The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 31st March 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 Part 1

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 31st MARCH 2020, 2.00pm – 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	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
2.3	Minutes of the meeting held on 28th January 2020	Chair		1
2.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report and COVID-19 Briefing	Chief Executive	2.20pm	2 3 – Late
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	4
3 Items for discussion				
3.2	Gender Services Divisional Report – GIDS Action Plan – One Year On – GIDS Data Strategy	Divisional Director	2.35pm	5 – Late
3.3	NHS Staff Survey 2019	Director of HR & Corporate Governance	2.55pm	6
4 Items for decision or approval				
4.1	Clinical Quality Strategy	Medical & Quality Director	3.05pm	7
5 Items to note				
5.1	Board Assurance Framework	Chief Executive	3.15pm	8

		Presenter	Timing	Paper No
5.2	Higher Level Responsible Officer (HLRO) Action Plan	Medical & Quality Director	3.20pm	9
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.30pm	10
6.2	Integrated Governance Committee	Committee Chair	3.35pm	11
6.3	Training and Education Committee	Committee Chair	3.40pm	12
6.4	Strategic and Commercial Committee	Committee Chair	3.45pm	13
7 Any other matters				
7.1	Any other business	All	3.50pm	
8 Date of Next Meeting				
	19th May 2020, 1.30pm – 4.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			

Board of Directors Meeting Minutes (Part 1)
28 January 2020, 1.30pm – 3.50pm

Present:			
Paul Burstow Trust Chair	Paul Jenkins Chief Executive	David Holt Senior Independent Director	Dinesh Bhugra Non-Executive Director
Deborah Colson Non-Executive Director	Helen Farrow Non-Executive Director	Celestine Keise Associate Non-Executive Director	Terry Noys Deputy Chief Executive / Finance Director
Craig de Sousa Director of Human Resources and Corporate Governance	Ailsa Swarbrick Director of Gender Services	Sally Hodges Clinical Chief Operating Officer	Dinesh Sinha Medical and Quality Director
Rachel James Divisional Director – CYAF	Rachel Surtees Director of Strategy	Chris Caldwell Director of Nursing	Tim Kent Primary Care Service Lead
Attendees:			
Rosie Allan Personal Assistant			
Apologies:			
David Levenson, Brian Rock			

AP	Item	Action to be taken	Resp	By
1	1.3.1	Amendments to the minutes of the previous meeting	CdS	Immed
2	1.4.1	(Carried forward) Schedule of learning lessons and suicide prevention events to be sent to the board of directors	DS	Immed
3	2.4.4	A breakdown of SDS figures to be reviewed	DS	March
4	2.4.7	Narrative to be provided on mitigation plans for ongoing T1 and T2 delays in TAP	SH/DS?	March
5	2.4.8	Inconsistencies in data formatting to be resolved in preparation for Health Information Exchange go live date in May 2020.	DS	March
6	4.2.3	Updated Flows of Assurance paper to be approved.	CdS	March
7	7.2.1	Modern slavery paragraph to be submitted to the Executive Management Team for approval.	CdS	March

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 Dr Colson declared that she was a REC member of the South Thames Research Ethics Committee and had been so for the past year and that she would refrain from discussion if any matters arise that would conflict with this appointment.

1.3 Minutes of the previous meeting

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

1.4 Matters arising and action points

1.4.1 All the actions were noted as completed, with the exception of one action carried forward. **[AP2]**

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 Bhugra reported that he had attended a Healthcare Financial Management Association (HFMA) leadership day at which Baroness Dido Harding had discussed the potential implications of the merger between NHS England and NHS Improvement. He highlighted the importance of the trust's response in terms of Quality Improvement.

2.1.2 The board of directors noted the report.

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:
    - A standard Operating Procedure had been implemented for the capturing and documentation of consent.
    - He and Ms Swarbrick had completed a series of meetings with Regional teams in the GIDs service.
    - A wider report would be produced in the Spring on what has been achieved against the action plan.
- Mr Wyndham-Lewis, Director of Technology and Transformation, had now left the trust.
- Jon Rex had been appointed as an interim IM&T consultant and Ms Surtees' role had been extended to Director of Strategy and Transformation.
- Gill Rusbridger had completed her final term as the Trust's Freedom to Speak up Guardian and Dan Sumpton, a clinician working in the TAP service, had been appointed as the Trust's new Freedom to Speak up Guardian.

- The Trust had received a formal claim for a judicial review around issues of consent in the GID service. The Board of Directors would be fully briefed on the Trust's response to the claim.

2.2.2 In response to a query from Ms Keise, Ms Swarbrick noted that applicants had been received for all vacancies advertised so far in the GIDS.

2.2.3 In response to a query from Ms Farrow, Mr Jenkins noted that consistent views were heard across the Regional teams in the GIDS.

2.2.4 The board of directors noted the report and expressed thanks to Mr Wyndham Lewis and Ms Rusbridger for their significant contributions.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- The Trust expects to achieve its planned control total for the financial year.
- Staff costs were below budget, reflecting lower new business income and the fact that some budgeted staff costs are now reflected in non-staffing costs.
- Discussions are ongoing with the Trust's external auditors regarding the accounting treatment for relocation costs.

2.3.2 The board of directors noted the report.

2.4 Quality dashboard

2.4.1 Dr Sinha presented the report and particularly highlighted:

- There had been an increase in referrals Trust wide, specifically for Camden CAMHS.
- Overall, the Trust has seen the lowest number of patient contacts in the last four quarters. Decreases were most noticeable in Gender services.
- Waiting time improvements are noted for the Portman and most of CYAF service lines, especially for the second appointments target.
- 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 data on ethnicity; employment status (adults) and accommodation status (adults).
- There had been an increase in the number of adult safeguarding reports and a decrease in reports for children and young adults. Additional children's safeguarding training had been provided.

- There had been a decrease in complaints received from 60 in Q2 to 30 in Q3, due to a significant drop in GIC complaints from 51 to 18.
- There continued to be a high level of adverse media coverage reported.
- Outcome measures will be a Trust quality priority as some are currently below expected target rates.
- The HR mandatory training rate had increased from 63% to 82% in Q3 as a result of an INSET day being held.

2.4.2 In response to a discussion around patient contacts, Dr Hodges noted that a mitigation activity plan was in place to understand the reasons as to why there had been a decrease in the number of patient contacts in Gender services.

2.4.3 Responding to a query around historical lack of data on ethnicity employment status, Dr Hodges noted that higher rates were expected in Q4 due to improved internal governance and implementation of an electronic referral system.

2.4.4 In response to a query from Prof Bhugra, Dr Hodges noted that it was particularly challenging to capture ethnicity employment status data for GIC patients as they typically have one or two appointments a year. Dr Sinha agreed to provide a breakdown of SDS figures and a narrative around Gender Services at the next meeting. **[AP3]**

2.4.5 In response to a question from Dr Sinha, Dr Caldwell noted that a new ESQ form would continue to be tested using a Quality Improvement approach before being rolled out across the organisation.

2.4.6 Reflecting on a challenge from Mr Holt, Mr de Sousa noted that the increased trend in sickness absence reflected higher levels of sickness absence reporting across the Trust and a small number of long term sickness cases.

2.4.7 Dr Hodges noted that an increase in referral rates and skills shortages in TAP had led to delays in T1 and T2 times. She emphasised that mitigation plans to address a continuation of the current trend would be provided. **[AP4]**

2.4.8 Dr Hodges noted that Health Information Exchange was due to go live in May 2020. She highlighted that data formatting inconsistencies were currently being addressed. **[AP5]**

2.4.9 The board of directors noted the report.

3. Items for decision

3.1 Annual Quality Priorities

3.1.1 Dr Sinha presented the proposed annual quality priorities for 2020/21.

3.1.2 In response to a challenge from Mr Holt, Mr Kent noted that patient and carer involvement would be included in the implementation of an updated ESQ.

3.1.3 Responding to a challenge from Mr Holt, Dr Caldwell noted that the PPI strategy addressed patient involvement in care plans.

3.1.4 In response to a challenge from Ms Farrow, Dr Hodges noted that the Trust would aim to have a better understanding of waiting times and would not necessarily be able to resolve them due to current resource limitations.

3.1.5 The board of directors approved the annual quality priorities, subject to revised wording of priority 3.

3.2 Integrated Governance Committee Terms of Reference

3.2.1 Mr de Sousa presented the terms of reference and noted that the trust had reviewed their governance arrangements following the Care Quality Commission (CQC) well-led review in September 2018.

3.2.2 The board of directors approved the terms of reference subject to minor amendments.

3.3 Equality, Diversity and Inclusion Committee Terms of Reference

3.3.1 Mr De Sousa presented the terms of reference and noted that the document had been amended as part of the annual cycle of review.

3.3.2 The board of directors approved the terms of reference subject to minor amendments.

4. Items for discussion

4.1 Strategic Objectives – 2020/21

4.1.1 Mr Jenkins presented the draft objectives and noted that 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, aligned with our mission and values.

4.1.2 In response to a challenge from Mr Holt, it was agreed that Mr Jenkins would be named as the lead director for objective one.

4.1.3 The board of directors noted the paper and were content with the draft objectives being used as a basis to develop the strategic objectives for 2020/21.

4.2 Governance Flows of Assurance

4.2.1 Mr de Sousa presented the paper and noted:

- that the CQC had suggested the Trust reflect on how to improve their oversight mechanisms as an outcome of the well-led review in September 2018.

- The flows of assurance had been re-mapped following the re-structure of the Trust's clinical services and new operational oversight functions.

4.2.2 In response to a challenge from Prof Burstow, Mr de Sousa noted that the document would be amended to reflect Gloucester House's statutory obligation towards Ofsted and the directorate of education and training and include a map of the reporting system between each committee. **[AP6]**

4.2.3 The board of directors noted the paper.

5. Items for information

5.1 Serious Incidents Quarterly Report (Q3)

5.1.1 Dr Sinha presented the report and highlighted:

- 5 serious incidents had been logged externally on StEIS in Q3, 4 of which were patient deaths and the other gang related violence.
- After discussion at Incident Panel 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 had begun and was due for completion in four months.
- The board of directors would be provided with a thematic report on completion of the review.
- Trust wide lessons learned events continue to be relatively well attended and are open to all staff with a Trust contact.

5.1.2 Ms Keise welcomed the review and noted that gang violence had historically been dealt with as a criminalisation issue rather than a health issue.

5.1.3 Responding to Prof Bhugra, Dr Sinha noted that NHSE best practice in reporting required the Trust to log unnatural causes of death for discharged patients on StEIS. He highlighted that the Trust would only accept clinical responsibility if the patient had been on the waiting list and/or if the patient had been discharged for up to six months.

5.1.4 The board of directors noted the report.

5.2 Guardian of Safe Working Report (Q3)

5.2.1 Dr Sinha presented the report and highlighted:

- The number of exception reports over this quarter remain low however the number of hours worked above the expected amount has increased.
- A process has been put in place to manage fine disbursement.
- Dr Sheva Habel had would be stepping back from her role as Guardian of Safer Working Hours.

5.2.2 The board of directors noted the report and acknowledged the work of Dr Sheva Habel with thanks.

5.3 Emergency Preparedness, Response & Recovery (EPRR) Annual Plan

5.3.1 Dr Sinha presented the report and highlighted that Trust had been awarded a 'substantial' level of compliance as part of the EPRR assurance process. He expressed thanks to all colleagues involved in the process.

5.3.2 The board of directors noted the report and approved the subsequent action plans.

5.4 Annual Equality, Diversity & Inclusion Report

5.4.1 Mr de Sousa presented the report and highlighted key changes that had been made to the committee in the past year.

5.4.2 In response to a challenge from Mr Holt, Mr de Sousa noted that future reports would provide more granular detail of equality, diversity and inclusion issues across the organisation.

5.4.3 The board of directors noted the report.

5.5 Flu Self-Assessment Assurance Reporting

5.5.1 Mr de Sousa presented the report and highlighted:

- The Trust launched its flu campaign in October 2019 and will continue to 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.
- In the lead up to the flu campaign the Trust was transitioned to a separate Occupational Health provider, which led to a degree of fragmentation.
- The trust were now working with a new provider, Team Prevent, and had implemented peer to a peer vaccination scheme.
- It was unlikely that the trust will hit the target vaccination rate by February 2020.

5.5.2 The board of directors noted the report.

6. Board Committee Reports

6.1 Audit Committee

6.1.1 Mr Holt presented the report and it was noted that an extraordinary board would be held to sign off the annual account and annual reports.

6.1.2 The board of directors noted the report.

6.2 Equality, Diversity & Inclusion Committee

6.2.1 Mr de Sousa presented the report and highlighted:

- 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 undertaking 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.

6.2.2 The board of directors noted the report.

7. Any other matters

7.1 Questions from Public Observers

7.1.1 There were no members of public in attendance.

7.2 Any other business

7.2.1 In response to Dr Hodges query, it was noted that a paragraph on modern day slavery would be submitted to the Executive Management Team for approval. **[AP7]**

7.2.2 The meeting closed at 3.50pm.

Report to	Date
Board of Directors	31 March 2020

Chief Executive's Report

Executive Summary

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

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. COVID-19 Virus

1.1 We have circulated a separate briefing for the Board of Directors and Council of Directors on the issues relating to COVID-19. This is attached **annex A.** As for the rest of the NHS, this has become, in the last couple of weeks, the dominant issue facing the organisation. I have been delighted with the response of staff to this unprecedented challenge and to the need for major changes in how the organisation undertakes its work.

1.2 Given the fast-moving nature of this issue I intend to circulate a further update to Board members in advance of the Board meeting.

2. Judicial Review

2.1 As we have previously briefed the Board of Directors, we have been notified that a Judge has granted permission for a hearing on the Judicial Review claim brought against the Trust on the issue of the ability of young people under the age of 18 to consent to use of puberty blockers and cross sector hormones.

2.2 The claim is brought by Keira Bell, a former patient of GIDS.

2.3 The story generated a significant amount of media coverage on 1st and 2nd March. Polly Carmichael did a number of broadcast interviews and Channel 4 and ITV used an interview of a mother who had taken part in the 2016 Channel 4 documentary "Kids on the Edge".

2.4 The hearing is fixed for 17th and 18th June.

3. GIDS Action Plan

3.1 Work has been continuing to take forward the implementation of the GIDS Action Plan and we are close to completing the roll out of the key recommendations. A full report on the progress we have made in the last year on the Action is on the agenda for this meeting.

3.2 A report detailing progress on the development and implementation of a data strategy for GIDS is also on the agenda. The GIDS Review highlighted some of the historic difficulties around the completeness of aspects of GIDS data. The service has grown extremely rapidly, and so there are some historic inconsistencies in data input and collection which this work is also addressing, placing the service on a sound footing to make the best use in the future of its valuable data resource.

Paul Jenkins
Chief Executive
25th March 2020

Annex A – COVID-19 briefing

COVID-19 – Briefing for Members of the Board and Council of Governors

Introduction

1. This note provides some background briefing for members of the Board and Council of Governors on the current in relation to CoVid19 and its impact on the work of the Trust.

2. As you will be aware this is a very fast-moving situation and we are having to move on an almost daily basis in responding to new developments.

3. To ensure we keep NEDS and Governors in the loop I intend to issue a regular briefing on what is happening.

4. We are very much at the early stage of this issue. We can anticipate that it will continue to have a major impact over a significant period of time.

Focus

5. In determining the Trust's response, we are focusing on three objectives:

- Continuing, where possible, to meet our obligations to support patients and students.

- Looking after our staff in line with national guidance issued by Public Health England and supporting them through a very difficult period.

- Responding, appropriately, to requests to support our colleagues in other parts of the health and care system.

6. In doing so we are looking to maximise the use of technology to allow us to deliver activities on a remote basis.

What we have done so far

7. We have established an internal system of command and communication to manage the situation. I chair a daily EPRR (Emergency Preparedness, Resilience and Response) group with other members of the Executive to review emerging issues and to agree key decisions and communications to staff and other stakeholders.

8. We are holding twice weekly online question times for staff. These have been very well attended (around 150 staff at each session). They have worked well and provided a good opportunity to hear and respond to staff concerns.

9. We have made a number of changes to our activities:

- For **clinical services** we have asked all teams to review and triage those patients they expect to see in the next month with the aim of moving to a model, from next week, of remote (phone or Zoom) in all but the most essential cases.

- For **education and training** we have discontinued face to face teaching, with immediate effect, for the last week of term. We are working on plans to enable remote teaching for all courses from the start of next term on 19th April.

- We have cancelled or postponed **events**. This has included our annual graduation which was due to be held on Saturday 21st March. We will be working on options for the online delivery of any future events.

- We are reducing the number of **meetings** and where possible holding those meetings which do take place on a remote basis. We are continuing to prioritise the importance of continuing to hold **clinical team meetings and supervisions** during this period.

- We have promoted the use of Zoom across the staff group for small meetings and have issued over 100 Zoom pro accounts to allow larger meetings to go ahead. This, combined with an **IT equipment** strategy, is permitting most of our staff, even those in vulnerable groups, to be able to continue with the bulk of their work. This includes laptops and Trust desktops when these are required to be able to access Trust systems such as Care Notes and My Tap when staff are working remotely.

- When staff have the option to **work from home,** we are agreeing this subject to the agreement of line managers and the need to maintain a basic level of service or support to patients, students or other colleagues.

Current impact on staffing

10. As of today (19th March) 24 staff have been medically suspended (self-isolating). Of those:

- 11 remain suspended
- 13 have returned to work
- There is one member of staff off with confirmed COVID-19

Other issues

11. We are working through a number of issues:

- We are addressing the consequences of yesterday's decision about the **closure of schools**. This includes the requirement for Gloucester House to stay open as it provides for pupils with Education Healthcare Plans. More widely the impact will

depend on what arrangements are made to keep provision open for the children of key workers such as NHS staff.

- With other NHS organisations we are struggling with the lack of access to **testing** for staff who are self-isolating because they or a family member are presenting with possible symptoms of CoVid19.

Contribution to system initiatives

12. We are working closely with other parts of the system in NCL and across London on work relating to CoVid 19.

13. In particular:

- We are working to identify on options for diverting young people in presenting to A&E in Camden and Islington in mental health crisis.

- We have been asked to develop proposals for supporting staff across NCL impacted by anxiety or trauma. We are looking at a number of options for this including the running of online Balint groups.

- We are offering support to the NCL STP communications effort.

Conclusion

14. This is a very challenging situation to manage. Understandably, staff are very anxious about the impact of the issue on themselves and their work.

15. We are working hard to contain anxiety and to manage some significant changes in our operating model in a timely and orderly manner.

Paul Jenkins
Chief Executive
March 2020

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board	31 March 2020

Finance and Performance Report – January 2020

Executive Summary

The Finance and Performance Report for the 10 months ending January 2020 is attached.

This shows a net YTD surplus of £447k, versus a Budget deficit of £(227)k, a positive variance of £674k.

All Directorates are ahead of Budget except for AFS which is £158k adverse to Budget. This reflects the writing-off of the TAP risk share accrued in 2018/19 and 2019/20 and reduced levels of NPA income.

Income is £1.8m 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 TAP income (see above) 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 £2.1m below budget reflecting lower than Budget new business income and the fact that most of the areas within the Trust have been carrying vacancies plus some Budget staff costs are now reflected in non-staffing (consultancy) costs.

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

The Trust expects to meet its Control Total for the year of £141k (after STF monies of £700k).

Recommendation to Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Executive Director
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 10 **Jan-20**

Section

Period 10
03 January 2020

	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	44,626	**47,530**	49,284	(1,755)	**(4)%**
Staff costs	(31,534)	**(34,369)**	(36,468)	2,099	**6%**
Non-staff costs	(10,243)	**(10,930)**	(11,154)	224	**(2)%**
Operational costs	(41,777)	**(45,298)**	(47,622)	2,324	**5%**
EBITDA	2,850	**2,232**	1,662	**569**	**34%**
- Margin	6%	**5%**	3%		
Interest receivable	29	46	30	16	54%
Interest payable	(23)	(29)	(42)	13	(30)%
Depreciation / amortisation	(993)	(1,231)	(1,336)	105	(8)%
Public Dividend Capital	(540)	(541)	(542)	0	(0)%
Restructuring costs	(25)	(30)	0	(30)	
Net surplus	1,298	**447**	(227)	**674**	**297%**
- Margin	3%	**1%**	(0)%		

COMMENTARY
The Trust surplus is £447k, which is £674k above budget.

Revenue is £1,755k adverse vs budget due mainly to reduced new business and Trainee income in DET, reduced new business and complex needs revenue in CYAF, write off of Camden TAP risk share revenue, reduced levels of NPA income in Complex Needs from AFS and reduced NIHR programme grant revenue in Corporate.

Pay costs are £2,099 favourable vs Budget, with underspends in E&T (NWSDU and Portfolios), CYAF (GIDS, GIC) AFS (Adult Complex Needs and City & Hackney) and a range of areas within Corporate including finance and research

Non pay costs are £224k favourable vs budget due mainly to underspends in GIDS/GIC as a result of reduced activity and delayed office moves and new business in DET, partially offset by non-recoverable VAT charges from 18/19 in Corporate.

FINANCE AND PERFORMANCE REPORT **Section 2** **Page 3**
Period 10
03 January 2020

	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	105		
Land and buildings	19,577	19,771	20,052	20,396	20,573	20,761	20,830	21,018	21,217		
IT equipment	3,383	3,479	3,487	3,471	3,472	3,521	2,849	2,813	2,650		
Other		0	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	23,867	0	0
Total non-current assets	23,115	23,405	23,694	24,022	24,201	24,437	23,797	23,944	23,973	0	0
Trade and other receivables	5,901	3,291	6,677	5,257	7,796	6,203	6,463	8,396	7,559		
Accrued Income and prepayments	3,896	6,336	3,456	3,290	3,833	4,917	4,264	4,300	3,538		
Cash / equivalents	8,569	7,426	9,866	9,768	8,537	6,866	7,609	7,873	8,822		
Total current assets	18,366	17,053	19,999	18,315	20,167	17,986	18,335	20,569	19,919	0	0
Trade and other payables	(3,685)	(2,552)	(2,528)	(2,413)	(2,861)	(2,965)	(2,411)	(2,346)	(2,567)		
Accruals	(2,075)	(4,216)	(4,017)	(5,159)	(4,416)	(4,077)	(3,988)	(3,747)	(3,987)		
Deferred income	(4,513)	(2,890)	(6,006)	(3,831)	(6,154)	(4,549)	(4,794)	(7,336)	(6,045)		
Provisions	(212)	(120)	(118)	(74)	(78)	(76)	(76)	(76)	(75)		
Total current liabilities	(10,485)	(9,778)	(12,669)	(11,477)	(13,509)	(11,667)	(11,270)	(13,505)	(12,673)	0	0
Total assets less current liabilities	30,995	30,680	31,024	30,860	30,858	30,756	30,862	31,008	31,219	0	0
Non-current provisions	(248)	(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)	(3,778)		
Total assets employed	26,748	26,432	26,776	26,852	26,833	26,730	26,837	26,982	27,194	0	0
Public dividend capital	3,474	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	12,621		
I&E reserve	10,653	10,338	10,682	10,758	10,739	10,636	10,743	10,888	11,100		
Total taxpayers equity	26,747	26,433	26,776	26,852	26,833	26,731	26,837	26,983	27,194	0	0

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

Period 10

03 January 2020

	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	Jan Act £'000	**YTD Act £'000**
Net Surplus	(315)	343	77	(20)	(103)	107	145	212	**447**
Depreciation / amortisation	401	134	132	135	134	(19)	117	198	**1,232**
PDC dividend paid	163	54	54	54	54	54	54	54	**541**
Net Interest paid	(1)	(1)	(6)	0	(2)	(1)	(2)	(4)	**(17)**
(Increase) / Decrease in receivables	170	(506)	1,586	(3,083)	510	394	(1,970)	1,599	**(1,300)**
Increase / (Decrease) in liabilities	(616)	2,893	(1,148)	2,028	(1,840)	(398)	2,236	(831)	**2,325**
Increase / (Decrease) in provisions	(92)	(2)	(44)	4	(2)	0	0	(2)	**(137)**
Non operational accural movement	(563)	(184)	(383)	370	(270)	878	(346)	(77)	**(575)**
Net operating cash flow	(853)	2,732	269	(512)	(1,519)	1,016	234	1,150	**2,516**
Interest received		18	5	6	5	4	4	4	**46**
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	238	1,154	**2,252**
Purchase of property, plant & equipment	(290)	(310)	(150)	(415)	(158)	(276)	(263)	(227)	**(2,089)**
Capital Accruals							290	23	**313**
Capital purchases - cash	**(290)**	**(310)**	**(150)**	**(415)**	**(158)**	**(276)**	**27**	**(204)**	**(1,776)**
Net cash flow before financing	(1,143)	2,440	124	(1,230)	(1,672)	744	265	950	**476**
Repayment of debt facilities	0		(222)						**(222)**
Net increase / (decrease) in cash	**(1,143)**	**2,440**	**(98)**	**(1,230)**	**(1,672)**	**744**	**265**	**950**	**254**
Opening Cash	8,569	7,426	9,866	9,768	8,536	6,866	7,609	7,873	8,569
Closing cash	**7,426**	**9,866**	**9,768**	**8,536**	**6,865**	**7,610**	**7,873**	**8,823**	**8,823**
	0	*0*	*(0)*	*(1)*	*0*	*0*	*0*	*0*	*0*

Jan-20	ANNUAL				Y.T.D		
10	£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	246	259	14		220	115	(105)
Endpoint Procure/Config/Compliance/Monitor	98	167	69		87	167	80
Patient-Level Individual Costing System (PLICS)	-	-	-		-	-	-
e-Referrals System Implementation	42	54	12		42	54	12
Programme & PMO Development	-	-	-		-	-	-
Tavistock Centre Data Centres Power Provision	6	65	59		-	65	65
IMT Service Improvement	15	30	15		15	30	15
SMS Appointment Reminders	-	-	-		-	-	-
Digital Dictation, Transcription, & Hybrid Mail	-	-	-		-	-	-
Cyber Essentials	-	16	16		-	16	16
Data Warehouse Optimisation & Dashboards	-	-	-		-	-	-
Care Notes Renewal	(21)	-	21		(21)	-	21
Health Information Exchange	291	15	(276)		192	8	(184)
MyTap Annual Upgrade 2019/20	185	41	(144)		157	41	(116)
Health & Social Care Network	17	33	15		-	33	33
Endpoint Replacement 2018/19	15	-	(15)		15	-	(15)
DET Record Management System	(3)	-	3		(3)	-	3
Scheduling & Robotic Process Automation	300	404	104		240	227	(13)
Data Warehouse & Dashboard	-	-	-		-	-	-
Network Replacement	17	-	(17)		17	-	(17)
Default	-	-	-		-	-	-
STP FUNDING	(250)	-	250		-	-	-
IT	**960**	**1,085**	**125**	-	**962**	**756**	**(205)**
Ventilation	26	59	33		26	56	30
Security	-	-	-		-	-	-
Safety	-	31	31		-	31	31
Pumps	-	29	29		-	29	29
Water	-	68	68		-	62	62
Electrics	-	66	66		-	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	182	-	(182)		182	-	(182)
Tavistock Centre - Phase 1	-	-	-		-	-	-
ESTATES	**290**	**396**	**105**	-	**290**	**381**	**90**
FNP Database - COST	906	-	(906)		101	-	(101)
FNP Database - FUNDING	(880)	-	880		-	-	-
F.N.P DATABASE	**(0)**	**-**	**0**		**101**	**75**	**0**
RELOCATION	**1,286**	**1,322**	**36**		**734**	**895**	**162**
DIGITAL ACADEMY	119	505	386		2	235	233
TOTAL	**2,654**	**3,307**	**653**		**2,089**	**2,343**	**254**

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	31 March 2020

The NHS Staff Survey

Executive Summary

The NHS Staff Survey takes place each year between September and December. In 2019 the Trust offered all staff who were employed on or before 01 September 2019 the opportunity to respond to the survey.

60% of eligible staff responded to the survey which is the same level as participation as the previous year and is above average for mental health and learning disability trusts.

Experience across the Trust has not changed in a statistically significant way from the previous year. There are some really positive messages to celebrate but at the same time there are some areas where the organisation needs to focus.

The Trust ranks best performing organisation in the following theme areas:

- Bullying and harassment;
- Safety

A key focus area for the organisation where our results are showing signs of concern are within the health and wellbeing theme area.

Recommendation to the Board

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

Trust strategic objectives supported by this paper

People

Author	Responsible Executive Director
Director of Human Resources and Corporate Governance	Director of Human Resources and Corporate Governance

The NHS Staff Survey

1. Introduction

The NHS Staff Survey takes place each year between September and December. In 2019 the Trust offered all staff who were employed on or before 01 September 2019 the opportunity to respond to the survey.

60% of eligible staff responded to the survey which is the same level as participation as the previous year and is above average for mental health and learning disability trusts.

This paper provides a summary of the results for the board to consider and discuss.

2. Things to be proud of

It is really pleasing to report that engagement across the organisation remains high and that for another year running the Trust ranks the best performing mental health and learning disability trust in two of the eleven theme areas, these are:

- Bullying and harassment; and,
- Safety.

When reading the results carefully it is noticeable that staff would recommend the organisation as a place to receive care and that staff feel able to make improvements in their areas of work.

Staff engagement also remains to be above average when compared to Trusts in our peer group.

3. Where we need to do more

The survey does, however, share that there are a number of areas where there are issues, some which were similar to last year. These include:

- That a high number of staff are feeling unwell, stressed and coming to work when they are poorly.

- There is also a strong feeling that people who are responsible for managing teams should focus on their staff's wellbeing.

- The experience of black, asian and minority ethnic staff, in terms of fairness in career progression and development, has declined quite significantly in the last year.

- That whilst appraisals happen across the organisation, they are not used effectively as a means of having ongoing conversations about career development and progression.

- Confidence in feeling safe when raising concerns and reporting incidents has declined.

- Staff recommending the organisation as a place to work has also reduced.

These messages have been shared with a number of senior managers across the organisation and conversations have started to understand the depth of meaning behind them.

4. What we have done since the 2018 survey

As a result of last year's survey findings, which had similar themes, we have done a number of things, these include:

- We have invested in a management development programme, specifically designed for people who are responsible for line managing staff, normally for the first time. The programme will be launched in May 2020 for an initial cohort of 15 participants and a second cohort commencing in October 2020.

- Our investment in developing both existing and aspiring leaders has continued with a high number of people participating on the range of programmes and courses that we offer.

- In September 2019, we expanded the required to have diversity champions on all interview panels to further demonstrate our commitment to challenging unconscious bias.

- Opening two bursaries, with generous charitable support, for people from underrepresented backgrounds to some of our education and training programmes.

There are, of course, many other things that we have done and our work to build on feedback will continue.

5. Next steps

Divisional directors, associate deans and heads of corporate functions have been provided with results data specific to their service. They have been tasked with gathering narrative about the results and developing action plans and taking local ownership of these.

In May 2020 a further paper will be brought forward to the board detailing a series of two year actions that will be put in place to address the challenges and issues identified by the results.

6. Conclusions and recommendations

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

Craig de Sousa
Director of Human Resources and
Corporate Governance

March 2020

Survey Coordination Centre

NHS England

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey

Summary Benchmark Report

Organisation details

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey

Organisation details

Completed questionnaires **441**

2019 response rate **60%**

See response rate trend for the last 5 years

Survey details

Survey mode **Online**

Sample type **Census**

This organisation is benchmarked against:

Mental Health / Learning Disability Trusts

2019 benchmarking group details

Organisations in group: **23**

Median response rate: **54%**

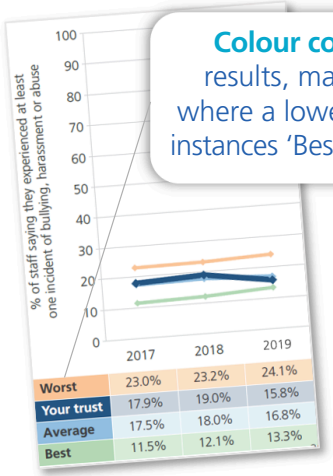
No. of completed questionnaires: **38,413**

Using the report

Key features

Question number and text (or the theme) specified at the top of each slide

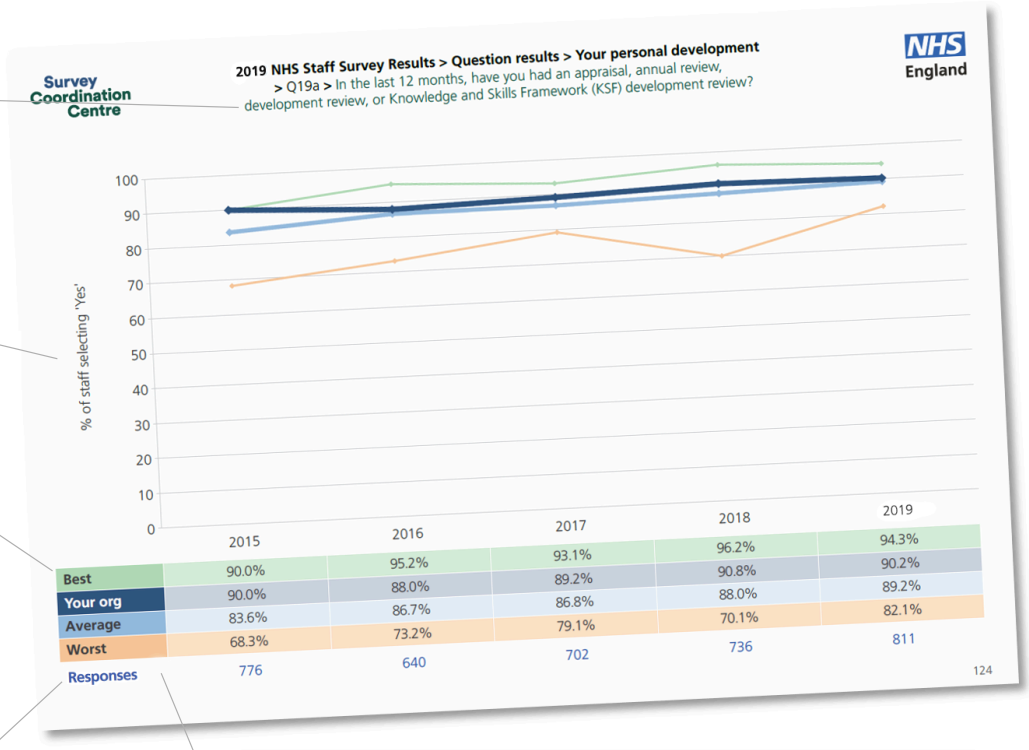
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Full details on how the scores are calculated are provided in the **Technical Document**, under the Supporting Documents section of our results page

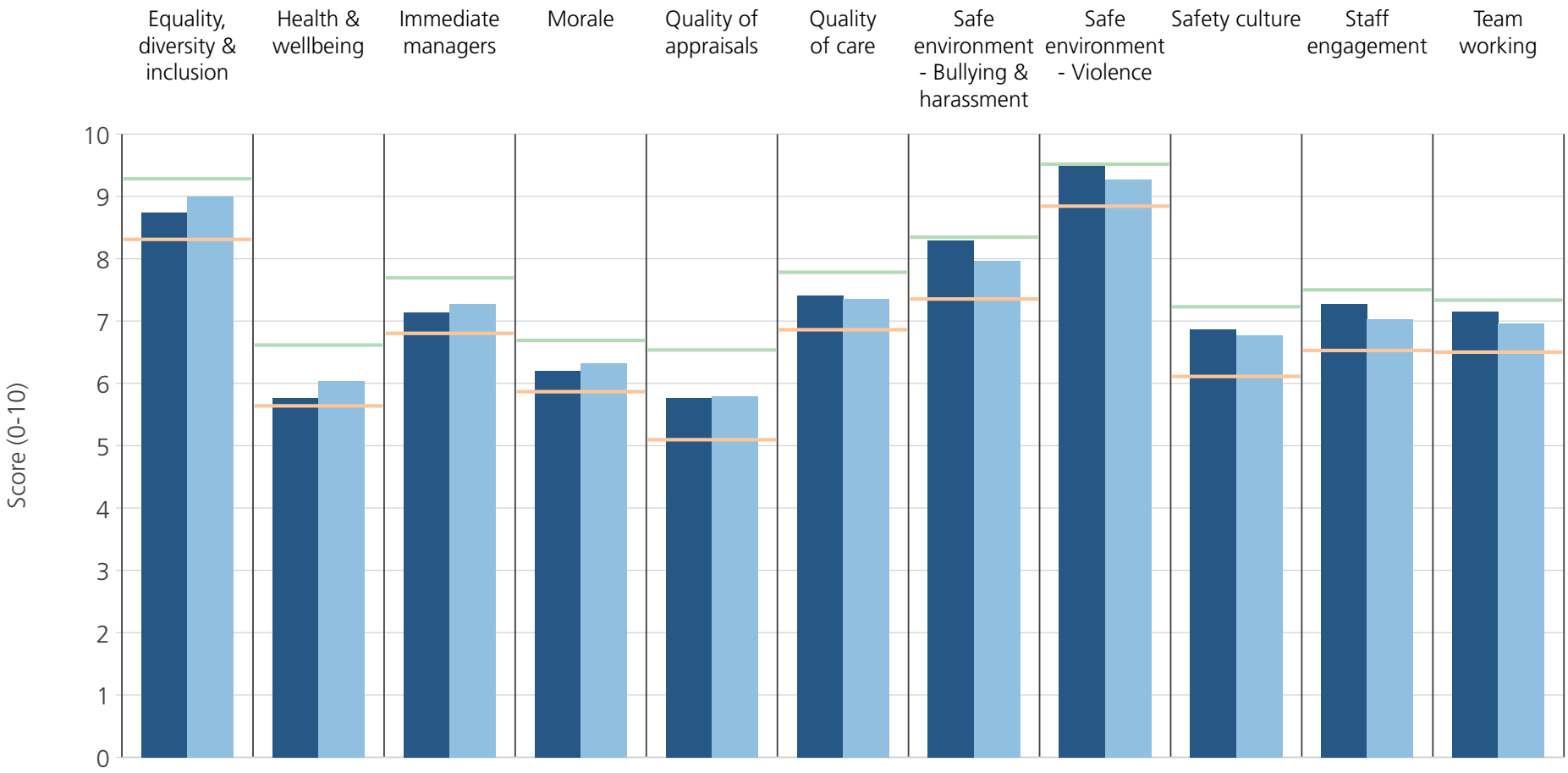
Survey Coordination Centre

NHS England

Theme results

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	8.7	5.8	7.1	6.2	5.8	7.4	8.3	9.5	6.9	7.3	7.2
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	428	434	435	423	392	343	432	430	427	439	434

