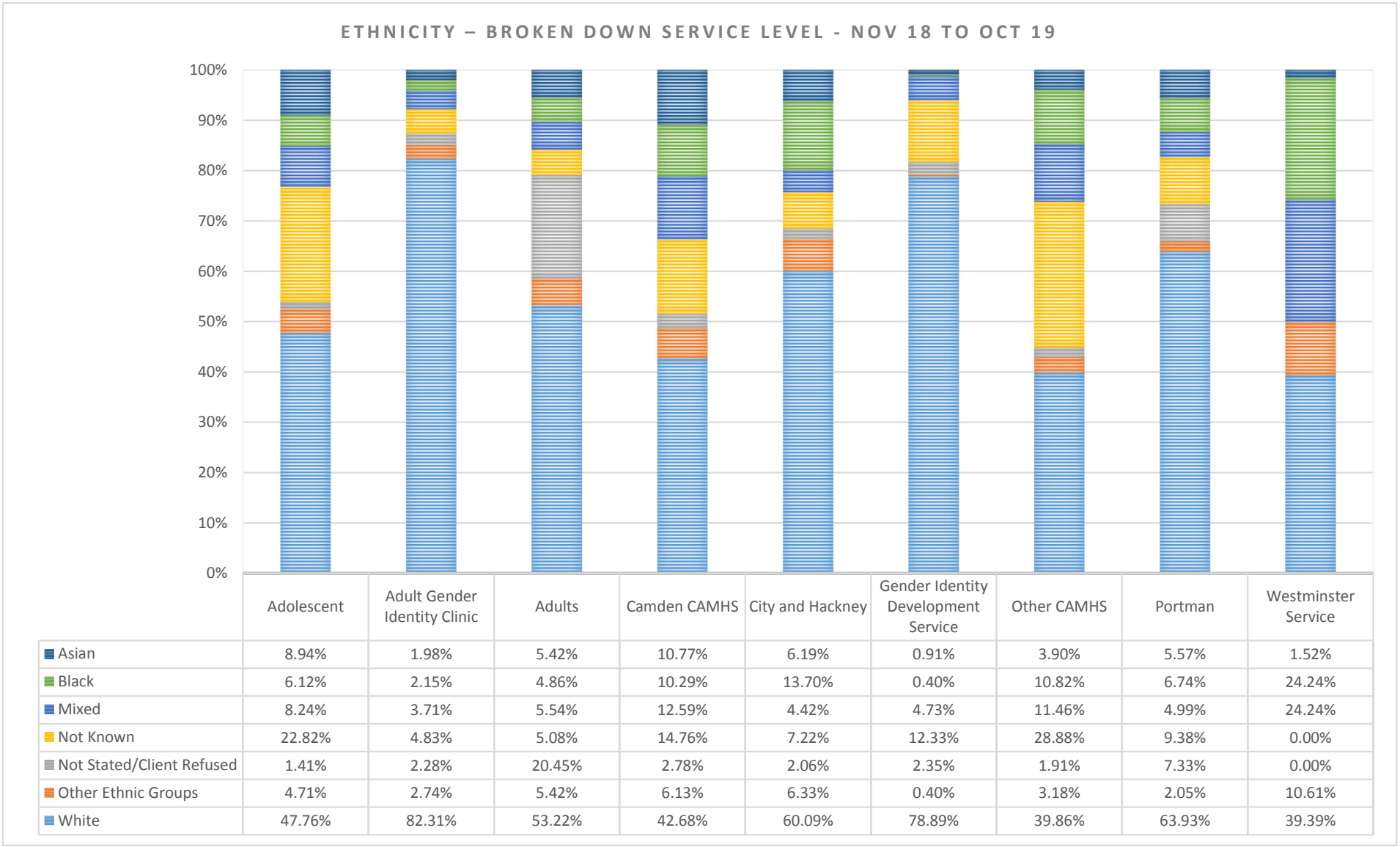




Below is ethnicity breakdown per service line, which should help our understanding of who is accessing our services by ethnicity distribution. Please note that both the

Gender Identity Clinic (GIC) and Gender Identity Development Service (GIDS) have a much higher ratio of white ethnicities and a smalled proportion of Asian backgrounds. The Westminster service which works very closely with families, often providing court reports, has the highest representation of patients with mixed and black backgrounds.

