

# Board of Directors Part One

## **Agenda and papers**

of a meeting to be held in public

2.00pm–4.30pm  
Tuesday 23<sup>rd</sup> May 2017

Lecture Theatre,  
Tavistock Centre,  
120 Belsize Lane,  
London, NW3 5BA

## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 23<sup>rd</sup> May 2017, 2.00 – 5.00pm  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Enc.	p.6
4.	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	<b>Patient Story</b> GIDS patient	To note	Verbal	-
6.	<b>Service Line Report: GIDS</b> Ms Polly Carmichael, Director GIDS	To discuss	Enc.	p.7
7.	<b>Trust Chair's and NED's Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.30
9.	<b>Annual Report and Accounts</b> <ul style="list-style-type: none"> <li>a. Annual Report</li> <li>b. Annual Accounts</li> <li>c. Quality Report</li> <li>d. External Audit Report</li> <li>e. Letters of Representation</li> </ul> Ms Sarah Anderson, Interim Trust Secretary Mr Terry Noys, Deputy CEO and Finance Director Ms Marion Shipman, Associate Director Quality	To approve	Enc.	p.33 p.40 p.146 p.183 p.251 p.259 late
10.	<b>Annual Self Certifications</b> Ms Sarah Anderson, Interim Trust Secretary	To approve	Enc.	p.264
11.	<b>Finance and Performance Report</b> Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.285
12.	<b>T&amp;E Report</b> Mr Brian Rock, Director of E&T/ Dean	To note	Enc.	p.290

<b>13.</b>	<b>CQSG Report Q4</b> Dr Rob Senior, Medical Director	To discuss	Enc.	p.299
<b>14.</b>	<b>CQSG Annual Report</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.310
<b>15.</b>	<b>Serious Incident Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.318
<b>16.</b>	<b>Staff Survey and HR and Organisational Development Annual Report</b> Mr Craig de Sousa, Director of HR	To discuss	Enc.	p.322
<b>17.</b>	<b>T&amp;E Complaints Report</b> Mr Brian Rock, Director of E&T/ Dean	To discuss	Enc.	p.335
<b>CLOSE</b>				
<b>18.</b>	<b>Notice of Future Meetings:</b> <ul style="list-style-type: none"> <li>• 27<sup>th</sup> June Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> <li>• 25<sup>th</sup> July Board of Directors' Meeting, 2.00-5.00pm, Board Room</li> <li>• 26<sup>th</sup> September Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> </ul>			

# Board of Directors Meeting Minutes (Part One)

Tuesday 25<sup>th</sup> April 2017, 2.00 – 4.00pm

Present:			
Prof. Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Dr Chris Caldwell Nursing Director	Ms Helen Farrow NED
Ms Jane Gizbert NED	Dr Sally Hodges Director of CYAF	Mr David Holt NED, SID, Audit Chair	Mr Paul Jenkins Chief Executive
Ms Louise Lyon Director of Q&PE	Ms Edna Murphy NED, Deputy Chair	Mr Terry Noys Deputy CEO and FD	Mr Brian Rock Director of E&T/ Dean
Dr Rob Senior Medical Director	Dr Julian Stern, Director of AFS		
Attendees:			
Ms Sarah Anderson, Interim Trust Secretary (minutes)	Ms Katie Argent, Portfolio Manager (item 5,6)	Ms Rohima Bibi, Student (item 5)	Mr Craig de Sousa, HR Director (item 9,10)
Ms Amanda Hawke, Complaints Lead (item 13)	Mr David Wyndham Lewis, Director of IMT (item 18)		
Apologies:			
Ms Marion Shipman, Associate Director of Quality (items 13,14,16,20)			

## Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to the March minutes	SA	Immd.
2	6	Submit the scope of the reputation audit to the Strategy and Commercial Committee	PJ	May
3	10	Update on complaints at the GIC in June	AH	June
4	13	A report on the increase in incidents at Gloucester House to be provided to the next Board meeting	AH	May
5	14	An update on the fall in recording of outcome measures to be included in the Chief Executive's report	PJ	June
6	16	An update on the delivery of the IM&T Strategy is to be provided to the July Board	DWL	July

### 1. Chair's Opening Remarks

Prof. Burstow welcomed the directors to the meeting.

### 2. Apologies for Absence and declarations of interest

Apologies as above.

Prof. Burstow reminded directors of his interest in ASH with regard to item 13 Smoke Free Policy.

### **3. Minutes of the Previous Meeting**

**AP1** The minutes were approved with minor amendments

### **4. Matters Arising**

Action points from previous meetings were noted.

### **5. Patient Story**

Ms Bibi gave a presentation about her experience of studying with the Trust. She explained how flexible and accessible to module had been and how it had fitted with her family life and work commitments. She praised the support offered by the tutors and how much the course has helped her to deepen her understanding.

### **6. Service Line Report: Psychoanalytic Portfolio**

Ms Argent introduced the report outlining the courses on offer and the challenge of attracting students in the current economic climate. In addition, the specification of courses that will be supported by HEE funding is changing and the Trust is seeking to ensure that courses remain applicable to students and also attract financial support. She noted that many courses provide an extension of understanding for students as opposed to an academic qualification.

Ms Murphy asked what the Trust could do to secure HEE funding and how this could be balanced with keeping courses accessible for people like Ms Bibi. Ms Argent responded that this is the challenge to design courses that provide insight and deeper understanding for students whilst meeting the HEE criteria.

The Board **noted** the report.

### **7. Trust Chair's and NEDs' Reports**

Prof. Bhugra noted that he had attended a European Psychotherapy conference. This had identified a gap in training and the Trust is considering what it could provide.

Ms Farrow identified that she had attended a meeting of the whole Family and Perinatal team. There was some concern expressed about responsibilities and how the organisations are working together, given changes at the Local Authority.

### **8. Chief Executive's Report**

Mr Jenkins reported that he had identified a resource to undertake a reputation audit of the Trust. It would focus on a small number of key influencers and the markets that the Trust wished to enter. Mr Holt requested that the scope of the review be circulated to the Strategy and Commercial Committee.

**AP2**

Mr Holt asked whether the Trust would receive any of the STP transformation funding. Mr Jenkins explained that the Trust will get an element of the £0.75m to fund an integrated IAPT pilot.

Prof. Burstow highlighted the BAFTA nomination for the Channel 4 documentary series Kids on the Edge, which the Trust had participated in.

The Board **noted** the report.

### **9. People Strategy**

Mr de Sousa introduced the Strategy which includes specific statements around bullying and harassment. He also highlighted the Delivery Plan and priorities for 2017/18. Mr Jenkins noted that the Strategy is being discussed with the SPC on 26<sup>th</sup> April 2017.

Ms Gizbert asked for more detail on the turnover of staff and why staff left the organisation. Mr de Sousa noted that this was a way for staff to develop due to the low turnover of staff in more senior posts.

Mr Holt asked about diversity in applications and the low conversion level to diversity in the workforce. The need for a clear action plan and not just monitoring was expressed by Ms Murphy.

The Board **approved** the People Strategy and the Delivery Plan.

#### **10. Mitigating the impact of the Apprenticeship Levy**

Dr Caldwell presented the report and noted that this provides a cost pressure for the Trust. The Trust is working with other organisations to identify ways that it can access the funds to pay for courses for staff.

The Board **noted** the report.

#### **11. Mental Health Workforce Development Collaborative**

Mr Jenkins introduced the report and noted that this is being taken to all boards in the collaborative. He noted that a Partnership Board is being established along with work programmes.

Prof. Bhugra requested that consideration be given to research being in scope of the Collaborative as the bigger cohort will provide more opportunities. Ms Gizbert and Dr Caldwell noted the diversity of the organisations involved and that this provides opportunities for shared learning.

The Board **approved** the involvement of the Trust in this collaborative.

#### **12. Annual Complaints Report 2016/17: Patient Services**

Ms Hawke presented the report and noted key themes of the complaints received. She noted that patients have responded positively to our actions arising from their complaint. Some issues take a while to address and the patient is kept informed of the progress of their complaint. The children and young people's GID service received the largest number of complaints in 2016/17 with waiting times being the main subject.

In the coming year the key area for receiving complaints is likely to be the Gender Identity Clinic (GIC) which the Trust took responsibility for on the 1<sup>st</sup> April and this is around communications and waiting times. The Trust is identifying ways to maintain communication on this busy service as well as identifying different ways of working given the pressures on the service and funding.

Mr Jenkins noted that the Trust is seeking more openness in receiving and addressing complaints and that the main topic does not relate to waiting times.

Given that the based on past years statistic the GIC is likely to generate as many complaints as the rest of the Trust's services combined Prof. Burstow asked that the Board receive an

update on complaints to the GIC in June.

The Board **noted** the report.

### **13. Smoke Free Policy**

Ms Lyon introduced the report and led a discussion including the use of e-cigarettes. She was asked to consider the policies of other trusts as to whether vaping was permitted in the buildings or only in Smoking areas. In addition, some concerns were raised about the tone of some elements of the Policy which Ms Lyon will address.

The Board **endorsed** the policy and **delegated approval** to the Chair and Chief Executive of the amended policy.

### **14. Draft Quality Report 2016/17**

Ms Lyon introduced the draft report and noted that this was the Board's opportunity to comment on the content of the report but noting that much is prescribed by NHS Improvement. She circulated a table of minor amendments to the draft in the Board pack which have arisen as data has been further worked on in the last week. Ms Lyon noted that responses are awaited from stakeholders and these will be chased as some are formally required.

Mr Noys queried why the non-clinical whistle-blowing incident had not been included in the report. This is to be added by Ms Lyon.

The Board **noted** the Draft Quality Report.

### **15. Q4 Dashboards**

**AP4**

Mr Jenkins presented the report. A discussion followed on the increase in incidents at Gloucester House. A report on this is to be provided to the next Board meeting.

The Board **noted** the report.

### **16. Quality Report Commentary Quarter 4**

**AP5**

Ms Lyon presented the report. The fall in the recording of outcome measures was noted and referred to CQSG for review and an update in the Chief Executive's report.