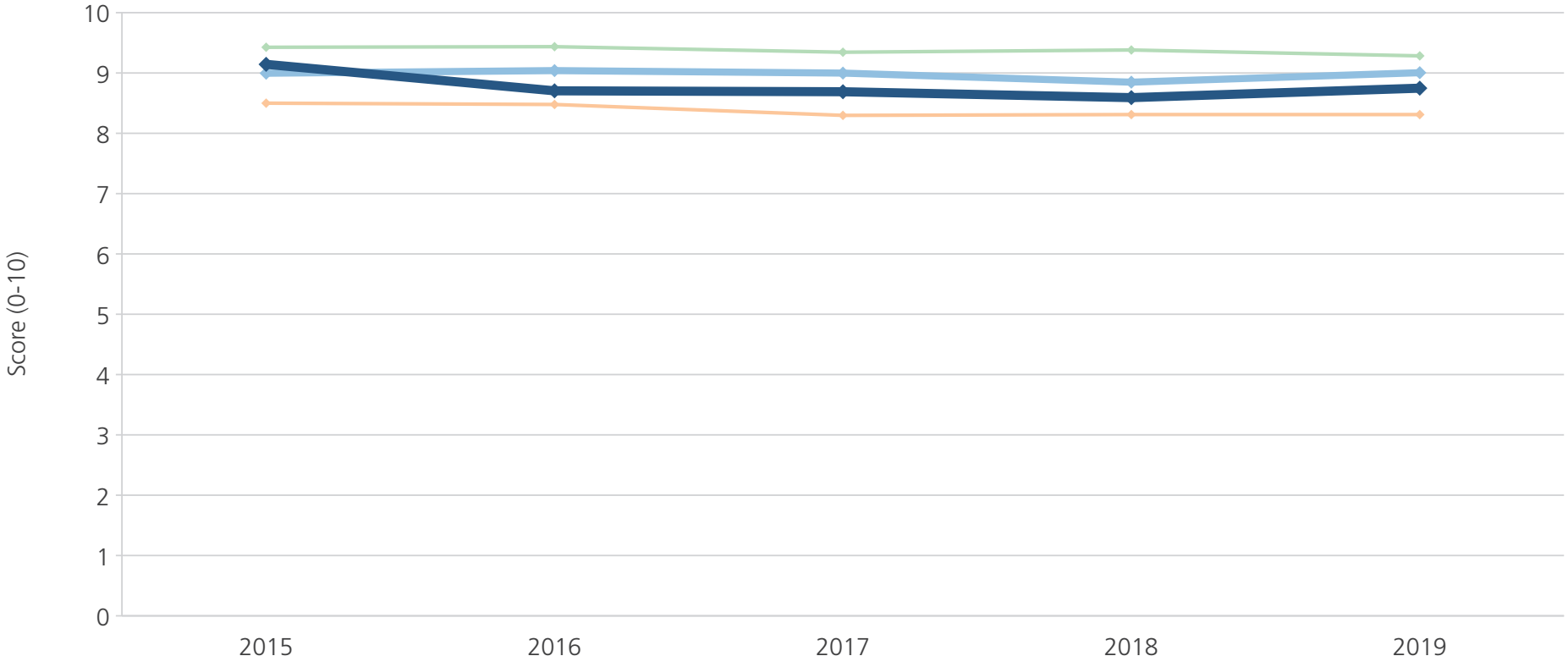
Survey Coordination Centre

NHS England

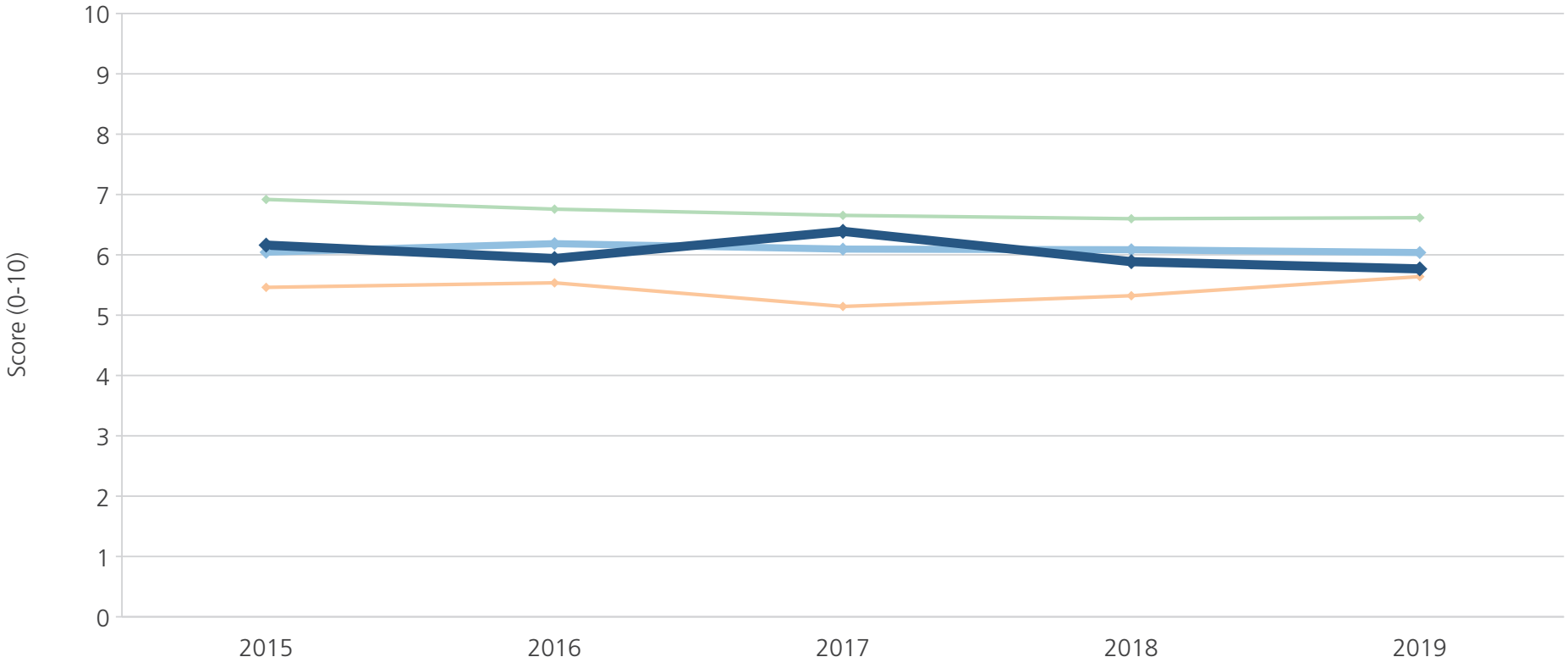
Theme results – Trends

Tavistock and Portman NHS Foundation Trust

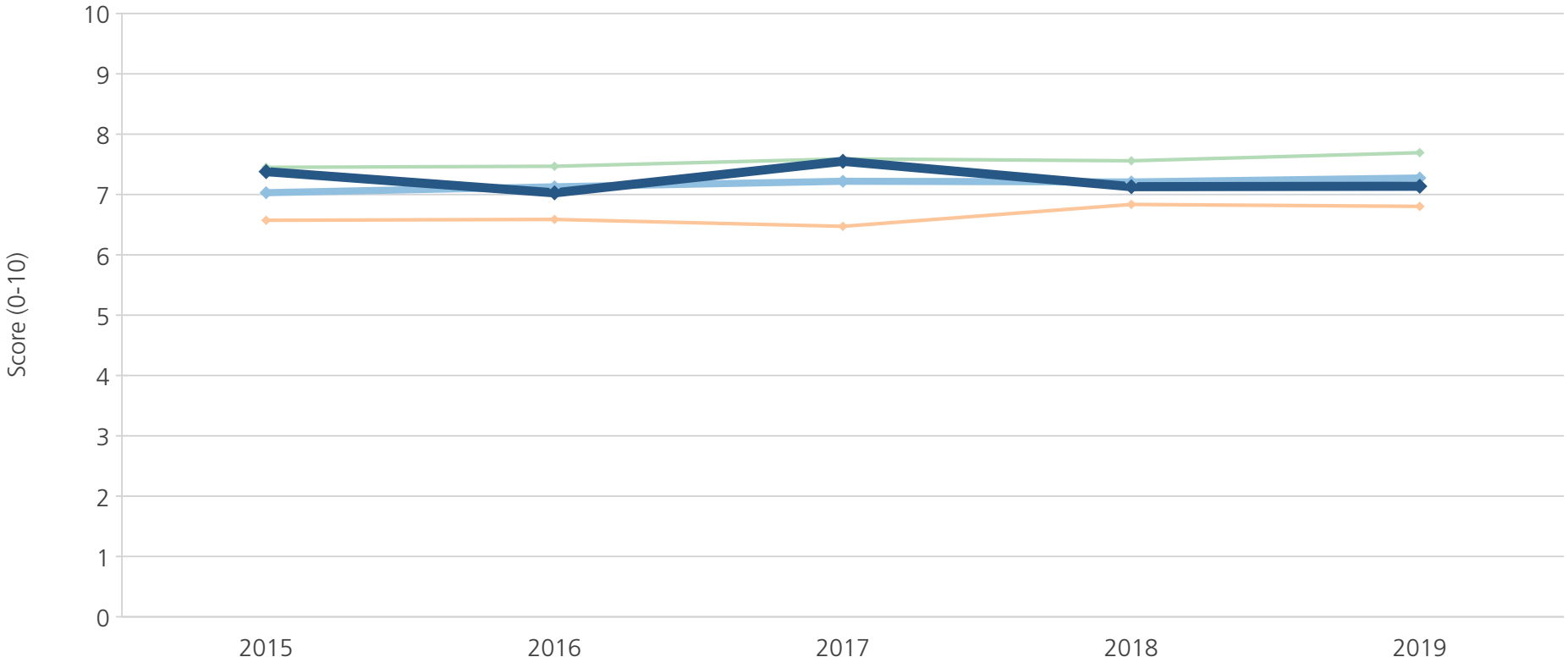
2019 NHS Staff Survey Results



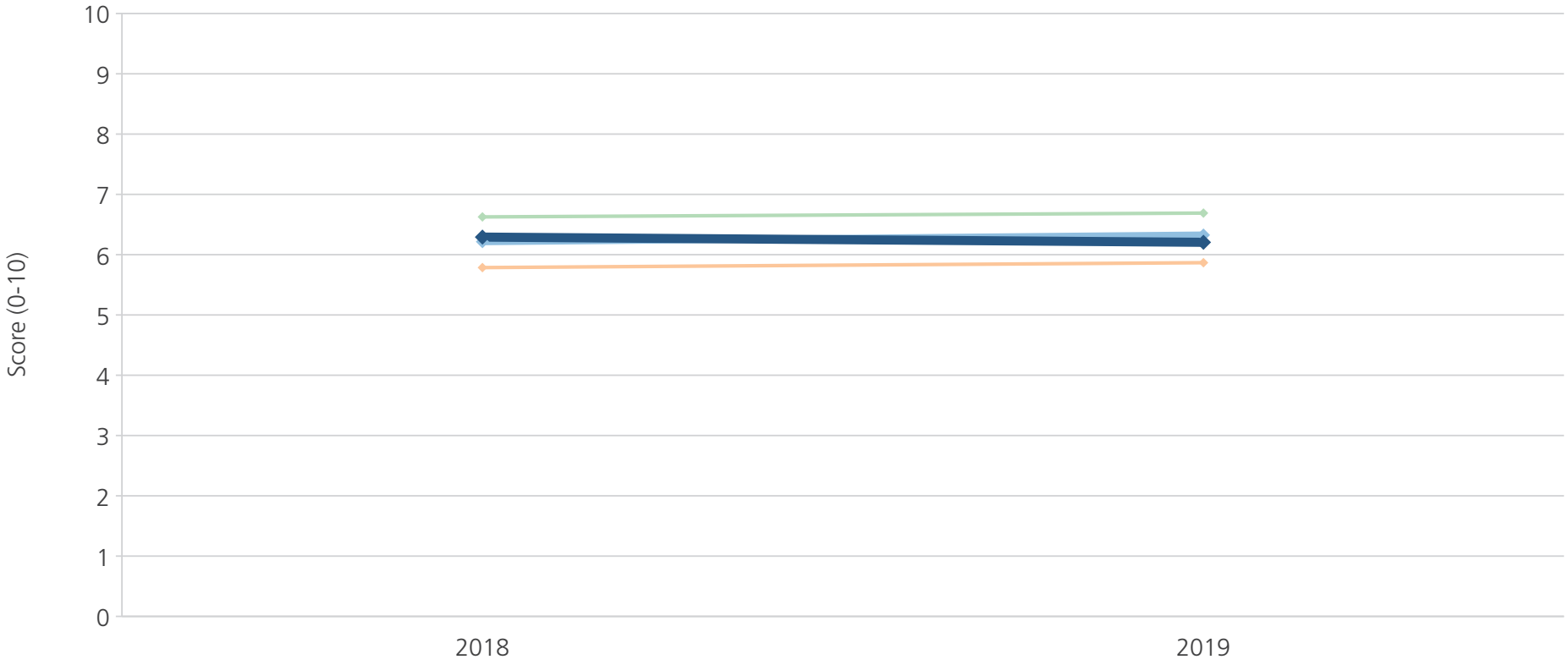
	2015	2016	2017	2018	2019
Best	9.4	9.4	9.3	9.4	9.3
Your org	9.1	8.7	8.7	8.6	8.7
Average	9.0	9.0	9.0	8.8	9.0
Worst	8.5	8.5	8.3	8.3	8.3
Responses	253	307	341	382	428



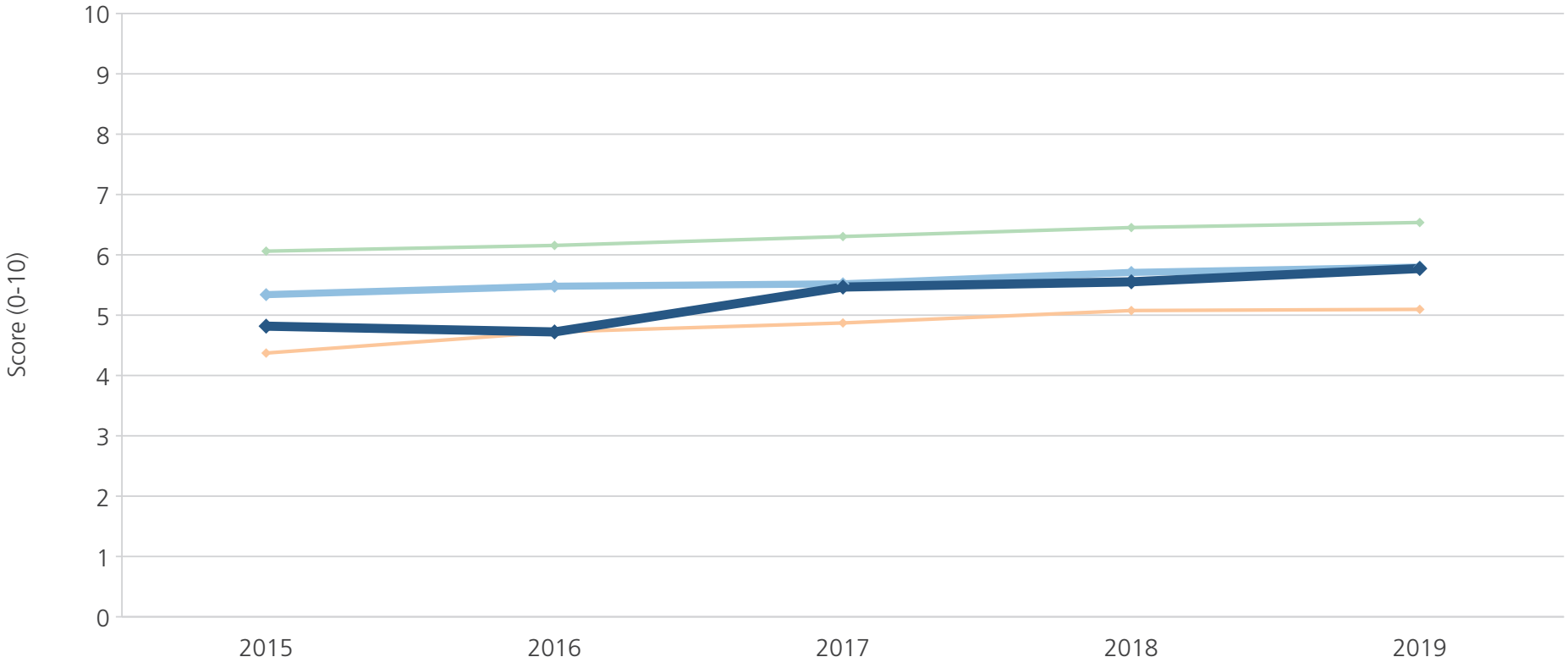
	2015	2016	2017	2018	2019
Best	6.9	6.8	6.7	6.6	6.6
Your org	6.2	5.9	6.4	5.9	5.8
Average	6.0	6.2	6.1	6.1	6.0
Worst	5.5	5.5	5.1	5.3	5.6
Responses	252	314	340	381	434



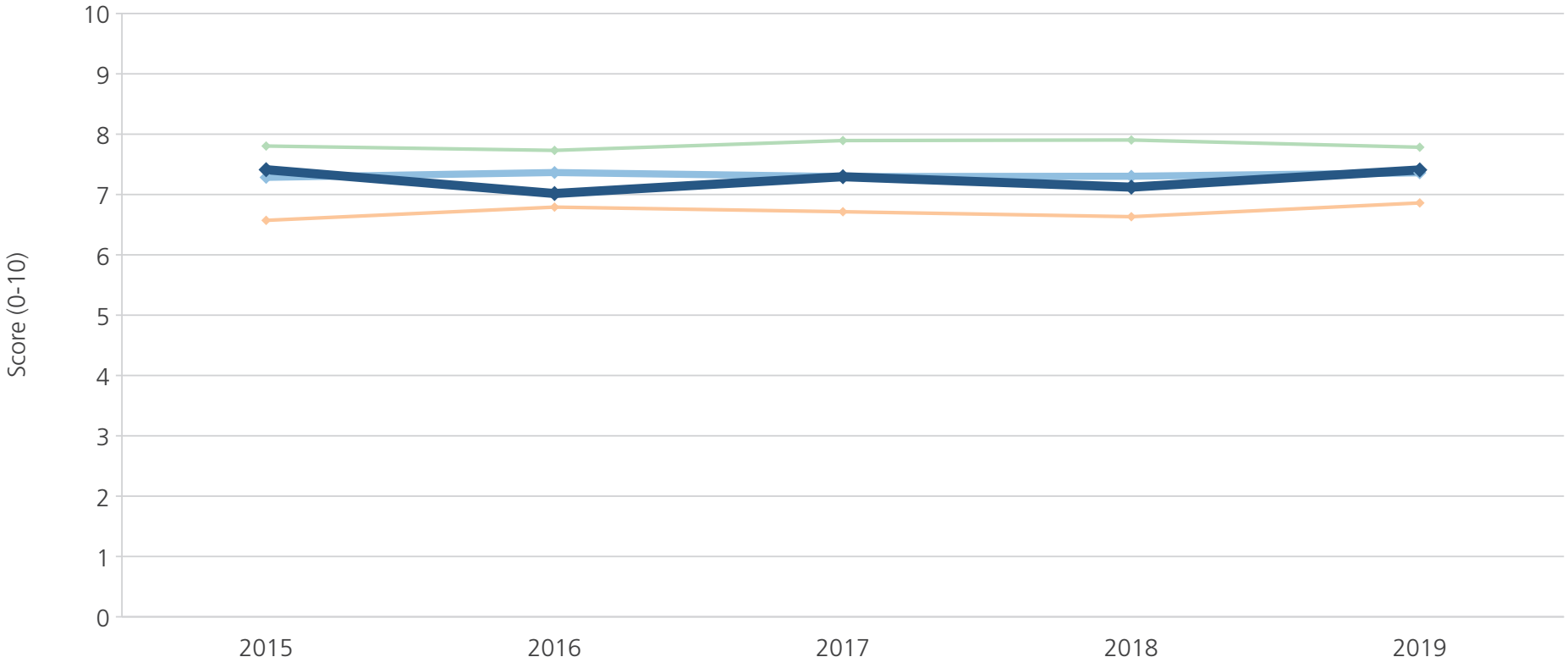
	2015	2016	2017	2018	2019
Best	7.5	7.5	7.6	7.6	7.7
Your org	7.4	7.0	7.6	7.1	7.1
Average	7.0	7.1	7.2	7.2	7.3
Worst	6.6	6.6	6.5	6.8	6.8
Responses	254	313	339	379	435



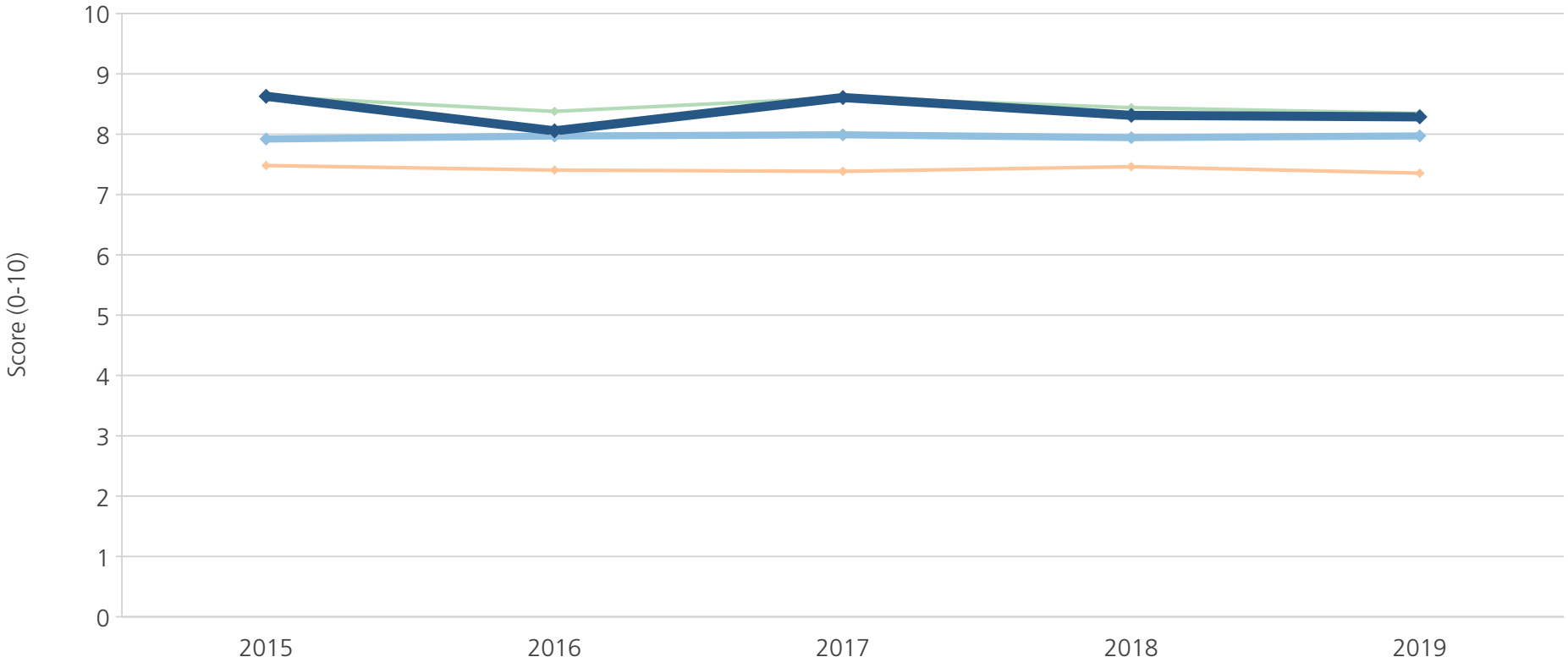
	2018	2019
Best	6.6	6.7
Your org	6.3	6.2
Average	6.2	6.3
Worst	5.8	5.9
Responses	379	423



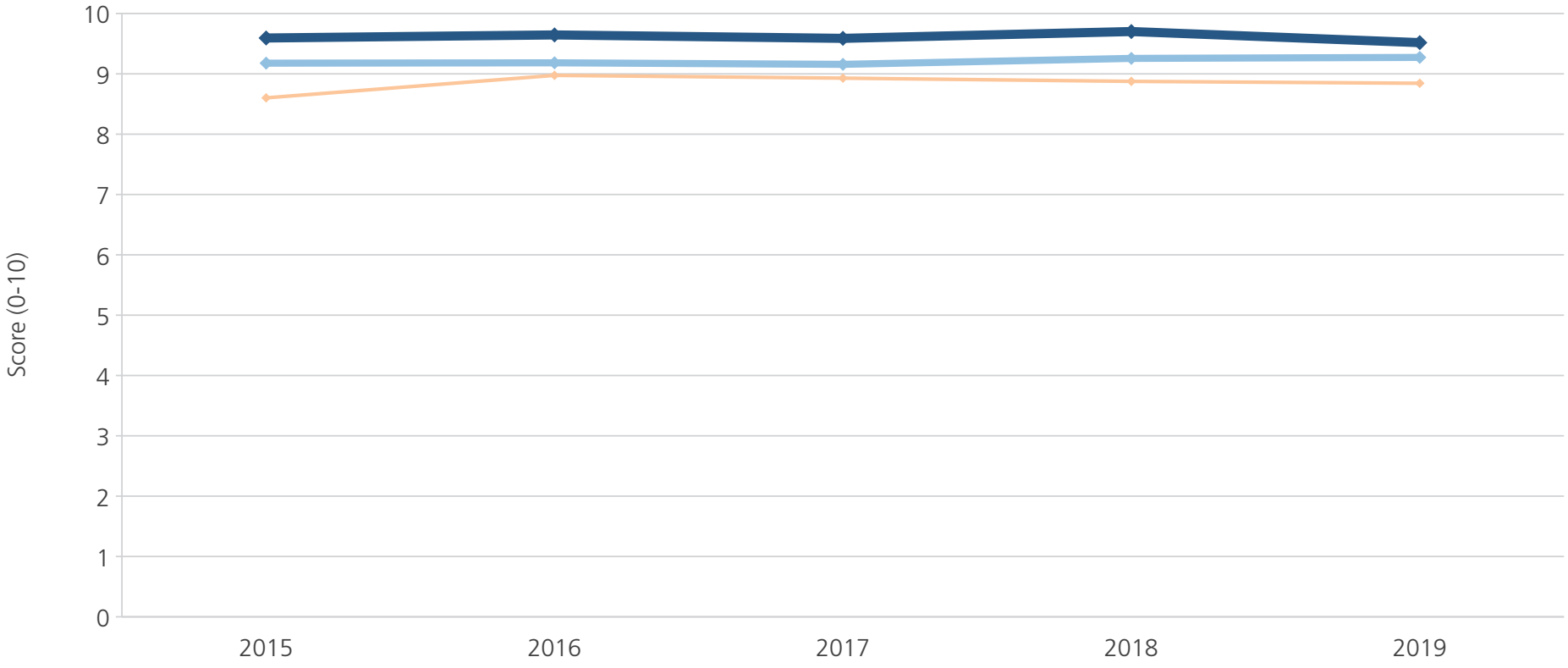
	2015	2016	2017	2018	2019
Best	6.1	6.2	6.3	6.5	6.5
Your org	4.8	4.7	5.5	5.6	5.8
Average	5.3	5.5	5.5	5.7	5.8
Worst	4.4	4.7	4.9	5.1	5.1
Responses	212	256	307	355	392



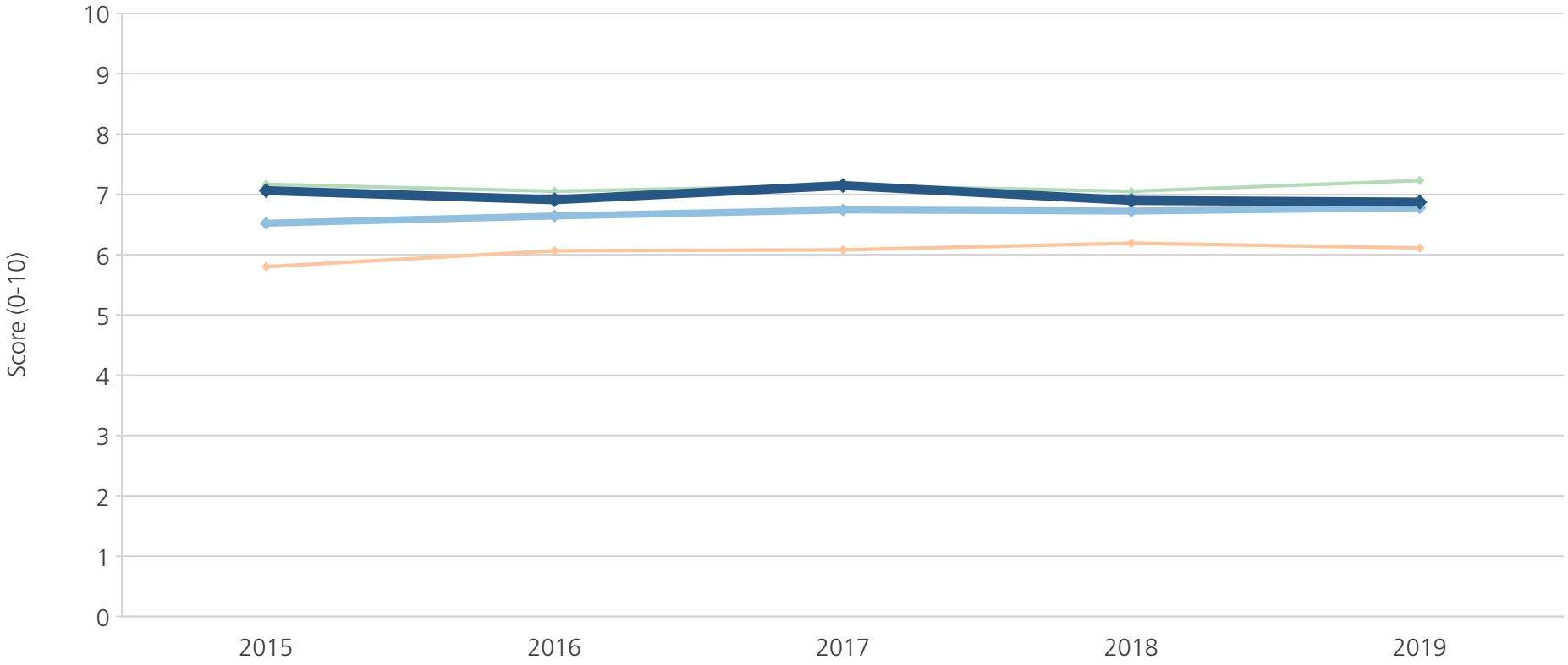
	2015	2016	2017	2018	2019
Best	7.8	7.7	7.9	7.9	7.8
Your org	7.4	7.0	7.3	7.1	7.4
Average	7.3	7.4	7.3	7.3	7.4
Worst	6.6	6.8	6.7	6.6	6.9
Responses	199	250	267	304	343



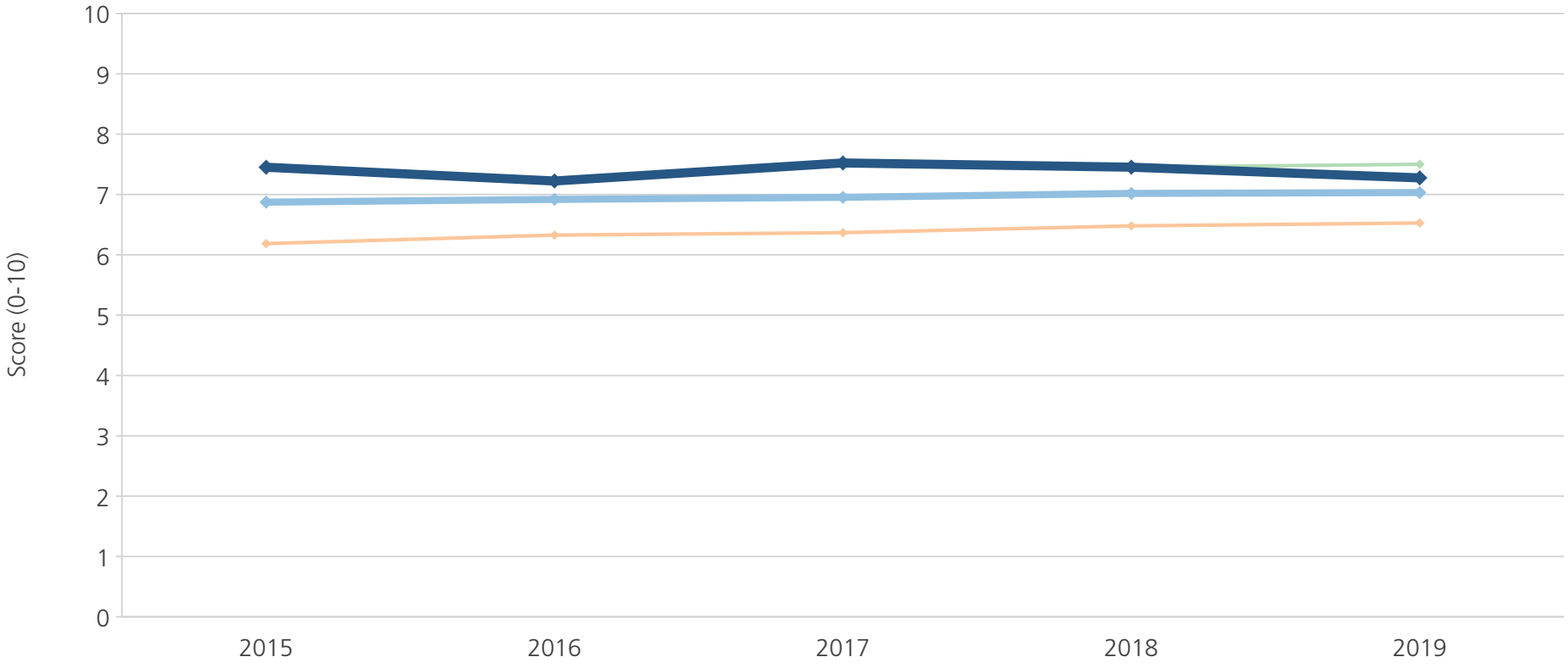
	2015	2016	2017	2018	2019
Best	8.6	8.4	8.6	8.4	8.3
Your org	8.6	8.1	8.6	8.3	8.3
Average	7.9	8.0	8.0	7.9	8.0
Worst	7.5	7.4	7.4	7.5	7.4
Responses	246	303	337	379	432



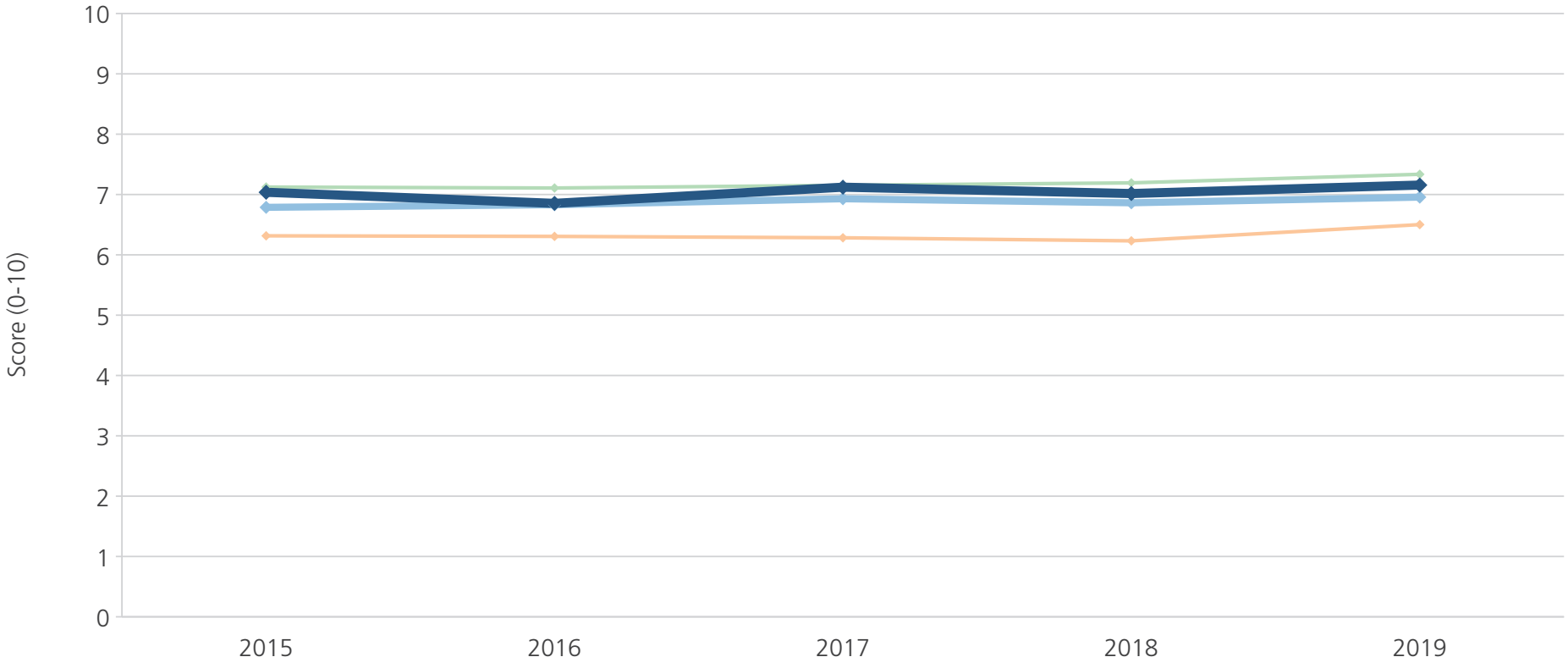
	2015	2016	2017	2018	2019
Best	9.6	9.6	9.6	9.7	9.5
Your org	9.6	9.6	9.6	9.7	9.5
Average	9.2	9.2	9.2	9.3	9.3
Worst	8.6	9.0	8.9	8.9	8.8
Responses	251	304	336	382	430



	2015	2016	2017	2018	2019
Best	7.2	7.1	7.1	7.1	7.2
Your org	7.1	6.9	7.1	6.9	6.9
Average	6.5	6.6	6.7	6.7	6.8
Worst	5.8	6.1	6.1	6.2	6.1
Responses	254	309	340	382	427