Percentage of ethnicity – broken down by year and service level



	Adolescent	Adult Gender Identity Clinic	Adults	Camden CAMHS	City and Hackney	Gender Identity Development Service	Other CAMHS	Portman	Westminster Service
Asian	8.94%	1.98%	5.42%	10.77%	6.19%	0.91%	3.90%	5.57%	1.52%
Black	6.12%	2.15%	4.86%	10.29%	13.70%	0.40%	10.82%	6.74%	24.24%
Mixed	8.24%	3.71%	5.54%	12.59%	4.42%	4.73%	11.46%	4.99%	24.24%
Not Known	22.82%	4.83%	5.08%	14.76%	7.22%	12.33%	28.88%	9.38%	0.00%
Not Stated/Client Refused	1.41%	2.28%	20.45%	2.78%	2.06%	2.35%	1.91%	7.33%	0.00%
Other Ethnic Groups	4.71%	2.74%	5.42%	6.13%	6.33%	0.40%	3.18%	2.05%	10.61%
White	47.76%	82.31%	53.22%	42.68%	60.09%	78.89%	39.86%	63.93%	39.39%

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 January 2020

Flu Self-Assessment Assurance Reporting

Executive Summary

The board of directors will be aware from the chief executive's November report that the Trust launched its flu vaccination campaign in October 2019. The campaign continues to be active and will run until February 2020.

NHS England have asked all provider trusts to publish an assessment to their board about the steps which have been put in place to try and maximise vaccine update. This paper provides the required self-assessment document.

Recommendation to the Board

Members of the board of directors are asked to note this paper.

Trust strategic objectives supported by this paper

People

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

Flu Self-Assessment Assurance Reporting

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The executive management team confirmed their commitment to achieving the ambition of 100% vaccine uptake in September 2019.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	The Trust ordered quadrivalent stock in June 2019 from its occupational health provider. Owing to distribution issues in October the Trust set up an account with an alternative vaccine supplier and procured the required medical equipment to store vaccines onsite.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	The board champion for this year's flu campaign has been the medical director.
A5	All board members receive flu vaccination and publicise this	Executive directors have been actively receiving the vaccine and promoting this.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The Trust's flu campaign is being coordinated within the human resources directorate with input from clinical colleagues across the organisation.
A7	Flu team to meet regularly from September 2019	The flu campaign has been monitored within the HR senior management team. There is also a small group of peer vaccinators from the nursing discipline who have met.
B	**Communications plan**	

B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Achieved
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	As a specialist provider trust, clinics have been proactively scheduled and a team of peer vaccinators have been trained.
B3	Board and senior managers having their vaccinations to be publicised	Achieved
B4	Flu vaccination programme and access to vaccination on induction programmes	A vaccination clinic was scheduled to coincide with the November induction.
B5	Programme to be publicised on screensavers, posters and social media	Posters and internal media (intranet and daily digest) have been used to publicise the campaign
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly statistics are being submitted to NHS England through the regional monitoring and support structures.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	A small number of peer vaccinators from the nursing discipline have been trained to administer the vaccine.
C2	Schedule for easy access drop in clinics agreed	Agreed and publicised.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Not applicable, the Trust is a specialist provider that does not operate on a 24/7 basis.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	The executive management team have considered this and were unable to determine any incentives which could be quickly or easily achieved.
D2	Success to be celebrated weekly	Not achieved

Report to	Date
Board of Directors	28 January 2020

Report on Audit Committee Meeting – 14 January 2020

Executive Summary

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

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

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

1. INTRODUCTION

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

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

2. OPERATIONAL RISK REGISTER DEEP DIVE

2.1 The Committee had a discussion with David Wyndham-Lewis ("DWL"), the Trust's Director of Technology and Transformation and Marion Shipman, Associate Director, Quality and Governance regarding the approach of the IM&T Directorate towards operational risks.