The software to remind patients of appointments is not yet live due to other priorities in the IM&T Department.

The Board **noted** the report.

### **17. Waiting Times Analysis by Team**

Ms Lyon presented the report and noted that some teams are returning some very positive waiting times.

The Board **noted** the report.

### **18. IM&T Strategy and Programme Q4 Update**

Mr Wyndham Lewis presented the report. He highlighted that a significant resource had been required for the integration of the GIC service which had delayed some other projects. He noted that resource would be released back to these projects in the second week of May.

**AP6**

Ms Gizbert asked about the GIC relocation and the impact on prioritisation of schemes. An update on the delivery of the IM&T Strategy is to be provided to the July Board.

The Board **noted** the report.

**19. Finance and Performance Report**

Mr Noys introduced the report by noting the Trust had met the Control Total for the year. He circulated some updated figures which had arisen from late guidance being provided by NHS Improvement. He noted that agency costs were 2% above the cap.

The Board **noted** the report.

**18. Training and Education Report**

Mr Rock introduced the report and noted that the comparisons requested at the last meeting are now included in the report.

The Board **noted** the report.

**19. Any Other Business**

The Board noted its future meetings

Part one of the meeting closed at 4.55pm



## Outstanding Action Part 1

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Jan-17	Develop Race Equality Strategy	Louise Lyon	Apr-17	Due May , revised to June
1	Feb-17	Include W/T plans in GICS Service Line Report	Polly Carmichael	May-17	
2	Mar-17	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	Rob Senior	Sep-17	
3	Mar-17	Audit cases similar to BB to check closure procedures followed.	Sally Hodges/ Rob Senior	Jun-17	
2	Apr-17	Submit the scope of the reputation audit to the Strategy and Commercial Committee	Paul Jenkins	May-17	
3	Apr-17	Update on complaints at the GIC in June	Amanda Hawke	Jun-17	
4	Apr-17	A report on the increase in incidents at Gloucester House to be provided to the next Board meeting	Amanda Hawke	Sep-17	
5	Apr-17	An update on the fall in recording of outcome measures to be included in the Chief Executive's report	Paul Jenkins	Jun-17	
6	Apr-17	An update on the delivery of the IM&T Strategy is to be provided to the July Board	David Wyndham-Lewis	Jul-17	

## Board of Directors : May 2017

**Item : 6**

**Title : Service Line Report: Gender Identity Development Service (GIDS)**

**Purpose:**

This paper is written to provide the Board of Directors with assurance of achievements and progress towards meeting Service and Trust-wide objectives by the Gender Identity Development Service

This report has been reviewed by the following Committees:

- Management Team, 16<sup>th</sup> May 2017

**This report focuses on the following areas:**

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Finance

**For : Noting**

**From : Polly Carmichael – GIDS Director**

# Service Line Report – Gender Identity Development Service (GIDS)

## Executive Summary

### 1. Introduction

- 1.1 The GIDS is a highly specialist nationally designated interdisciplinary service unique to the NHS. We see children and young people up to the age of 18 years and their families who are experiencing difficulties in the development of their gender identity.

The Service operates from two main bases, London and Leeds, with outreach clinics in the South West. We have links with CAMHS in many areas of the UK and on occasion use their rooms for outreach clinics. NHS England have indicated that they support a hub and spoke service delivery model. We are looking to develop new outreach clinics in the Midlands and Manchester.

The service is funded via a National Contract with NHS England covering patients from England and Scotland. Patients from Wales are not covered under the national contract and are funded via Named Patient Agreements. The service receives some referrals from European Countries (e.g. Ireland and Malta). The service offers regular consultations in Belfast and supported the development of a service there based on the GIDS model and protocol. In the case of Ireland the service has been involved in supporting the development of a local Irish Service.

## **2. Areas of Risk and/or Concern**

### **2.1 Waiting list**

Following an unprecedented and unpredictable increase of 100% in our referrals in 2015/16 the GIDS has been breaching its 18 week waiting time target since September 2015. Funding from NHS England increased in 2016/17 to support the service to achieve its waiting time targets again. This allowed the service to double in size over the course of 2016/17, from around 40 to 80 staff employed by the Tavistock directly. Referrals continued to increase, albeit at a slower rate (42%), in 2016/17.

Addressing the waiting list remains a priority for the service.

#### **Media**

The service receives many requests from the media. We take the approach that it is important to disseminate accurate information and provide a balanced view. Health care provision for young people with gender dysphoria is a contentious area and contact with the press requires care and judgement. The communications team in the trust provide excellent support. There is a risk associated with the number of requests received and the time it takes for senior clinicians to provide responses. We are mindful of this risk and regularly refuse requests or agree that the communications team provide a short written response.

#### **Transfer to adult services**

Work is ongoing with both Charing Cross adult gender clinic and the adult gender CRG. We met with members of the Charing Cross team on 4/4/17 to agree how transfers would be managed in the immediate future. For the time being referrals will be accepted from 17.9 years. Charing cross are doing a scoping exercise to assess the feasibility of slotting into their waiting list according to the original date of referral, referrals from the GIDS waiting list who

have not been offered an appointment by 17.9 years. They are also looking at possibilities, including extra clinics, to see young people referred from the GIDS, who are established on hormone treatment, more quickly.

The adult CRG led by John Dean are developing transfer guidelines to go in the adult specifications in collaboration with the GIDS. Sarah Davidson from the GIDS is leading on this. We have emailed responses to proposals on a number of occasions and are awaiting a response from John Dean.

It has been accepted that adult services should see referrals from the GIDS as quickly as possible and that they should not go on the general waiting list. However John Dean is proposing that this is only the case for young people on physical interventions or for those who have had a full assessment and are ready for physical interventions. This does not allow for older adolescents attending the GIDS who fulfil the criteria for a diagnosis of gender dysphoria but are not yet certain that they wish to undertake physical treatment. It is suggested this group, if referred, would be placed on the general adult services waiting list.

### **3. Proposed Action Plan**

#### **3.1 Waiting list**

New staff are now in a position to pick up more cases. Applications have been received to fill vacant posts and interviews will take place in May 2017. There was an increase in the number of referrals this year, at a slower rate than previous years, but more resources will be needed if the increase in demand for the service is to be met as the increase in referral numbers was not wholly reflected in the contract value.

We are developing a group for peri-pubertal young people referred to the service. The aim of the group is to offer a first contact with

the GIDS more quickly and to assess if this approach allows us to triage young people into assessment appointments according to need. This age group has been identified as some may be appropriate for physical intervention in the early stages of puberty. In these cases a timely assessment is important.

In Leeds all new referrals are seen in assessment clinics. In Leeds the waiting list is now at around 6 months. Not all clinicians in London are undertaking assessment clinics. There are benefits to this approach as set clinics enable the service to know in advance how many first appointments will be available each month, which in turn facilitates planning around managing the waiting list. The team Psychiatrist is leading a project with the service project manager to assess the feasibility of the whole London team moving to an assessment clinic format for first appointments and what this would mean for the waiting list, caseloads and follow ups.

### **Transfer to adult services**

One proposal is that the GIDS takes referrals up to age 17 and is commissioned to see people up to 21 years. This would allow assessments to be completed before referral to adult gender services. This has implications for the GIDS contract which currently commissions the GIDS to see young people up to the age of 18 years.

## **Main Report**

### **4. Overview of the Service**

4.1 The Gender Identity Development Service (GIDS) is a national highly specialist service, commissioned by NHS England and is staffed by an interdisciplinary team. The team consists of a child and adolescent psychiatrist, clinical psychologists, social workers, family therapists and child and adolescent psychotherapists.

4.2 We see children and adolescents (up to the age of 18) and their families who are experiencing difficulties in the development of gender identity. Typically, these young people feel that their biological or assigned sex does not match their gender identity. Some may be boys who feel or believe they are girls and vice versa. There are an increasing number of referrals for young people who identify in other less binary ways, i.e. non-binary or gender queer. The onset of puberty is commonly associated with an escalation of distress and an increased risk of self-harming behaviours.

4.3 The Service offers counselling to children with a transsexual parent. Assessment and advice are provided to the Courts at their request. Court reports usually result in referral to the GIDS which is covered by the national contract. In practice, this work has significantly reduced in the last 5 years.

4.4 Referrals to the service have increased year on year as follows:

- 2009/10 – 97 referrals
- 2010/11 – 139 referrals
- 2011/12 – 208 referrals
- 2012/13 – 314 referrals
- 2013/14 – 468 referrals
- 2014/15 – 697 referrals

- 2015/16 – 1419 referrals (104% increase)
- 2016/17 – 2016 referrals (42% increase)

4.5 The GIDS offers comprehensive and interdisciplinary assessment and treatment of children and adolescents with Gender Dysphoria (GD). The Service recognises that GD can be an extremely distressing condition, both for young people referred to the service and their families/carers. We endeavour to help young people and their families manage uncertainty regarding the outcome of gender dysphoria and provide on-going support and opportunities for exploration of gender identity.

4.6 We require local CAMHS teams to remain involved in referred cases and regularly convene local network meetings at the young person's local CAMHS or school. Many of the young people we work with have significant associated difficulties and the meetings are used to discuss these, as well as the management of issues associated with gender identity development and agree roles and actions moving forward.

4.7 The GIDS team at the Tavistock (London and Leeds) work closely with Paediatric Endocrine colleagues at University College London Hospital (UCLH) and Leeds General Infirmary (LGI) who are commissioned by us through a Service Level Agreement to provide Endocrine Liaison clinics. Following a detailed assessment and a period of therapeutic work, a referral may be considered for a selected number of cases to the Paediatric Endocrinology Liaison Clinic.

4.8 We provide two types of endocrine liaison clinic: The Early Intervention Clinic is available for carefully selected young adolescents in at least Tanner stage 2 of puberty and up to age 15; and Standard clinics for adolescents aged 15 – 18 years.