	2015	2016	2017	2018	2019
Best	7.5	7.3	7.5	7.5	7.5
Your org	7.5	7.2	7.5	7.5	7.3
Average	6.9	6.9	7.0	7.0	7.0
Worst	6.2	6.3	6.4	6.5	6.5
Responses	255	321	349	384	439



	2015	2016	2017	2018	2019
Best	7.1	7.1	7.2	7.2	7.3
Your org	7.0	6.9	7.1	7.0	7.2
Average	6.8	6.8	6.9	6.9	7.0
Worst	6.3	6.3	6.3	6.2	6.5
Responses	227	319	343	381	434

Survey Coordination Centre

NHS England

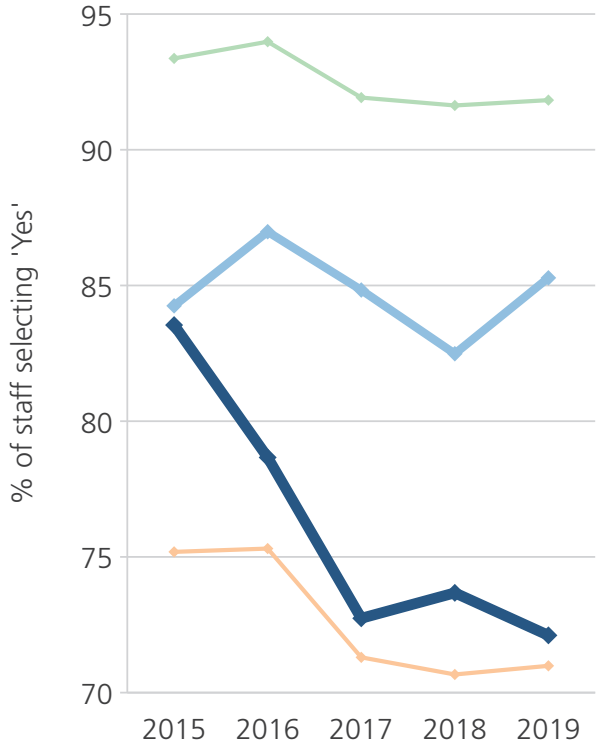
Theme results – Detailed information

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results

Q14

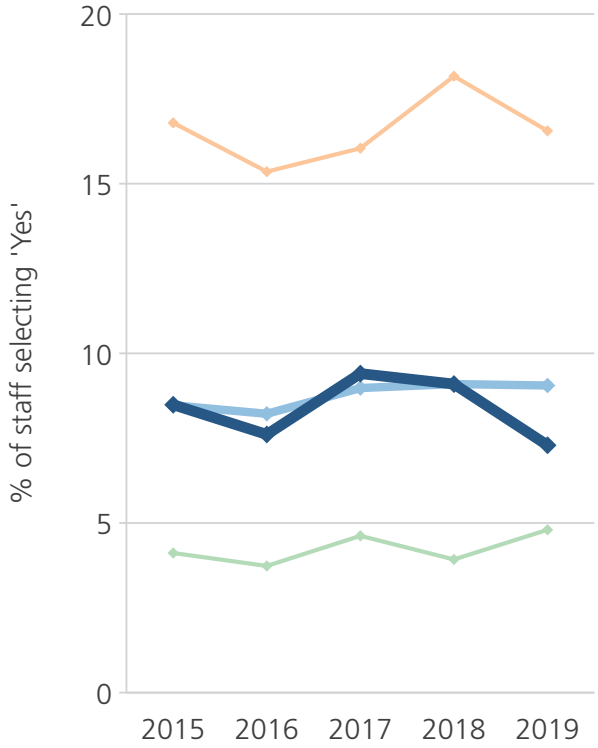
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2015	2016	2017	2018	2019
Best	93.4%	94.0%	91.9%	91.6%	91.8%
Your org	83.5%	78.7%	72.7%	73.7%	72.1%
Average	84.2%	87.0%	84.8%	82.5%	85.3%
Worst	75.2%	75.3%	71.3%	70.7%	71.0%

Q15a

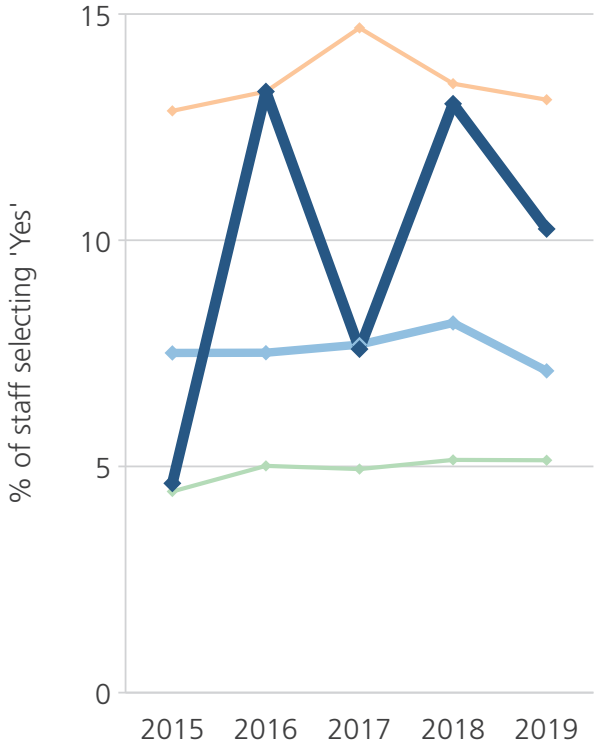
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	16.8%	15.4%	16.0%	18.2%	16.6%
Your org	8.5%	7.6%	9.4%	9.1%	7.3%
Average	8.5%	8.2%	9.0%	9.1%	9.1%
Best	4.1%	3.7%	4.6%	3.9%	4.8%

Q15b

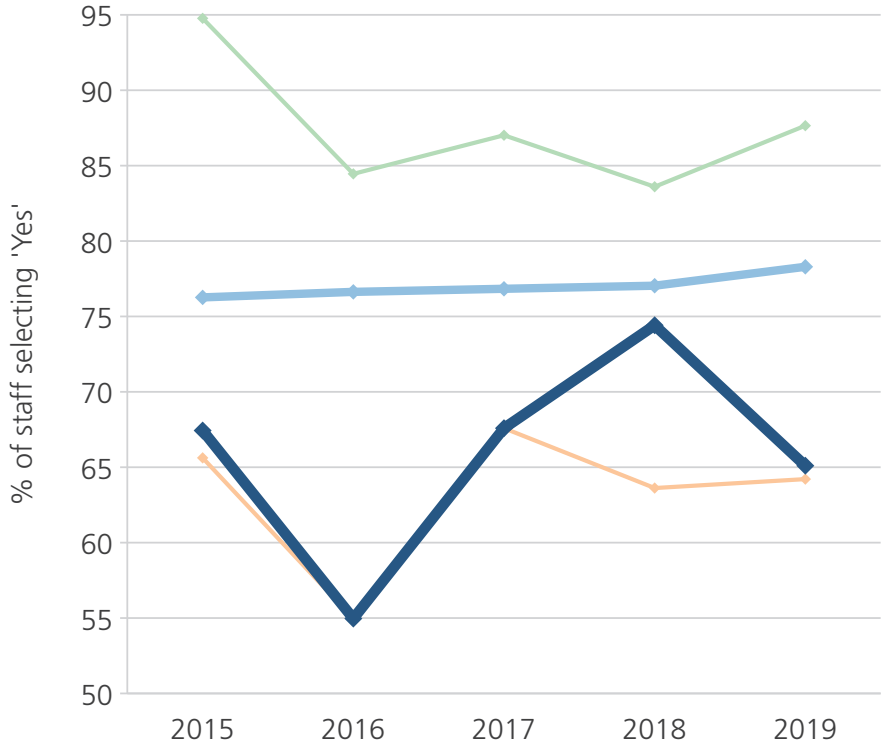
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2015	2016	2017	2018	2019
Worst	12.9%	13.3%	14.7%	13.5%	13.1%
Your org	4.6%	13.3%	7.6%	13.0%	10.2%
Average	7.5%	7.5%	7.7%	8.2%	7.1%
Best	4.4%	5.0%	4.9%	5.1%	5.1%

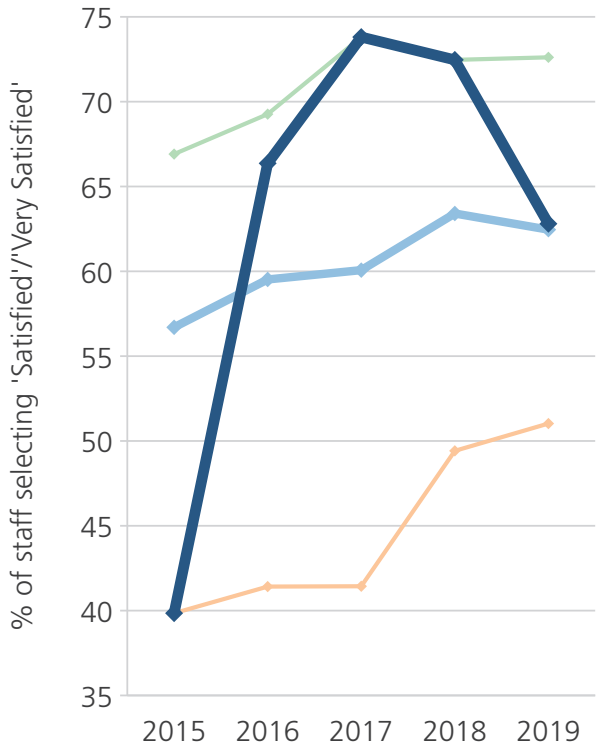
Q28b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



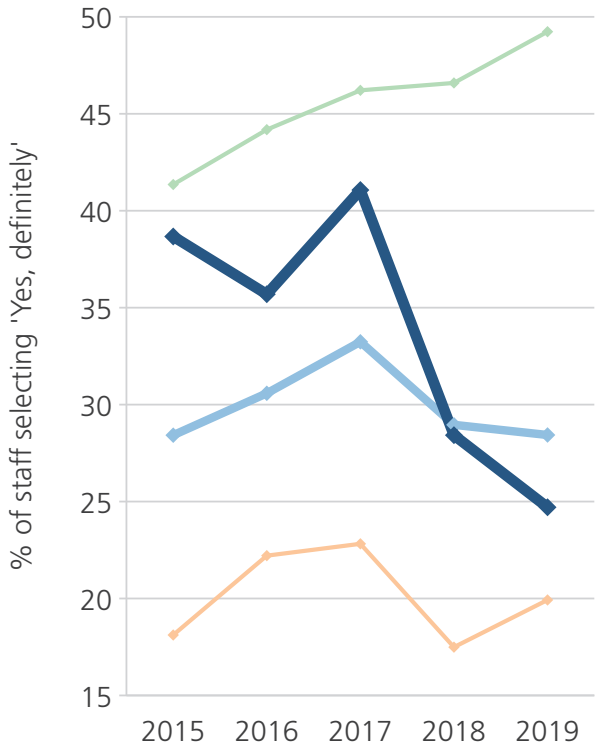
Best	94.8%	84.5%	87.0%	83.6%	87.7%
Your org	67.4%	55.0%	67.6%	74.4%	65.1%
Average	76.3%	76.6%	76.8%	77.0%	78.3%
Worst	65.6%	55.0%	67.6%	63.6%	64.2%

Q5h
The opportunities for flexible working patterns



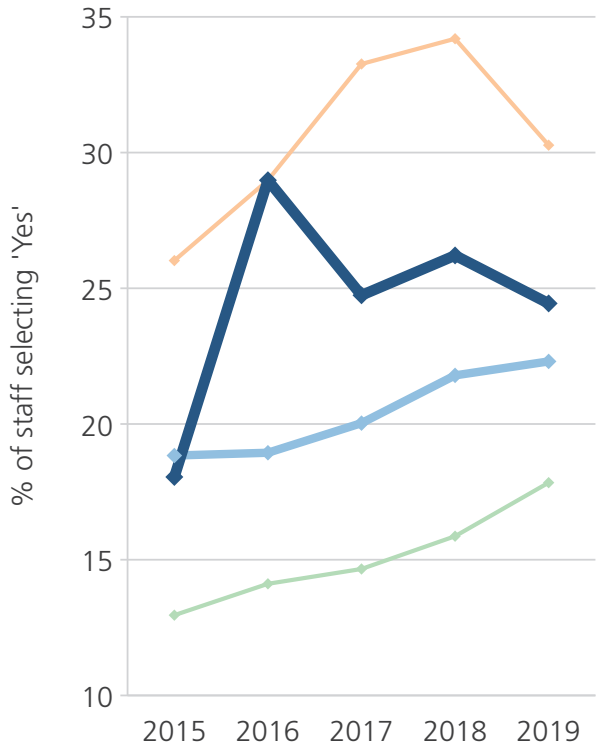
	2015	2016	2017	2018	2019
Best	66.9%	69.3%	73.8%	72.5%	72.6%
Your org	39.8%	66.4%	73.8%	72.5%	62.8%
Average	56.7%	59.5%	60.1%	63.4%	62.5%
Worst	39.8%	41.4%	41.4%	49.4%	51.0%

Q11a
Does your organisation take positive action on health and well-being?



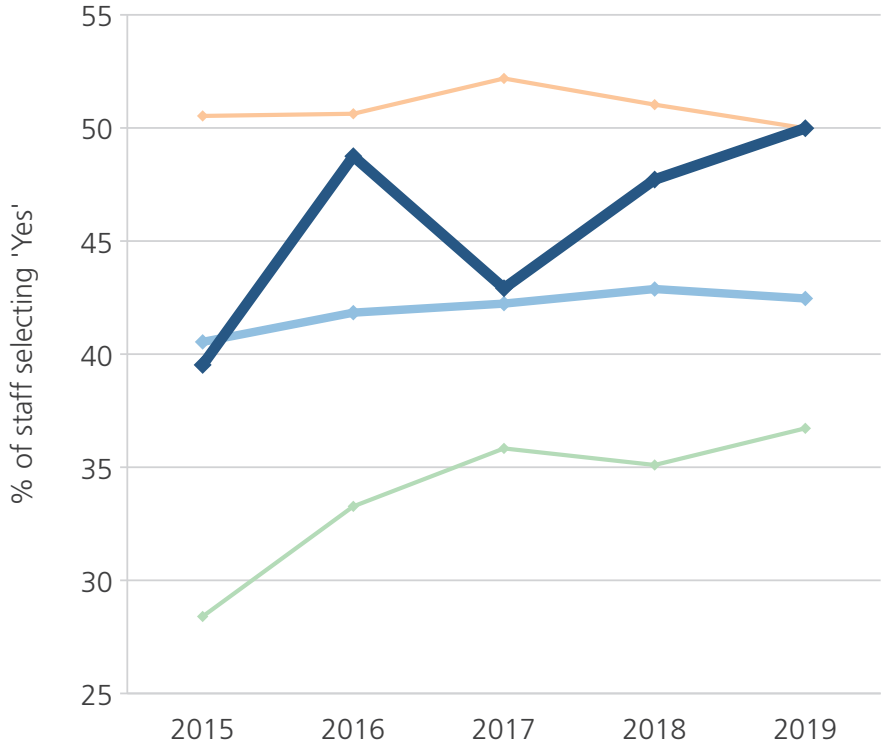
	2015	2016	2017	2018	2019
Best	41.4%	44.2%	46.2%	46.6%	49.2%
Your org	38.7%	35.7%	41.1%	28.4%	24.7%
Average	28.4%	30.6%	33.2%	29.0%	28.4%
Worst	18.1%	22.2%	22.8%	17.5%	19.9%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



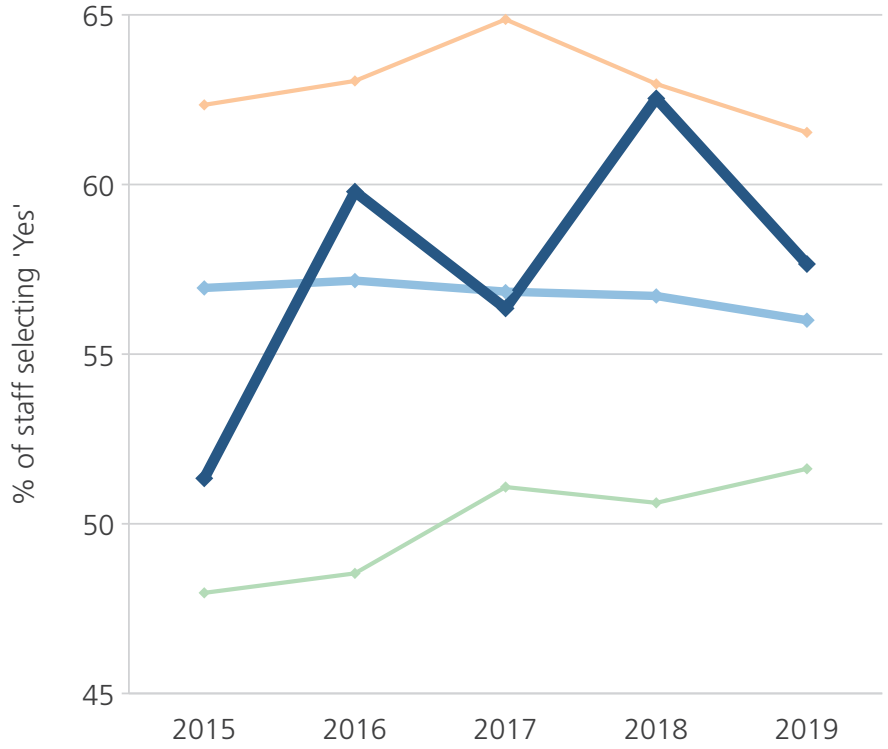
	2015	2016	2017	2018	2019
Worst	26.0%	29.0%	33.3%	34.2%	30.3%
Your org	18.0%	29.0%	24.7%	26.2%	24.4%
Average	18.8%	18.9%	20.0%	21.8%	22.3%
Best	13.0%	14.1%	14.7%	15.9%	17.8%

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



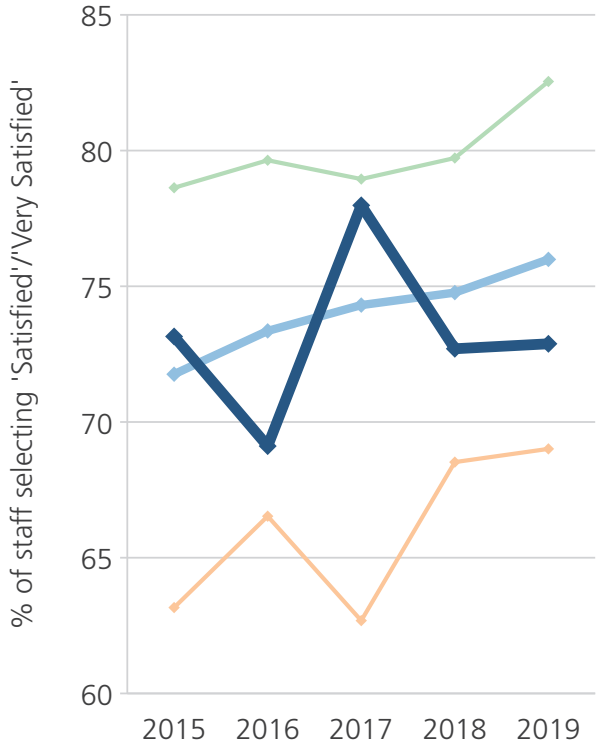
	2015	2016	2017	2018	2019
Worst	50.5%	50.6%	52.2%	51.0%	50.0%
Your org	39.5%	48.8%	42.9%	47.7%	50.0%
Average	40.5%	41.8%	42.2%	42.9%	42.5%
Best	28.4%	33.3%	35.8%	35.1%	36.7%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



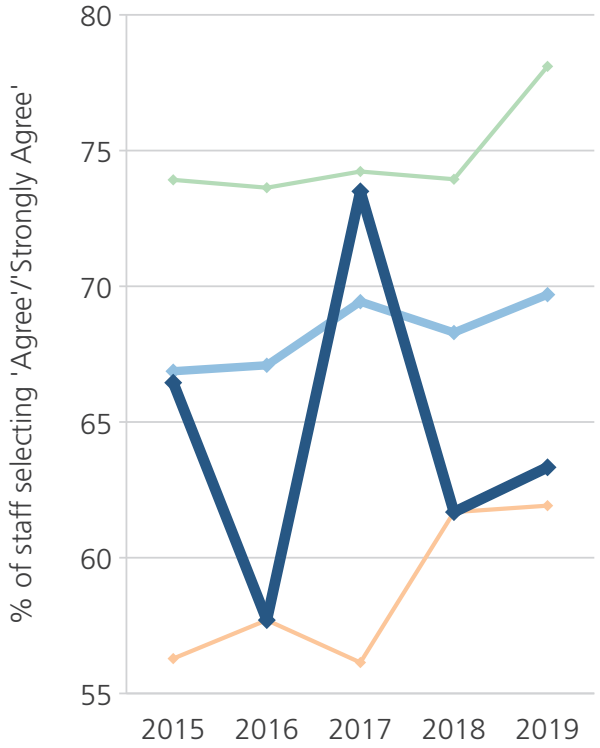
	2015	2016	2017	2018	2019
Worst	62.3%	63.1%	64.9%	63.0%	61.5%
Your org	51.3%	59.8%	56.3%	62.5%	57.7%
Average	57.0%	57.2%	56.8%	56.7%	56.0%
Best	48.0%	48.5%	51.1%	50.6%	51.6%

Q5b
The support I get from my immediate manager



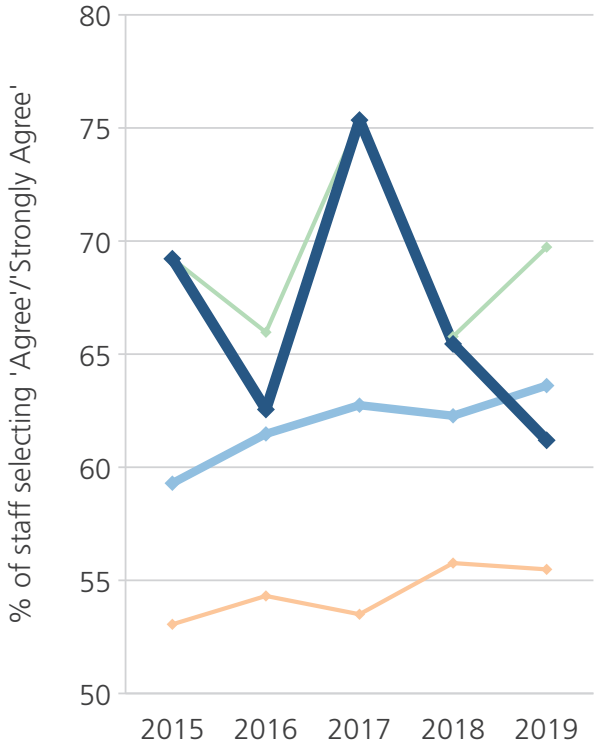
	2015	2016	2017	2018	2019
Best	78.6%	79.6%	79.0%	79.7%	82.5%
Your org	73.2%	69.1%	78.0%	72.7%	72.9%
Average	71.8%	73.4%	74.3%	74.8%	76.0%
Worst	63.2%	66.5%	62.7%	68.5%	69.0%

Q8c
My immediate manager gives me clear feedback on my work



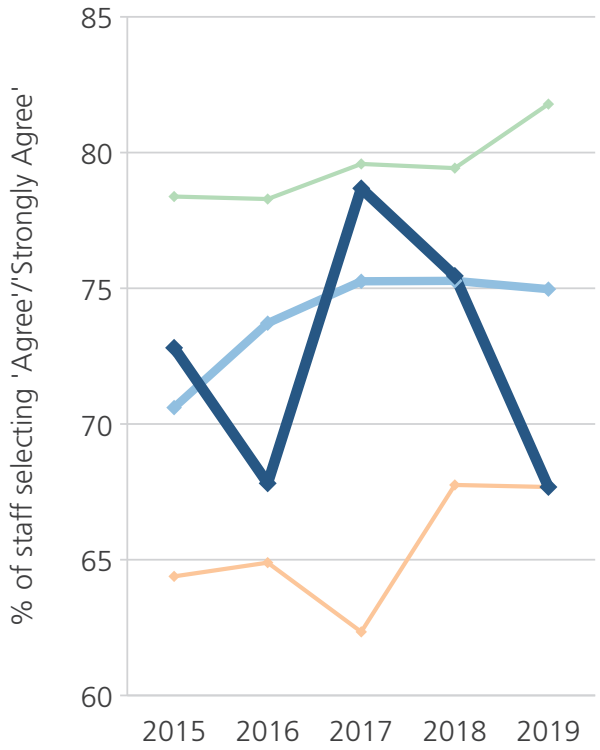
	2015	2016	2017	2018	2019
Best	73.9%	73.6%	74.2%	73.9%	78.1%
Your org	66.4%	57.7%	73.5%	61.7%	63.3%
Average	66.9%	67.1%	69.4%	68.3%	69.7%
Worst	56.3%	57.7%	56.1%	61.7%	61.9%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



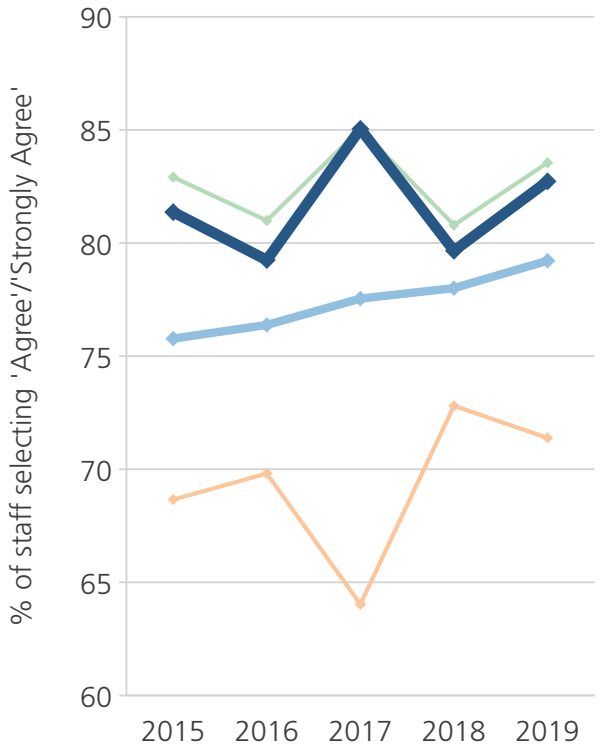
	2015	2016	2017	2018	2019
Best	69.2%	66.0%	75.3%	65.8%	69.7%
Your org	69.2%	62.6%	75.3%	65.5%	61.2%
Average	59.3%	61.5%	62.7%	62.3%	63.6%
Worst	53.1%	54.3%	53.5%	55.8%	55.5%

Q8f
My immediate manager takes a positive interest in my health and well-being



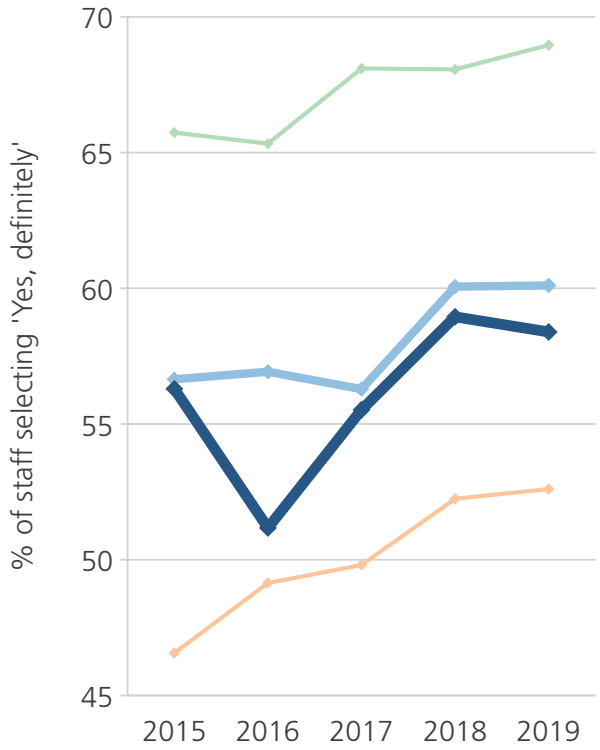
	2015	2016	2017	2018	2019
Best	78.4%	78.3%	79.6%	79.4%	81.8%
Your org	72.8%	67.8%	78.7%	75.5%	67.7%
Average	70.6%	73.7%	75.3%	75.3%	75.0%
Worst	64.4%	64.9%	62.3%	67.8%	67.7%

Q8g
My immediate manager values my work



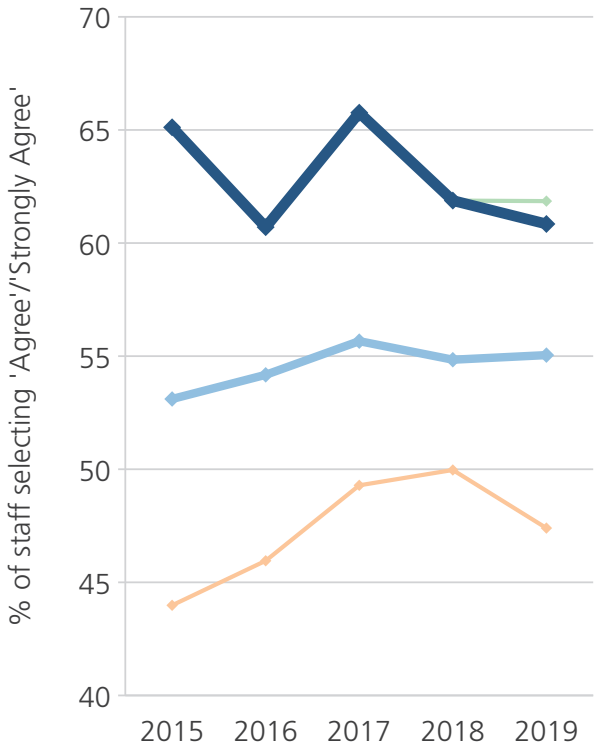
	2015	2016	2017	2018	2019
Best	82.9%	81.0%	85.0%	80.8%	83.5%
Your org	81.4%	79.2%	85.0%	79.7%	82.7%
Average	75.8%	76.4%	77.5%	78.0%	79.2%
Worst	68.7%	69.8%	64.0%	72.8%	71.4%

Q19g
My manager supported me to receive this training, learning or development



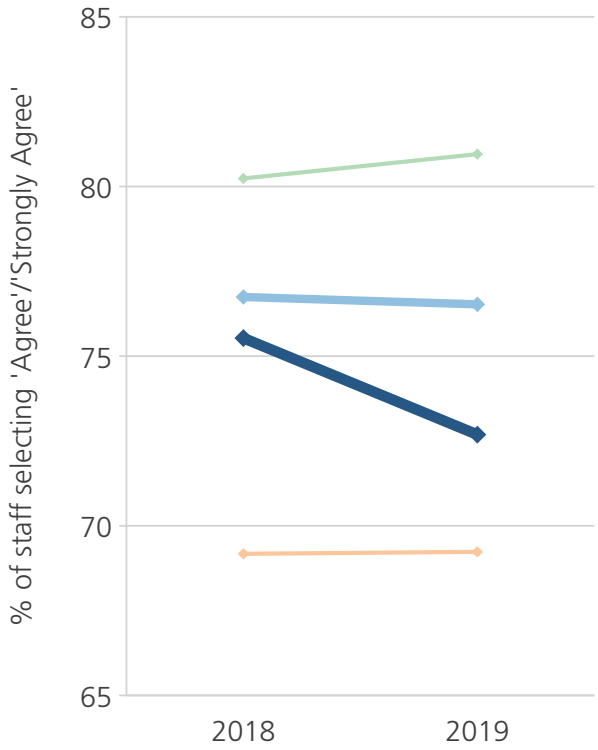
	2015	2016	2017	2018	2019
Best	65.7%	65.3%	68.1%	68.1%	69.0%
Your org	56.3%	51.2%	55.5%	58.9%	58.4%
Average	56.6%	56.9%	56.3%	60.1%	60.1%
Worst	46.6%	49.1%	49.8%	52.2%	52.6%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



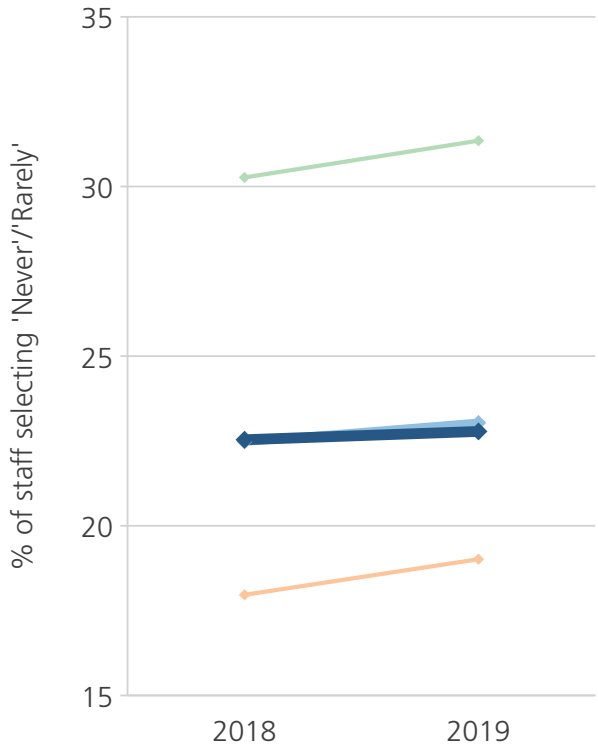
	2015	2016	2017	2018	2019
Best	65.1%	60.7%	65.8%	61.9%	61.9%
Your org	65.1%	60.7%	65.8%	61.9%	60.8%
Average	53.1%	54.2%	55.7%	54.8%	55.0%
Worst	44.0%	46.0%	49.3%	50.0%	47.4%

Q4j
I receive the respect I deserve from my colleagues at work



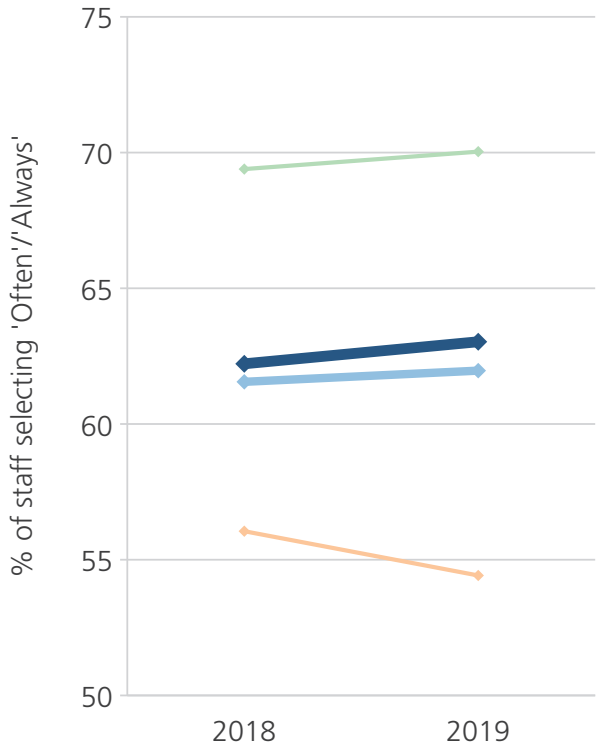
	2018	2019
Best	80.2%	81.0%
Your org	75.5%	72.7%
Average	76.7%	76.5%
Worst	69.2%	69.2%

Q6a
I have unrealistic time pressures



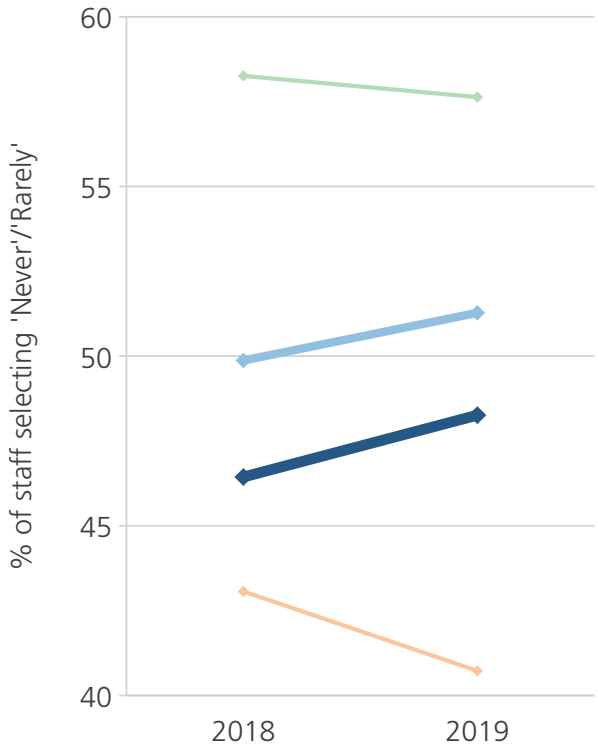
	2018	2019
Best	30.3%	31.4%
Your org	22.5%	22.8%
Average	22.5%	23.0%
Worst	18.0%	19.0%

Q6b
I have a choice in deciding how to do my work



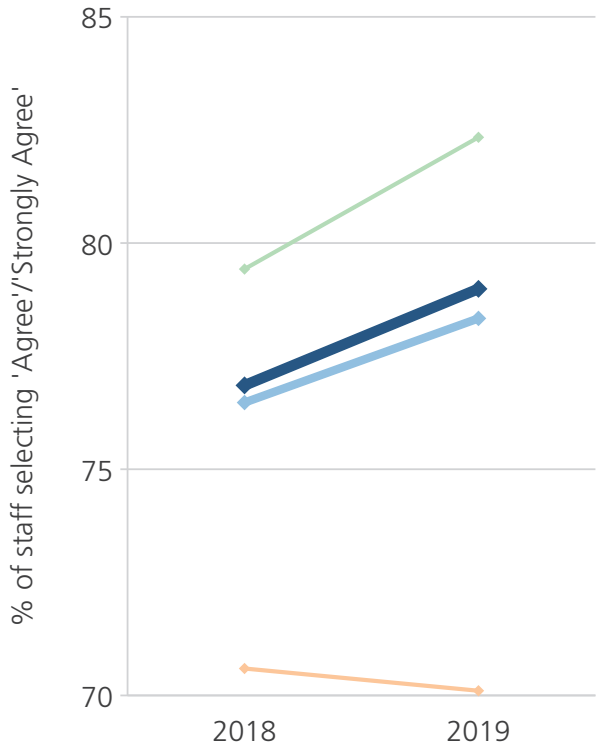
	2018	2019
Best	69.4%	70.0%
Your org	62.2%	63.0%
Average	61.6%	62.0%
Worst	56.1%	54.4%