2.2 In doing so, the Committee was interested, in particular, in the Trusts structures and processes for managing operational risks and the accountability for such risks.

2.3 DWL noted that, as a function, IM&T carried a large range of risks and that whilst mitigation of these was important, so was the willingness to live with a relatively high level of 'accepted' risk – as the cost of eliminating many IT risks would be unaffordable (if even achievable).

2.4 It was noted that IM&T has a dedicated Risk Action Group (which meets monthly) and at which all risks (existing and new) are reviewed, any actions monitored and the decision taken as to whether or not any risks need to be escalated further.

2.5 The Committee noted the way in which project, as opposed to programme, risks are monitored via the relevant project / programme board.

2.6 DWL described the history of a particular risk – provision of power to the Trust's data centres – noting how this risk had originally materialised and the action plans that had been put in place to address the risk. DWL noted that as the original risk was investigated, additional / subsidiary risks were identified – which also required mitigation. Over the course of two years, the likelihood and consequences associated with the risk were both materially reduced.

2.7 The Committee noted that the risk discussed represented a fairly fundamental risk and debated how the Trust could be sure that all / other fundamental risks were being addressed.

2.8 It was recognised that, without a substantial amount of work, this would be difficult to get complete assurance on. The Committee noted, however, that with the introduction of the new electronic version of the risk register, there was an opportunity for staff / managers to (re)consider any fundamental risks affecting their activities. The Committee also noted that the Trust received assurances from third parties e.g. internal and external audit, SBS (for financial systems) and undertook regulatory returns (in

Estates for example) which frequently addressed the fundamental risks in the relevant areas.

2.9 The Committee also queried the degree of sophistication across the Trust in terms of risk management. It was noted that whilst there was a good understanding across the Trust of basic risk management that, with a handful of exceptions, the Trust was not very sophisticated in terms of risk management e.g. ensuring risks in one area were, where relevant, explicitly recorded in other areas of the Trust.

2.10 It was hoped that further training in risk management would help address this but that it was unlikely that this state of affairs would change quickly.

3. INTEGRATED GOVERNANCE COMMITTEE MINUTES

3.1 The Committee heard that there was an on-going review of the terms of reference of the IGC and that, in light of this review, the membership of the IGC had been reviewed to ensure that the members were of sufficient seniority and had the appropriate skill sets to ensure that the IGC was operating effectively. Some additional work was also being undertaken to map relevant regulatory assurances through the IGC structures.

3.2 The Committee noted that here had been three serious incidents with patients involved in knife crimes and that a thematic review of this subject had been commissioned.

3.3 The Committee also noted the increase in the number of incidents being recorded and that the Operational Delivery Board was reviewing what actions should be taken by the Trust in this regard.

3.4 The Committee queried the status of the RAG (Red / Amber / Green) ratings in the IGC minutes. It was noted that there was some disparity on this: some ratings represented the current position, whilst others reflected the position anticipated at the year end. The Committee heard that the IGC regularly discussed this issue. To assist understanding, in future, the RAG ratings were to have an arrow showing the movement from the previous report. It was also noted that the reports seen by the IGC always show the anticipated year end outcome.

3.5 Finally, the Committee noted the importance of the Board having clear line of sight on assurances around matters such as complaints, incidents and deaths.

4. ANNUAL REPORT AND ACCOUNTS / QUALITY REPORT

Timetable

4.1 The proposed timetables for these documents were reviewed.

4.2 It was noted that the May Board meeting had been changed and that an Extraordinary Board Meeting would be required for 26 May, to allow for the signing of the annual report and accounts.

4.3 The Committee was keen to understand how the Board would be involved in the production of the annual report and, in particular, any themes that the report would address.

Quality Indicators

4.4 The Committee noted the Quality Indicators chosen by the Council of governors being the Workforce Race Equality Standard and the Friends and Family (patients) test as the two indictors to be formally reported upon and DNA (Did Not Attend) rates as the optional, non-reportable indicator.

4.5 The Committee welcomed the report on this subject which included an appendix on indicators reported to the Board and the status of the data quality of each of these.