4.9 Physical intervention is available within a staged approach. After a series of physical tests young people may be prescribed hormone blockers. This intervention is putatively completely reversible. The blockers produce a state of hormonal neutrality. The pausing of pubertal development aims to reduce distress associated with this and so facilitates reflection and further exploration of the young person's gender identity. Such interventions are considered as part of an overall treatment plan offered by the Gender Identity Development Service and other therapeutic treatment/consultation and psychological monitoring remain ongoing. When possible the GIDS clinicians attend the endocrinology liaison clinics with their patients but when not possible another GIDS clinician will be present. This is considered important as it represents the integration of the mind and body.

4.10 The service protocol is regularly reviewed to identify innovative and cost effective ways of providing the service without compromising the quality of care. Examples of recent initiatives include family days, groups for young people and parents/carers and education days at UCLH to provide information about physical treatments.

## **5. Clinical Services and Activity Data**

5.1 The GIDS is funded by a Block Contract with NHS England. Last financial year we underperformed on planned activity. This was associated with the time it takes for new staff to build up a caseload which was affected by a number of factors. New staff found it difficult to develop a caseload as quickly as activity had been planned. There exists no formal training in this area of work and so clinicians largely learn on the job by taking on cases with existing experienced members of staff. As existing staff already have full caseloads it was difficult for new staff to find experienced

co-workers to work with on new cases. The impact of this factor had not been fully appreciated when we recruited the staff. Most new staff have now been in post a few months are now developing a caseload and associated activity.

- 5.2 New targets have been formulated for staff at different bands in the service in recognition that senior staff carry more managerial responsibilities and therefore are unable to see as many patients as lower banded staff who don't have these responsibilities.
- 5.3 The current waiting time for a first appointment as an average across the service is 6–7 months. This has reduced from almost a year at the start of the last financial year. We are continuing to address the waiting list and it is planned that we will meet our 18 week waiting time targets by September 2017.
- 5.4 Our DNA rate in Q4 of 2016/17 was 8%. We have consistently maintained a DNA rate of less than 10% over the last few years.
- 5.5 It is difficult to comment on dormant cases for GIDS because the majority our patients are seen infrequently. Therefore there are many cases that may not have been seen in over 3 or 6 months, but appropriately so.
- 5.6 All clinical staff are offered regular supervision on a one to one basis. We also hold several clinical discussion groups each month with various senior members of staff in the Trust.

## **6. Financial Situation**

- 6.1 The current GIDS budget is £5.8million. This is an increase of £800k on the previous year.

- 6.2 There are vacancies that are yet to be filled which will lead to an under spend. We plan to use this underspend to employ locum staff to manage the increases in referral numbers.

## **7. Outcome Monitoring**

- 7.1 The GIDS uses several outcome measures to assess Gender Dysphoria and associated difficulties over time. Questionnaires are usually completed during the assessment stage and then repeated at regular intervals post assessment, usually at one year, depending on the measure. For a list of questionnaires used by the Service, please see appendix 1.
- 7.2 The CGAS, ESQ & self-harm questionnaires are used to provide agreed outcome data to NHS England. In general they show an increase in general functioning and a reduction in self-harming behaviour post contact with the service.

## **8. Feedback**

- 8.1 Please see appendix 2 for ESQ data relating to the financial year 2016–17.
- 8.2 Response rates are typically low across the Trust. We are working with our receptionists to try and get more forms handed out with a view to people completing them in the waiting room before their appointment. If people leave the building with the forms, most often we don't get them back.
- 8.3 The number of complaints to the service is relatively low both in relation to the number of referrals to the service and the sometimes contentious debate around timing of physical intervention. The CQC, in its inspection in January 2016, noted the low levels of

complaints received by the service. There were reports that families felt unable to complain for fear it would affect their care. We have been clear this is not the case and have tried to show we welcome complaints, by, for example, ensuring we have complaints leaflets in all or waiting rooms, and explaining to all staff how to advise patients on making a complaint.

8.4 There has been a noticeable increase in the number of complaints to the service since the CQC inspection, however they remain low in relation to the number of referrals we receive. The complaints vary but general themes include:

- Unhappiness with protocols around the timing of physical interventions
- Unhappiness with the style of a particular clinician and requesting another
- Complaints about the length of the waiting list – particularly complaints with regard to provision for 17 year olds and conflicting messages from adult services
- Complaints about misinformation / conflicting messages from clinicians
- Complaints about rudeness of staff
- Complaints from parents who are separated where one parent is unsupportive of the referral to GIDS
- Complaints regarding post sent to the wrong address, or using the birth name of a Young Person rather than preferred name

8.5 All complaints are generally investigated by the Director of the Service in collaboration with the clinicians and/or administration staff involved. The Trust's complaints management team is actively involved and formal complaint responses are sent from the Chief Executive.

## **9. Serious Untoward Incidents and Safety Issues**

- 9.1 There was one serious incident in 2016/17: the suicide of 17 year old patient on the waiting list in May last year. There was a delay in referral arriving from the referrer and a further delay as the referrer had confused us with adult services and waited results of blood tests before responding to our enquiries. By the time all paperwork was received, YP was past the stage to be seen by GIDS service before their 18<sup>th</sup> birthday. A letter was sent to the young person and their family explaining this and that they would need to be referred to adult services. Sadly, the YP committed suicide and the GIDS letter was found in the young person's bedroom.
- 9.2 GIDS investigated this as a Level 5 serious incident. In the end, the Coroner made no communication with the Tavistock. Media attention was made, without mention of the Tavistock. To be noted: nothing in referral was mentioned about the vulnerability/risks of the YP in the referral. Investigation internally was led by the Trust Medical Director.
- 9.3 Lessons learned/Outcome: additional wording has since been included in letters out to families. Communication with Adult Services regarding transferring cases still to be resolved. In addition: GIDS do not advise on adult services, but do promote young people in transit to phone adult services and find out the latest regarding waiting time and referral criteria. Young people are also advised of contact lists and addresses on our website which is sign posted through NHS Choices.

## **10. Education and Training**

- 10.1 The GIDS holds regular CPD and Conference Events. The last major conference in July 2014 celebrated the work and achievements of

Dr Domenico Di Ceglie, the founder and former Director of the Service from 1989–2009.

10.2 The service holds CPD events targeted at professionals working with young people experiencing gender dysphoria 4–5 times a year, in both London and Leeds.

## **11. Research and Audit**

11.1 The GIDS is actively involved in Research and Audit. A list of current audit and research projects is listed in Appendix 3.

11.2 Many of our clinicians write for professional journals and books. Members of the team regularly attend and present at National and International Conferences. A number of papers were selected for presentation at the World Professional Association for Transgender Health (WPATH) Biannual Conference in Amsterdam in June 2016 and the newly established European equivalent (EPATH) in Belgrade in April 2017.

11.3 We hold regular monthly research meetings where all members of the team can contribute to audit and research planning.

11.4 The GIDS are committed to collaborating with European colleagues to increase the evidence base around gender dysphoria and appropriate treatment.

11.5 We regularly provide opportunities for research for post-graduate students undertaking further professional training(s).

## 12. Consultancy

12.1 The service receives various requests for teaching and training. We consider these jointly at a senior staff meeting given the current priority of the service is to increase activity and clear the waiting list. Where possible we signpost people to our CPD days, but as the national specialist service, we do accommodate larger requests wherever possible.

## 13. Staffing and HR issues

13.1 The rapid growth in the service and associated increase in staff have presented challenges around ensuring adequate training and support for new staff. The team has been re-organised and split into 4 teams, three in London and one in Leeds. We have reviewed the team structure and identified the need for team leaders for each team. This will be taken forward this year.

13.2 A 'Staff Statement' – provided by Trilby Langton, Highly Specialist Clinical Psychologist:

"I joined the team in September 2012 as a Clinical Psychology trainee and had a year in the team as part of my final year placement. I was really pleased to then be offered a Band 7 position and become a full time, permanent member of staff. At this time I was also moving to Bristol and so began to commute to London for half the week whilst also taking on a more active role to develop outreach clinics in the South West. Over time these clinics have grown and now we run two very busy outreach services in Exeter and Bristol. I currently only come to the London base once a week to participate in team meetings, supervision and appointments whilst the rest of my working week involves running clinics and attending networks meetings in this area. I have seen huge value in this set up over time in that I have developed really helpful and strong links with local clinicians. In Bristol we are based in a CAMHS team and hold a monthly clinical interest group whereby local

clinicians come to discuss cases, understand more about our process, reflect on work they are doing and in turn we can understand more about local support and improve joined up working. In the longer term I hope to work towards the possibility of having a third base in the South West that would reflect the high levels of need and access issues that are faced in this region. GIDS is a team in which ideas are welcomed and innovation is encouraged, this makes for a vibrant and active working environment which I really value.

Following a complicated pregnancy I had twins in June 2015 and had a year of maternity leave following this. Throughout this I felt hugely accommodated by Polly and the senior management team in GIDS and I feel very grateful and lucky to have been working in such a supportive and dedicated team at this time in my own life. On my return I applied for and was successfully appointed to an 8a role which I think reflects my efforts to develop the service and I have been pleased to settle into this role over the last year whilst managing my equally busy home life.

In relation to my own skill set and career I sometimes worry that I have found myself in a very specialist area at an early point in my career. However I also realise that the work requires such a huge variety of clinical skills and that I see such a range of families facing a variety of challenges and dilemmas. I feel that now I've been in the team for several years I have had the great opportunity to see children develop into adolescents and adolescents develop into adults in a way that is quite rare in the current climate."