Q6c
Relationships at work are strained



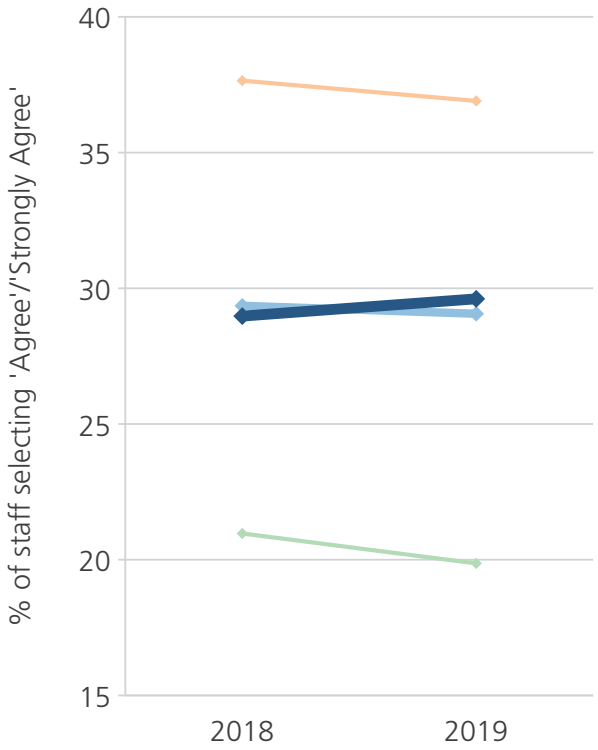
	2018	2019
Best	58.3%	57.6%
Your org	46.4%	48.3%
Average	49.9%	51.3%
Worst	43.1%	40.7%

Q8a
My immediate manager encourages me at work



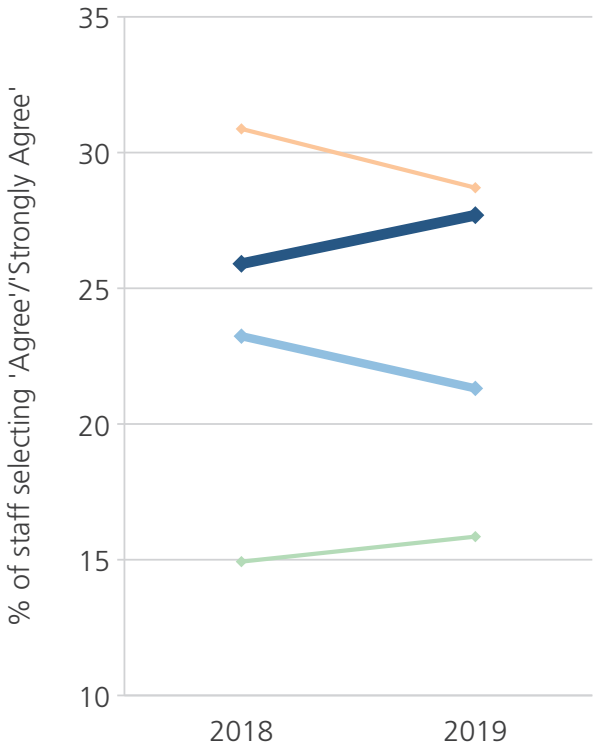
	2018	2019
Best	79.4%	82.3%
Your org	76.9%	79.0%
Average	76.5%	78.3%
Worst	70.6%	70.1%

Q23a
I often think about leaving this organisation



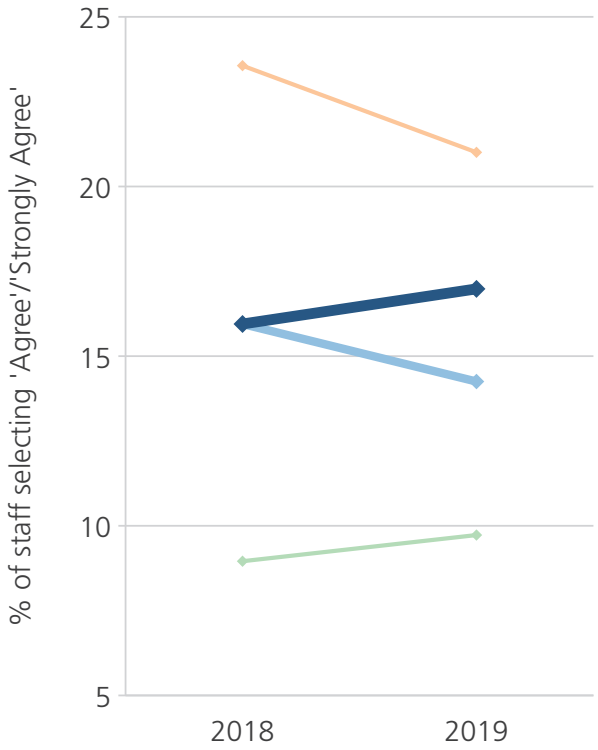
	2018	2019
Worst	37.6%	36.9%
Your org	29.0%	29.6%
Average	29.4%	29.1%
Best	21.0%	19.9%

Q23b
I will probably look for a job at a new organisation in the next 12 months



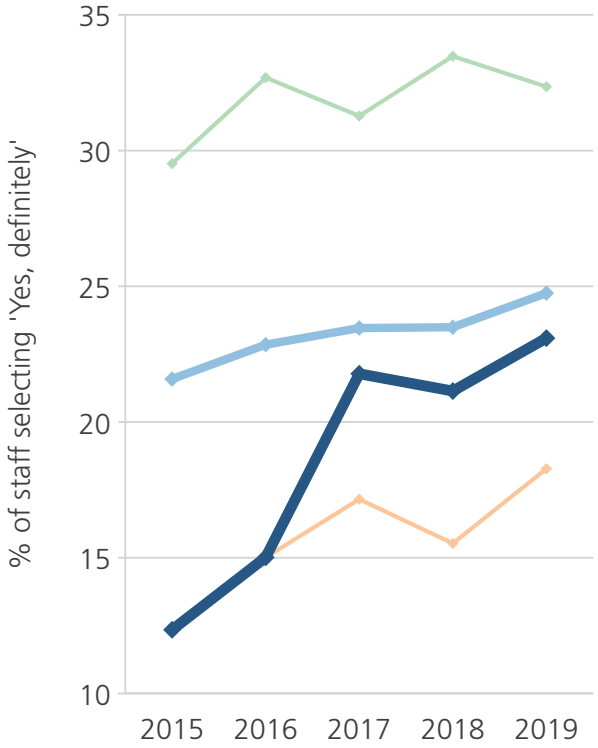
	2018	2019
Worst	30.9%	28.7%
Your org	25.9%	27.7%
Average	23.2%	21.3%
Best	14.9%	15.9%

Q23c
As soon as I can find another job, I will leave this organisation



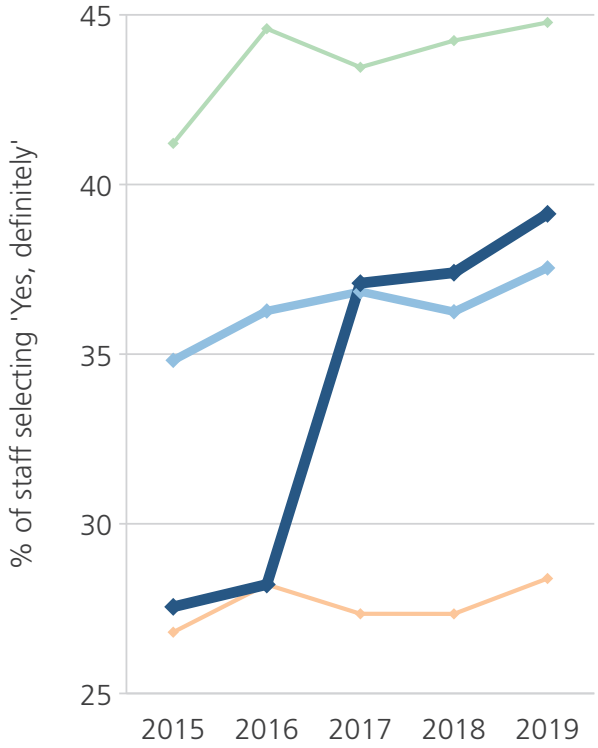
	2018	2019
Worst	23.6%	21.0%
Your org	15.9%	17.0%
Average	15.9%	14.3%
Best	9.0%	9.7%

Q19b
It helped me to improve how I do my job



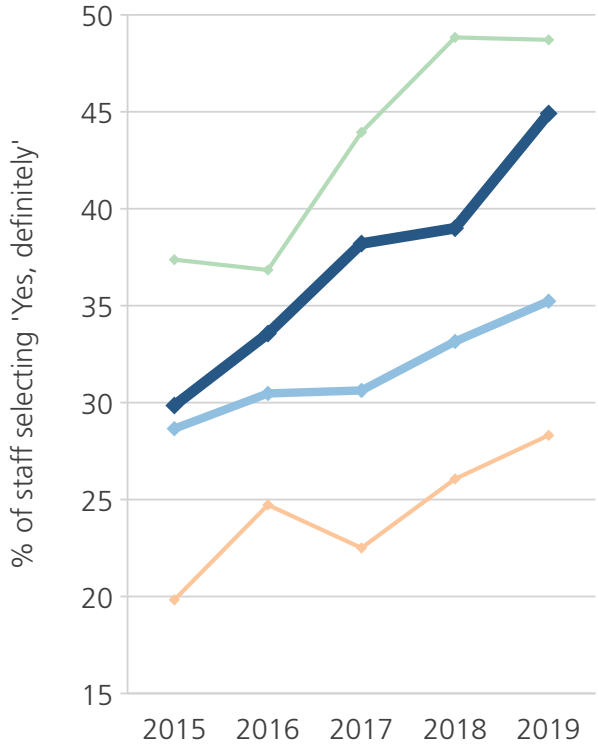
	2015	2016	2017	2018	2019
Best	29.5%	32.7%	31.3%	33.5%	32.4%
Your org	12.3%	15.0%	21.8%	21.1%	23.1%
Average	21.6%	22.8%	23.5%	23.5%	24.7%
Worst	12.3%	15.0%	17.2%	15.5%	18.3%

Q19c
It helped me agree clear objectives for my work



	2015	2016	2017	2018	2019
Best	41.2%	44.6%	43.5%	44.2%	44.8%
Your org	27.6%	28.2%	37.1%	37.4%	39.1%
Average	34.8%	36.3%	36.8%	36.3%	37.5%
Worst	26.8%	28.2%	27.3%	27.3%	28.4%

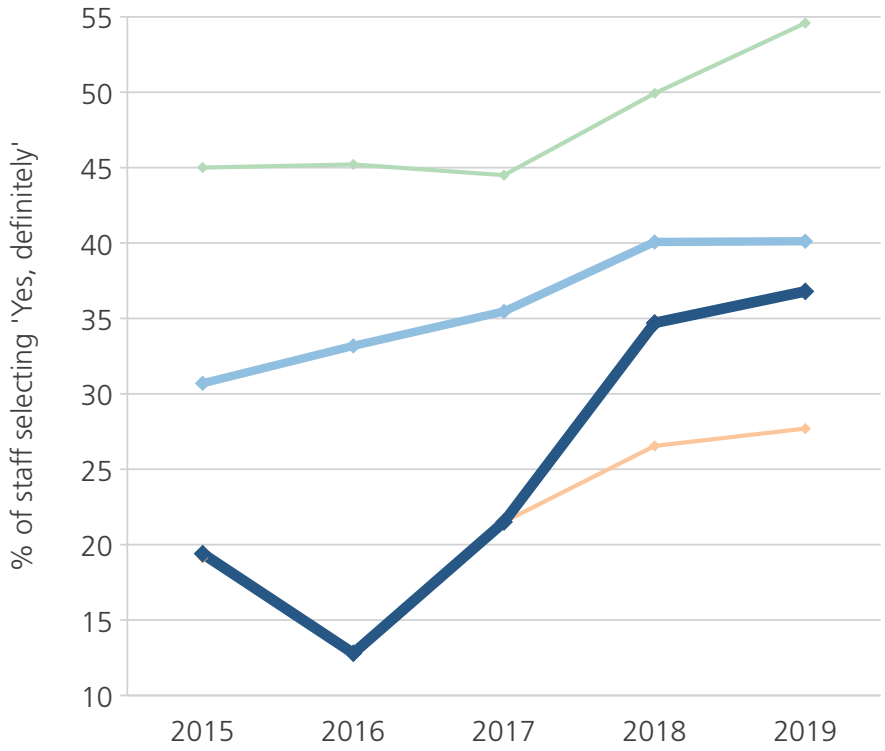
Q19d
It left me feeling that my work is valued by my organisation



	2015	2016	2017	2018	2019
Best	37.4%	36.8%	43.9%	48.8%	48.7%
Your org	29.9%	33.6%	38.2%	39.0%	44.9%
Average	28.7%	30.5%	30.6%	33.2%	35.2%
Worst	19.8%	24.7%	22.5%	26.1%	28.3%

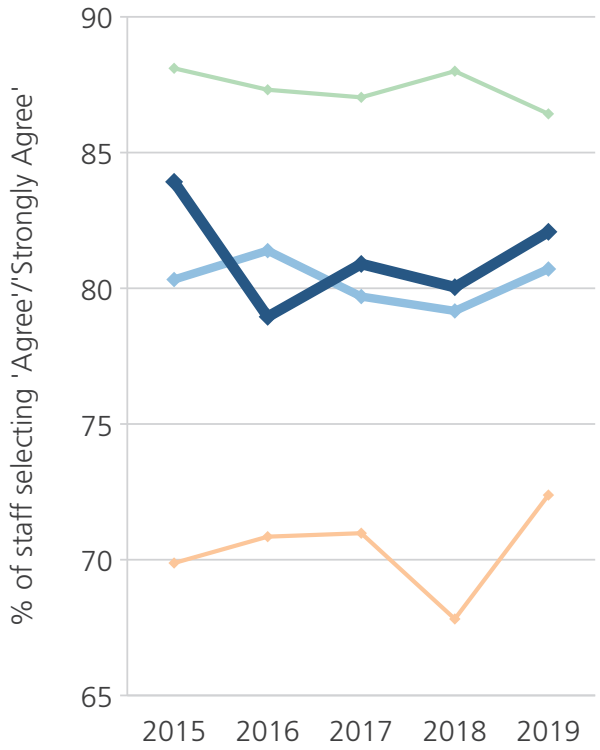
Q19e

The values of my organisation were discussed as part of the appraisal process



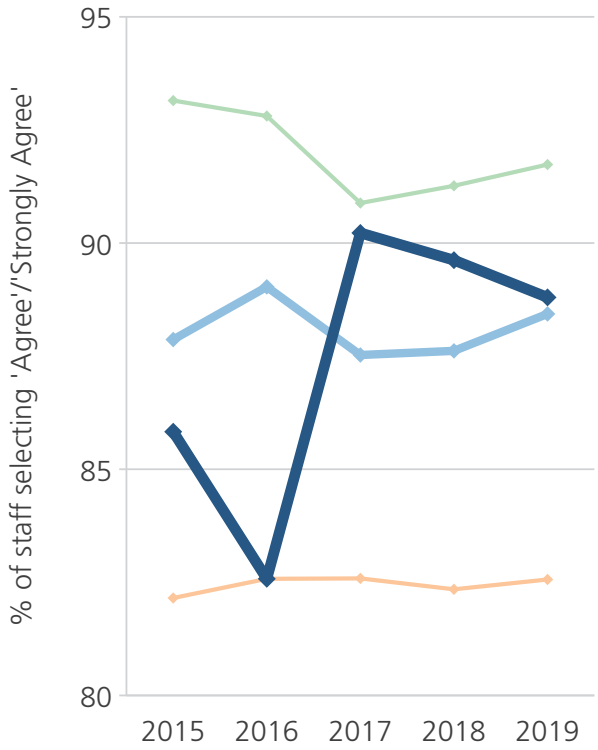
	2015	2016	2017	2018	2019
Best	45.0%	45.2%	44.5%	49.9%	54.6%
Your org	19.4%	12.8%	21.5%	34.7%	36.8%
Average	30.7%	33.2%	35.5%	40.1%	40.1%
Worst	19.1%	12.8%	21.5%	26.5%	27.7%

Q7a
I am satisfied with the quality of care I give to patients / service users



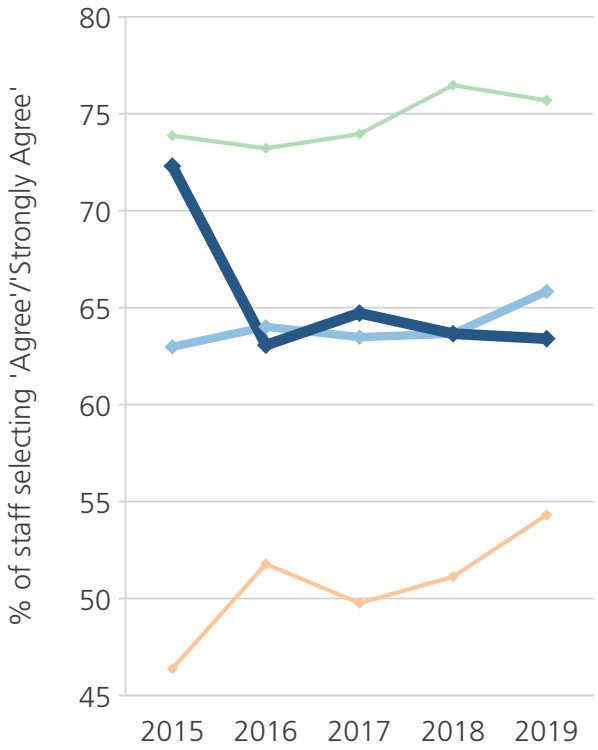
	2015	2016	2017	2018	2019
Best	88.1%	87.3%	87.0%	88.0%	86.4%
Your org	83.9%	78.9%	80.9%	80.0%	82.1%
Average	80.3%	81.4%	79.7%	79.2%	80.7%
Worst	69.9%	70.8%	71.0%	67.8%	72.4%

Q7b
I feel that my role makes a difference to patients / service users



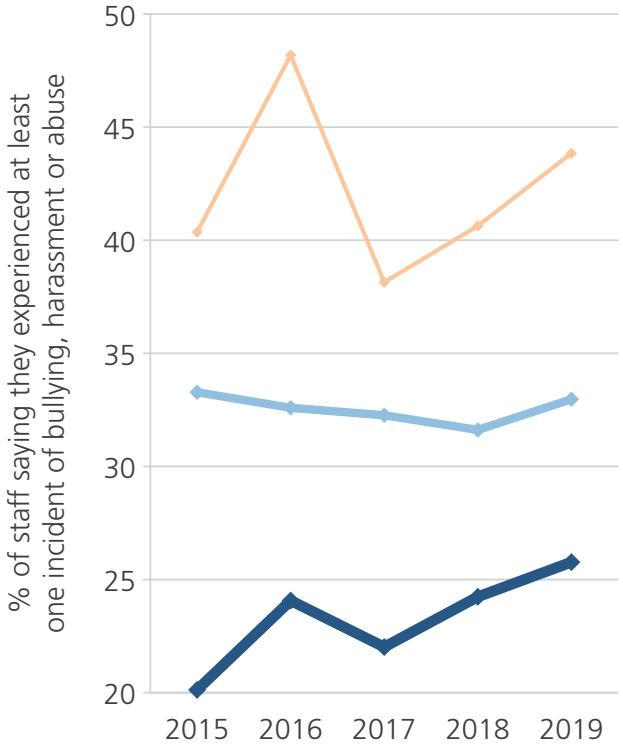
	2015	2016	2017	2018	2019
Best	93.1%	92.8%	90.9%	91.3%	91.7%
Your org	85.8%	82.6%	90.2%	89.6%	88.8%
Average	87.9%	89.0%	87.5%	87.6%	88.4%
Worst	82.2%	82.6%	82.6%	82.3%	82.6%

Q7c
I am able to deliver the care I aspire to



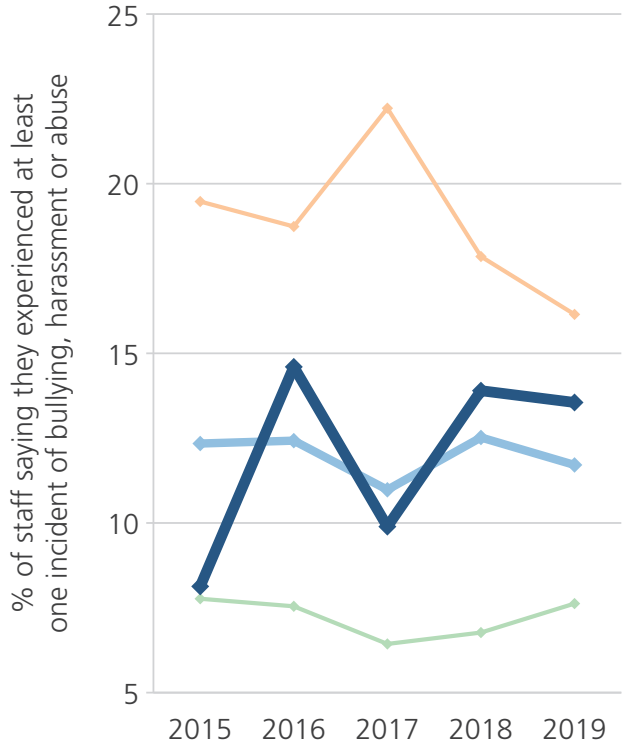
	2015	2016	2017	2018	2019
Best	73.9%	73.2%	74.0%	76.5%	75.7%
Your org	72.3%	63.1%	64.7%	63.7%	63.4%
Average	63.0%	64.0%	63.5%	63.7%	65.8%
Worst	46.4%	51.8%	49.8%	51.1%	54.3%

Q13a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



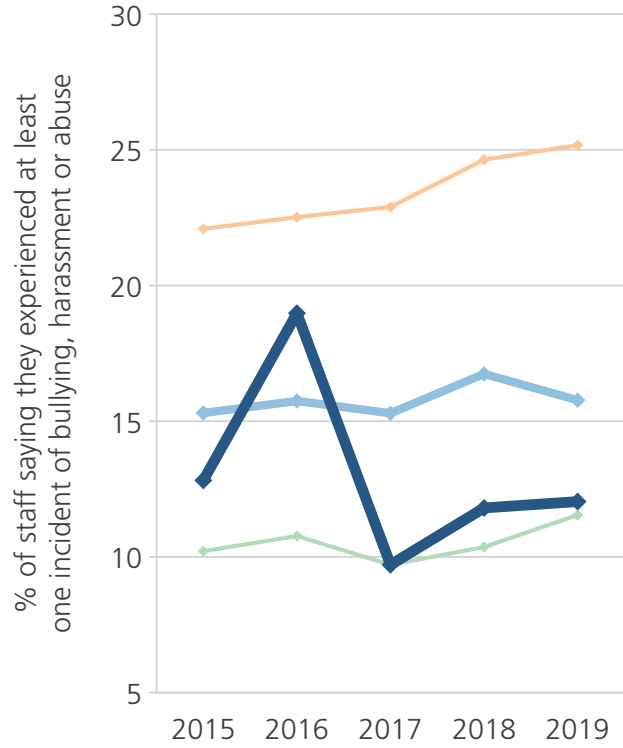
	2015	2016	2017	2018	2019
Worst	40.4%	48.2%	38.1%	40.6%	43.8%
Your org	20.1%	24.1%	22.0%	24.2%	25.8%
Average	33.3%	32.6%	32.3%	31.6%	33.0%
Best	20.1%	24.1%	22.0%	24.2%	25.8%

Q13b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2015	2016	2017	2018	2019
Worst	19.5%	18.7%	22.2%	17.9%	16.1%
Your org	8.1%	14.6%	9.9%	13.9%	13.6%
Average	12.3%	12.4%	11.0%	12.5%	11.7%
Best	7.8%	7.5%	6.4%	6.8%	7.6%

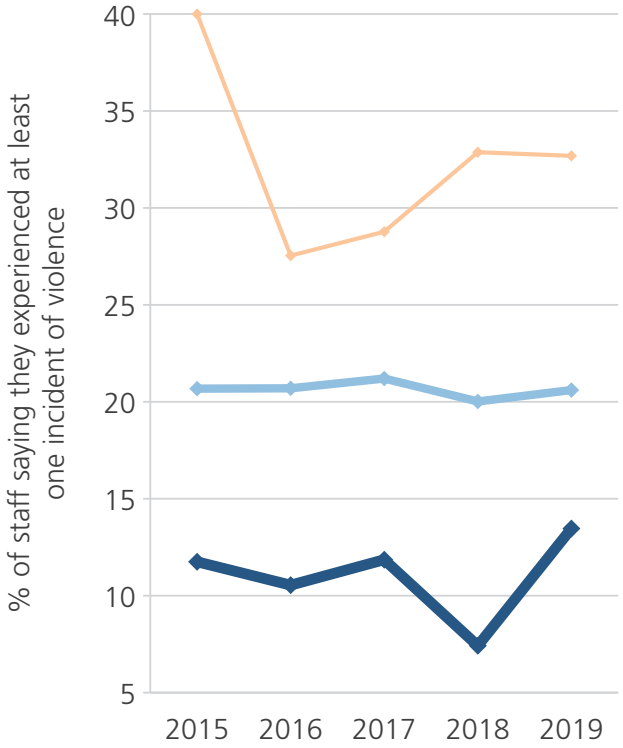
Q13c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2015	2016	2017	2018	2019
Worst	22.1%	22.5%	22.9%	24.6%	25.2%
Your org	12.8%	19.0%	9.7%	11.8%	12.0%
Average	15.3%	15.7%	15.3%	16.7%	15.8%
Best	10.2%	10.8%	9.7%	10.4%	11.5%

Q12a

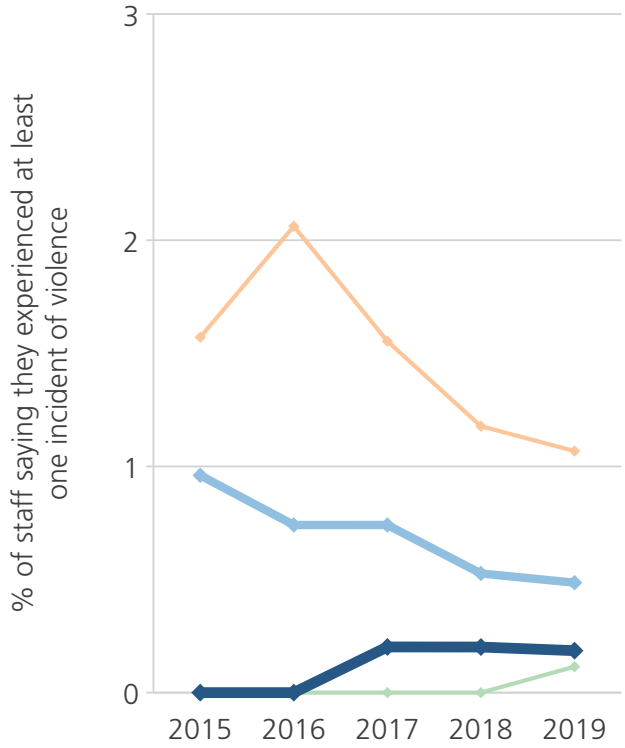
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



	2015	2016	2017	2018	2019
Worst	40.0%	27.5%	28.8%	32.9%	32.7%
Your org	11.7%	10.5%	11.9%	7.4%	13.5%
Average	20.7%	20.7%	21.2%	20.0%	20.6%
Best	11.7%	10.5%	11.9%	7.4%	13.5%

Q12b

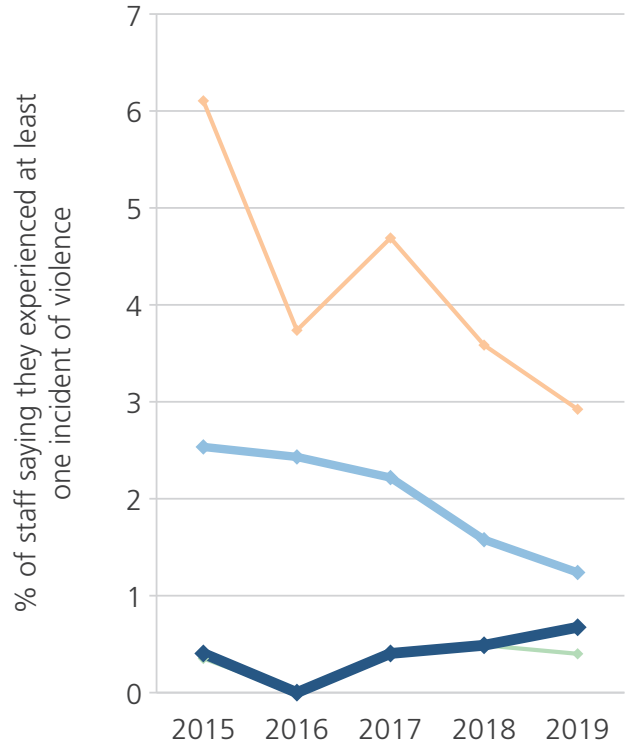
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2015	2016	2017	2018	2019
Worst	1.6%	2.1%	1.6%	1.2%	1.1%
Your org	0.0%	0.0%	0.2%	0.2%	0.2%
Average	1.0%	0.7%	0.7%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.1%

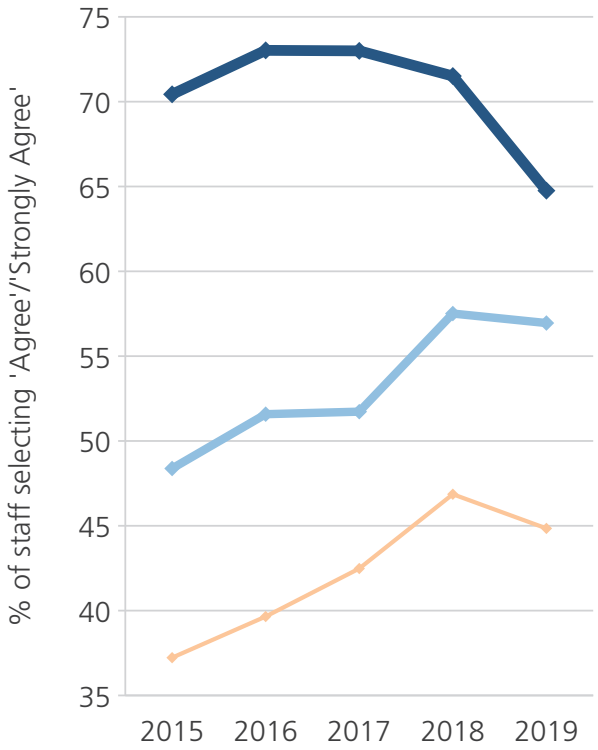
Q12c

In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



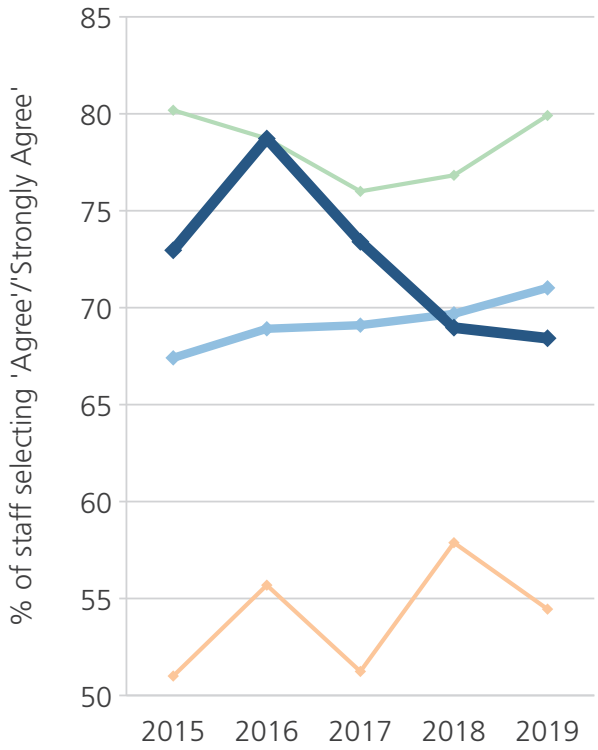
	2015	2016	2017	2018	2019
Worst	6.1%	3.7%	4.7%	3.6%	2.9%
Your org	0.4%	0.0%	0.4%	0.5%	0.7%
Average	2.5%	2.4%	2.2%	1.6%	1.2%
Best	0.4%	0.0%	0.4%	0.5%	0.4%

Q17a
My organisation treats staff who are involved in an error, near miss or incident fairly



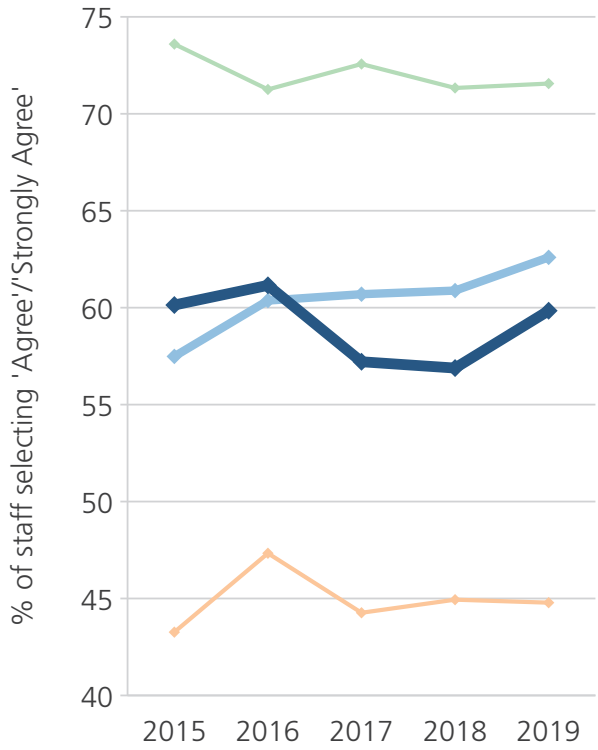
	2015	2016	2017	2018	2019
Best	70.4%	73.0%	73.0%	71.5%	64.8%
Your org	70.4%	73.0%	73.0%	71.5%	64.8%
Average	48.4%	51.6%	51.7%	57.5%	57.0%
Worst	37.2%	39.7%	42.5%	46.9%	44.8%

Q17c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



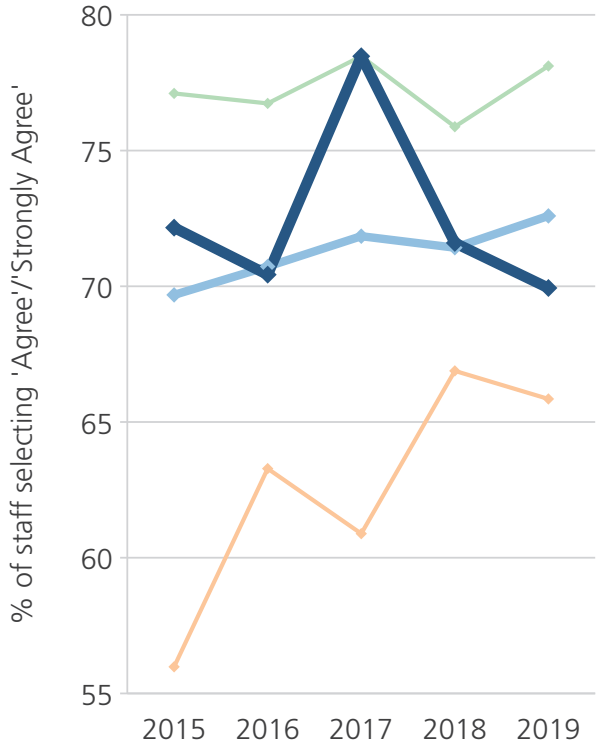
	2015	2016	2017	2018	2019
Best	80.2%	78.7%	76.0%	76.8%	79.9%
Your org	73.0%	78.7%	73.4%	69.0%	68.4%
Average	67.4%	68.9%	69.1%	69.7%	71.0%
Worst	51.0%	55.7%	51.2%	57.9%	54.5%

Q17d
We are given feedback about changes made in response to reported errors, near misses and incidents



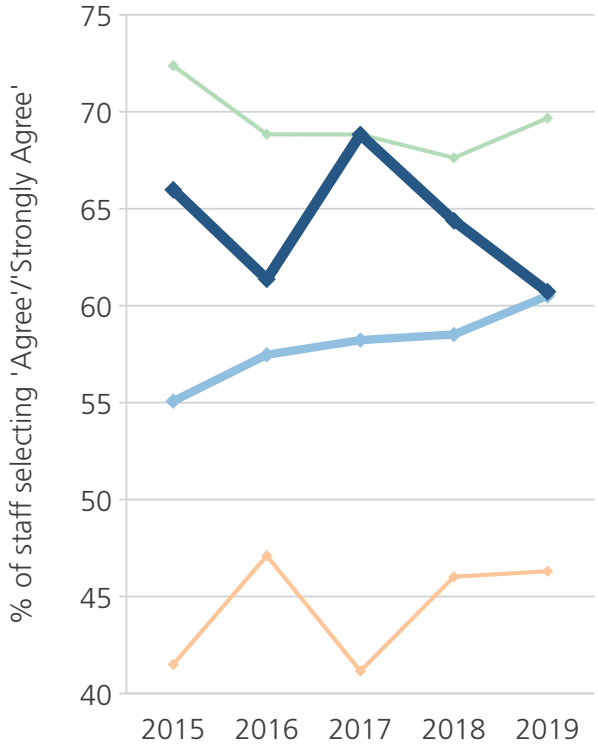
	2015	2016	2017	2018	2019
Best	73.6%	71.3%	72.6%	71.3%	71.6%
Your org	60.1%	61.2%	57.2%	56.9%	59.8%
Average	57.5%	60.4%	60.7%	60.9%	62.6%
Worst	43.3%	47.3%	44.3%	44.9%	44.8%