Financial Statements - Planning

4.6 The Committee reviewed a report on some of the more 'judgemental' areas for financial statements reporting. The two areas of most sensitivity are revenue recognition and capitalisation of costs associated with relocation. The former is not expected to cause any issues. The Trust is to meet with Mazars to understand their stance regarding the accounting treatment of relocation costs.

5. LOCAL COUNTER FRAUD / INTERNAL AUDIT

5.1 Progress reports on both of these were reviewed and discussed. The RSM Local Counter Fraud Service representative noted the good progress that had been made by the trust in recent years and stated that RSM had no concerns regarding the Trust, in terms of fraud / fraud reporting.

5.2 There was also an update on the potential credit card fraud, which RSM are investigating.

5.3 The Committee also reviewed the Internal Audit work plan for 2020/21, querying the suggestion of an audit on governance arrangements. An audit on NICE procedures was suggested instead. It was agreed to ask the Executive Management Team to reconsider the plan (in relation to Governance) and to revert to the March Committee meeting.

6. EXTERNAL AUDIT

6.1 The Mazars external audit plan for the 2019/20 annual report and accounts was reviewed and approved by the Committee.

Terry Noys
Finance Director
15 January 2020

Report to	Board of Directors
Report from	Equality, Diversity and Inclusion Committee – 16 January 2020

Key items to note

The committee met in January and was well attended. The meeting followed its usual pattern of business and received updates from the divisional equality leads and trust wide diversity champions.

During the meeting, the committee considered the draft annual report and also reviewed its effectiveness over the last year. The committee also reviewed its terms of reference and have made recommendations to the board for minor amendments to be made to these.

The board should also be aware that:

- An equality, diversity and inclusion strategy will be developed, consulted and then brought to the board in the spring for approval.
- A series of events are being planned for the upcoming LGBT history month which will happen in February 2020. At this time, the organisation will also be launching and adopting the NHS rainbow badge scheme.
- In March, the committee will be undertaken an assessment of progress, achievements and challenges with achieving the race equality strategy.
- Work is being co-ordinated to engage staff from different protected characteristics about their experience of working in the organisation. This work will be informed by the latest NHS staff survey data.

Actions required of the Board of Directors

The board are asked to:

- Consider the annual report
- Review and approve the revised terms of reference.

Report from	Prof Dinesh Bhugra, Chair of the EDI Committee
Report author	Craig de Sousa, Director of HR and Corporate Governance
Date of next meeting	12 March 2020

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 28th JANUARY 2020, 1.30pm – 4.00pm
BOARD ROOM 3RD 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 26th November 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 (Q3)	Medical and Quality Director	2.05pm	4
3 Items for decision or approval				
3.1	Annual Quality Priorities	Medical and Quality Director	2.25pm	5
3.2	Integrated Governance Committee Terms of Reference	Medical and Quality Director	2.35pm	6
3.3	Equality, Diversity and Inclusion Committee Terms of Reference	Director of HR & Corporate Governance	2.40pm	7
4 Items for discussion				
4.1	Strategic Objectives – 2020/21	Chief Executive	2.45pm	8
4.2	Governance Flows of Assurance	Director of HR & Corporate Governance	2.55pm	9

5 Items for information				
5.1	Serious Incidents Quarterly Report (Q3)	Medical and Quality Director	3.05pm	10
5.2	Guardian of Safe Working Report (Q3)	Medical and Quality Director	3.10pm	11 – Late
5.3	Emergency Preparedness, Response & Recovery (EPRR) Annual Plan	Medical and Quality Director	3.15pm	12
5.4	Annual Equality, Diversity & Inclusion Report	Director of HR & Corporate Governance	3.20pm	13
5.5	Flu Self-Assessment Assurance Reporting	Director of HR & Corporate Governance	3.25pm	14
6. Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.30pm	15
6.2	Equality, Diversity & Inclusion Committee	Committee Chair	3.35pm	16
7 Any other matters				
7.1	Questions from Public Observers	Trust Chair	3.40pm	
7.2	Any other business	All	3.55pm	
8 Date of Next Meeting				
	3rd March 2020, 1.30pm – 5.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			