## **14. Patient Story**

14.1 We are in the process of identifying a patient to present to the Board. In addition the Board may be interested in patient stories we have published on our website. These are accessible via the following link: <http://gids.nhs.uk/young-people#main-content>



Dr Polly Carmichael  
GIDS Director  
May 2017

## Appendix 1

### List of Clinical Outcome Measures/Questionnaires used by GIDS

Measure	Person	Ages
Youth Self Report	Self	12 to 18
Gender Identity Interview (Natal M)	Self	12 to 18
Gender Identity Interview (Natal F)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal M)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal F)	Self	12 to 18
Body Image Scale (Natal M)	Self	12 to 18
Body Image Scale (Natal F)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal M)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal F)	Self	12 to 18
Child Behaviour Checklist	Parent	All Ages
Social Responsiveness Scale 2	Parent	All Ages
GIDS Questionnaire for Children (Natal M)	Parent	Under 12
GIDS Questionnaire for Children (Natal F)	Parent	under 12
Teachers Report Form	Teacher	All Ages
Associated Difficulties	Clinician	All Ages
C-GAS	Clinician	All Ages
Self Harming Thoughts and Behaviours	Clinician	All Ages
Dimensional DSM Criteria	Clinician	12 to 18
Gender Identity Biographic Data	Clinician	12 to 18

#### **Post-Assessment**

CHI-ESQ Child (9 - 11)	Self	9 to 11
CHI-ESQ Young Person (12 - 18)	Self	12 to 18
CHI-ESQ Parent	Parent	All Ages
Self Harming Thoughts and Behaviours	Clinician	All Ages
Closing sheets	Clinician	All ages

## Appendix 2

### GIDS ESQ Data – 2016/17

<b>Q1. I feel that the people who had seen my child/who saw me listened to me</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	86%	8%	0%	0%
Parent	97%	3%	0%	0%
<b>Q2. It was easy to talk to people who have seen my child/who saw me</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	65%	32%	2%	1%
Parent	92%	8%	0%	0%
<b>Q3. I was treated well by the people who have seen my child/who saw me</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	97%	1.5%	0%	1%
Parent	99%	1%	0%	0%
<b>Q4. My views and worries were taken seriously</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	91%	8%	1%	0%
Parent	92%	5%	0%	2%
<b>Q5. I feel the people here know how to help with the problem I came here for</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	71%	27%	1%	1%
Parent	90%	10%	0%	0%
<b>Q6. I have been given enough explanation about the help available here</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	77%	22%	1%	0%
Parent	84%	13%	1%	0%
<b>Q7. I feel that the people who have seen my child/me are working together to help with the problems</b>				

	Certainly true	Partly true	Not true	Don't know
Young person	82%	16%	1%	2%
Parent	89%	8%	0%	2%
<b>Q8. The facilities here are comfortable</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	83%	16%	1%	0%
Parent	91%	7%	1%	0%
<b>Q9. The appointments are usually at a convenient time</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	44%	38%	18%	0%
Parent	45%	39%	14%	2%
<b>Q10. It is quite easy to get to the place where the appointments are</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	34%	41%	25%	0%
Parent	48%	33%	16%	1%
<b>Q11. If a friend needed similar help I would recommend that he/she come here</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	87%	10%	1%	1%
Parent	92%	8%	0%	0%
<b>Q12. Overall, the help I have received here is good</b>				
	Certainly true	Partly true	Not true	Don't know
Young person	92%	8%	0%	0%
Parent	96%	3%	0%	1%

N=231 responses

**Free text entries:**

**What was really good about the service?**

I have found the people that we have seen to be very helpful and informative. I have never at any point felt uncomfortable about discussing the problems that my child has had to endure

People were really friendly and courteous. Nothing was ever too much for them, willing to go out of their way and always interact with you at reception

It gave my son space and time to explore his feelings and allowed him to think about his gender in a non-judgemental environment.

The person I spoke to was really nice and easy to talk to. Everything was explained well and clearly.

**Was there anything you didn't like or anything that needs improving?**

Leeds is too far to travel. A service in Manchester is greatly needed.

More frequent appointments, more centres across the UK for easier access to service. Means it would be easier to attend family days etc

Set up an email support group for Parents.

Longer sessions. 1 hour wasn't long enough. 90 minute sessions would be better.

**Is there anything else you want to tell us about the service you/your family received?**

It felt personal and like you would be taken seriously no matter your feelings/age and family are involved to the degree you want but are offered help and support too.

Helped me and my mum in understanding all different options and not to feel rushed

On the whole we are very happy with the service we have/are receiving at the GIDS.

## Appendix 3

### List of ongoing Audit and Research Projects

#### LEEDS & LONDON

##### Research

N.M. De Graaf, A. Taylor & P. Carmichael. - *Well-being of Gender Dysphoric Adolescents on Puberty*

*Suppression: A Qualitative Follow-up Study.*

R. Whittaker, M.Dunsford & A. Taylor - *Autistic and Non-Autistic Gender Dysphoric Adolescents: a comparative analysis.*

#### LONDON

##### Research

A. Churcher Clark, W. Mandy, & D Clin Psy Student. – *Qualitative project examining process of gender identity development in adolescents with ASD*

B. Wren & X. Lee (D. Clin Psy Student) - *An exploration of transgender youth's experience with social media and its influences on their gender identity.*

J. Twist. N.M De Graaf, M. Dunsford. - *Exploring Gender Diversity: New questionnaire proposal*

M. Bristow, Alexandra Cole (trainee clinical psychologist), Prof Chris Barker, Dr Stephen

Butler – *Endocrine Related Research*

N.M. de Graaf – *Fertility preservation in gender variant young people, a qualitative study.*

P.Carmichael, N.M. De Graaf, E. Skagerberg, R.Viner, D. Di Ceigle - *Psychological Outcome of Young Adolescents with Gender Dysphoria After One Year of Puberty Suppression Treatment.*

P. Carmichael, N.M. De Graaf, E. Skagerberg, R.Viner, D. Di Ceigle - *Second Year Follow Up: Gender variant young adolescents accessing physical interventions*

S. Davidson & L. Hobbs (D.ClinPsy Student) - *Longitudinal follow-up*

T. Langton & N. Wheeler – *Siblings of Children with Gender Dysphoria*

##### Audit

A. Churcher Clark & G. Richardson - *Supporting the gender identity development of a trans female adolescent in a secure children's home: opportunities and challenges*

M. Bristow - *Finding the you that fits you: a young adult's account of their trans journey and reflections from their former clinician*

M. Dunsford, L. Barnett, V. Holt - *Young people with features of gender dysphoria: A comparative*

*review of demographics and associated difficulties in 2015.*

M. Dunsford & P. Carmichael - *Challenging 80:20: A post-pubertal follow up of children referred to the Gender Identity Development Service-*

M. Dunsford & P. Carmichael & S. Davidson. - *An evaluation of patients leaving the Gender Identity Development Service: pathways, presentations and outcomes.*

N.M. De Graaf, P. Carmichael, K. Dhondt, J. Laridaen, D. Pauli, J. Ball, A. De Vries & T.D. Steensma -

*Behavioural & emotional functioning in adolescents with Gender dysphoria: A European perspective - European cross-clinical comparison study between Swiss, Belgian, Dutch and British adolescents with GD*

T. Matthews, S. Sahin, V. Holt & A. Taylor – *Looked-After Children with Gender Dyphoria*

S. Davidson - *Working together with families of gender diverse youth - a multi-disciplinary, multi service workshop*

### **Salomons Trainee Clinical Psychologist projects**

F. Caryer- *Exploring puberty and gender identity in gender variant young natal females with an autism diagnosis.*

G. Harwood- *Parental experiences of having a child with ASD who socially transitioned to their preferred gender.*

L. Fisher- *Gender Development: Autism and Gender dysphoria*

## **LEEDS**

### **Research**

H. Wood - *Perceived barriers to social transition in male-female transgender adolescents.*

### **Audit**

H. Wood - *Bioethics and transgender youth, moral ways of working*

L. Charlton, J. Charlsley, & A. Taylor - *Service pathway for older teenagers in GIDS*

R. Witthaker - *Working with conflict in families of gender variant youth: a narrative*

*approach*

S. Phillot, L. Charlton, J. Charlsley, & A. Taylor - *Not seeing double: gender variance in twins under 18.*

S. Phillot & A. Taylor . - *Increase in referrals and social transitions in under 11s: Dilemmas and Implications.*

S. Phillott & A. Taylor & M. Dudu – *“To Speak or not to speak”: The Impact of voice satisfaction in adolescents with gender dysphoria*



## Board of Directors : May 2017

**Item :** 08

**Title :** Chief Executive's Report

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

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Student Mental Health Roundtable

- 1.1 The Trust hosted on 26<sup>th</sup> April a well-attended roundtable on student mental health. This focused on the experience in Camden and UCL but the event was also attended by a number of wider stakeholders in this field. The event was due to be attended by Dr Jackie Cornish, NHS England's Clinical Director for Transitions but she had to pull out due to issues relating to purdah. Our intention is to follow up the event after the Election.

### 2. Cyber-Attack

- 2.1 On 12<sup>th</sup> May a range of NHS organisation were subject to a widespread and aggressive cyber-attack. The attack took the form of ransomware which locked down infected PCs with a demand for payment to release them. There were no reported infected PCs at the Trust had already implemented in March a patch to combat the virus used in the attack. We have communicated with staff to remind them of the importance of vigilance in relation to the threat of cyber-attacks.

### 3. Kids on the Edge

- 3.1 As reported at our last Board meeting Kids on the Edge, the documentary screened on Channel 4 last year about the Trust's work with children and young people was shortlisted for a BAFTA for best Factual Series. While pipped to the post on the night it is a great recognition of the quality of the programme and the great job it did in helping raise awareness of the experience of young people and families seeking help at the Trust.

#### **4. Public Affairs Strategy**

- 4.1 Due to the opportunity to carry out a Reputation Audit we have decided to postpone the Public Affairs Strategy, originally planned for this Board meeting to the July Board.

#### **5. Medically Unexplained Symptoms**

- 5.1 I chaired a successful conference on medically unexplained symptoms on 10<sup>th</sup> May in Birmingham which we ran jointly with Healthcare Conferences UK. Presentations included the work of our City and Hackney and TAP Services.

Paul Jenkins  
Chief Executive  
15<sup>th</sup> May 2017

## Board of Directors : 23 May 2017

**Item :** 10

**Title :** Annual Certifications and Corporate Governance Statement 2017

**Purpose:**

NHS Improvement require the Trust to complete an annual self-certification declaring whether the Trust is compliant with G6 the general condition, FT4 the governance standards and CoS7 the Commissioner Requested Service standard.