Q18b
I would feel secure raising concerns about unsafe clinical practice



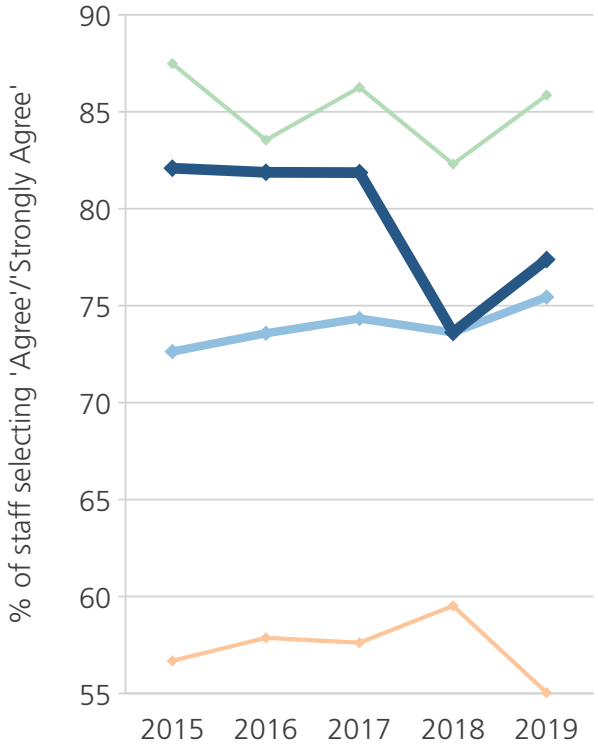
	2015	2016	2017	2018	2019
Best	77.1%	76.7%	78.5%	75.9%	78.1%
Your org	72.2%	70.4%	78.5%	71.6%	69.9%
Average	69.7%	70.7%	71.8%	71.4%	72.6%
Worst	56.0%	63.3%	60.9%	66.9%	65.8%

Q18c
I am confident that my organisation would address my concern



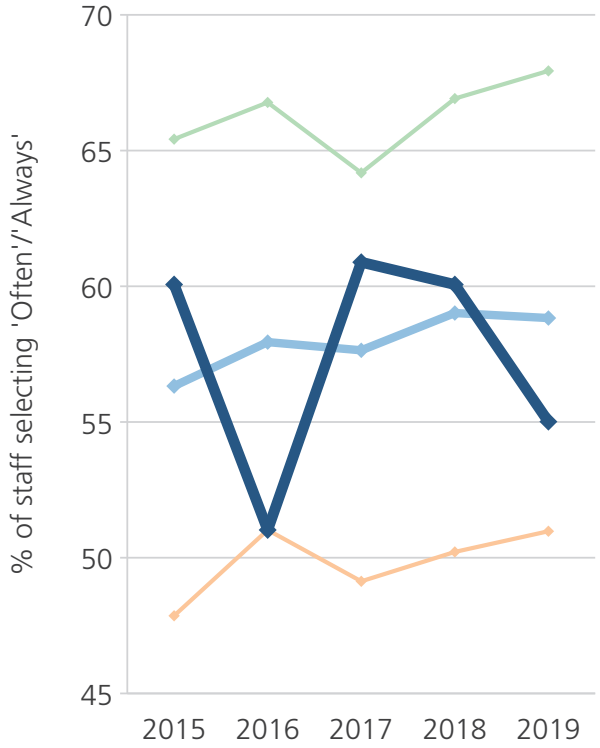
	2015	2016	2017	2018	2019
Best	72.4%	68.8%	68.8%	67.6%	69.7%
Your org	66.0%	61.4%	68.8%	64.4%	60.7%
Average	55.1%	57.5%	58.2%	58.5%	60.5%
Worst	41.5%	47.1%	41.2%	46.0%	46.3%

Q21b
My organisation acts on concerns raised by patients / service users



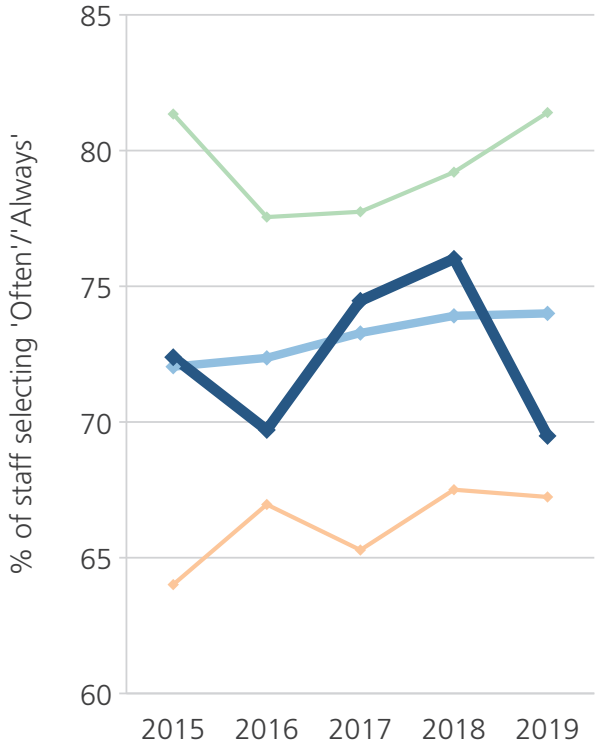
	2015	2016	2017	2018	2019
Best	87.5%	83.5%	86.3%	82.3%	85.9%
Your org	82.1%	81.9%	81.9%	73.6%	77.4%
Average	72.6%	73.6%	74.3%	73.6%	75.4%
Worst	56.7%	57.9%	57.6%	59.5%	55.0%

Q2a
I look forward to going to work



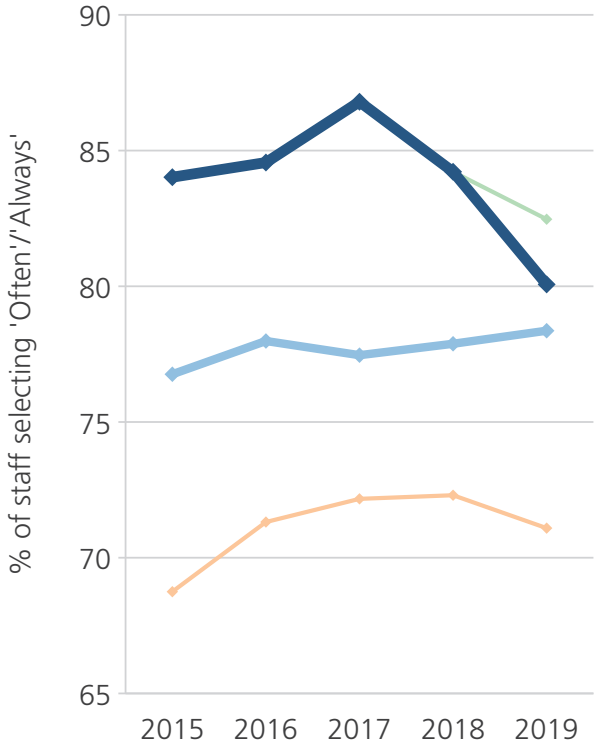
	2015	2016	2017	2018	2019
Best	65.4%	66.8%	64.2%	66.9%	67.9%
Your org	60.1%	51.0%	60.9%	60.1%	55.0%
Average	56.3%	57.9%	57.6%	59.0%	58.8%
Worst	47.9%	51.0%	49.1%	50.2%	51.0%

Q2b
I am enthusiastic about my job



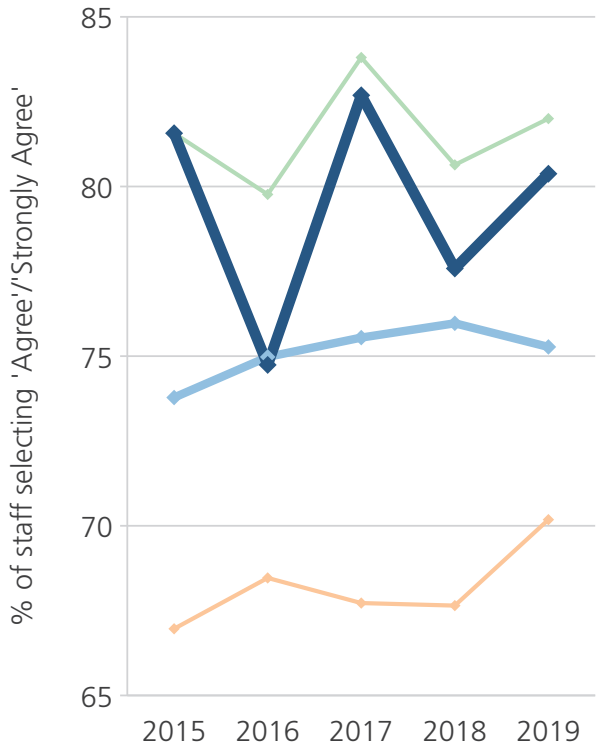
	2015	2016	2017	2018	2019
Best	81.3%	77.5%	77.7%	79.2%	81.4%
Your org	72.4%	69.7%	74.5%	76.0%	69.5%
Average	72.0%	72.4%	73.3%	73.9%	74.0%
Worst	64.0%	67.0%	65.3%	67.5%	67.2%

Q2c
Time passes quickly when I am working



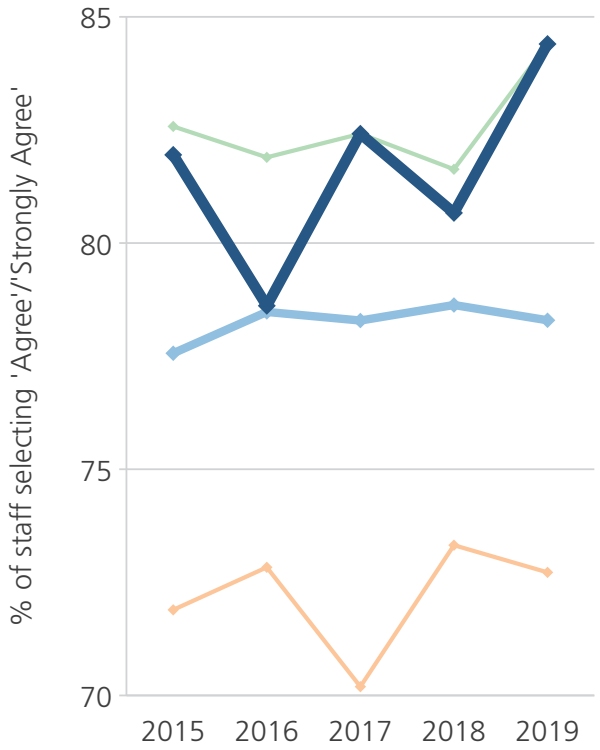
	2015	2016	2017	2018	2019
Best	84.0%	84.6%	86.8%	84.2%	82.5%
Your org	84.0%	84.6%	86.8%	84.2%	80.1%
Average	76.8%	78.0%	77.5%	77.9%	78.4%
Worst	68.7%	71.3%	72.2%	72.3%	71.1%

Q4a
There are frequent opportunities for me to show initiative in my role



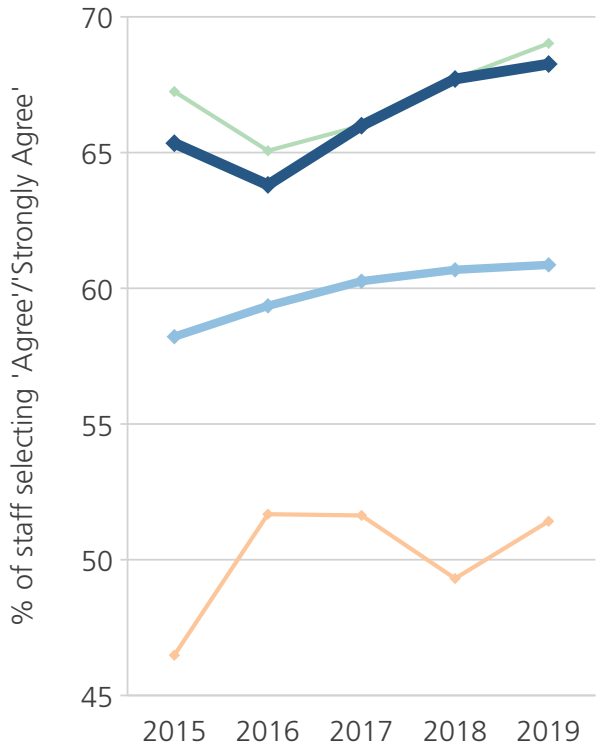
	2015	2016	2017	2018	2019
Best	81.6%	79.8%	83.8%	80.6%	82.0%
Your org	81.6%	74.7%	82.7%	77.6%	80.4%
Average	73.8%	75.0%	75.5%	76.0%	75.3%
Worst	67.0%	68.5%	67.7%	67.6%	70.2%

Q4b
I am able to make suggestions to improve the work of my team / department



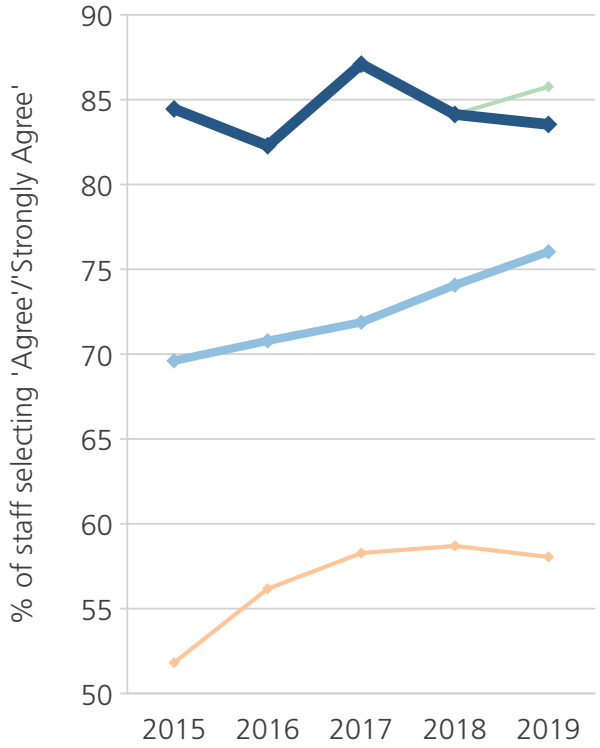
	2015	2016	2017	2018	2019
Best	82.6%	81.9%	82.4%	81.6%	84.4%
Your org	81.9%	78.6%	82.4%	80.7%	84.4%
Average	77.6%	78.5%	78.3%	78.6%	78.3%
Worst	71.9%	72.8%	70.2%	73.3%	72.7%

Q4d
I am able to make improvements happen in my area of work



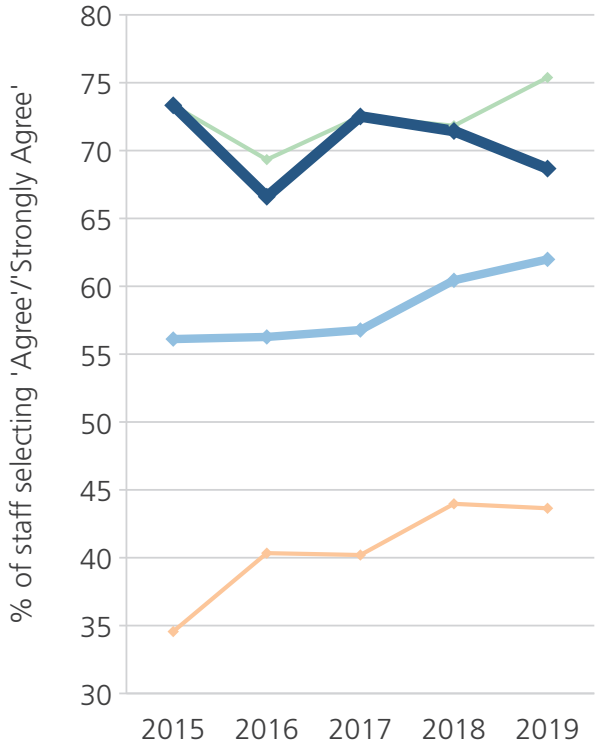
	2015	2016	2017	2018	2019
Best	67.2%	65.1%	66.0%	67.7%	69.0%
Your org	65.3%	63.8%	66.0%	67.7%	68.3%
Average	58.2%	59.4%	60.3%	60.7%	60.9%
Worst	46.5%	51.7%	51.6%	49.3%	51.4%

Q21a
Care of patients / service users is my organisation's top priority



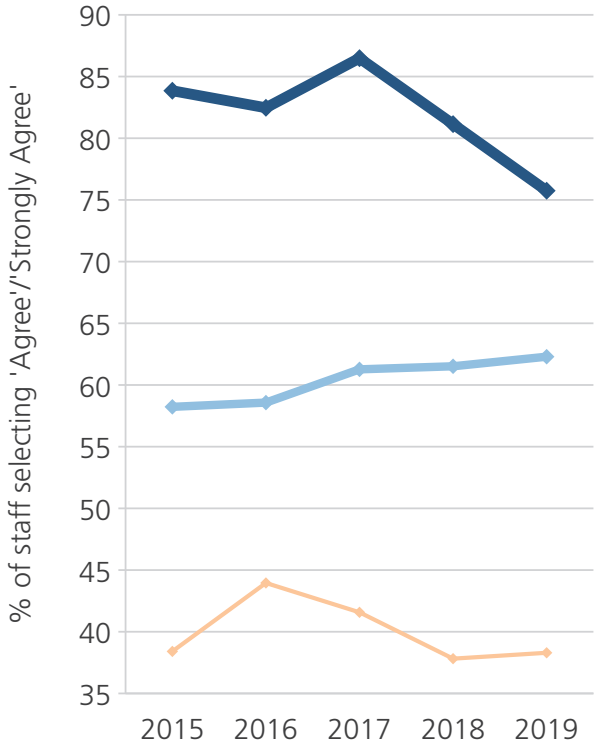
	2015	2016	2017	2018	2019
Best	84.5%	82.3%	87.1%	84.1%	85.8%
Your org	84.5%	82.3%	87.1%	84.1%	83.5%
Average	69.6%	70.8%	71.9%	74.1%	76.0%
Worst	51.8%	56.2%	58.3%	58.7%	58.0%

Q21c
I would recommend my organisation as a place to work



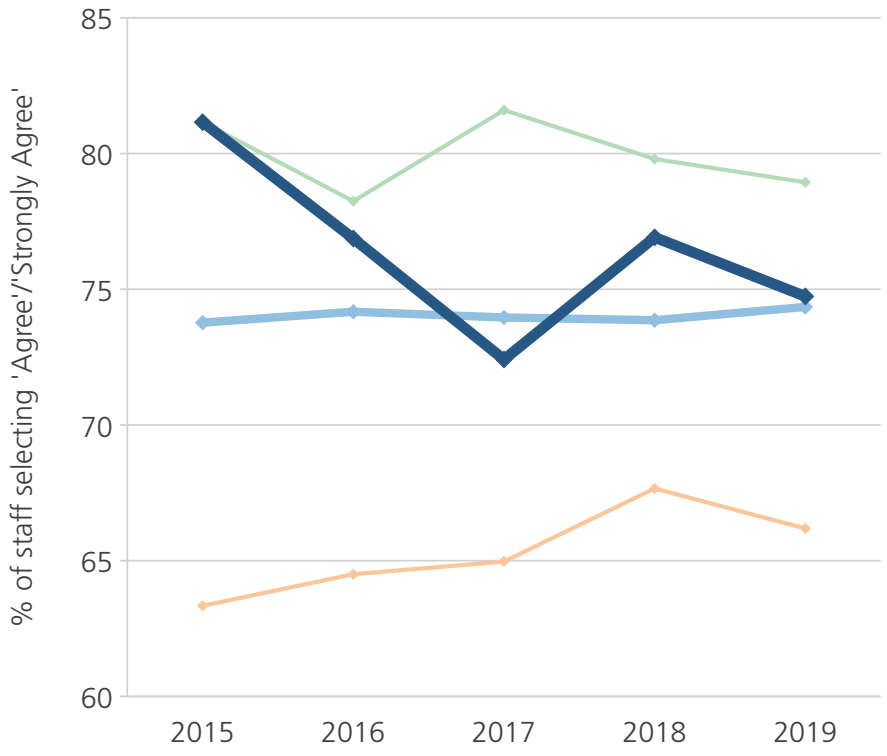
	2015	2016	2017	2018	2019
Best	73.3%	69.3%	72.5%	71.8%	75.4%
Your org	73.3%	66.6%	72.5%	71.4%	68.7%
Average	56.1%	56.3%	56.8%	60.4%	62.0%
Worst	34.6%	40.3%	40.2%	44.0%	43.6%

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



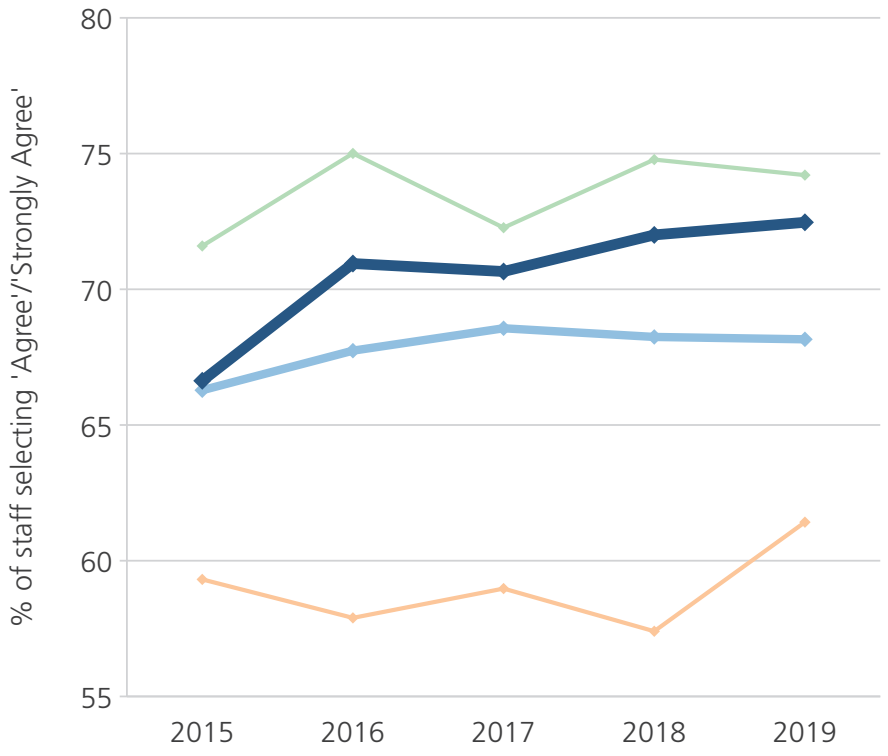
	2015	2016	2017	2018	2019
Best	83.8%	82.5%	86.5%	81.1%	75.7%
Your org	83.8%	82.5%	86.5%	81.1%	75.7%
Average	58.2%	58.6%	61.3%	61.5%	62.3%
Worst	38.4%	44.0%	41.6%	37.8%	38.3%

Q4h
The team I work in has a set of shared objectives



	2015	2016	2017	2018	2019
Best	81.2%	78.2%	81.6%	79.8%	78.9%
Your org	81.2%	76.9%	72.4%	76.9%	74.7%
Average	73.8%	74.2%	74.0%	73.9%	74.4%
Worst	63.3%	64.5%	65.0%	67.7%	66.2%

Q4i
The team I work in often meets to discuss the team's effectiveness



	2015	2016	2017	2018	2019
Best	71.6%	75.0%	72.3%	74.8%	74.2%
Your org	66.6%	70.9%	70.7%	72.0%	72.5%
Average	66.3%	67.7%	68.6%	68.2%	68.2%
Worst	59.3%	57.9%	59.0%	57.4%	61.4%

Survey Coordination Centre

NHS England

Workforce Equality Standards

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results

Workforce Equality Standards

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13, and q14 split by disabled staff compared to non-disabled staff. It also shows results for q28b (for disabled staff only), and the staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

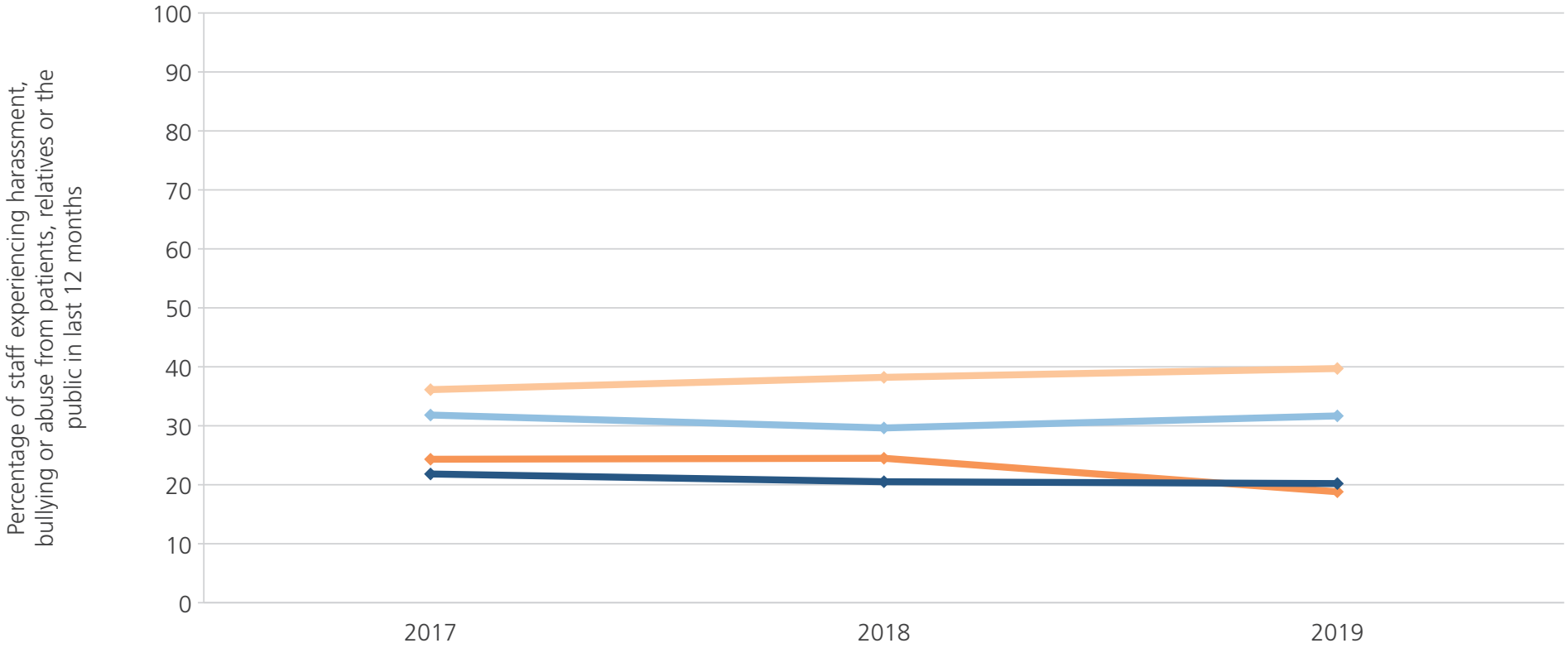
Survey Coordination Centre

NHS England

Workforce Race Equality Standard (WRES)

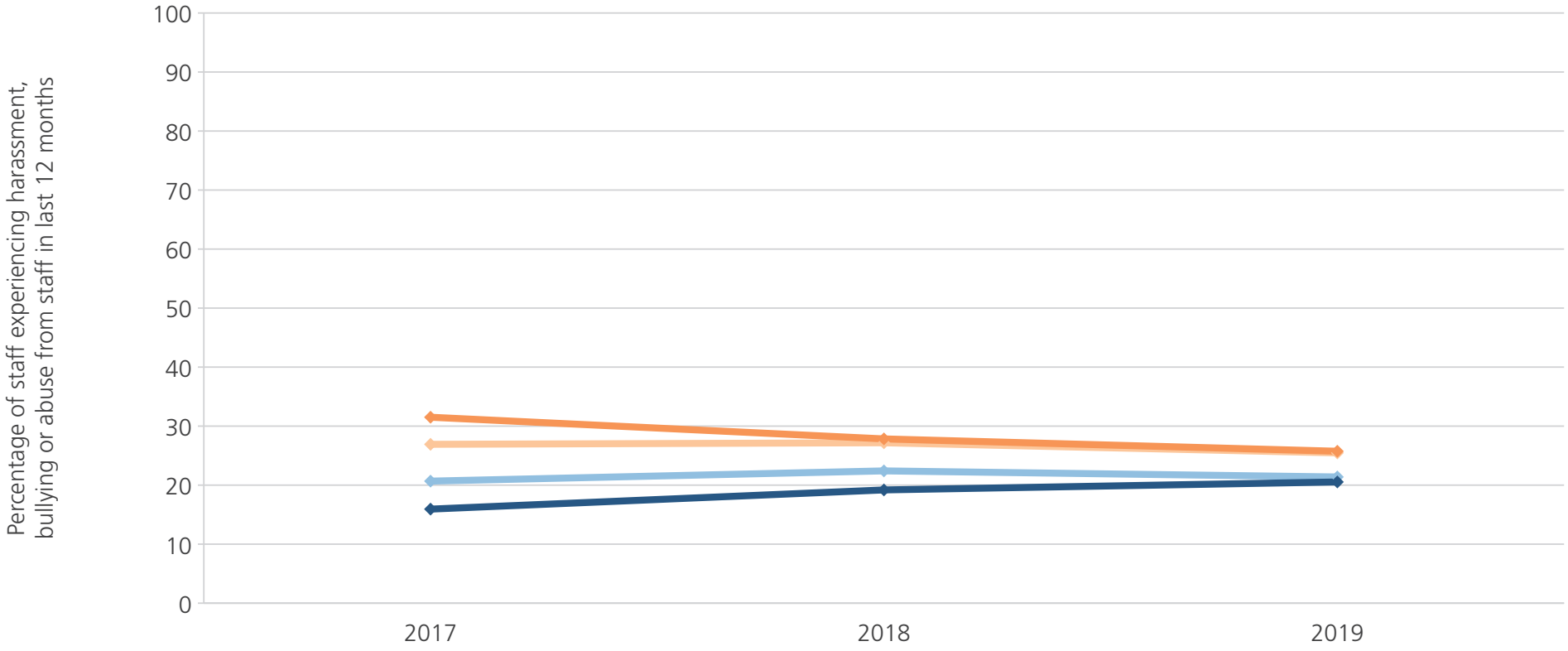
Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results



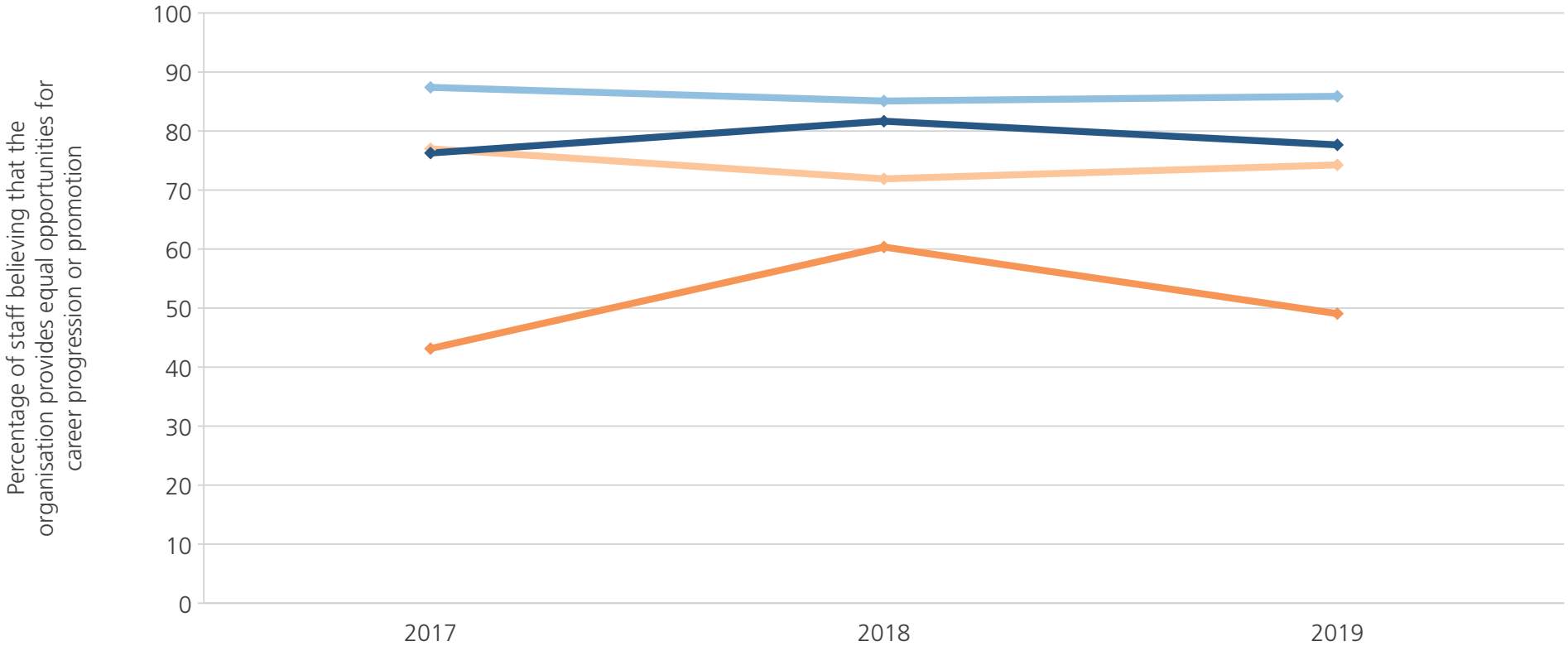
	2017	2018	2019
White: Your org	21.8%	20.5%	20.2%
BME: Your org	24.3%	24.5%	18.8%
White: Average	31.8%	29.6%	31.7%
BME: Average	36.1%	38.2%	39.7%
White: Responses	252	273	297
BME: Responses	74	98	101

Average calculated as the median for the benchmark group



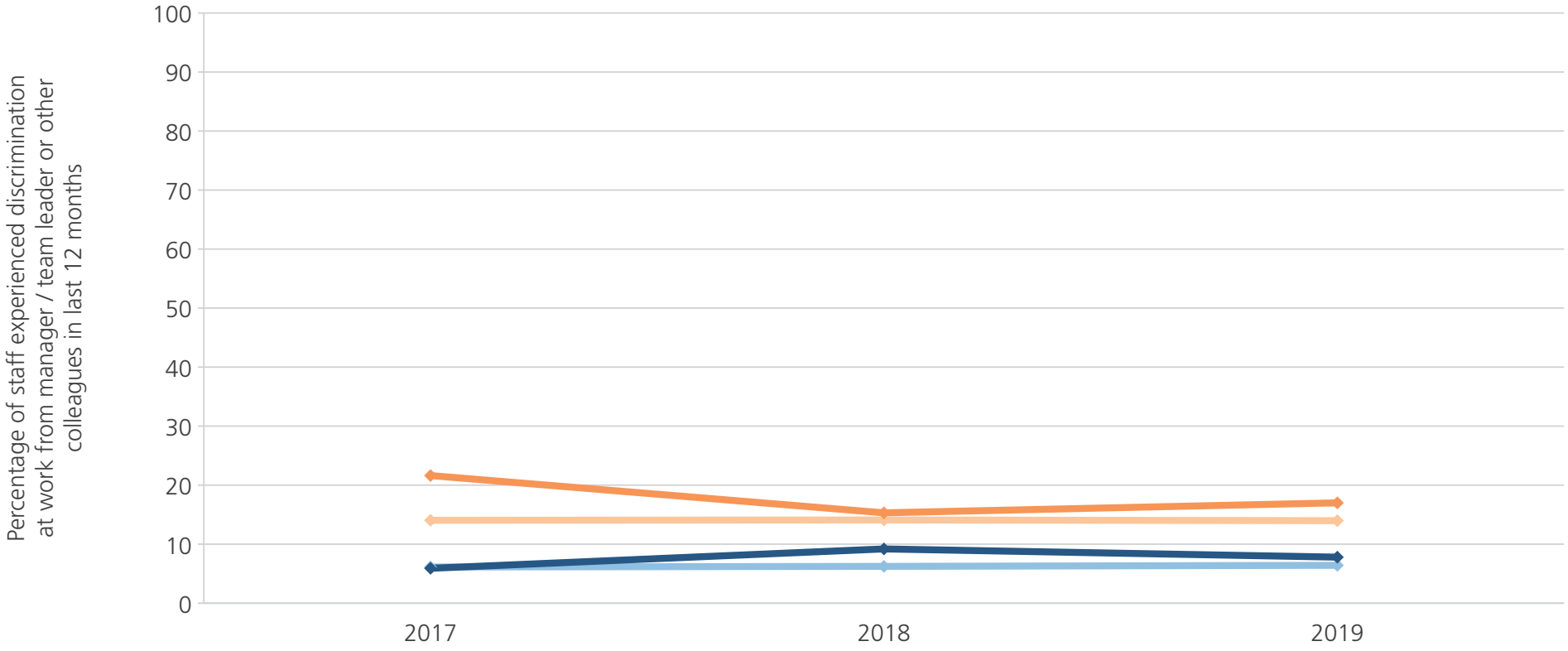
	2017	2018	2019
White: Your org	15.9%	19.2%	20.5%
BME: Your org	31.5%	27.8%	25.7%
White: Average	20.7%	22.4%	21.4%
BME: Average	26.9%	27.2%	25.5%
White: Responses	251	271	297
BME: Responses	73	97	101

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	76.3%	81.7%	77.7%
BME: Your org	43.1%	60.3%	49.1%
White: Average	87.4%	85.1%	85.9%
BME: Average	77.0%	71.9%	74.3%
White: Responses	177	180	179
BME: Responses	51	58	53

Average calculated as the median for the benchmark group



	2017	2018	2019
White: Your org	5.9%	9.2%	7.8%
BME: Your org	21.6%	15.3%	17.0%
White: Average	6.1%	6.2%	6.4%
BME: Average	14.0%	14.1%	14.0%
White: Responses	254	272	295
BME: Responses	74	98	100

Average calculated as the median for the benchmark group

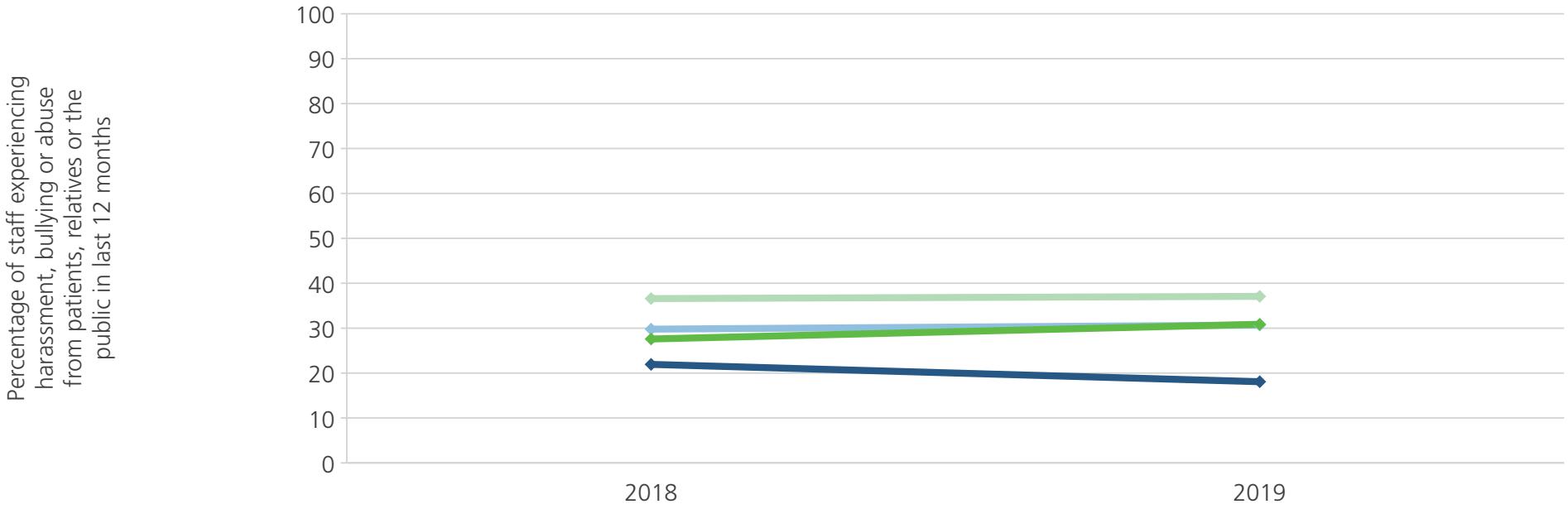
Survey Coordination Centre

NHS England

Workforce Disability Equality Standard (WDES)

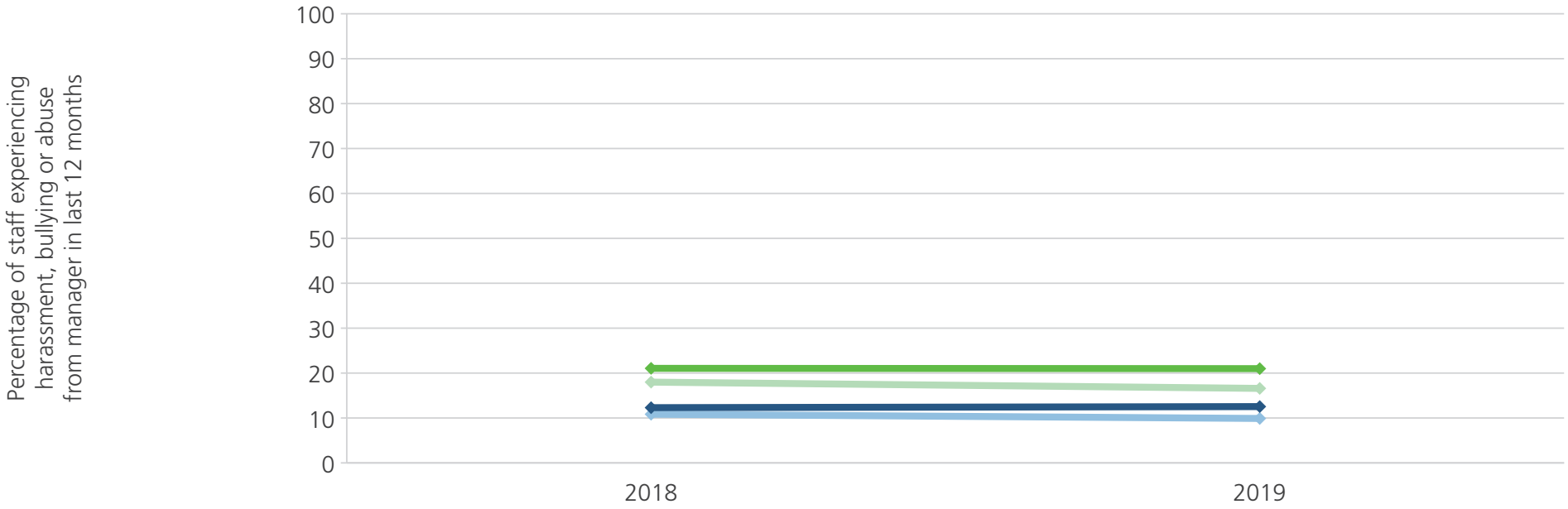
Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results



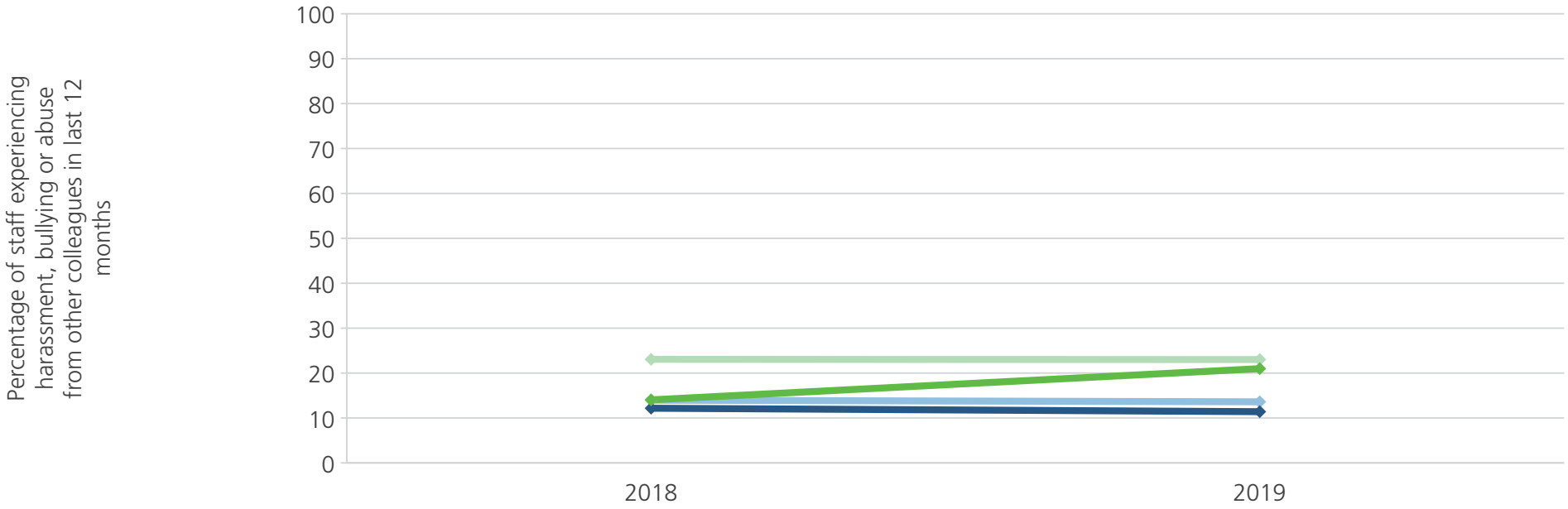
	2018	2019
Disabled staff: Your org	27.6%	30.9%
Non-disabled staff: Your org	21.9%	18.1%
Disabled staff: Average	36.6%	37.1%
Non-disabled staff: Average	29.8%	30.7%
Disabled staff: Responses	58	81
Non-disabled staff: Responses	310	343

Average calculated as the median for the benchmark group



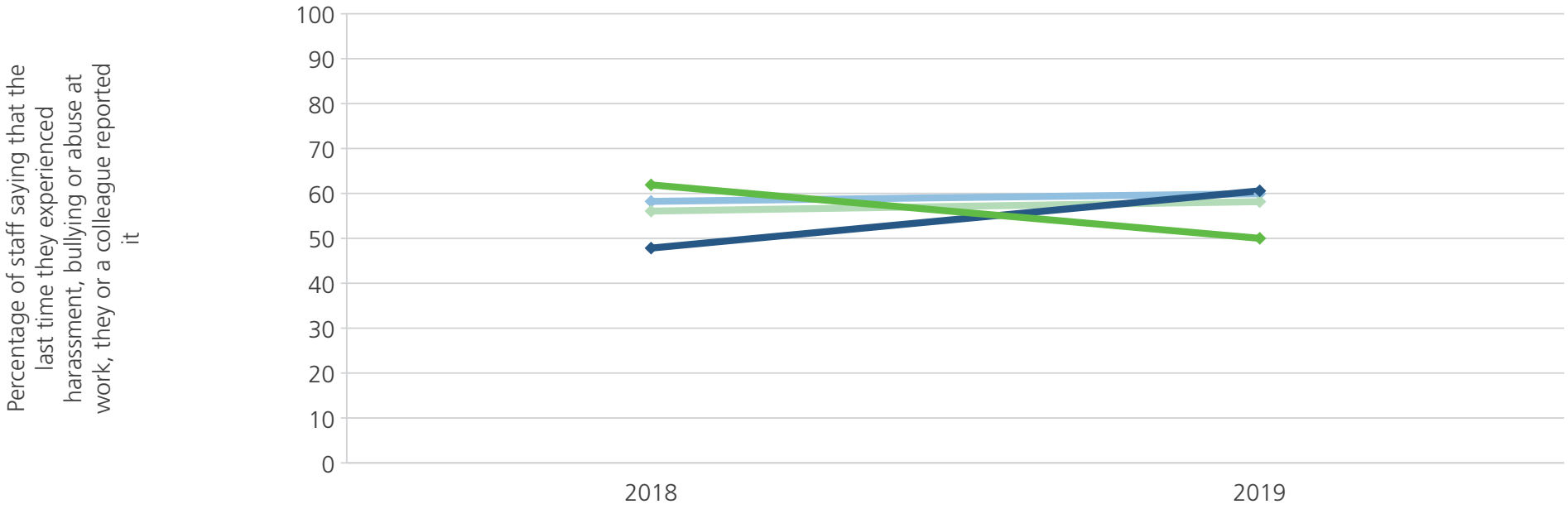
Disabled staff: Your org	21.1%	21.0%
Non-disabled staff: Your org	12.3%	12.5%
Disabled staff: Average	18.0%	16.6%
Non-disabled staff: Average	10.8%	9.9%
Disabled staff: Responses	57	81
Non-disabled staff: Responses	309	343

Average calculated as the median for the benchmark group



Disabled staff: Your org	14.0%	21.0%
Non-disabled staff: Your org	12.2%	11.4%
Disabled staff: Average	23.1%	23.0%
Non-disabled staff: Average	14.0%	13.6%
Disabled staff: Responses	57	81
Non-disabled staff: Responses	304	342

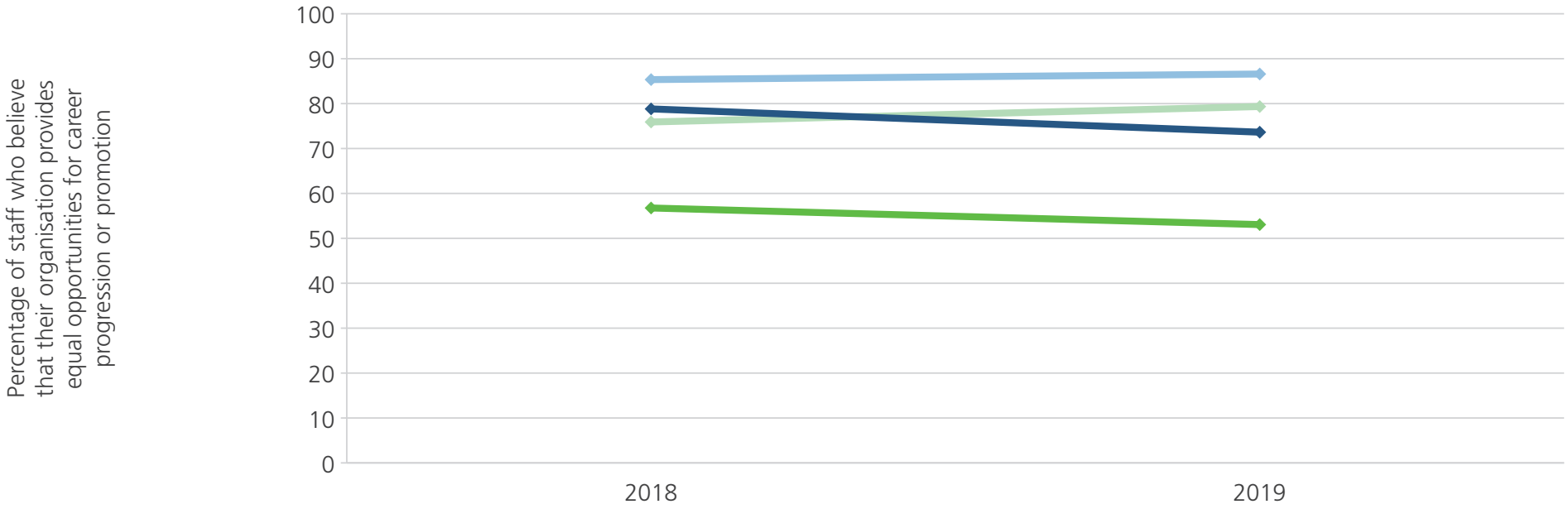
Average calculated as the median for the benchmark group



Disabled staff: Your org	61.9%	50.0%
Non-disabled staff: Your org	47.8%	60.6%
Disabled staff: Average	56.1%	58.2%
Non-disabled staff: Average	58.2%	59.9%

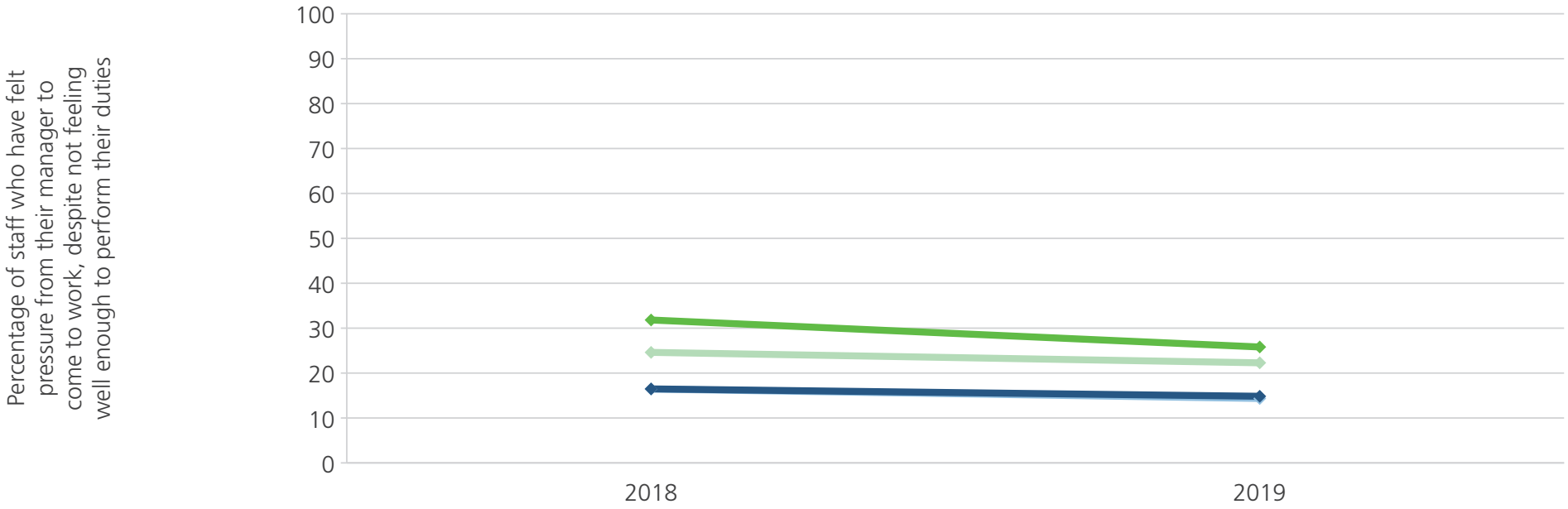
Disabled staff: Responses	21	36
Non-disabled staff: Responses	92	104

Average calculated as the median for the benchmark group



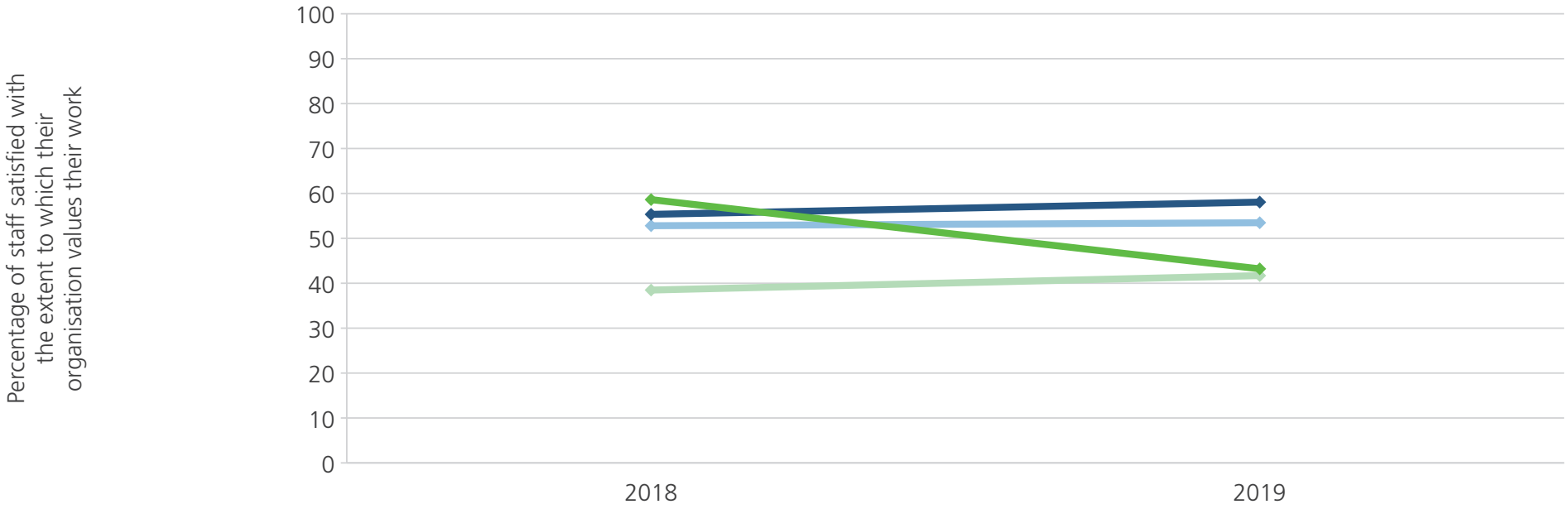
	2018	2019
Disabled staff: Your org	56.8%	53.1%
Non-disabled staff: Your org	78.8%	73.6%
Disabled staff: Average	75.9%	79.3%
Non-disabled staff: Average	85.3%	86.6%
Disabled staff: Responses	37	49
Non-disabled staff: Responses	203	201

Average calculated as the median for the benchmark group



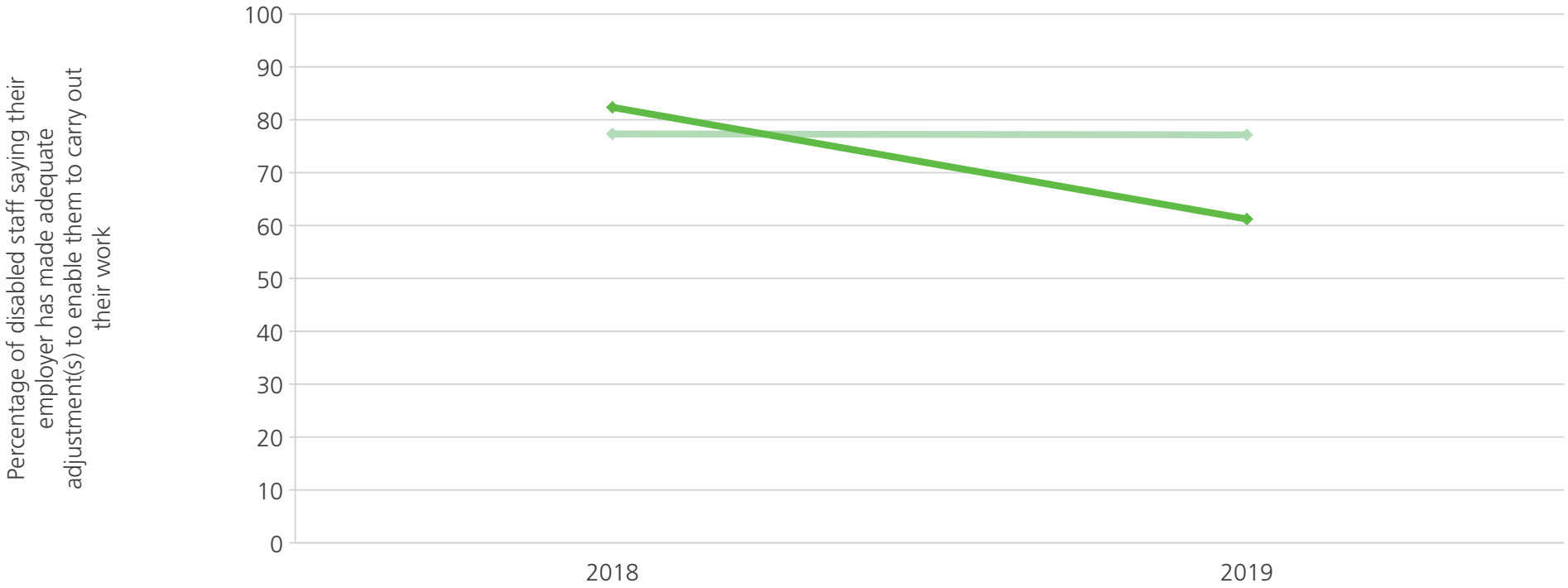
Disabled staff: Your org	31.8%	25.8%
Non-disabled staff: Your org	16.5%	14.8%
Disabled staff: Average	24.6%	22.3%
Non-disabled staff: Average	16.4%	14.3%
Disabled staff: Responses	44	62
Non-disabled staff: Responses	176	182

Average calculated as the median for the benchmark group



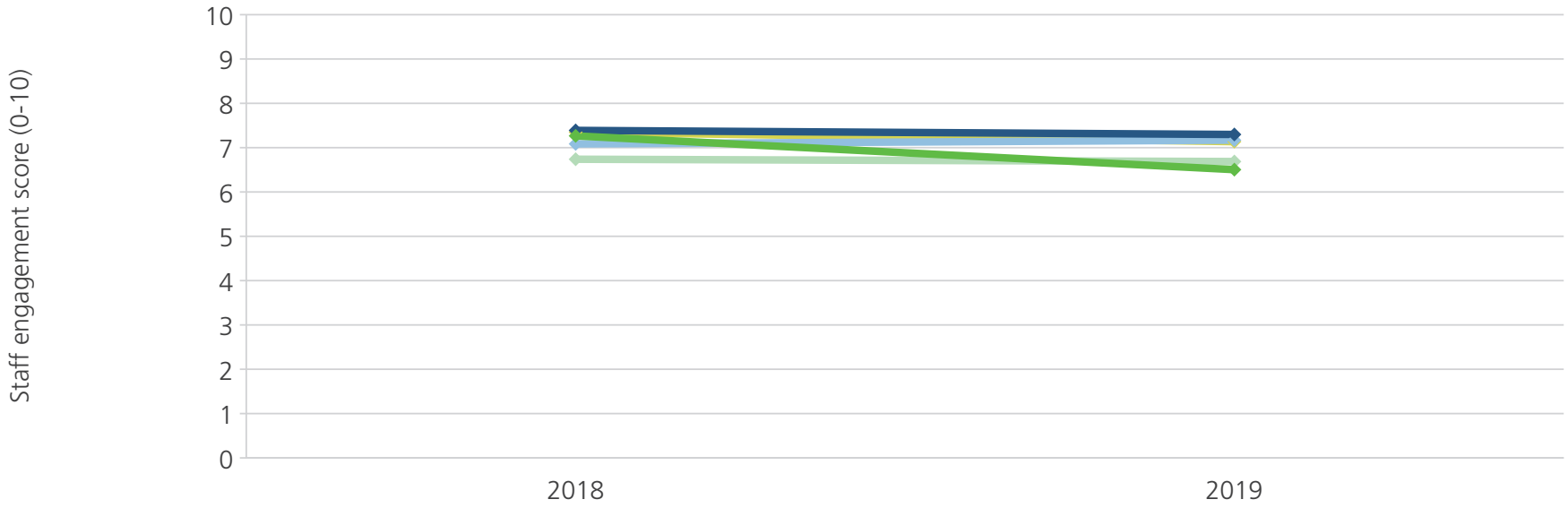
	2018	2019
Disabled staff: Your org	58.6%	43.2%
Non-disabled staff: Your org	55.3%	58.1%
Disabled staff: Average	38.5%	41.7%
Non-disabled staff: Average	52.8%	53.5%
Disabled staff: Responses	58	81
Non-disabled staff: Responses	309	341

Average calculated as the median for the benchmark group



Disabled staff: Your org	82.4%	61.2%
Disabled staff: Average	77.3%	77.1%
Disabled staff: Responses	34	49

Average calculated as the median for the benchmark group



Organisation average	7.3	7.1
Disabled staff: Your org	7.3	6.5
Non-disabled staff: Your org	7.4	7.3
Disabled staff: Average	6.7	6.7
Non-disabled staff: Average	7.1	7.2

Organisation Responses	384	439
Disabled staff: Responses	58	80
Non-disabled staff: Responses	310	342

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS England

Appendices

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results

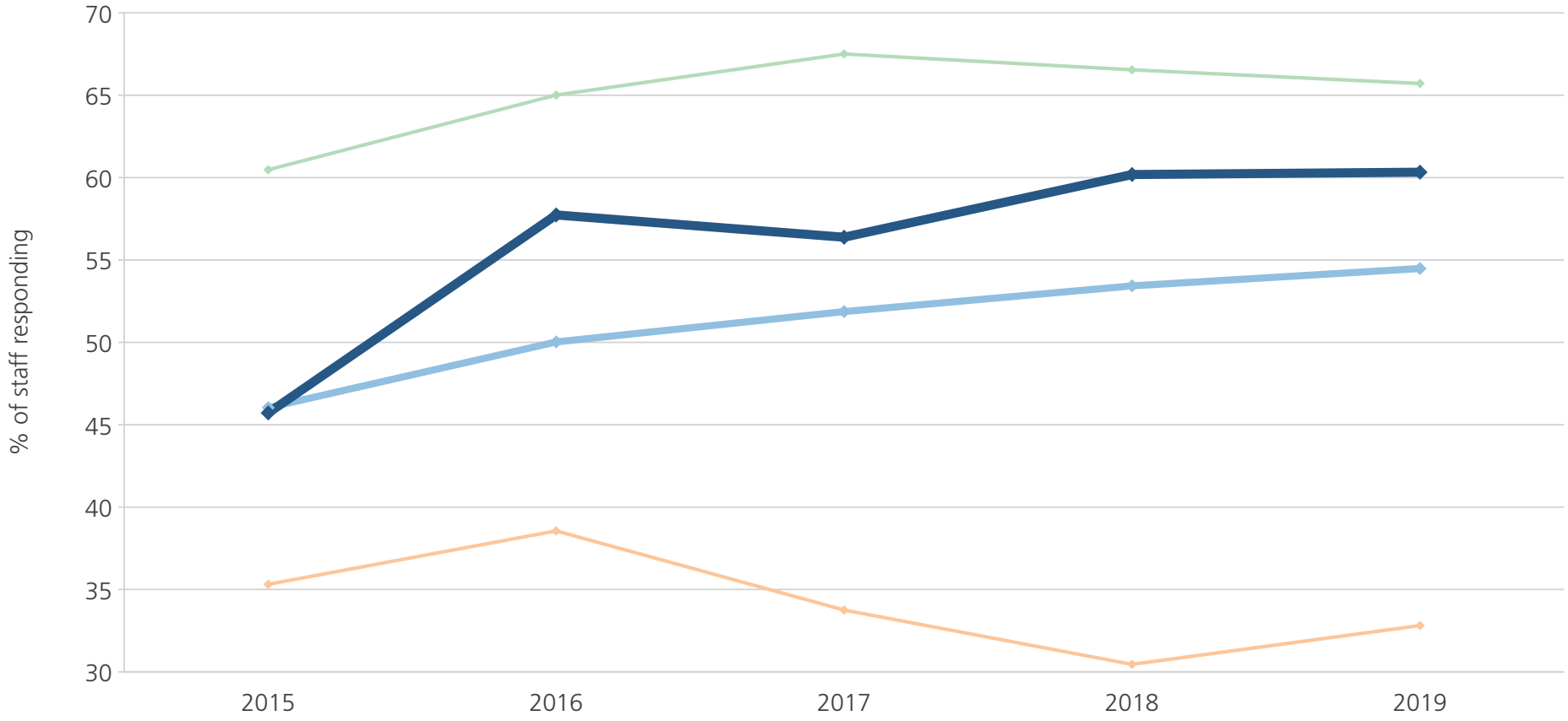
Survey Coordination Centre

NHS England

Appendix A: Response rate

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results



	2015	2016	2017	2018	2019
Best	60.5%	65.0%	67.5%	66.5%	65.7%
Your org	45.7%	57.7%	56.4%	60.2%	60.3%
Median	46.0%	50.0%	51.9%	53.4%	54.5%
Worst	35.3%	38.6%	33.8%	30.5%	32.8%

Survey Coordination Centre

NHS England

Appendix B: Significance testing - 2018 v 2019 theme results

Tavistock and Portman NHS Foundation Trust

2019 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2019 score is significantly higher than last year's, whereas ↓ indicates that the 2019 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.6**	382	**8.7**	428	Not significant
Health & wellbeing	**5.9**	381	**5.8**	434	Not significant
Immediate managers	**7.1**	379	**7.1**	435	Not significant
Morale	**6.3**	379	**6.2**	423	Not significant
Quality of appraisals	**5.6**	355	**5.8**	392	Not significant
Quality of care	**7.1**	304	**7.4**	343	Not significant
Safe environment - Bullying & harassment	**8.3**	379	**8.3**	432	Not significant
Safe environment - Violence	**9.7**	382	**9.5**	430	Not significant
Safety culture	**6.9**	382	**6.9**	427	Not significant
Staff engagement	**7.5**	384	**7.3**	439	Not significant
Team working	**7.0**	381	**7.2**	434	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Trust Board	31/03/2020

Quality Strategy

Executive Summary

The Trust's Quality Strategy was due a review, as the last clinical quality strategy covered 2017-19. There have since been many continuing improvements and growth in delivering quality improvement (QI) across the Trust.

This version of our quality strategy is a further story of growth and progress in the use of QI across the Trust.

We have successfully implemented various improvements to the QI structures and engagement with QI. We are doing a series of actions to deliver our annual objectives, as agreed in June 2019 with the CEO.

This paper sets out our strategy for embedding quality improvement, as an integral approach to developing high quality clinical services tailored to our patients needs in the context of a changing health and social care landscape.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Continue to deliver high quality clinical and educational services

Author	Responsible Executive Director
Dr Dinesh Sinha	Dr Dinesh Sinha, Medical Director and Director of Quality

Quality Strategy 2019-21

Quality Improvement at Tavistock & Portman NHS Foundation Trust

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PURPOSE

This version of our quality strategy is a further story of growth and progress in the use of QI across the Trust.

We have successfully implemented various improvements to the QI structures and engagement with QI. We are doing a series of actions to deliver our annual objectives agreed in June 2019 with the CEO.

This paper sets out our strategy for embedding quality improvement, as an integral approach to developing high quality clinical services tailored to our patients needs in the context of a changing health and social care landscape.

Introduction

The Trust has an excellent record of providing high quality care to a very diverse groups of patients, their carers and families. The quality improvement strategy has been developed through a process of discussion and consultation. Staff have been involved in developing a quality improvement approach, which is congruent with our reflective and contextually-aware approach to our work.

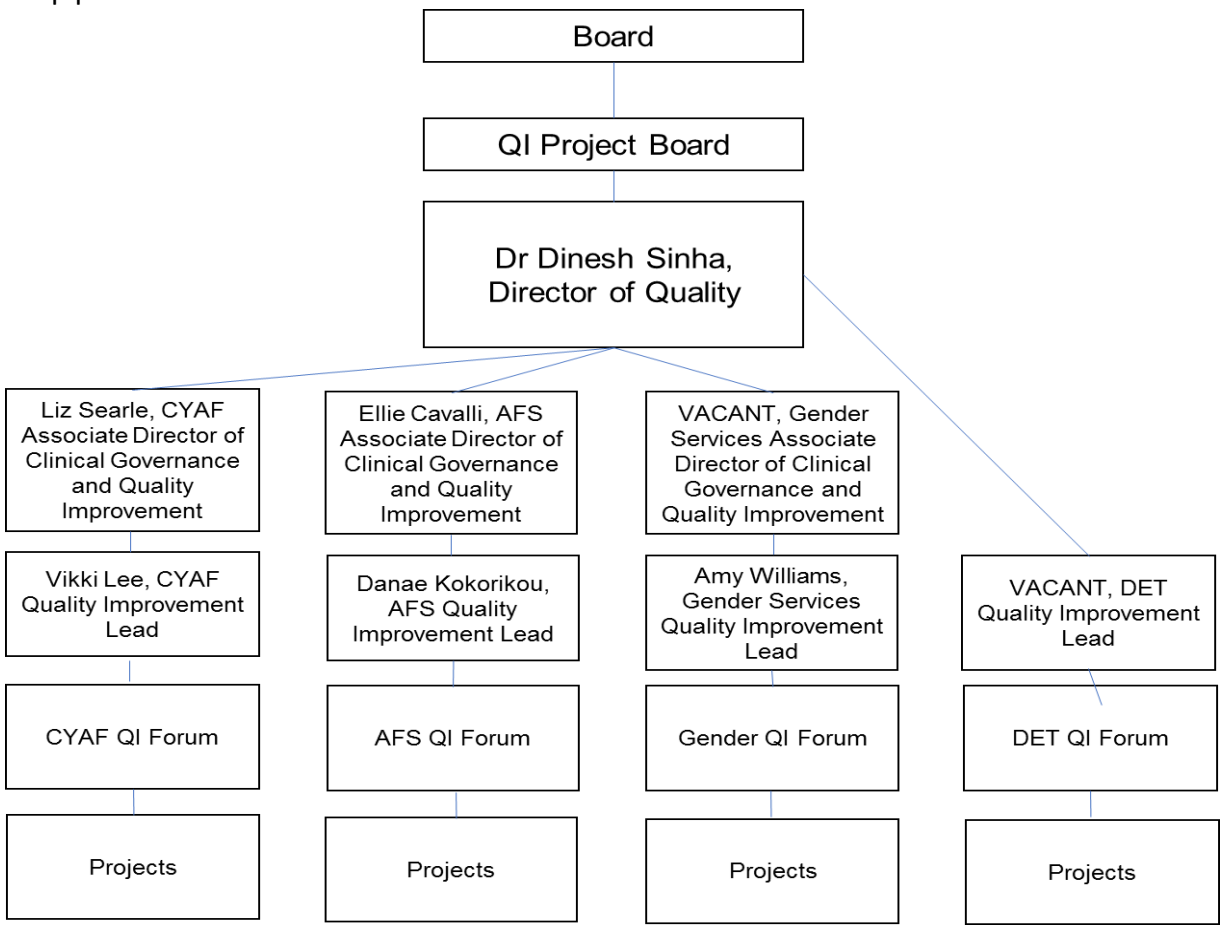
Quality Improvement (QI) at the Trust is focused on improving patient outcomes, system performance and professional development. At the heart of our approach is our strong commitment to improving patient experience and outcomes. We recognize the importance and centrality of an active culture of Quality Improvement (QI) activity within the organisation as a means to help achieve this.

The Director of Quality and the QI Group sets out to do this by supporting and encouraging teams and clinicians to use QI methodologies to identify improvement needs and address challenges and issues, linking practice, innovation and research.

DEVELOPING OUR APPROACH

We have addressed various themes of actions, including training, setting up structures to support QI across our divisions and finally tracking outcomes from ongoing projects. There was a relaunch of the QI intranet pages and there have been several events that have already happened from the annual calendar, which is live on the intranet page.

Trust Quality Improvement Support structure



EMBEDDING CLINICAL QUALITY IMPROVEMENT

Quality improvement needs to become further embedded and owned across the trust from the frontline staff to the Board. There have already been several improvements since the last report.

These include:

- The Quality Improvement (QI) Group meets 2 weekly and oversees the QI work across the Trust.

- A QI Board involving directors has been established and meets quarterly for strategic oversight.

- Board QI workshops have been held, including one delivered in partnership with MHSIP (Mental Health Safety Improvement Programme).

- The QI Board is involved with NHSI and the MHSIP to support us in developing a strong QI culture. Colleagues from NHSI challenged us to consider our QI priorities for the next two years and we have agreed objectives to take this work forward.

- Each of our clinical division now has a QI lead supported by an associate director for clinical governance and QI

- We have appointed an administrator to provide central support for QI work

- Each division has at least one active quality forum to support staff in their QI projects.

- QI Coaching training currently being delivered with a cohort of coaches being trained

- QI intranet page has been relaunched, which includes a staff QI handbook

- QI Events programme information has been collated for the heightening engagement

- We have also been embedding the use of both quantitative and qualitative methods of analysis and measurement of improvement, which will remain priorities for QI in the Trust.

MAKE BETTER USE OF DATA TO DRIVE IMPROVEMENT

- Continuing improvement of our skills and confidence in the use of quantitative and qualitative data through training and support from the Quality Improvement Group.