The Board of Directors is invited to confirm the statements as set out in the appendices to this report.

**This report focuses on the following areas:**

*(delete where not applicable)*

- Corporate Governance

**For :** Approval

**From :** Sarah Anderson, Interim Trust Secretary

## Introduction

NHS Foundation Trusts are required to make the following declarations:

- Systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence **(Declarations 1 and 2 appendix 1)**;
- Corporate Governance Statement – in accordance with the Risk Assessment Framework – **(Declaration 3 – appendix 2)**;
- Certification on training of Governors – in accordance with s151(5) of the Health and Social Care Act – **(Declaration 5 – Appendix 3)**

## Statements in declaration

To assist the Board in determining that it can confirm the required statements an assurance report on the Trust's compliance with the provider licence conditions is provided at appendix 4.

The Board is asked to consider each of the declarations and assurance provided in turn and if satisfied confirm compliance against each of the required certifications.

In previous years the Trust was required to submit these annual certifications to NHS Improvement (NHSI), however, from 2017/18 the Trust is only required to ensure that they are made. This requirement will be audited by NHS Improvement in July 2017.

In addition, the Trust is required to publish Self Certification G6 on its website by the end of June 2017.

## **Recommendation to the Board**

The Board of Directors is requested to:

- **REVIEW** the assurance provided to enable the Board to positively confirm against each of the declarations
- **NOTE** the requirement to publish self-certification G6 on the Trust's website
- **NOTE** that these self-certifications may be audited by NHS Improvement.

## Board of Directors : May 2017

**Item:** 11

**Title:** Finance And Performance Report for the period  
ended April 2017

**Summary:** The Board are asked to note the contents of the report

**For :** Noting / Discussion

**From :** Terry Noys, Director of Finance  
16 May 2017

**MONTHLY FINANCE AND PERFORMANCE REPORT**

**Period 1**

**30 April 2017**

**Schedule**

- 1 Summary I&E**
- 2 Highlights**
- 3 Balance Sheet**

**Issued to EMT on**

**15 May 2017**

**By**

**Terry Noys, Director of Finance**



**FINANCE AND PERFORMANCE REPORT**
**Schedule 1 - SUMMARY I&E**
**Period 1**
**30 April 2017**

	2016/17 Actual Month £'000	2017/18 Actual Month £'000	2017/18 Budget Month £'000	Variance 2017/18 v 2016/17 £'000	Variance Actual v Budget £'000
<b>Income</b>	3,834	3,966	4,111	132	(145)
<b>Staff costs</b>	(2,510)	(2,957)	(3,144)	(447)	187
<b>Non-staff costs</b>	(963)	(750)	(795)	213	45
<b>Operational costs</b>	(3,473)	(3,707)	(3,939)	(234)	232
<b>EBITDA</b>	361	259	172	(102)	87
<b>- Margin</b>					
<b>Interest receivable</b>	1	0	1	(1)	(1)
<b>Interest payable</b>	0	0	0	0	0
<b>Depreciation / amortisation</b>	(61)	(75)	(65)	(14)	(10)
<b>Public Dividend Capital</b>	(40)	(46)	(48)	(6)	2
<b>Restructuring costs</b>	(4)	0	0	4	0
<b>Other</b>					
<b>Net surplus</b>	256	138	60	(118)	78
<b>- Margin</b>					

	2016/17 Actual YTD £'000	2017/18 Actual YTD £'000	2017/18 Budget YTD £'000	2017/18 F'Cast YTD £'000	Variance 2017/18 v 2016/17 £'000	Variance Actual v Budget £'000	Variance Actual v Budget %
<b>Income</b>	3,834	3,966	4,111		132	(145)	(3.5)%
<b>Staff costs</b>	(2,510)	(2,957)	(3,144)		(447)	187	6.0%
<b>Non-staff costs</b>	(963)	(750)	(795)		213	45	5.6%
<b>Operational costs</b>	(3,473)	(3,707)	(3,939)	0	(234)	232	5.9%
<b>EBITDA</b>	361	259	172	0	(102)	87	50.7%
<b>- Margin</b>							
<b>Interest receivable</b>	1	0	1		(1)	(1)	
<b>Interest payable</b>	0	0	0		0	0	
<b>Depreciation / amortisation</b>	(61)	(75)	(65)		(14)	(10)	
<b>Public Dividend Capital</b>	(40)	(46)	(48)		(6)	2	
<b>Restructuring costs</b>	(4)	0	0		4	0	
<b>Other</b>							
<b>Net surplus</b>	256	138	60		(118)	78	
<b>- Margin</b>							

**COMMENTARY**

After one month, net surplus is £78k ahead of Budget. This reflects an underperformance on income of £145k more than compensated for by a better than Budget performance on costs. The underperformance on income is primarily in Education and Training. The better than Budget performance on costs is found mainly in Education and Training and in CYAF.

Relocation Project costs have been capitalised.

**FINANCE AND PERFORMANCE REPORT**  
**Period 1**  
**30 April 2017**

**Schedule 2 - HIGHLIGHTS**

<b>RATINGS</b>	<b>Year To Date</b>	<b>Full Year Forecast</b>
Net surplus	GREEN	GREEN
Cash flow	GREEN	GREEN
Agency spend	GREEN	GREEN
SOF rating for finance and resources	GREEN	GREEN
Supplier payments	AMBER	GREEN

- Net surplus is positive and head of Budget
- Agency spend of £51k against a Budget of £61k
- The Single Oversight Framework has 5 reportable metrics for finance. Currently, all of these are forecast to show a rating of '1'

<b>STAFF NUMBERS (WTE)</b>	<b>YTD Budget</b>	<b>YTD Actual</b>
	669	632

<b>PROVISIONS / ACCRUALS</b>	<b>31-Mar-17</b>	<b>30-Apr-17</b>
Holiday pay accrual	305	305
Bad debt provision	305	305
Restructuring	179	179
Adult GIC Employee Claim	15	15
Other staff related	65	65
Camden Shed'	50	50

<b>CREDITORS / BETTER PAYMENT PRACTICE CODE</b>	<b>Target</b>	<b>YTD Actual</b>
Number of invoices	95%	96%
Value of invoices	95%	93%





## Board of Directors : May 2017

**Item : 12**

**Title : Directorate of Education and Training Board Report**

**Purpose:**

To update on issues in the Education & Training Directorate.  
To report on issues considered and decisions taken by the  
Training & Education Programme Management Board at its  
meeting of 8<sup>th</sup> May 2017.

**This report focuses on the following areas:**

- Quality
- Risk
- Finance
- Communications

**For : Noting**

**From : Brian Rock, Director of Education and  
Training/Dean of Postgraduate Studies**

## **Directorate of Education and Training Board Report**

### **1. Introduction**

- 1.1 This report provides an update on the issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 8<sup>th</sup> May 2017

### **2. National Contract/National Workforce Skills Development Unit (NWSDU)/Mental Health Workforce Development Collaborative**

- 2.1 Paul Jenkins and Brian Rock had their first monitoring discussion with HEE regarding the contract. There has been a positive response to the report that we submitted and there was recognition of the progress made in reporting on the contract.
- 2.2 Peter Rolland, National Training Contract Advisor, attended the meeting and provided an update on the NWSDU.
- 2.3 He explained that they are currently focussing on developing the staff base and the programmes of work for year 1.
- 2.4 The ongoing perinatal programme will be moving within the unit so it can be better supported by the team.
- 2.5 A recruitment process is underway for the role of Associate Director to lead the unit.
- 2.6 There continue to be issues in finding space for the staff of the unit to work together consistently.
- 2.7 A third meeting of the Mental Health Workforce Development Collaborative took place in May, and this had been positive.
- 2.8 There are two areas of focus at present namely primary care and apprenticeships. Further there is enthusiasm to undertake work focussing on staff resilience.

### **3. Student Recruitment, Marketing, and Alumni**

- 3.1 Laure Thomas, Director of Marketing and Communications, presented a paper on this item.
- 3.2 There are currently 421 submitted applications which is a 24% increase compared to last year. There is also a 40% increase in offers that have been accepted. Further information can be found in Appendix A. Courses that are not tracked on MyTap (SITS) are reflected separately following a request at the TEPMB to include these courses.
- 3.3 There is an issue around the user experience for students who wish to change the course they are applying for once they have begun their application. This is also resulting in duplicate applications. This will be addressed with the project team.
- 3.4 The recent open evening was well attended and there will be an open day in June as well as several course specific open evenings taking place in the coming months.
- 3.5 Brian Rock requested that thought is given and a plan developed for facilitating the conversion of incomplete applications to submitted applications without relying solely on open evening events, for example by offering Webinars. A proposal for this will be brought to the next programme board meeting
- 3.6 Financial information is still not included in the report. This was due to a focus on audit this month, however it was agreed by the TEPMB that this information be available for the July TEPMB.
- 3.7 There has been more focused discussions around the recruitment to the courses in the Forensic Portfolio. Elisa Reyes-Simpson, Associate Dean for Academic Governance and Quality Assurance has met with Jessica Yakeley, Director of the Portman Clinic, Julian Stern, Director of Adult and Forensic Services and Stephen Blumenthal, Forensic Portfolio Manager have agreed that there was a need for a course within the portfolio that would enable students to bridge the current gap to be ready for the existing courses.

3.8 It was agreed that further work would be undertaken to RAG rate courses according to the pipeline of applications in order to take decisions as to which courses may not run and which courses may possibly need to be run in parallel because of the demand for places. Edna Murphy emphasised that it would be necessary to identify why courses are not recruiting well in terms of market appeal as this would influence any decisions taken. This will come to the next TEPMB for consideration to give the operational team and faculty an opportunity to plan accordingly.

3.9 It was agreed that the impact of over recruiting to courses with a clinical component needed to be discussed with clinical services and a meeting will be arranged.

#### **4. SITS (MyTaP)**

4.1 David Wyndham Lewis, Director of Technology and Transformation attended for this item.

4.2 He explained that there are issues at the moment in regard to the finance module and the execution of recurrent card payments. This is in hand and should not impact on other areas of the project.