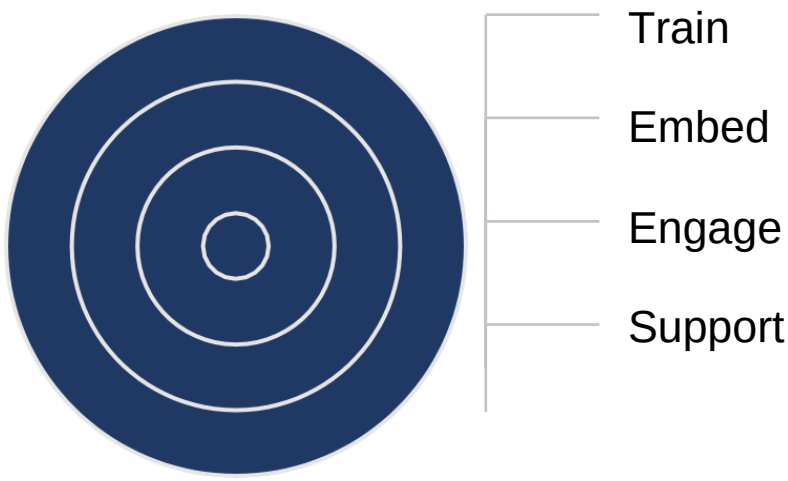
- Continue to develop our capacity to make data more accessible through the use of integrated information at Board, service and team levels. The Board has received specific training in using QI for the interpretation of data.

- Develop the capacity to track changes over time so as to test out the impact of any intervention aimed at improving quality. Run charts are commonly used for this purpose and most of our data in our quality dashboard presented at board is now presented in this format. This helps us to analyse trends rather than snapshots.

- The support of our Quality Assurance team is vital to taking this work forward. It therefore requires recognition of the impact of this additional work and a decision about the extent to which it can be supported given the Trust's range of priorities.

- We will continue to increase use of qualitative methods, including single case studies to help illuminate complex issues and inform analysis.

Objectives of Quality Improvement 2019-2020



Train	*Staff and patients are trained in Quality Improvement methodology*
Embed	*Quality Improvement is built into Trust Infrastructures*
Engage	*Calendar of events keeps everyone aware of QI developments*
Support	*Staff have places to take their ongoing development needs*

The Trust is committed to continually improving the quality and experience of care for patients and staff by fully embedding quality improvement (QI) in all its work.

The Director of Quality and the QI Group sets out to do this by supporting and encouraging teams and clinicians to use QI methodologies to identify improvement needs and address challenges and issues. The QI Group's objectives for 19/20 are:

1. To increase staff engagement in Quality Improvement
2. To evidence change and demonstrate measurable improvement
3. To increase patient engagement in Quality Improvement projects

BUILD OUR CAPACITY

Quality Improvement needs to become part of everyday work. We have a highly-motivated staff group who are uniformly caring and committed, as evidenced by our CQC report in 2018. This commitment, specialist skills and reflective practice are key to continuing to improve our clinical services.

However, we do have issues with the levels of activity that burden our staff, similar to other organisations across the NHS. Engagement in quality improvement work could be seen as another demand but in practice staff can find this work rewarding, stimulating and satisfying, especially when positive benefits can be realised. Hence, we plan to incentivise QI work in appraisal and job planning and have already offered time to staff who take up QI projects.

The Quality Improvement Group decided to adopt the Institute for Health Care Improvement model as a basic model with which to take forward the programme. This decision was based on the knowledge and experience of members of the Quality Improvement Group and an appraisal of the benefits or various models.

Across the Trust a number of staff have trained to use some common quality improvement tools e.g. driver diagrams, in order to analyse necessary steps to achieve impactful change. The development of further skills will be required.

Developing leadership and Support Structures for QI

We have secured funding for an appointed QI leads for all our divisions. We have also appointed Associate Directors for QI for each of our divisions.

There was a relaunch of the communications for QI with the internal communications objectives of:

- Achieving [a specific, agreed level of] visibility, frequency and consistency of QI messages and content in Trust internal communications channels to support the QI strategy.
- Developing clear, consistent messages about what QI is, why it is important, how it is being applied within the Trust and what needs to happen [what "you" need to do] in order to achieve the Trust's QI ambitions.
- Ensuring QI resources are of good enough quality (design, format and plain English) to support use and uptake by staff in the Trust.

Developing capability of staff

The approach to date has been to offer the training to staff who show an interest in developing their quality improvement skills.

We will soon have a whole tranche of QI coaches to support colleagues and service users in any projects. Our new QI coaches will take on the training needs of other staff for quality improvement work and will be key to supporting this implementation across the organisation.

PATIENT AND PUBLIC INVOLVEMENT

Our aim is to deliver services of the greatest benefit to our patients, their carers and families within the resources available. It is therefore essential that, in aspiring to improve our clinical services, we constantly check that that improvements match patients' needs and their wishes as to how services are delivered.

The Quality Improvement Group has a stable and active membership drawn from across the Trust. We have ensured that the group is structured such as to empower the voice of patients in taking forward quality improvement and our aim is the co-creation of QI projects and aims for the next year.

The Associate Directors have been involved in developing the Trust's approach to quality improvement. The PPI team has supported plans to engage and facilitate work with patients, carers and their families, bringing them together with clinicians to develop together testable improvements to services.

We have a good capacity for involving patients and service users and consulting with them on areas for improvement. Service users are actively involved in representative groups across the Trust. Service user involvement is central to quality improvement and in order to take the next steps we need to offer more training to staff and service users in, for example, experience-based co-design.

TRAINING

Training is vital so that there is a shared understanding of quality improvement across the Trust. This should include the Board and Management Team, as well as clinical and administrative staff in clinical teams.

Staff engaged in leadership programmes should also have training in quality improvement.

We need to provide quality improvement training to clinical teams so that there is a shared understanding of the quality improvement approach. It is important that team members train together if possible, as successful and enjoyable quality improvement depends on team collaboration.

The Quality Group will propose suitable training courses and will then require funds and support for releasing staff to attend training.

QI Trust-wide Development Plan 2019/20

VISION

Train Staff and patients are trained in QI methodology
Embed QI is built into Trust infrastructures
Engage Calendar of events keeps everyone aware of QI developments
Support Staff have places to take their ongoing development needs

Objective	Tasks	When/who	Desired outcomes	Strategic links
1. Increase staff engagement in QI	Map out QI infrastructure visually and identify any gaps	Marion/ADs	Increased clarity around who is involved in delivering QI objectives	
	Identify appropriate staff to train as QI coaches	Dinesh	Develop in-house capacity to support staff to carry out projects	
	Arrange training for QI coaches	Dinesh	Develop in-house capacity to support staff to carry out projects	

	Produce training plan across the Trust for 2020/21: Identify levels of training to be offered	QI Leads	Clear options for training are provided alongside dates/times	
	Establish QI forums within each directorate	Associate directors	Staff have a space to take projects for development	
2. Evidence change and demonstrate measurable improvement	Improve communication to staff with a robust QI page on the intranet, an article for In Mind and a clear schedule of events	Amy and Ellie	Increase ease of access to relevant QI information and documentation	
	Produce a Tavistock-specific QI handbook	Dinesh/ QIG	Staff have practical guidance on how to complete a project	
	Develop a system for logging and reviewing all projects within the Trust	QIG	There is an overview of live and completed projects	
	Identify success and learn from completed projects using project board meetings	Dinesh	We can make strategic use of the learning from projects across the organization	
3. Increase patient engagement in the Trust	Provide QI familiarity/ training for patients	QIG	Patients understand the purpose and function of QI within the Trust	PPI
	PPI to attend QI forums		Patient voice can contribute meaningfully to the ongoing process of improvement	PPI

Next steps for 2019-20

We are now working towards a centenary QI Conference, which will be free for all staff to attend and will feature various completed projects, discussion about improvement techniques and finally reflection on outcomes and benefits for individuals and teams from engaging in QI.

REFERENCES and Helpful links

A promise to learn- a commitment to act: Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, Berwick, D, 2013.

Improving quality in the English NHS: a strategy for action, Ham, C, Berwick, D, Dixon, J, King's Fund, 2016

http://www.ihi.org/resources/Pages/Tools/default.aspx

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

https://www.hqip.org.uk/resource/guide-to-quality-improvement-methods/#.XjFP6ZBvLIU

Free brief online introduction to Quality Improvement:

http://app.ihi.org/lmsspa/#/1431fa43-38e4-4e40-ab3b-7887d3254f72/41b3d74d-

f418-4193-86a4-ac29c9565ff1

Dr Dinesh Sinha
Medical Director and Director of Quality

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	31 March 2020

Board Assurance Framework

Executive Summary

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

There are two risks rated 16 and five rated 12. Three risks reduced, one from 9 to 6 (risk 4), one from 15 to 12 (risk 5) and one from 15 to 9 (risk 13). See page 3 for summary detail.

The development of the new electronic risk register module is still being tested and will not be used for reporting until 2020.

The BAF was reviewed by the Executive Management Team 24th March 2020.

Recommendation to the Board

The Board are asked to discuss the board assurance framework

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

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

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

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

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

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

2. APPROACH TO RISK SCORING

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

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

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

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

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

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

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

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

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

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

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

3. RISK SUMMARY [risk descriptions are shortened]

3.1 There are two risks rated 16

- Risk 8 (see 3.2 below)
- Risk 9: Inadequate staff capacity possibly leading to poor morale, failure to deliver the GIDS action plan and negative Trust reputation

3.2 There are two risks which increased from November 2019 to March 2020

- Risk 6: Insufficient staff capacity / engagement with the quality agenda (risk level 6 to 8)
- Risk 8: Wider financial pressure in NCL with negative consequences for delivering the mental health programme in STP and Trust (risk level 12 to 16)

3.3 There are five risks rated 12 as follows:

- Risk 2: The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience
- Risk 3: Pressures on leadership impacting negatively on staff morale and engagement to deliver strategic objectives
- Risks 5 and 13 are covered under 3.4.
- Risk 11: Risk to developing the Trust's educational offering and continuing to be sustainable.

3.4 Three risks reduced in March 2020

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

3.4.2 Risk 5: Risk of failure to deliver affordable and appropriate Estates solutions (risk level 15 to 12)

3.4.3 Risk 13: Failure to deliver the Trust financial plan (risk level 15 to 9)

RISK APPETITE

4.1 Risk Appetite Statement:

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

Overarching risk appetite descriptions

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

Risk Appetite assessment against Strategic Aims

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

3. CONCLUSION

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

March 2020 BAF HEAT MAP

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

November 2019 BAF HEAT MAP

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

Board Assurance Framework 2019/20 – Summary

					Current Risk Score					
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**July 2019**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
1	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.	DoHRCG	People	1	8 (2x4)		8 (2x4)	8 (2x4)		**Green (1x4)**
2	The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience	CEO	People	2	12 (4x3)		12 (4x3)	12 (4x3)		**Yellow (2x3)**
3	The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	DoHRCG	People	3	12 (3x4)		12 (3x4)	12 (3x4)		**Yellow (2x4)**

4	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	DoN	People	4	6 (2x3)		9 (3x3)	6 (2x3)		**Green (1x3)**
5	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	DoF	People	5	15 (3x5)	15 (3x5)	15 (3x5)	12 (4x3)		**Amber (2x5)**
6	The risk that insufficient staff capacity /engagement with the quality agenda has a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care	CCOO	Services: Clinical	6	6 (3x2)		6 (3x2)	8 (4x2)		**Green (2x2)**
7	The risk that our data systems do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	CCOO	Services: Clinical	6	8 (4x2)		6 (3x2)	6 (3x2)		**Green (2x2)**

8	The risk that wider financial pressures in North Central London with negative consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	CEO	Services: Clinical	8	12 (3x4)		12 (3x4)	16 (4x4)		**Amber (3x3)**
9	The risk inadequate staff capacity may lead to poor morale with possible failure to deliver the GIDS action plan resulting in negative impact on the reputation of the Trust	CCOO	Services: Clinical	9	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)		**Amber (3x3)**
10b	The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total.	DoS	Growth and Development	11			9 (3x3)	9 (3x3)		**Yellow (2x3)**
11	The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision	DoET/ DeanPGS	Services: Education	12	12 (3x4)		12 (3x4)	12 (3x4)		**Amber (3x3)**
12	If the Trust fails to meet its regulatory responsibilities to CQC and QAA there will be negative consequences for our reputation and the quality of patient and student experience	CEO	Finance and Governance	14	8 (2x4)		8 (2x4)	8 (2x4)		**Green (1x4)**

13	Failure to deliver the Trust financial plan will negatively impact on the delivery of our Control Total and quality of our services due to funding limitations resulting in possible external sanctions	DepCE	Finance and Governance	15	15 (3x5)	15 (3x5)	15 (3x5)	9 (3x3)		**Amber (2x5)**

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

Strategic Aim: People

Corporate Objectives:

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

<table>
<tr><td colspan="2">RISK 1): The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.</td></tr>
<tr><td>Risk Owner: Craig de Sousa</td><td>Date reviewed March 2020</td></tr>
<tr><td colspan="2">INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 TARGET risk rating 1 x 4 = 4
CURRENT risk rating: Likelihood 2 x Consequence 4 = 8 (unchanged March 2020)</td></tr>
<tr><td colspan="2">Rationale for current score:
The Trust has established a race equality strategy to a number of recurrent themes around black, asian and minority ethnic staff experience.</td></tr>
<tr><td>Controls/Influences (what are we currently doing about this risk?):
Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee

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

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

Corporate Governance provides feedback on the implementation as the Strategy is under review in the BAME network 2019 action plan developed and approved by the Trust board.	in consultation with BAME network, approved by the Board March 2019 (+)
Gaps in controls/influences: Further training for managers who have attended Thinking Space events to ensure clarity about action necessary to implement the strategy at local level	Action plans in response to gaps identified: *(with lead and target date)* Develop further training plan for managers, (DoHRCG, May 20) Using funds allocated by the Tavistock Clinic Foundation, review the implementation and impact of the bursary scheme to support individuals to gain access to Trust professional qualifying programmes (DoHRCG, Sept 2020) Increase capability and confidence of senior leaders, across the organisation, to engage in conversations about race, culture and difference (DoHRCG, May 2020) Review and implement ways of integrating discussion on health inequalities and access issues within clinical and training team meetings (CCOO, ongoing)

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

RISK 3): **The risk that pressures on leadership within the organisation impact negatively on staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.**	
Risk Owner Craig de Sousa	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12 (unchanged March 2020)	TARGET risk rating 2 x 4 = 8
Rationale for current score: There are continuing signs through the NHS Staff Survey and from feedback from our staff there continues to be work based pressure which is resulting in stress and a long hours working culture.	
Controls/Influences *(what are we currently doing about this risk?)*: OD and People Strategy Implemented Localised actions plans following each staff survey Leadership Development Programmes launched to improve capacity, capability and resilience Business Development Group established to provide structured oversight of growth opportunities. Quality improvement programme launched. Quality Impact Assessments launched at directorate and service level. Revised appraisal process linked to corporate objectives. Reducing the burden programme launched	Assurances received *(independent reports on processes; when; conclusions)*: NHS Staff Survey 2018 (+ /-) Quarterly Friends and Family Test Results (+) Quarterly HR & OD Assurance Reports (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Capacity to engage with structured development. Succession plans to cope with long periods of absence at service director / portfolio manager level. Increased media attention impacting morale of staff	OD and People Strategy delivery plan (DoHRCG Mar2020) Staff survey plans developed (DoHRCG Mar 2020) Select 2 teams to undertake Stress and Resilience Framework (with facilitation) (DoHRCG Mar 2020) Staff Education Programme (DoHRCG Mar 2020) New OD and People Strategy 2020 – 2023 (DoHRCG September 2020)

RISK 4): The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	
Risk Owner: Chris Caldwell	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE decreased from risk level 9 to 6 following: 1. Positive review of the Unit by HEE MH Delivery Board and recommendation to HEE national Board that the Unit element of the NTC is rolled continued and rolled into the NTC annually renewable contract 2. Feedback from HEE London (contact managers) that they are recommending no change to the NTC contract for 2021/22 The NWSDU has maintained a profile and exposure in year through conferencing and the engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity. DET recruitment and CPPD profile has been positive and demonstrated measurable contribution to increased supply and upskilling of MH workforce. If HEE national Executive agree 'no change' position risk rating will be reduced to 1x3	
Controls/Influences *(what are we currently doing about this risk?)*: NWSDU and NMHWDC Communications strategies and Plans in place NWSDU/ IJT /CC Objectives: Planned conference delivered to March 2020 IJT attendance at Pan ALB Health & Wellbeing Group CC profile in MH workforce and wider nursing agenda locally and nationally T&P presentation of work to HEE national MH Delivery Group meeting in Jan 2020 IJT Engagement in Pearson 'Learner MH & Wellbeing' HEE Workstream Exposure of Stress & Resilience work to Cavendish Square and 'Top Leaders' groups	Assurances received *(independent reports on processes; when; conclusions)*: Coms Strategy and Plan documents in place (+) Conference evaluation and end of project report (+) Communications support proposal and contract (+)

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
None identified	Communications support in place from July19 (IJT July 19) NWSDU delivered on presence at NHS Employers Health & Wellbeing conference – May 19 NHS Confed – June 19 and PWP conference Sheffield June 19. (IJT July 19) Confirmed presence and conference presentation at NHS Expo Sept 19, Presence at NHS Providers Oct 19. (CC March 2020) Agreement and ongoing work for development of shared communications strategy with HEE Mental Health Programme Board (CC March 2020) Ongoing work with Pearson Commission Group and Pan ALB H&WB group (CC March 2020)

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

Strategic Aim: Services: Clinical

Corporate Objectives:

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

RISK 6): The risk that insufficient staff capacity /engagement with the quality agenda has a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care	
Risk Owner: Sally Hodges	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 2 = 6 CURRENT risk rating: Likelihood 4 x Consequence 2 = 8	TARGET risk rating 2 x 2 = 4
Rationale for current score: staff report capacity issues. Staff survey results reflect this also. The QI forums have reported poor engagement, however the QI board process was relaunched in October with renewed focus on engagement. The newly created Operations board will monitor engagement however this is in its infancy. There has been a general improvement in the quality of patient information on Carenotes. COVID-19 significantly affecting staff capacity	
Controls/Influences *(what are we currently doing about this risk?)*: New divisional director structure to ensure engagement New Operations Delivery Board will provide a drive to engagement and will address issues that prevent engagement	Assurances received *(independent reports on processes; when; conclusions)*: Directors appointed July 2019 (+)
Gaps in controls/influences: New board and new general manager roles need to bed in.	Action plans in response to gaps identified: Work on structure and engagement, led by CCOO, new structure to be in place by October 2019, embedded by April 2020

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

RISK 8): The risk that wider financial pressures in North Central London with negative consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	
Risk Owner: Paul Jenkins	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 ↑	TARGET risk rating 3 x 3 = 9
Rationale for current score: Wider financial pressure across the STP	
Controls/Influences *(what are we currently doing about this risk?)*: Strong engagement with the STP with CEO as SRO for Mental Health Work close with partner provider organisations Engage in development of Medium-Term Financial Plan Commitment on protecting MH investment	Assurances received *(independent reports on processes; when; conclusions)*: Agreement by Regulators of Medium-Term Financial Plan (+/-) STP plan for mental health (+)
Gaps in controls/influences: Decisions of the regulators Wider financial position across the STP	Action plans in response to gaps identified: *(with lead and target date)* Implementation of medium-term financial plan (PJ Ongoing) Agreement of STP investment plan for mental health with agreement over use of ring-fenced investment for mental health (PJ Mar 2020) Successful implementation of Tier NCEL Provider Collaborative (SH Ongoing)

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

Strategic Aim: Growth and Development

Corporate Objectives:

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

RISK 10b): The risk that if the Trust is unable to establish sustainable new income streams it will be unable to achieve the level of new growth required to meet the Control Total.	
Risk Owner: Rachel Surtees	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9	TARGET risk rating 2 x 3 = 6
CURRENT risk rating: Likelihood 3 x Consequence 3 = 9 (unchanged March 2020)	
Rationale for current score: The NHS is in a period of change with the accelerated pace of development of Integrated Care Systems. A consequence of this is that there has been a sharp reduction in the number of CCG commissioned procurement exercises that are designed to encourage competition between different providers. Alongside this, there have been a number of events in the external environment that have disrupted the traditional business development cycles, making it harder to predict or anticipate trends. For example, the general election in December 2019; delays to procurement announcements in anticipation of the new Budget statements; preparations for CCG mergers; and most recently, diverted activity to respond to delaying the spread of COVID-19.	

Controls/Influences *(what are we currently doing about this risk?)*: - Active management of pipeline to have even spread of prospects across the three directorates and at different stages of development (prospect development; proposal writing; in implementation). - Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG). - Named target markets, including areas outside of health commissioning, to enable better focus and prioritisation on our target routes to growth and diversification of income source	Assurances received *(independent reports on processes; when; conclusions)*: Pipeline report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Contribution forecast report to Business Development Group on a monthly basis and SaCC on quarterly basis (+/-) Regular Business Development representation at Divisional & DET Executive Management meetings (+/-)
Gaps in controls/influences: Lack of income generation opportunities that don't rely on traditional CCG tender-led exercises. Restrictions in the level of upfront investment available to support income generating activities outside of the context of funding secure through a tender. Trust-wide strategy for spanning growth, maintenance and transformation planning required.	Action plans in response to gaps identified: *(with lead and target date)* Development of income generation opportunities that don't rely on traditional CCG led tender exercises (e.g. service developments, or service provision outside of health contexts) (ongoing RS) Active engagement with a number of STP forums focused on integration and transformation across the patch so as the NCL Mental Health Programme Board, CAMHS Board, and Directors of Transformation Group (SH; PJ; RS - ongoing) Development of Trust-wide strategy spanning growth, maintenance and transformation planning (30/9/2020)

Strategic Aim: Services: Education

Corporate Objectives:

10. Continue to delivery high quality educational services adopting quality improvement processes across the Trust to ensure continuous improvement **DoE&T/DPGS**

RISK 11): The risk that a failure to develop and modernise the Trust's educational offering has a negative impact on the sustainability of our provision	
Risk Owner: Brian Rock	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16	TARGET risk rating 3 x 3 = 9
CURRENT risk rating: Likelihood 3 x Consequence 4 = 12 (unchanged March 2020)	
Rationale for current score: Progress is being made in the establishment of the Digital Academy following Board sign off. International development is being adversely impacted by COVID-19 though we continue to focus on communicating our offer and developing potential partnerships. We expect a dip in activity and income through FY20/21 but believe this position will be mitigated following a resolution to the spread of coronavirus. Preparation is underway to continue with our educational provision in the last academic term (Q1) through online delivery and this should provide some impetus for innovation and development. The current focus on supporting core Trust activity in this period of uncertainty and reduced capacity will limit new course developments.	
Controls/Influences *(what are we currently doing about this risk?)*: Clarity in the focus on the international strategy and plan. Project team established for Phase 2 of the DA. Successful procurement leading to the identification of preferred partner. Task & Finish group phase 2 has led to greater market insights for each portfolio and internal discussion with portfolio managers though the achievements are more incremental. Scoping of Phase 3 underway.	Assurances received *(independent reports on processes; when; conclusions)*: Agreement on international strategy at ETC (July 2019) (+) International coordinator in role to support core team (April 2020) (+) Board sign-off on phase 2 of the DA (Sept 2019). (+)

Working group with internal and Essex representatives underway of scoping new long course development with agreed milestones including focus groups with students and employers. New development forum to be introduced in DET in collaboration with the business development team.	
Gaps in controls/influences: International plan delivery is slowed by current COVID-19 situation, Focus diverted and capacity reduced in the foreseeable future on new developments.	Action plans in response to gaps identified: *(with lead and target date)* Continued focus on international operational plan with modifications for FY20/21 (Director of Education & Training / Dean – April 2020. Incorporate where possible changes to delivery model reviewed in T&F phase 2 can be implemented (DoET /ADs / PMs – March 2020)

Strategic Aim: Finance and Governance

Corporate Objectives:

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

RISK 12): If the Trust fails to meet its regulatory responsibilities to CQC and QAA there will be a negative consequences for our reputation and the quality of patient and student experience leading to CQC and QAA formal action	
Risk Owner: Paul Jenkins	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4 = 8 CURRENT risk rating: Likelihood 2 x Consequence 4 = 8 (unchanged March 2020)	TARGET risk rating 1 x 4 = 4
Rationale for current score: CQC Well Led Inspection expected shortly.	
Controls/Influences *(what are we currently doing about this risk?)*: Completed well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps Implementation of QAA review action plans and established plans from university partner institutional reviews (Essex and UEL) Annual student survey completed	Assurances received *(independent reports on processes; when; conclusions)*: Work streams reporting to the Board level Clinical Quality Safety and Governance Committee provide assurance of compliance and raise issues of risk to compliance with CQC (+) Formal CQC report – 'good overall' and 'outstanding' for the Effective KLOE. Requires improvement in gender services for Responsiveness KLOE because of waiting times (+) Excellent outcome from 2018 QAA monitoring visit (+) Positive university partner institutional reviews commending course provision and faculty expertise and commitment (+)

	Detailed action plan to address areas identified by CQC for improvement drawn up and approved by the CQC, the CQSGC and the CQRG. Progress monitored via EMT and CQSGC (+) Service Line self assessments for CQC compliance (+/-)
Gaps in controls/influences: Current service line assessment of CQC compliance required	Action plans in response to gaps identified: *(with lead and target date)*

RISK 13): Failure to deliver the Trust financial plan will negatively impact on the delivery of our Control Total and quality of our services due to funding limitations, resulting in possible external sanctions	
Risk Owner: Terry Noys	Date reviewed: March 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9 ↓	TARGET risk rating 2 x 5 = 10
Rationale for current score: Additional in-year costs have been incurred and in-year contribution from new business substantially below Budget. Contribution from TAP risk share assumed to be zero. A number of contract losses being incurred, with uncertainty over any related redundancy costs. Potentially significant, unbudgeted legal costs being incurred. Anticipated that staff costs will continue to run at below Budget levels. Potential for negative impact depending on outcome of Relocation	
Controls/Influences *(what are we currently doing about this risk?)*: Board approved Budget (setting out key assumptions) Management accounts reviewed monthly by EMT and Board Regular reforecasting of full year out-turn Business Development Group and Strategic and Commercial Committee review new business pipeline	Assurances received *(independent reports on processes; when; conclusions)*: Management accounts reviewed monthly by EMT and Board (+ / -) In-year forecasts reviewed by EMT and Board (+ / -)
Gaps in controls/influences: Uncertainty over contribution from new business Uncertainty over staff spend	Action plans in response to gaps identified: *(with lead and target date)* Financial reforecast to be undertaken (TN: November) Review of historic accruals (UC: November) Additional income opportunities being sought (RSt)

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Trust Board	31/03/2020

HLRO Action Plan

Executive Summary

The Trust has a motivated medical workforce who engage well with the appraisal and revalidation requirements, as set out by the General Medical Council and HLRO.

The Trust's Responsible Officer is the Medical Director who holds responsibility for various obligations to deliver a well-functioning appraisal and revalidation process.

The Trust recently hosted the Higher London Responsible Officer Quality Review Visit. The report from the HLRO team was very positive about many recent improvement initiatives and approved the overall structures for appraisal and revalidation for medical staff.

Attached is the action plan and included in the appendix is the report from the from the visit.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Meet the Trust's requirements with its national regulators

Author	Responsible Executive Director
Dr Dinesh Sinha	Dr Dinesh Sinha, Medical Director and Director of Quality

Final Report

Higher Level Responsible Officer Quality Review Visit **Designated body:** Tavistock and Portman NHS Foundation Trust		
Date: Tuesday 15 October 2019 **Time:** 10:00 am start **Venue:** Committee Room, Tavistock and Portman NHS Foundation Trust		
Key Personnel		
Dr Carol McGrath	AMD (Revalidation) and Regional Appraisal Lead	NHS England (London)
Maxine Hastings	Regional Revalidation Lead	NHS England (London)
Sol Mead	Lay Representative	NHS England (London)
Louisa Sanfey	Regional Revalidation Project Support Officer	NHS England (London)
Dr Dinesh Sinha	Responsible Officer & Medical Director	Tavistock and Portman NHS Foundation Trust
Dr Caroline McKenna	Appraisal Lead	Tavistock and Portman NHS Foundation Trust
Lorna Campbell	Revalidation Manager	Tavistock and Portman NHS Foundation Trust
Umran Murad	Head of HR Operations	Tavistock and Portman NHS Foundation Trust
Dr Alex Sales	Appraiser	Tavistock and Portman NHS Foundation Trust
Dr Liz Searle	Appraiser	Tavistock and Portman NHS Foundation Trust
Dr Andrew Williams	Appraiser	Tavistock and Portman NHS Foundation Trust

Agenda

Agenda Item	
9:45	NHS England Pre Meet
10:00	Introductions and meet with Medical Director, Responsible Officer, Appraisal Facilitator, HR Manager & Medical HR Specialist
10:30	Meet with Medical Director, Responsible Officer & Appraisal Facilitator, review of processes and IT systems
11:00	Meet with Medical HR Manager & Medical HR Specialist
11:30	Break
11:45	Interview with appraisers
12:15	Meet with Medical Director, Responsible Officer, Appraisal Facilitator, HR Manager & Medical HR Specialist, visit summary
13:00	*Please consider the agenda timings and order flexible but we hope to finish by 13.00 at the latest.*

HLRO Quality Review Visit Report

DESIGNATED BODY:	Tavistock and Portman NHS Foundation Trust
RESPONSIBLE OFFICER:	Dr Dinesh Sinha
RO GMC Check	GMC 5196177
RO Appointed	24 August 2018
RO Training Dates	March 2019
RO Network Attendances	Dr Sinha has attended 2 out of 3 London RO Network events since he was appointed as RO

NHS England London Revalidation team would like to thank Dr Dinesh Sinha, Responsible Officer, and his team for their hospitality and openness to discussion with the visiting team.

The visit was conducted on behalf of the Higher Level Responsible Officer (HLRO) Dr Vin Diwakar, to provide him with assurance that the responsible officer (RO) and designated body has appraisal and revalidation systems and processes in place in keeping with 'The Medical Profession (Responsible Officers) Regulations 2010, Amendments 2013'. The purpose of the visit was to identify and disseminate good practice, maintaining and improving standards of quality and performance, and to provide the RO with support and advice on any appraisal and revalidation issues.

Prior to the visit we were provided with the following relevant policies and information documents as requested to help the panel prepare for the visit:

Annual Organisational Audit	✓
Statement of Compliance	✓
Annual Board report	✓
Quarterly report	✓
External Quality Assurance report (if available)	**n/a**
Never Events Summary (if applicable)	**n/a**
Care Quality Commission Report (if available on CQC website)	✓
Examples of appraisal summaries	✓
Examples of PDPs	✓
Appraisal and revalidation policy	✓
Relevant policies	✓

Tavistock and Portman NHS Foundation Trust is a specialist mental health trust based in Camden, London, offering high quality mental health care and training.

There have been recent structural changes in the Trust with the introduction of a new division for Gender. A consultant away day was introduced in June 2019 to develop the workforce and identify leadership potential. The organisation as a whole enjoys high levels of staff retention.

There are currently 55 connected doctors. The majority of these doctors work for the Tavistock and Portman, with a small cohort of independent doctors. A review was carried out within the past year in association with the HLRO team and ELA to check the basis for proscribed connection with these independent doctors. As a result, a small number of doctors moved on, and the Trust is currently setting up contractual frameworks with the remaining independent doctors.

Responsible Officer

Dr Sinha became RO in August 2018. He completed RO training in March 2019 and has participated in RO Network events. The RO enjoys the opportunity to build peer networks and would like to take a more active role in future to bring ROs together to discuss workforce and revalidation issues.

The RO stated that he has been well supported by colleagues as he settled into his new role over the past year. There have been some challenges associated with bringing in changes to systems and processes, but the RO has largely found colleagues to be motivated and understanding of the need for change.

The RO feels well supported by the Board. He has a fortnightly one-to-one with the Chief Executive and can access the Executive Management Team if there are any issues with engagement. The RO provides an annual report to the Board. Additionally, the RO chairs the Integrated Governance Committee which reports quarterly to the Board.

The RO is additionally the Medical Director but has not experienced any issues related to holding a dual role. In cases of conflict of interest, the RO would seek support from a peer within a similar Trust, such as Camden and Islington NHS Foundation Trust (C&I). The RO recently sought advice from Maxine Hastings, Regional Revalidation Lead about a potential conflict of interest, and was commended on how that case had been handled.

The RO confirmed that he has appropriate indemnity for his role, including Trust level indemnity and personal indemnity for the Medical Director role.

Appraisal Lead and Appraisers

Dr McKenna has acted as Appraisal Lead for a number of years and remained in post when Dr Sinha came onboard as the new RO. She trained with MIAD and has completed in-house train-the-trainer training.

There is a committed group of 24 Appraisers within the organisation. All Appraisers only appraise for the Tavistock & Portman. The average number of appraisals carried out per year is 4-5, with the minimum number being 2 appraisals. The Appraisal Lead would like all consultants to undergo Appraiser training going forward to ensure a high level of engagement and knowledge across the organisation.

The Appraisal Lead runs refresher training for Appraisers, most recently focussing on improvement of PDPs and summaries. Appraisers meet quarterly to raise and discuss any issues, and the RO attends these meetings.

The Appraisal Lead is available on an ad hoc basis to provide support and assistance to Appraisers. As a small organisation, the Appraisal Lead has a good overview of appraisals and has strong relationships with Appraisers and Appraisees. Most issues are able to be resolved with a conversation with those involved. There is not currently a system to provide formal or regular feedback to Appraisers. There is a tool on the SARD toolkit that could be used in future to provide feedback. The RO and Appraisal Lead are currently looking at ways to collate and anonymise feedback.

There were some concerns around potential for conflict of interest due to long-serving staff knowing one another very well within a relatively small organisation. There is a need to provide outside scrutiny. As a move towards this, the Appraisal Lead was appraised externally by the Deputy Medical Director from Camden & Islington NHSFT, which has led to suggestions about ways to improve the appraisal system. An agreement has been

made with the Appraisal Lead at Camden & Islington to conduct an informal quality assurance peer review to learn from each other.

The Appraisal Lead is planning an appraisal audit using the ASPAT tool. She plans to ascertain whether there has been an improvement in the quality of PDPs and appraisal summaries since the refresher training that was carried out in September 2019. If there has not been an improvement, she will carry out additional refresher training to embed it.

The Appraisal Lead monitors appraisals to ensure that no Appraisee goes over the recommended 3 sessions with the same Appraiser.

Appraisals

There is a cultural ethos across the Trust that appraisal is taken seriously as a tool to manage professional development. There has been a move away from a quantitative approach towards quality and content of appraisals.

The SARD toolkit is used. The RO and Appraisal Lead commented that the SARD toolkit focusses primarily on portfolio collection rather than reflection. There is some additional work to be done to ensure that reflection is discussed during appraisal and that this is appropriately recorded in the appraisal summary. The RO would like to replace SARD with an alternative toolkit more focussed on the specialisation of the Trust in future, but at present is focussed on implementing other changes.

Feedback is collected via the 360 function on SARD. The RO was initially unsatisfied with the efficiency of feedback so undertook an exercise with doctors to ensure that feedback was collected more objectively. Doctors formerly collected patient feedback themselves, now the Revalidation Manager collates or forwards feedback to SARD for bulk upload. The RO sought advice from the HLRO team and the ELA to ensure that changes to the process were made in line with GMC recommendations. There is further work to be done around options for gathering feedback from children and young people, such as visual feedback or carer feedback if the patient is unable to provide feedback themselves.

There is a need to consider ways to avoid bias when gathering colleague feedback in a small organisation. Doctors are encouraged to seek a wide range of feedback, and Appraisers are asked to check that this is carried out. There is a need to ensure that there is adequate reflection on feedback received.

The Royal College of Psychiatrists recommends that doctors undertake 2 case-based reviews per year. There is some work to be undertaken to ensure that doctors understand that appraisal goes beyond case-based review to reflect on other challenges experienced during the year and identify areas of learning.

Dr McGrath noted that the example PDPs provided were of good quality. The appraisal summaries did not reflect the full discussion and should be evidence-based. She reminded the Appraisal Lead of the need to map good medical practice back to the evidence.

Revalidation

Lorna Campbell, Revalidation Manager started in post this year and has supported the RO to improve the administration of the revalidation process.

There is a Responsible Officer's Advisory Group (ROAG) comprised of the RO, Appraisal Lead, Revalidation Manager and a representative from HR. The ROAG has a clear understanding that systems to review progression must be fair and applicable to all. There is a fixed agenda:

- Review of list of doctors approaching revalidation;
- Discussion of individual issues and portfolios to identify any individuals needing additional support;
- Identify any systemic issues or needs within the organisation;
- External interfaces.

The Revalidation Manager notifies doctors that they are approaching their revalidation date in writing 3 months in advance, with another written notification 1 month in advance. Revalidation dates are also recorded on SARD. The RO has introduced an expectation that doctors upload documents 1 month in advance of their revalidation date to allow sufficient time for the ROAG to address any issues.

The appraisal schedule has been adjusted to align with the revalidation process, and doctors are encouraged to see appraisal and revalidation as an integrated process. The ROAG will advise "Less is more, ready by 4."

The Trust has a relatively high deferral rate. The RO noted that this is connected to processes as deferral is recommended where a doctor's portfolio is incomplete, most commonly where 360 has either not been completed or is not sufficient, or where there is inadequate evidence of reflection. The RO noted that the deferral rate has come down as doctors become more familiar with the requirements. Doctors receive written communication about expectations, however these are not currently documented in the Appraisal and Revalidation Policy.

There have been 3 deferrals during the RO's tenure. In each case the RO wrote to the doctor giving the reason for deferral, providing the new revalidation date and outlining what actions must be taken.

The RO makes all recommendations personally via GMC Connect.

Policies and Procedures

The NHS England London Revalidation team noted that the policies and procedures provided in advance of the visit were very comprehensive.

HR

The RO and his team have a good working relationship with HR.

The ESR system is used.

HR administrators use an employment checklist during recruitment. Registration is checked using GMC Connect and a screenshot is saved on the doctor's personnel file. Revalidation dates are uploaded onto ESR. If there are any issues with registration, such as a lapse, HR make an initial contact with the doctor and escalate to the RO if there is no response.

The RO has not had cause to use the MPIT form to date due to the strong retention rate within the Trust and low usage of locums.

The RO meets with the ELA twice per year and maintains regular telephone contact.

Managing Concerns

A Managers Form has been introduced which is uploaded to the SARD toolkit and incorporated into appraisal.

There are not currently any trained Case Investigators within the organisation, however the Chief Executive has authorised future training for some individuals including the Appraisal Lead, in order to gain this skillset within the organisation.

As a small organisation, the preference would be to seek an external, independent Case Investigator to avoid any potential for conflict of interest. There is potential for an agreement with another organisation to cover investigations for one another in order to maintain independence of investigations.

Significant Incidents

There is an expectation that doctors comment on their breadth of practice including significant incidents or complaints if relevant. The RO and Appraisal Lead are not aware of any occasion where an incident has deliberately been overlooked from an appraisal and would be concerned if this were the case.

It happens on occasion that a doctor is not made aware that they have been named in a complaint. Complaints sit with the Chief Executive and are managed by the Complaints Manager.

The SARD toolkit does not have the functionality for the RO to record comments or to link any significant incidents automatically to appraisals. Appraisal documents are only visible to the Appraisee and Appraiser until they are signed off, and can't then be edited, so would need to be re-started if any information relating to incidents had been overlooked. It may be possible to work with SARD around improving the toolkit functionality in future. Additionally, the new Managers Form will help pass on information about complaints or concerns from the Clinical Manager.

Discussion with Appraisers

The Appraisers noted that the Trust is proactive in encouraging staff to train as Appraisers. The NHS England London Revalidation team questioned whether there may be downsides to having so many trained Appraisers.

Doctors are highly specialised so the importance of broad awareness across the organisation was emphasised. It was noted that there are generic values promoted across the Trust.

Doctors are asked to review scope of practice at appraisal, with equal evidence for their private practice as for their work within the Trust.

Appraisals are allocated a 2 hour meeting slot. Appraisers allocate around 1 day of work to each appraisal including preparation time and writing up notes.

The Appraisers noted that they felt listened to and supported when they raise any issues or make suggestions for improvements to the process. However, they would appreciate more feedback from Appraisees.

There was discussion of how to appraise doctors who are doing limited clinical work. Dr McGrath agreed to share the guidance 'Supporting doctors who undertake a low volume of NHS General Practice clinical work' with the Appraisal Lead.

Lay Representation

The Trust currently involve Lay Representatives in an advisory group. The RO would like to set up lay representation that is sustainable and adds value. Sol Mead, the Lay Representative advised that some organisations make use of a Governor as a first step towards meaningful involvement of lay representatives.

Summary and Recommendations

The RO requested that the Regional Revalidation Lead attend one of the quarterly Appraiser Meetings to help doctors better understand the RO role and revalidation process. The RO suggested that an information pack would be beneficial to bring together information about the role of the HLRO and ELA.

The Regional Revalidation Lead reminded the RO and team that they can contact the HLRO team with any suggestions or questions going forward.

Areas of good practice and suggested areas for development are outlined below:

Examples of good practice
There is ample evidence of good practice and processes in place, with a clear commitment to updating processes and policies where needed.
The RO is clear sighted, articulate and has a positive vision of the direction they want to go in, combining a good balance of respect for the history and culture of the Trust with sensitive steering on the changes that are needed.
The RO is well-supported by excellent teamwork from the Appraisal Lead, Revalidation Manager, HR team and wider organisation.
The RO and team demonstrate an open and transparent attitude. They are eager to engage with and learn from the HLRO and NHS England London Revalidation team.
There is a proactive and practical approach to problem-solving with strong strategic thinking.
There is a strong organisational culture of democratic principles which engages with staff to bring about change in a sustainable manner.

Suggested areas for development
Appraisals Recommendation to identify an appropriate quality assurance tool and to carry out regular quality assurance of appraisals. Recommendation to strengthen the process around complaints to link with appraisal process. Recommendation to investigate whether the functionality of SARD can be improved to better suit the needs of the organisation, or whether an alternative toolkit would be more appropriate. Reminder of the importance of reflection in appraisals and that appraisal summaries should be evidence-based.
Revalidation Recommendation to formalise expectations around Revalidation by tightening the process and introducing a checklist which should be disseminated to all doctors.
Feedback Recommendation to review processes for gathering feedback to ensure that appropriate Multi-Source Feedback (MSF) and Patient Satisfaction Questionnaire (PSQ) is gathered. Recommendation to introduce system for regular Appraiser feedback.
Case Investigation Recommendation to train staff as Case Investigators to gain valuable skills within the Trust.
Lay Representation Recommendation to consider ways in which Patient and Public Involvement (PPI) may prove beneficial to the Appraisal and Revalidation process.

References:

ASPAT Tool. The Appraisal Summary and PDP Audit Tool (ASPAT), Annex J (routine appraiser assurance tools) of the revised NHS England Medical Appraisal Policy https://www.england.nhs.uk/medical-revalidation/appraisers/aspat-notes/

NHS England Medical Appraisal Policy: https://www.england.nhs.uk/revalidation/appraisers/app-pol/

Quality assurance of appraisal: guidance notes (NHS England 2016) (Annex J for QA): https://www.england.nhs.uk/revalidation/appraisers/qa-guidance-notes/

Medical appraisal guide (MAG) model appraisal form: https://www.england.nhs.uk/revalidation/appraisers/mag-mod/

Doctor's Medical Appraisal Checklist embedded within the MAG form but also found as a separate document here: https://www.england.nhs.uk/revalidation/doctors/doctors-medical-appraisal-checklist/

Improving the inputs to medical appraisal (NHS England 2016): https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/

Information flows to support medical governance and responsible officer statutory function (2016): https://www.england.nhs.uk/revalidation/ro/info-flows/Medical appraisal logistics handbookhttps://www.england.nhs.uk/revalidation/ro/ma-handbook/

Medical appraisal logistics handbook: https://www.england.nhs.uk/revalidation/ro/ma-handbook/

Appraisal skills training videos:
https://www.england.nhs.uk/revalidation/appraisers/video-workshops/
https://www.youtube.com/playlist?list=PL6IQwMACXkj1zbMA27JZs9SgPXOuwgPWm

HEE appraiser workshop resources:
https://www.england.nhs.uk/revalidation/appraisers/meetings/hee-resources/

Sir Keith Pearson's independent report, Taking revalidation forward: Improving the process of relicensing for doctors (pdf).

GMC website http://www.gmc-uk.org/doctors/revalidation/9610.asp

NHS England, Conflict of Interest or Appearance of Bias Policy (14th August 2018)
https://www.england.nhs.uk/publication/responsible-officer-conflict-of-interest-or-appearance-of-bias/

Framework for Managing Performer Concerns: https://www.england.nhs.uk/wp-content/uploads/2017/04/framework-managing-performer-concerns-v3.pdf

Medical Revalidation
right for patients, right for doctors

NHS England

Action plan template

Please complete the below action plan and return to: ENGLAND.revalidation-london@nhs.net

By: (insert date)

Name of designated body: Tavistock and Portman NHS Foundation Trust		
Name of responsible officer: Dr Dinesh Sinha		
Area/concern/issue identified at Review Visit	**Action**	**Timescale**
Recommendation to identify an appropriate QA tool and to carry out regular quality assurance of appraisals	• Appraisal lead to set framework for Annual appraisal audit • Use APSAT tool • Revalidation manager will administer audit	End of April 2020
Recommendation to strengthen the process around complaints to link with appraisal process	• Complaints manager and revalidation manager to create quarterly report about Consultants who have had a complaint made against them • Agree a complaints timetable for Complaints Manager to pass to ROAG • Appraisal lead to speak with Complaints Manager	End of March 2020
Recommendation to investigate whether the functionality of SARD can be improved to better suit the needs of the organisation, or whether an alternative toolkit would be more appropriate	• The Trust will continue to review the use of SARD and its functionality.	Ongoing
Reminder of the importance of reflection in appraisals and the appraisal summaries should be evidence based	• Appraisal lead will reinforce this message in future appraiser meetings	10th February 2020 Completed and

		ongoing
Recommendation to review processes for gathering feedback to ensure that appropriate Multi-Source Feedback (MSF) and Patient Satisfaction Questionnaire (PSQ) are gathered. **Recommendation to introduce a new system for regular Appraiser feedback**	• Further work will continue to reinforce the improvements made in process for collecting MSF in 2019 • Revalidation Manager to activate SARD link for feedback to appraisers from appraisees	Ongoing Completed
Recommendation to train staff as case investigators to gain valuable skills within the Trust	• RO will approach a candidate for case investigator training • However size of organisation may mean that an independent investigator is often considered more suitable	Completed
Recommendation to consider ways in which Patient and Public Involvement (PPI) may prove beneficial to the Appraisal and Revalidation Process	RO has invited Lay person (Non-Executive Director) to join ROAG and will review her involvement	Completed Lay person invited to meetings
Follow up meeting / Telecon	We will send as draft to HLRO and put forward for the board in March	March 2020
As responsible officer I confirm that the information above has been discussed and agreed with my Board or equivalent	*Signature & Date* 	
Date of Board sign-off		

Report to	Date
Board of Directors	31 March 2020

Report on Audit Committee Meeting – 5 March 2020

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 5 March 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 5 MARCH 2020

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 5 March 2020.

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

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

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

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

3. ANNUAL REPORT AND ACCOUNTS ("ARA")

3.1 There was discussion on how the Board could contribute to the themes and narrative within the ARA. The Committee noted that the Chief Executive's report, in particular, tended not to be compiled until the bulk of the rest of the report was available. The Committee noted, however, that there were a number of themes / issues which it would expect to see within the ARA, notably:

- CQC Inspection
- Corona Virus (COVID-19) / EU Exit
- Gender, notably Judicial Review
- Relocation
- NCL STP / Integrated Care Systems.

3.2 It was noted that the draft ARA would be circulated to the main Board as soon as a reasonable working draft was available.

4. PRESSURE ON STAFF

4.1 The Committee noted the very high level of non-business as usual activities which the Trust was having to deal with, notably:

- CQC inspection
- NCL STP / Integrated Care Systems
- The issues confronting the Gender services during the period
- Corona Virus (COVID-19)Relocation
- Cost Improvement Programmes.

4.2 This was clearly placing a strain on an already stretched staffing group.

5. INTEGRATED GOVERNANCE COMMITTEE

5.1 The Committee heard from the Medical Director regarding the Trust's practises regarding the Safeguarding of patients and staff within sub-contract arrangements used by the Trust. The Committee noted the intention to pro-actively seek assurances from these external partners.

5.2 A brief update on the GIDS action plan was provided and the Committee was told that the recently established framework for Incidents reporting was working well.

5.3 The Medical Director advised the Committee on Trust preparations regarding the Coronvirus. The Committee heard that whilst some staff had self-isolated there had, as yet, been no confirmed cases of infection.

5.4 The Medical Director also noted the need for the Trust to think more carefully about how it put the 'patient voice' more at the forefront of its thinking / activities.

Terry Noys
Finance Director
13 March 2020

Report to	Date
Board of Directors	24th March 2020

Integrated Governance Committee Minutes
Q3 Board Report

Executive Summary

This report provides the minutes from the Q3 February, Integrated Governance Committee.

All six work streams have reported good progress during this difficult period with no notable issues highlighted.

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

Integrated Governance Committee (IGC)
Minutes of the committee meeting on Wednesday, 19th February 2020

Members	Present?
Dinesh Sinha, Medical Director (& IGC Chair) (DS)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	N
George Wilkinson, Public Governor (GW)	Y
Dinesh Bhugra, Non-Executive Director (DB)	Y
Debbie Colson, Non-Executive Director (DC)	Y
David Levenson, Non-Executive Director (DL)	N
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	N
Sally Hodges, Chief Clinical Operating Officer (SH)	N
Jon Rex, Interim Interim IMT Consultant (JR)	Y
Caroline McKenna, Associate Medical Director (CMK)	Y
Chris Caldwell, Director of Nursing covering Quality and Patient Experience (CC)	N
Tim Kent, Director of Adult and Forensic Services (TK)	N
Ailsa Swarbrick, Gender Services Divisional Director (AS)	N
Rachel James, CYAF Divisional Director (RJ)	N
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Elisa Reyes Simpson, Deputy Director of Education and Training / Associate Dean, Academic Governance & Quality Assurance for DET (ERS)	N
Craig de Sousa, Director of HR (CdS)	Y
Liz Searle, Consultant Child Psychiatrist & Clinical Governance Lead for Children, Young Adults and Families (CYAF) (LS)	Y
Ellie Cavalli, Clinical Governance Lead for Adult Forensic Services (AFS) (EC)	N
Ian Garlington, Director of Estates, Facilities & Capital (IG)	Y
Eilis Kennedy, Director of Research and Development (EK)	Y
Janice Abraham, Associate Director of Data Security (JA)	N
Irene Henderson, Clinical Governance & Quality Manager & IGC Secretary (IH)	Y

SUMMARY OF ACTION POINTS

AP	Item	Action	By	Due
3	3.1	IH to circulate ToR to the committee.	IH Complete	Feb 2020
	3.1	DS & CdS agreed to review the flow charts to ensure all aspects were correctly captured.	DS & CdS	Apr 2020
	3.3	AS to get myth busting document produced for review at the May IGC.	AS	Apr 2020
4.1		JR to produce additional paper on HIE for the May IGC prior to go live.	JR	Apr 2020
4.1		IH to investigate NEDs having Tavistock email addresses	IH	Mar 2020
4.1		Include in future work stream reports: • Information incidents updates, including visual representations of narration, trends and analysis • Updates on significant projects, such Health Information Exchange (HIE)	JR	Apr 2020

		• Updates and summary of all significant events such as the recent large data breach • Rolling action plan addressing work stream delivery		
4.2	4.2.3	CMK to bring issues contacting social services to the Safeguarding Unit for further discussion.	CMK	Feb 2020
4.2	4.2.7	CMK agreed to request a graph for the adult safeguarding figures from the new adult safeguarding lead for future PSCR reports.	CMK	APR 2020
4.3		MS to feed back to CC re whether any more can be done to ensure the work stream reports reflect services as seen via the patient lens.	MS & CC	Mar 2020
4.5	4.5.1	IG & DS to plan next Trust wide BCP exercise with expanded scope to involve estates issues, such as operational security, access, etc.	IG & DS	Apr 2020
4.6	4.6.4	EK agreed to circulate the work shop date.	EK	Mar 2020
	4.6.4	EK agreed to invite JR to future research steering group meetings.	EK	Mar 2020

1		**Chair's opening remarks** DS opened the meeting and confirmed that the reports being considered were for the Q3 2019/20 and that this may possibly be the last IGC meeting prior to the CQC inspection.	
	1.2	**Attendance** There was a brief round of introductions and apologies were received from Paul Burstow, Ailsa Swarbrick, Elisa Reyes-Simpson, Sally Hodges, Rachel James, Terry Noys, Chris Caldwell, Janice Abraham, Tim Kent, Ellie Cavalli and David Levenson.	
2		**Notes from the last meeting** The notes from the last meeting were accepted as accurate, except for action point 6.4.4, which was removed.	

3		**Matters Arising** DS confirmed all previous actions have been completed except the action regarding the IGC Terms of Reference.	
	3.1	**Terms of Reference (ToR)** CdS confirmed the new ToR had now been ratified by the Board with some minor amendments and asked **IH to circulate ToR to the committee**. CdS confirmed the committee will undertake an annual review of the ToR at each February IGC. There was a brief discussion around the items that were removed from the Patient Experience work stream and DS confirmed that all items have been reallocated within existing work streams, except for the Specialist Services Report, which is possibly being considered for the Operational Delivery Board. It was agreed the new structure would be reviewed at the May IGC and **DS & CdS agreed to review the flow charts to ensure all aspects were correctly captured.**	IH
	3.2	**CQC Action Plan** DS noted this had been circulated as a late paper but that it contained all current concerns and risks relating to the impending Well Led inspection, which will include one of our key services. DS also confirmed that the plan was monitored on monthly at the Executive Management Team (EMT) meetings to ensure readiness and gave a brief overview of the preparations to date including: • Set of Board Seminars and service lead seminars, which will be repeated again next week. • Mock inspections are being conducted with 3 of our services to try to identify any gaps in process or practice. • As GIDS is likely to be one of the services inspected, there is a separate action plan which also has a task and finish group attached to it. The OBD will sign off the plan but the IGC will also receive for assurance an annual review of the plan. • There will also be some comms around the new process of annual cycles of inspections by the CQC to ensure staff awareness. CMK confirmed she and Ian Tegerdine (who also happens to be a CQC inspector) will begin the first mock inspection tomorrow with both clinical and admin, looking at many aspects including: • How the service responds to the service waiting list • How the waiting lists are monitored and managed • Issues around consent and any gaps in Mental Capacity Act (MCA) training, although DS confirmed this is now covered in the adult safeguarding training. IG noted that the GIC patient populations in Leeds, Bristol and Fulham Palace Road, are very anxious regarding relocation and suggested some good comms is required to allay fears. DS confirmed that comms was a challenge in this area, but confirmed relocation is part of the action plan. IG also noted the overall security of the main centre may be looked at and DS confirmed that was also being considered in relation to recent incidents within the clinical setting. DS also confirmed there is an operational group set up to address any issues.	DS & CdS

	3.3	MS noted that we are producing an information pack for service leads staff across the Trust, including small crib cards covering the most relevant information, and it is hoped they will be ready in time to send out with the March staff pay slips. DS invited the committee to comment on the action plan or any omissions and send any further suggestions directly to him. **Gender Services Update** DS introduced SH's Gender Services update and noted its late circulation to committee. DS noted there was a lot of work being done within GIDS as previously discussed in the CQC action plan, including consent, safeguarding, SOPs, training and data strategy. DS confirmed this work with the gender services is monitored by the OBD and that the update paper has come to the IGC for any comment. PJ commented that the consent document was an exemplary piece of work, noting the challenge would be to embed this work in practice, operating at the current scale in terms of: a) Level of compliance in practice b) Question of decision making DS confirmed that although there may be policies in place, not all will be fully embedded in practice yet, eg, the safeguarding audit showed promising improvements in practice, but areas like consent need more work, but its implementation is vital. DC asked if there was a need for a myth busting document, especially in relation to some of our specialist services, which could dispel the public myths, misconceptions and assumptions around some of our services and the committee thought this would be very useful. However, PJ confirmed the response to the JIR (judicial review) is exactly that, but that having taken advice, the Trust had been advised not to produce such a document at this time, but did suggest that the document could be produced, appended to our website without a heavy promotion, as it could be seen as similar to clinical guidance or FAQs. It was suggested **AS take this forward and get the myth busting document produced for review at the May IGC.** DS asked if there are any further comments or suggestions that they are sent directly to SH and AS.	AS
4		**REPORTS FROM WORK STREAMS**	
4.1		**Data Security & Protection** Jon Rex, Interim IMT Consultant *(on behalf of Terry Noys, Director of Finance and Trust SIRO)*	
		JR introduced his report and confirmed the DSPT returns had now been completed and the baseline has been registered with the final submission still in process.	

		JR noted that in 2018/19 the initial requirement was a compliance report but that the returns for 2019/20 are much more detailed and requiring increasing amounts of evidence, all of which he confirmed were achievable. JR invited any questions. CdS asked if there was an update from the ICO in relation to the recent data breach incident and JR confirmed we are still waiting the outcome. MS asked if the Q2 &Q3 data showed trends and analysis and whether the report could include visuals of the data. JR agreed and confirmed the Hornbill system has this capability. DS asked if HIE was "going live" next month. JR confirmed as part of the London STP we will supply information into the central record, which is managed by Cerner, which aims to allow access sharing for end to end patient care. He confirmed the CCIO was fully engaged and although there was much work to do, the planned "go live" date is now May 2020. DS added SH is the Trust's SRO for this project and that there are many concerns around the proposed level of data sharing and confirmed the STP are doing the comms regarding contacting the patients. CMK confirmed there are many issues relating to the data sharing in HIE especially around the GP letters' contents and stressed the need to be especially mindful of the potential for inadvertently sharing 3rd party information. DS agreed and requested that **JR provide further updates in a separate paper on HIE to the May IGC prior to go live** providing further assurance in these areas. There was further discussion around staff compliance with mandatory IG training including the provision of this training for the Board and the NEDS. CdS confirmed the Board would complete the training as part of a Board seminar. The fact that the NEDS don't have Tavistock email addresses is problematic. Although they are able to receive confidential information via Crypt Share, it would be helpful for receiving diary invitations etc, but JR said there might be technical issues preventing this and **IH agreed to take this forward.** There was further discussion around the ICO including the newly introduced bulk email limit which has been set to a maximum of 50 recipients and JR confirmed there was still work to do to get the right balance to enable staff to work effectively and also restrict possible large scale breaches. There was a brief discussion around the use of hybrid mail, which JR explained the process briefly and why it would help to negate the recurring issue of incorrect disclosure by letters going to wrong addresses/recipients but noted there is still further work to do on this. Again it was asked if updates on this project could be included in future reports. After further discussion it was agreed that **JR would include the following in all future IMT work stream reports:** • **Information incidents updates, including visual representations of narration, trends and analysis** • **Updates on significant projects, such Health Information Exchange (HIE)**	JR IH

		• **Updates and summary of all significant events such as the recent large data breach** • **Rolling action plan addressing work stream delivery** The committee accepted the amber rating for this work stream for Q3.	JR
4.2		**Patient Safety and Clinical Risk** ***Caroline McKenna, Patient Safety and Clinical Risk Lead***	
	4.2.1	CMK's introduced her Q3 report, noting that some of the incidents cross over quarters, so this report will often include incidents from quarters either side of the reported quarter. CMK noted the following and invited any questions: **Serious Incidents** There were 5 serious incidents externally logged on StEIS in Q3, including 4 patient deaths and 1 serious stabbing. One young person was stabbed to death in August and had been known to Trust services previously. There was an ongoing Serious Case Review (SCR) and CMK contributed the chronology of our involvement. This case will form part of the thematic review that is currently underway. Another 17 year old young man was also shot and stabbed. These violent deaths and incidents will form part of the next Trust wide learning lessons event in April on gang related violence, which will be led by Liz Searle. There were 2 further patient deaths reported from the GIC service, plus a 19 year old patient from the Portman services, whose case had been closed for 6 months, who took his own life by jumping in front of a train. CMK confirmed all relevant incidents were discussed at the monthly Incident Panel with concise reports being completed by the services involved and any lessons that can be learned from these incidents is flagged for future lessons learned events. CMK also noted that the inquest around the death of a 19 year old young person in May 2018 had been completed in November and although this Trust was not criticised in any way, there was lots of learning to be taken from this sad incident. CMK confirmed there had been one more in question since the last IGC meeting, where it seemed the patient had taken their own life, but the coroner confirmed they had died from natural causes. There was some discussion around de-escalations of incidents and also the process of reporting incidents and CMK confirmed the following: • A training guide for the process for logging incidents has been produced and is available to all staff on the intranet, plus a quick reference guide that will be used to train local teams. • DS explained the system for external logging of serious incidents and noted that all patient deaths need to be reported externally on the National Reporting & Learning System (NRLS) and with our commissioners on the Strategic Executive Information System (StEIS).	

	4.2.3	We are tasked to report all patient deaths that were seen by our services for 6 months either side of the incident, but the trust aims to be over inclusive in our reporting. • De-escalation is normally requested once an inquest has confirmed the cause of death or when there is no further action to be taken in relation to the incident. There was some discussion around the learning from these events and CMK confirmed the types of learning have included looking at : • Processes for front line staff • Mental Health training for staff in hostels, not all incidents will directly involve our staff • Lone practitioner – how connected they are to their organisations • Interagency communication, increasingly important for patients transitioning services and how that is managed • Patient deaths from the refugee service led to a reconfiguration of that service, which was felt to be working in silo, so it is now amalgamated with 2 other services to enable more joint working and a clearer overall patient picture. DS commented that we have changed the format of the lessons learned events and they now look at live cases and that IH is organising for this information to be available on the intranet specific lessons learned pages which are currently being worked on. This will also include relevant action plans from SIRs to cascade the learning further. Benchmarking of numbers of SIRs was discussed and it was noted it is very difficult to make comparisons with other non-comparable services. **Safeguarding Supervision Recording** The number of recorded safeguarding supervisions has increased and CMK confirmed we have now recruited to the adult Safeguarding & Prevent lead role for 2 sessions per week and it is hoped they will be in post shortly. PJ asked what had helped to increase these figures and CMK confirmed it was achieved by the patient safety officer continually reminding staff and chasing. It was agreed that this must not turn into a tick box exercise but must help support staff in their practice. DS said we hope this will continue to improve as we now have service level safeguarding leads and champions, who meet every two months at the Safeguarding Unit Meetings. CMK noted that there is an increasing need to contact social services and this involves a lot of time and continued effort to get social services to respond and DS asked **CMK to bring issues contacting social services to the Safeguarding Unit meeting taking place tomorrow for further discussion.** **Complaints** CMK reported that complaints have reduced slightly in Q3 but that the themes broadly remain the same. **Coronavirus**	CMK

	4.2.4 4.2.5 4.2.6 4.2.7	CMK confirmed this would be included in the Q4 report. DS noted that there was lots of advice available to acute, mental health and community services and at the last Medical Directors forum noted it was not helpful to have multiple conflicting advice, and noted that specific areas of risk exist as in the tube network etc, with the current advice to staff being if you suspect you have contracted coronavirus you use your mobile to call 111 and self-isolate until you are able to be tested, but do not go to your GP or any A&E departments. **Medical Revalidation** This item will be removed from the PSCR work stream from Q4 as this work is now being monitored by the ROAG meetings. **Safeguarding Children** CMK confirmed this area is a constant focus and is moving in the right direction with no specific concerns. MS noted that the graphs displaying the children's safeguarding was very helpful and asked if it could also be provided for adults and **CMK agreed to request a graph for the adult safeguarding figures from the new adult safeguarding lead for future PSCR reports** DS asked what the situation was in relation to teams having crisis and risk plans in place as we must demonstrate that we have this in hand for the CQC inspection. CMK confirmed that some services like the CAISS team are very robust in both areas, as are the CAMHS community teams, and also noted an improvement in the adult teams with crisis and risk planning. CMK confirmed teams have been undertaking local audits of 10 random cases to identify any gaps. LS noted that the crisis plan form for under 18 year olds has now been added to Carenotes so that will also improve the situation. The committee accepted an amber rating for Q3.	CMK
4.3		**Patient Experience & Quality** ***Chris Caldwell, Director of Nursing covering Quality and Patient Experience***	
		MS presented CC's report in her absence noting this work stream focuses on the delivery of service through the patient lens. MS confirmed there was good progress for the CQUINS but that some areas had not achieved their targets, including the flu vaccinations, which requires 80% uptake and to date we have not yet reached 60%. There was some discussion around whether the new occupations health provider (TeamPrevent) may have impacted the numbers and whether we are capturing if staff have received the vaccination elsewhere. PF noted the contribution from our nursing colleagues and also highlighted the possibility of a cultural barrier.	

		IG noted the report was good, but challenged whether the report was really viewing through the patient lens as sometimes it read as if it was the Trust telling patients that this is what they want. There was some discussion around the direct involvement of patients, and DC confirmed the Quality Advisory Group forum invites patient attendance to give their views. DC also suggested a change to the Experience of Service Questionnaire (ESQ), adding more free text to gain clearer patient feedback. It was also noted that the work of the PPI and lot of other patient groups who interact with our services was not reflected enough in the work stream report and where possible, it was agreed it would be helpful to have current and past patients' thoughts incorporated. MS noted that we needed to ensure there was no duplication in reporting patient outcomes as this is already covered in the PSCR work stream. **MS & CMK agreed to meet and confirm how patient outcomes would be reported across the two work streams.** **MS agreed to feed this back to CC noting that the report was well received but perhaps could include some more of the above.** PJ left the meeting for a prior engagement. The committee accepted a rating of amber for Q3.	MS & CMK MS
4.4		**Corporate Governance and Risk** ***Marion Shipman, Associate Director of Quality and Governance***	
	  4.4.1 4.4.2	MS introduced her report highlighting the following key issues and inviting any questions: **Report Overview:** • Work force stats are good • We received good NHS survey results • Sickness reporting remains low • Appraisal compliance remains good • Infection control and toy cleaning is on target • There is one outstanding incident on the central alert system (CAS) in r elation to a ligature point • New water heaters have now been signed off • Some BCPs are required for new Trust service locations and all other BCPs need to be updated including those which are dependent on external landlords and this will be done via Estates and Facilities. • Evacuation plans are now up to date • The 2 Judicial Reviews (JIR) regarding data breaches are under way and remain on track • No change on legal claims with no claims completed in Q3 **Non-clinical Incidents** MS noted that the GIC staff have required additional support in dealing with the numerous difficult phone calls and the social media hype around the gender services, and plans are being put in place to provide the necessary support for these staff teams. MS also confirmed an extra field had been added to the	

		incident reporting system, the Quality Portal (QP) for Social Media incidents, to enable their reporting.	
	4.4.3	**Gloucester House School Incidents (GH)** MS reported that the incidents at GH have halved in Q3 at 39 incidents comparted to 70 for Q2, which may in part be due to the change in children attending school during Q3. There have also been staff changes at GH including new team leads joining the school and further training is being planned. There was some general discussion and CdS noted the NHS staff survey did show some good results noting we did very well in the areas of safety and bullying and harassment but noted the warning that there are concerns over the health and wellbeing of our staff which may require managers to be more supportive, plus a declining perception of staff reporting these incidents, which is now only 64%. CdS also noted that the advocacy metric for whether staff would promote the Trust as a place to work or receive treatment, and although both had reduced, the Trust was still rated as the best in this area. There was some further brief discussion and DS commented that there are lots of changes within the managers' roles and that this staff group may be redefined during the coming year. The committee accepted the amber rating for Q3.	
4.5		**Estates, Facilities and Capital Work stream** ***Ian Garlington, Estates Consultant***	
	4.5.1	**Report Overview** IG introduced his report noting that in Q3 there were more greens to amber rating and that there would be a further review of recorded risks in Q4 to ensure we are aware of all real risks and confirmed due to the ongoing nature of the work this report is always likely to remain amber, such as the increased reporting required for things like external cladding risks etc. IG also confirmed he is investigating how information could be cloud based to provide managers with easy access to the information and invited any questions from the committee.	
	4.5.2	**Business Continuity Plans** DS asked if service BCPs have captured events like the flood at GIC and if they were effective. IG confirmed there BCPs could be better and noted that the event the Trust undertook last year had been useful, but added this event needs to be repeated and that a different scenario should be used. **IG & DS agreed to meet to plan the next Trust wide BCP exercise with expanded scope to involve estates issues, such as operational security, access, etc.** The committee accepted the amber rating for Q3.	IG & DS
4.6		Research and Development *Eilis Kennedy, Director of Research and Development*	

		EK introduced her report highlighting the following areas:	
	4.6.1	**Submitted Grants** EK confirmed that in December 2019 the Trust applied for 2 substantial grants; £100,000 for engagement as part of the £34,000,000 investment. EK confirmed that if this is granted, it will be followed by a launch in March 2020 but if it is unsuccessful it will be very disappointing.	
	4.6.2	**NIHR Personalised Programmes for Children Study** EK noted there is real concern regarding whether Public Health England (PHE) will provide the required excess treatment costs, and confirmed that without that investment, the study would not be able to continue for the 3rd year.	
	4.6.3	**NIHR LOGIC Study** EK noted there are concerns around this study, which is a very ambitious programme which is now beginning to stabilise and confirmed that we have completed the secondary data analysis and this is now with UEL.	
	4.6.4	**NIHR LOGIC (Longitudinal Outcomes)** EK noted that this Study's Steering Group had been an excellent source of support and noted how helpful JA had been throughout the process. EK also confirmed that now the study was using the UCL database, Qualitrix, previous data difficulties had been overcome. EK confirmed there remains many challenges, including the fact that the families involved in the study are based right across the UK and the majority have understandably requested home visits to enable their participation in the study, and this has sometimes put our travel budget and staff time commitments in a very difficult position. EK confirmed the two excellent research assistants have now moved onto clinical training and it has been difficult to manage the differing notice periods when appointing replacements. EK also confirmed the longitudinal study was over recruiting and continuing to do well, and this would be audited by our partners Noclor and the Trust Research Group. DS noted that the Chair and CEO had agreed that we need to ensure research is clearly and strategically present on the intranet which will enable us to not only raise the research profile across the Trust but also to encourage a research atmosphere within the organisation.. EK agreed confirming that there were 2 events already planned for this year including a half day workshop with a centenary focus which will take place during Research Week. **EK agreed to circulate the work shop date.** The Trust is also hosting a research conference, focusing on the centenary, with the University of Essex which is being planned for September 2020, with a possible guest speaker from the Netherlands. DS invited any thoughts or suggestions for either event. DB suggested we could request the Trust patron to open the conference and JR offered to join the research group for any technical issues. **EK agreed to invite JR to future research steering group meetings.** IG asked if there were any opportunities for intellectual property opportunities in relation to this work and it was confirmed this was not an option for these current studies.	EK

		The committee accepted the green rating for Q3.	EK
5.		**Any other business** There was no other business. DS thanked the committee for their attendance and closed the meeting.	
6.		**Future Meeting Dates:** Wednesdays, 11am – 1pm in the Tavistock Board Room 20th May 2020 16th September 2020 18th November 2020	

The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education and Training Committee – 6th February 2020

Key items to note

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

M80 Child Psychotherapy Programme

The committee noted the good outcome in relation to issues/concerns signalled by Essex University in relation to the M80 programme, with the first finishers of their doctoral research, and the development of a small working group and action plan.

Partnership with the University of Essex

The committee noted the ongoing renegotiation of the collaborative agreement and financial arrangements with the University of Essex, and the uncertainty posed by the lack of an outcome on our application to register with the Office for Students.

[Update since the meeting: Essex has agreed following our request to roll over the agreement and arrangements for one year, in light of the situation with Covid-19.]

Indemnity of Student Research

The committee noted the work undertaken to ensure a robust process around indemnity of student research, including the provision of resources to staff undertaking ethics approval and the involvement of a member of staff from the University of Essex on the Ethics Approval Committee.

Tavistock Society of Psychotherapists

Following the AGM on 6th February, we will be proceeding with incorporating the TSP into the Trust. Work is ongoing to ensure our current committee structures enables us to meet our obligations.

International Strategy

The committee noted the steps that had been taken to mitigate against losses resulting from the coronavirus outbreak, including looking at online platforms, postponing activity to later in the year, and continuing to explore our existing relationships international organisations and partners.

Honorary Doctorates

The committee considered nominations from across the Trust for honorary doctorates for graduation in 2021. The committee agreed to recommend Mike Solomon and Jacqui Dyer for honorary doctorates. The Board of Directors has agreed these nominations and they have been sent to the University of Essex for their consideration and approval.

Diversity of the Student Body

The committee noted the considerable work that has been put into establishing a reliable data set in relation to the diversity of our student body across the student journey by portfolio. The committee made recommendations in relation to developing the way the data is presented, and agreed that a prioritisation exercise should be undertaken to ensure this work is taken forward. It is envisaged that this work and the action plan from it will be presented to the Board in due course.

Marketing and Recruitment
The committee noted that work is ongoing to agree targets and to see where group sizes can be increased, within room limitations, to meet the overall target.

UKVI Audit
The committee noted the outcomes of an internal audit of compliance in relation to UKVI. The committee received an action plan with recommendations from the audit, and noted progress in relation to three key actions: the type of English test we get applicants to complete; support for particular students; and reporting changes of circumstance to UKVI. The committee noted the intention to draw up a policy for student engagement and attendance.

Digital Academy
The committee noted progress of phase 2, including the establishment of governance and milestones, and a clear project plan, as well as the allocation of a project manager.

Student Disabilities Policy
The committee endorsed the new Disabled Students Policy, subject to minor amendments, including the need to elaborate on the fluctuating nature of mental health and other conditions, a policy statement, and the development of clear communications out to staff and students about the new policy. This will be presented through the usual governance channels for approval.

Scheduling and Timetabling
The committee noted the approach to timetabling for academic year 2020-21.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	07 May 2020

Strategic and Commercial Committee Board Report

1. Adult Gender Identity Clinic Procurement

The Committee received an update on the adult gender identity clinic procurement, and discussed the tactical and strategic response to the bid announcements that were anticipated imminently. Though established as an invitation to tender (ITT), the procurement has in effect been used as a re-contracting mechanism during which incumbent providers were asked to provide existing baseline costs, rather than to build a model that would deliver the new service specifications. Rachel Surtees, Director of Strategy and Transformation, gave the Committee a brief update on the bid position taken. Notably, our clinic is one of the few GICs contracted via a block contract arrangement, and we don't consider the 19/20 contract value to be reflective of true baseline costs. We therefore took a decision to present an uplifted baseline position for 20/21, noting that this was the resource model that would allow us to maintain status quo, not to adopt the new service specification.

The Committee considered the risk of either NHS England refusing to accept the revised baseline, or, of enforcing the new specifications without committing the additional resource required to operationalise this. It was agreed that if either of these risks materialised, our response would take into account the wider relationship with NHS England.

2. Developing strategic intent

The Committee was presented with a paper setting out the internal and external context that was creating the impetus to refresh our organisational strategy. A significant consideration in this is the implication of the move towards integrated care systems (ICS), and our positioning as a specialist trust that combines education and clinical provision, delivered at a local and national level.

It was recognised that staff engagement, and student and patient voice, was important in this work. However, this needs to be framed within the context of our operating environment to ensure that the engagement is meaningful and constructive.

3. Contracts update

Amy Le Good, Associate Director of Contracts, gave an update on the 19/20 contract performance position, and progress finalising 20/21 contract, which must be completed by 27th February 2020. Activity underperformance has been a concern throughout the year, however, the action plan that was developed in Q2 has led to an improvement in activity across our CCG contracts which is being recognised in our negotiations for the year ahead.

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 31st MARCH 2020, 2.00pm – 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	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
2.3	Minutes of the meeting held on 28th January 2020	Chair		1
2.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report and COVID-19 Briefing	Chief Executive	2.20pm	2 3 – Late
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	4
3 Items for discussion				
3.2	Gender Services Divisional Report • GIDS Action Plan – One Year On • GIDS Data Strategy	Divisional Director	2.35pm	5 – Late
3.3	NHS Staff Survey 2019	Director of HR & Corporate Governance	2.55pm	6
4 Items for decision or approval				
4.1	Clinical Quality Strategy	Medical & Quality Director	3.05pm	7
5 Items to note				
5.1	Board Assurance Framework	Chief Executive	3.15pm	8

		Presenter	Timing	Paper No
5.2	Higher Level Responsible Officer (HLRO) Action Plan	Medical & Quality Director	3.20pm	9
6 Board Committee Reports				
6.1	Audit Committee	Committee Chair	3.30pm	10
6.2	Integrated Governance Committee	Committee Chair	3.35pm	11
6.3	Training and Education Committee	Committee Chair	3.40pm	12
6.4	Strategic and Commercial Committee	Committee Chair	3.45pm	13
7 Any other matters				
7.1	Any other business	All	3.50pm	
8 Date of Next Meeting				
	19th May 2020, 1.30pm – 4.00pm – The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			