4.3 We are waiting on confirmation from Tribal as to their proposal for CPD functionality. DWL feels that what he has been seen so far is a workable solution although there are cost concerns which we are awaiting confirmation on.

4.4 Assessment functionality should be delivered on the 9th June. Karen Tanner, Associate Dean for Learning and Teaching and Deputy Director of Education and Training is leading an operational group to ensure that any anticipated issues are discussed and that there are contingency plans in place to address any issues or gaps in the delivery of the progression boards.

4.5 Testing of the module will begin this week, and DWL indicated that the testing schedule has contingency built in.



- 4.6 Karen Tanner highlighted some of the data migration issues that the team are encountering, which is taking significantly more time than expected.
- 4.7 It was agreed that contingency planning would be made visible and Paul Jenkins asked to be kept aware of any major issues.
- 4.8 A paper will be brought to the July programme board outlining how we would assess benefits realisation from the project. This will ultimately form part of the project closure and planning for future development.

## **5. Visiting Lecturers**

- 5.1 Brian Rock updated the group on the work that has been ongoing with regards to Visiting Lecturers (VLs)
- 5.2 He met with a group of VLs in late April along with Elisa Reyes-Simpson, David Wyndham-Lewis and Craig de Sousa. The group appreciated the willingness to hold a meeting and discuss some of the issues. There will be a further meeting on 24<sup>th</sup> May for those who were unable to attend this meeting.
- 5.3 This meeting was also an opportunity to introduce the new contract for VLs that will be introduced at the beginning of AY17/18.
- 5.4 Brian Rock explained that there were a number of issues affecting the group, not just those linked to their pay or contracts, including a sense of belonging and the value placed on them by the Trust. There was also significant variability in the work that VLs did for different courses so it was important that we fully understand what would improve their capacity to deliver to our programmes.
- 5.5 A larger piece of work is ongoing in relation to Associate Lecturers is underway. Paul Jenkins will convene a meeting to review and discuss these plans.

## **6. National Centre Assessment Framework**

- 6.1 Karen Tanner presented a framework that has been compiled by the task and finish group she is leading on our national centres strategy.
- 6.2 It has been developed by a combination of professional support staff and faculty as a means to assessing the benefits of potential partnerships but can be used as a framework for reviewing our current partnerships too.
- 6.3 The group discussed the document and made suggestions for other areas that could be considered when making these assessments including links to clinical services
- 6.4 The University of Essex will be engaged in reviewing the document.

## **7. Finance Report**

- 7.1 Bhavna Tailor, Finance Manager presented a paper on this item.
- 7.2 She explained that there is a gap of £200,000 in savings to be found. Some savings were planned to be found through the portfolio review and budget setting for next year.
- 7.3 The group discussed the movement of resources in the case of under or over recruitment to courses and BT explained that this would be discussed in recruitment meetings.
- 7.4 This report will be brought to the programme board each month going forward.

## **8. QAA Visit Update**

- 8.1 Elisa Reyes Simpson explained that the Quality Assurance Agency had visited the Trust on Tuesday 2<sup>nd</sup> May.
- 8.2 She felt that the visit went well and was positive.
- 8.3 The QAA did raise an issue with regards to our ability to capture and act on student feedback which is something we will need to begin to work on.

8.4 A preliminary report will be sent by 18th May and the final report published on 13th June.

**Brian Rock**

**Director of Education and Training/Dean of Postgraduate Studies**

**15<sup>th</sup> May 2017**

## Appendix A May Recruitment Figures



**Adding non-SITS courses: offers accepted**

16  
Ed Psych

55  
Social Work

13 Refugee  
Care

119 SITS

**203 offers accepted**

## Board of Directors : May 2017

**Item :** 13

**Title :** Clinical, Quality, Safety and Governance Committee Q4  
Board Report

**Summary:**

This paper is the DRAFT minutes of the Clinical Quality Safety and Governance Committee for the Q4 meeting held on 2<sup>nd</sup> May 2017.

**For :** Consideration

**From :** Medical Director

**CQSGC MINUTES FROM A MEETING**  
**HELD AT 11:00, TUESDAY 2<sup>nd</sup> May 2017, BOARDROOM**

<b>Members</b>	<b>Present?</b>
Rob Senior, Medical Director (& CQSGC Chair) (RS)	Y
Paul Jenkins, Chief Executive (PJ)	N
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	Y
George Wilkinson, Public Governor (GW)	Y
Anthony Levy, Public Governor (AL)	Y
Jane Gizbert, Non-Executive Director	N
Edna Murphy, Non-Executive Director (EM)	Y
Dinesh Bhugra, Non-Executive Director (DB)	N
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
Sally Hodges, Director of CYAF (in part) (SH)	Y
David Wyndham Lewis, Director of IMT (DWL)	N
Caroline McKenna, Associate Medical Director (CMK)	Y
Louise Lyon, Director of Quality and Patient Experience (LL)	Y
Julian Stern, Director of Adult and Forensic Services (JS)	Y
Marion Shipman, Associate Director Quality and Governance (MS)	N
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	N
Irene Henderson, Clinical Governance & Quality Manager & CQSGC Secretary (IH)	Y

<b>SUMMARY OF ACTION POINTS</b>				
<b>AP</b>	<b>Item</b>	<b>Action</b>	<b>By</b>	<b>Deadline</b>
5		TN ensure this work stream report format is aligned with the other work streams reports and to produce an action plan showing how this work stream plans to go from red to green by Q1	TN	July 2017
6		CMK to organise an event to promote the wider learning from the patient suicide	CMK	2017
6		JS to provide some narrative for the student governance passport to enable it to be used for honoraries to ensure training compliance	JS	Jun 2017

7	b	JS to work with clinical governance leads to ensure staff are completing crisis plans and risk assessments on all appropriate patients.	JS	Jul 2017
7	b	CMK to add crisis plans and risk assessments to the PSCR work stream and report on the work of JS and the clinical governance leads.	CMK	Sep 2017
9		IH to send out new diary invites to membership for 6 <sup>th</sup> September and 8 <sup>th</sup> November 2017.	IH	May 2017

AP	Item		Action
1		<b>Chair's opening remarks</b> RS opened the meeting and confirmed that the workstream reports being considered today were covering Q4 2016-17.	
2		<b>Apologies for Absence</b> Paul Jenkins, Dinesh Bhugra, David Wyndham-Lewis, Jane Gizbert, Marion Shipman and Elisa Reyes-Simpson.	
3		<b>Notes from last meeting</b>  The previous minutes were accepted as an accurate account of the last meeting with the following three amendments: 1) Remove (CQC) from Julian Stern's title in the membership list. 2) Incomplete sentence on page 6, item 7b to read: JS accepted this and acknowledged the achievement was due to an exceptional input from staff but reminded the committee that in order to make a sustainable change, we will need to ensure the staff input remains sustainable. 3) On page 81, GBM competition rate, replaced by GBM completion rate.	
4		<b>Matters Arising</b>  RS noted that SH could only attend the meeting in part and therefore the work stream reports would be tabled to accommodate her timing.	



		<p>RS also confirmed that going forward all serious incidents (SIs) will now come to the CQSGC via the patient safety and clinical risk work stream, to provide Board assurance on all aspects of the SIs. There was discussion about whether SIs should be discussed at Part 1 of the Board and it was agreed that a summary and the action plan would come to Part 1 but not the whole report. This would balance the need for transparency but also provide the required confidentiality. AL asked if all NEDs and Non-Execs should receive a copy of the SI report and summary for comment. PB felt that the discussion would be more informed if both NEDs and Non-Execs have sight of the SI reports and RS agreed that the reports could go as part of the Part 2 Board papers so they are circulated to NEDs and Non-Execs but not made public.</p>	
		<b>REPORTS FROM WORK STREAM LEADS</b>	
5		<p><b>Information Governance</b> <i>Terry Noys, Senior Information Risk Owner (SIRO)</i></p> <p>TN presented the paper which was produced by the previous IG manager with an overall rating of green for Q4 stating there were no major issues to note. TN noted that work was underway to ensure we are accurately reporting Trust compliance as the red rag status was harsh, did not accurately reflect the Trusts current position and should in fact have been amber.</p> <p>RS asked if the data quality issues have been resolved and LL confirmed that we now have new systems in place which makes the relevant reports available. LL also noted that although there are still some weaknesses in relation to waiting times we are significantly further forward this year and can now submit data with confidence.</p> <p>PB asked what we should expect this work stream rating to be at Q1 and TN confirmed he expected it to be green rather than amber, sighting that although a small area may not be compliant, the overall rating would be expected to be green.</p>	TN

		<p>RS stated that in the absence of an action plan addressing an area of non-compliance he would prefer the rating to be amber rather than green. The Committee agreed to this.</p> <p>RS requested that TN ensure this work stream report format is aligned with the other work streams reports and to produce an action plan showing how this work stream plans to go from red to green by Q1.</p> <p>The committee accepted the current red rating for Q4 with an expectation for it to reach green by Q1.</p>	
6		<p><b>Patient Safety and Clinical Risk (Sign Up to Safety Plan)</b> <i>Caroline McKenna, Patient Safety and Clinical Risk Lead</i></p> <p>CMK presented her paper, with an update on the Sign up to Safety Plan and recommended an overall green rating for Q4 noting the following:</p> <ul style="list-style-type: none"> <li>• There were no patient deaths during Q4 but there were 2 serious incidents (SIs): <ol style="list-style-type: none"> <li>1) 11 year old child held in police custody for 5 days while a secure bed was sought – NHS England is investigating this incident as well as a Trust investigation.</li> <li>2) Portman patient tried to hang himself and Jessica Yakeley, Director of the Portman requested an investigation. AL noted that it was good that these incidents have triggered investigations as near misses can provide vital information to mitigate future occurrences.</li> </ol> </li> <li>• CMK also noted the patient suicide in August 2016 and provided the full report on this death and noted that there were many lessons to be learned and an action plan has been drafted to ensure the following: <ul style="list-style-type: none"> <li>➤ honorary staff are integrated or connected to a team and to Tavistock processes for mandatory training and case recording.</li> </ul> </li> </ul>	

	<ul style="list-style-type: none"> <li>➤ All clinical staff including honoraries have adequate and appropriate training on the patient administration system, Carenotes.</li> <li>➤ The provision of supervision is received and recorded</li> <li>➤ Systems in place to ensure smooth transfer of care for patients</li> <li>➤ Team managers know their responsibilities in relation to honoraries</li> <li>➤ Shared care is accurately documented and followed up</li> </ul> <p>GW noted the report was excellent and wanted to be assured that the report would take into account all the coroner's decisions so we can demonstrate to the coroner that our action plan addresses all concerns.</p> <p>CMK noted that the clinician in this case had sought supervision but unfortunately had not recorded it and that they had worked hard with the patient to keep them well and alive. This patient was also under the care of the community mental health team and the whole situation has proved very distressing for the staff group involved and that the Trust will provide full legal support for the staff member.</p> <p>RS reminded the committee of our obligation to deal appropriately and respectfully with the deceased's family but also noted our obligation to help and support staff in these difficult situations. CMK confirmed there would be an event organised to promote the wider learning from this incident.</p> <p>TN asked how many honoraries were working at the Trust and SH confirmed she has requested this information and will report back via this work stream once she has it.</p> <p>JS asked if the student governance passport could be used in any way to assist with ensuring honoraries are fully integrated and JS agreed to provide some narrative to ensure this is covered.</p> <p>CMK continued with the rest of the report –</p> <ul style="list-style-type: none"> <li>• There was a notable increase in violence incidents at the Gloucester House School (GH): from 81 incidents in Q3 rising to</li> </ul>	<p>CMK</p> <p>JS</p>
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	<p>125 in Q4. SH confirmed the pattern of incidents remained the same but the number rose sharply. SH met with RS and senior staff at GH and RS was asked to investigate the number of incidents of injuries to staff in particular. It was noted that the children at GH often needed to be restrained which sometimes resulted in the violence incidents. EM asked about the restraining methods and LT advised that mostly they are “holds” rather than restraints, and it is often done to enable a child to be removed to somewhere where they are more able to calm down. RS also stated that the cohort of students at GH were very troubled children and staff were operating in extremely difficult situation for most of the day. The number of referrals for GH was considered and SH confirmed that the head of the school was very careful to ensure a manageable balance of children at intake.</p> <ul style="list-style-type: none"><li>•</li></ul> <p>The committee accepted an overall rating of green for Q4 with the addition of the following two items to be added to the action plan:</p> <table><tr><td>The roles and responsibilities of team managers for honoraries</td></tr><tr><td>Ensure clear reporting and management lines for honoraries</td></tr></table>	The roles and responsibilities of team managers for honoraries	Ensure clear reporting and management lines for honoraries	
The roles and responsibilities of team managers for honoraries				
Ensure clear reporting and management lines for honoraries				
7a	<p><b>Clinical Quality and Patient Experience</b> <i>Louise Lyon, Director of Quality</i></p> <p>LL presented her paper noting that there was a varied mix of red or green areas within the report but she recommended that the overall rating for the work stream is amber. LL said there have been steady, significant and pleasing improvements made in our data gathering and submissions and noted some of the below:</p> <ul style="list-style-type: none"><li>➤ We are now achieving 89% of all ethnicity data but we need to increase our data collection on all the protected characteristics.</li><li>➤ More work is required to engage staff in completing the physical health form with all patients over 14 years old. The form is not tailored to mental health which hampers its use.</li><li>➤ The living well programme has had fewer referrals than we would have wanted.</li></ul>			

7b	<ul style="list-style-type: none"> <li>➤ The café has introduced more healthy options</li> <li>➤ The Trust has now trained 20 mental health first aiders and there is a waiting list of staff who wish to take up this training. LT explained this course lasts 2 days and provides staff with the knowledge and confidence to recognise mental health issues and respond appropriately with signposting etc. LT also confirmed that the Trust is currently training 2 staff members to be able to roll out internal training going forward.</li> <li>➤ Flu vaccines for staff – only a 26% uptake but it was noted that some staff have their vaccinations at their GP surgery but do not always let HR know, so the numbers may not be entirely accurate. PB had asked at the previous committee if there were any identified trends in relation to sickness and the uptake of vaccinations. LL provided the following figures, noting that most staff seem to take a few days off so this will never be reflected accurately in the HR data:</li> </ul> <p><b>2016/17</b></p> <p>Q1 = 63 Q2 = 64 Q3 = 26 Q4 = 38</p> <ul style="list-style-type: none"> <li>➤ LL noted the PPI report will be reduced for Q1 but cover all items.</li> <li>➤ Goal Based Measure (GBM) – we are still missing the targets for completing Time 1 and Time 2 GBMs. There are many reasons for this including too many outcome monitoring tools to be used and an exhausted staff group. LL confirmed she and CMK are working on a project with the clinical governance leads in “reducing the burden” for clinicians on Carenotes.</li> </ul> <p><b>CQC DRAFT Action Plan Update</b></p> <p>LL confirmed the CQC action plan for the adult GIC was still in draft form until we have the final copy agreed which is currently being done with SH and the CQC team. LL also confirmed that the CQC have requested a</p>	
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		<p>further action plan be put in place for the new service, Adult Gender Identity Clinic (AGIC) and to ensure this is reported on by the end of May 2017.</p> <p>JS noted that we should expect to see an increase in complaints or incidents and asked if our current arrangements for managing complaints is sufficient to manage the expected increase. CMK also noted we already have increased complaints in relation to waiting times, increased number of subject access requests (SARs) currently dealt with by Lotte Higginson and noted the recent adult AGIC patient death. It was noted that not all complaints turn into formal complaints or serious incidents so our current system with Amanda Hawke managing complaints should not be too affected by this service, however this will need monitoring and adding to the action plan if necessary.</p> <p>There was discussion around how these issues could be managed within AGIC and PB confirmed that there had been discussions at the recent Board lunch where the anxiety around the gap between the current and new AGIC contract had been noted. LL confirmed this should be raised as a risk.</p> <p>JS noted that in the CQC's action plan "Must Do's" it notes the requirement for patients to have completed risk assessments and crisis plans and asked if this now extended to AGIC? JS agreed to raise this with the clinical governance leads, Andrew Williams, for Adult and Forensic Services (AFS) and Liz Searle for family and children's services (CYAF). CMK agreed to take this up via the patient safety and clinical risk work stream.</p> <p>The committee accepted the assurance rating as amber for Q4.</p>	JS & CMK
8		<p><b>Corporate Governance and Risk</b> <i>Produced and presented by Lisa Tucker, Health &amp; Safety Manager</i></p> <p>LT introduced the paper with an overall rating of green for Q4 and highlighted the following area: the Operational Risk Register needs to be more fluid and useful to staff and DWL is working on how to make this more intuitive and beneficial for staff, ensuring items are listed quarterly.</p> <p>RS asked about remote site visits and their business continuity plans (BCPs) and LT confirmed she is working with Paul Waterman from Estates</p>	

		<p>to ensure we have local BCPs for all our sites and confirmed that the BCP usually needs to cover the whole organisation, or specific areas, rather than just the premises.</p> <p>TN asked if “robust” emergency preparedness was the correct term and LT confirmed that our plans are robust as far as possible, but noted that we will always remain apparently non-compliant with some areas because we do not have in-patients.</p> <p>The committee accepted the assurance of a green rating for Q4.</p>	
9		<p><b>Any Other Business</b></p> <p>The committee agreed the remaining 2017 CQSGC meeting dates would change from Tuesdays to a Wednesdays. IH to send out new diary invites to membership.</p> <p>RS closed the meeting.</p>	IH
10		<p><b>Notice of future meetings:</b></p> <p>11am, Wednesday 6<sup>th</sup> September 2017</p> <p>11am, Wednesday 8<sup>th</sup> November 2017</p>	

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## Board of Directors : May 2017

**Item :** 14

**Title :** Clinical Quality Safety Governance Committee (CQSGC):  
Annual Performance Review, 2016/17

### **Summary :**

The four individual work streams have completed their annual review which provides the Board of Directors with an overview of the CQSGC performance:

- Information Governance (IG)
- Patient Safety and Clinical Risk (PSCR)
- Clinical Quality and Patient Experience (CQPE)
- Corporate Governance and Risk (CGR)

The reviews from each of the above work stream leads are attached.

This paper confirms that the CQSGC has discharged its terms of reference, as evidenced by the work stream submissions and subsequent discussion at the CQSGC and at the Board.

**For :** Discussion and agreement

**From :** Rob Senior, Medical Director

<b>Lead: Terry Noys</b>	<b>INFORMATION GOVERNANCE Annual Review 2016/17</b>
	<p>Work has progressed well over the year with sound assurances provided for most areas of IG compliance. There have been changes in the management of IG with further developments included in the IMT programme for the coming year. All areas of IG data quality and collection have improved significantly and going forward this workstream will ensure that the Trust works towards meeting all IG requirements for a minimum of level 2 and will maintain that level, progressing to level 3 for essential clinical areas by the end of 2017/18.</p> <p>The overall rating for IG this year is projected as green.</p>
<b>Key Risks for 2016/17</b>	<p>There were two notable risks identified:</p> <p>The new national Information Governance training platform has yet to be launched for NHS staff and the late release of this software may disrupt our Q1 attainment locally for 2017/18.</p> <p>The recent malware attacks on the NHS have been well managed internally and work is underway in terms of ensuring our equipment and electronic information continues to be managed and stored safely. Forward planning is required to ensure the Trust electronic system are safe from these attacks.</p>
<b>Lead: Caroline McKenna</b>	<b>PATIENT SAFETY &amp; CLINICAL RISK Annual Review 2016/17</b>
	<p>The current patient safety and clinical risk lead took over the role in October 2017. Work stream meetings take place quarterly and the PSCR lead reports to the CQSG Committee.</p> <p><u>CQC re-inspection:</u></p> <p>Of particular note for 2016/17 is that the CQC inspected the Trust again on 24–25 November 2016 specifically under the domain of safety. During this inspection the CQC found that the Trust had addressed the three issues from the January 2016 inspection which led then to an initial rating of “requires</p>

improvement” and therefore changed the rating of safe to good. (report published 1 February 2017). The issues from the January 2016 inspection were the use of crisis plans, risk assessments and management plans and having a separate waiting area for people under 18 at the Portman Clinic.  
(<http://www.cqc.org.uk/provider/RNK>). Clearly the Trust will wish to at least maintain or possibly improve this rating at the next inspection.

Patient deaths:

The Trust investigated 3 patient deaths during 2016/17 under the serious incident procedure and the lessons learned have been shared across directorates. No action or omission on the part of Trust staff was felt to have contributed to the patient deaths. However the work stream lead has included a review of the lessons learned within the work plan for the year 2017/18 to ensure that these have been embedded and any necessary changes to processes and procedures have been made e.g. Procedure for employment of honorary clinicians.

Clinical incidents Gloucester House:

Over the course of the year there has been a significant and sustained increase in the number of reported clinical incidents at Gloucester House Day Unit. The situation is continuously monitored by the CYAF Director, Head Teacher and Health and Safety Manager. The Medical Director is carrying out a separate investigation in order to fully understand the reasons for the increase but factors are likely to include – GH staff diligence about reporting incidences, an increase in the number of pupils attending GH all of whom present with highly complex emotional and behavioural difficulties. Most of the incidences continue to relate to a few children and are in part a consequence of the increase in the number of pupils in GH this year compared to 2015/16. Children’s individual risk assessments are updated daily.

Staff are to be commended on the work they undertake with this very vulnerable and marginalised group of children.

Safeguarding Children and Safeguarding Adults:

Reports from the Safeguarding Meetings come to the PSCR work stream meeting and are reported by the lead to the CQSG Committee. Of particular note for the year 2016/17 were issues with the recording of safeguarding supervision of children /young people subject to Child Protection Plans. In September 2016 the Trust moved from a model of self-reporting supervision to evidencing safeguarding supervision via Care Notes records. The Q2 outcome was 13% recorded supervision which was felt to be low due to the anticipated disruption in the migration from self-report to electronic collection. The figure improved in Q3 to 27%, but was only 4.5 % for Q4.

Further to the Patient Safety and Clinical Risk work stream meeting of 10<sup>th</sup> April 2017, safeguarding supervision is now on the Trust's Risk Register. In addition, a draft action plan has been drawn up by the Named Professional for Safeguarding which includes identifying all allocated CPP cases without a safeguarding supervision in order that these are brought to the attention of named and supervising clinicians,

Complaints:

There has been no discernible change to the number (The Trust receives on average 10 patient complaints per quarter) or the themes of patient complaints during 2016/17. The main themes relate to communication issues, breach of confidentiality, waiting times, attitude of staff and involvement of parents in a young person's care.

Medical Appraisal and Revalidation:

The Annual Organisational Audit (AOA) questionnaire from NHS England is completed and submitted on a quarterly basis by the Revalidation Manager, to provide assurance to NHS England that processes and procedures are in place for the accurate reporting of appraisal and revalidation at the Trust. At the end of Q4 2016/17, 51 Doctors had a prescribed connection with the Trust and of those 3 doctors had not completed an appraisal within 12 months (end of Q4) had appraisal dates within the 2 month margin allowed. The Responsible Officer was satisfied with the reasons for these postponed appraisals.

	<p>2 appraisal training events for doctors with prescribed connection to the Trust took place during Q4.</p> <p><u>The Sign up to Safety Campaign:</u> The Sign up to Safety campaign is a national initiative that aims to harness the commitment of staff across the NHS in England to make care safer. Each Sign up to Safety lead provides quarterly updates to the Patient Safety and Clinical Risk Committee. The areas of focus are – improving physical health of patients, improving clinician’s knowledge of self-harm and suicide and improving awareness among clinicians of the role of digital media on patient mental health. This national initiative has been well received at the Trust.</p> <p>The overall rating for Patient Safety and Clinical Risk at year end was projected as green.</p>
<b>Key Risks for 2016/17</b>	<p>There were three notable risks identified:</p> <ol style="list-style-type: none"> <li>1. Honorary Clinical Staff – some honorary clinicians were identified as being quite peripheral to the respective directorate structures and processes. An action plan was signed off in February 2017 and will be reviewed quarterly during 2017/18 by the PSCR lead.</li> <li>2. Recording of Safeguarding Supervision has been added to the Trust’s Risk Register</li> <li>3. The significant increase in the frequency and number of Clinical incidents at Gloucester House is being investigated by the Medical Director.</li> </ol>
<b>Lead: Louise Lyon</b>	<b>CLINICAL QUALITY &amp; PATIENT EXPERIENCE Annual Review 2016/17</b>
	<p>The work this year of the Clinical Quality and Patient Experience work stream has reported good progress in relation to our clinical data collections and submissions notably in the key areas of the protected characteristics submissions. The quality team and clinical governance team have worked with the Informatics</p>

	<p>directorate to ensure our patient administration system Carenotes has been updated to ensure there are adequate methods of data collection with the relevant reports made available. There is still work to be done in this area in ensuring that all clinical teams are aware of all the information they are required to submit and further training will be rolled out to ensure data collection is robust.</p> <p>As noted, in the PSCR update above, this work stream is involved in the piece of work “reducing the burden” to make it easier for staff to work with Carenotes and reduce the number of outcome measures used with patients.</p> <p>Other areas of accomplishment are in the work of the Patient and Public Involvement team (PPI), which continues to grow with patient representatives sitting on all clinical and many non-clinical appointment panels.</p> <p>All other areas of this work stream have steadily improved across the year and work is underway to keep up the momentum in all identified areas of need.</p> <p><b>CQC Inspection and action plan:</b> The Trust received an overall rating from the CQC as GOOD, except for our Safety domain. Act was taken to address the three points on which improvement was required. The CQC re-inspected and confirmed the Trust rating of GOOD across all domains. The Trust’s new adult gender clinic, GIC service has not been included in our CQC rating of GOOD, however if the service is retained at the Trust next year, it will become part of our full services and be included in all future inspections. Meanwhile we are responsible for ensuring that GIC makes adequate progress on their action plan following inspection in 2016 whilst still part of West London Mental Health Trust</p> <p>The overall rating for Clinical Quality and Patient Experience this year is projected as amber.</p>
<b>Key Risks for 2016/17</b>	<p>There were two notable risks identified:</p>

	<p>Data quality remains on the agenda and it is acknowledged that staff will need to ensure:</p> <ul style="list-style-type: none"> <li>a) robust data collection and reporting of all data, including the protected characteristics</li> <li>b) essential reportable outcome measures, such as the Goal Based Measure (GBM) are completed in a timely manner</li> </ul> <p>The new adult gender service (GIC) may present a higher number of serious patient incidents due to the nature of the service and our complaints team are preparing to manage an increase in the number of clinical incidents, including serious incidents.</p>
<p><b>Lead: Marion Shipman</b></p>	<p><b>CORPORATE GOVERNANCE &amp; RISK Annual Review 2016/17</b></p>
	<p>Much of the work this year has concentrated on providing assurance that the Trust emergency preparedness is adequate and ensuring that robust business continuity plans (BCPs) are in place in terms of patient and staff care, but also in relation to electronic data and malware attacks, and this work has been facilitated by the Health and Safety Manager making site visits to our outreach services to ensure their compliance.</p> <p>All health and safety training is up to date for this year and we have introduced mental health first aiders (MHFA) to work with staff across the Trust. The Health and Safety Manager is now a qualified MHFA instructor and to date there are 20 trained mental health first aiders with a further 25 staff on the waiting list to be trained. This initiative has proved very popular and the H&amp;S Manager now has a rolling programme of training with a view to training 12 staff per quarter.</p> <p>Incident reporting this year has remained the same and there have been a range of incidents from across the Trust. This work stream continues to manage all non-clinical risks well and provide action plans and updates as required to ensure compliance. Lessons learned are shared with the relevant workstream and appropriate service lines.</p>

	The overall rating for Corporate Governance and Risk this year is projected as green.
<b>Key Risks for 2016/17</b>	<p>There was one main risk identified:</p> <p>The new adult gender service (GIC) presents a possible risk in relation to clinical governance. There is collaborative work underway with GIC to ensure that action plans are in place to support the work of this service.</p>



## Board of Directors : May 2017

**Item :** 15

**Title :** Patient Suicide (August 2016) Investigation and Subsequent Action Plan

### **Summary :**

The following paper provides a brief anonymised description of the recent suicide of an adult patient who died in 2016, who had been seen in the TADS project.

Also set out here is the action plan developed in response to this patient suicide. The full report and action plan was considered by the CQSG Committee on 2<sup>nd</sup> May 2017.

**For :** Discussion and agreement

**From :** Rob Senior, Medical Director

## **BRIEF SUMMARY**

Patient B, a 55 year old man, died on 10 August 2016. He had been known to the TADS (Tavistock Adult Depression Study) from 18 January 2010 to 25 October 2011 and then the case was transferred to AFS (Adult & Forensic Services Directorate at the Tavistock) in January 2012. The patient was being seen initially for 6 weekly intermittent psychotherapy until July 2014. At this stage he is noted to have deteriorated in mood, and is offered weekly psychotherapy again within AFS from 18 July 2014 up to the time of his death. The patient's last attended appointment was on 28 July 2016.

Clinician A who had seen patient B in the depression study secured an honorary contract in AFS to continue to see patient B until his death. Patient B had a relapsing condition that was characterised by periods of intense suicidality and his care was shared with the GP and with the locality Community Mental health Team. At the time of his death this was with North Kingston CMHT.

The investigating team, Dr McKenna and Dr Tandy, did not identify any root causes that linked the care provided by the Trust directly or indirectly to patient B's death. In the last session with clinician A on 28 July 2016 patient B talked about his idealized expectation of renewing contact with his younger son and the alternative of ending his relationship with him. The son's 16<sup>th</sup> birthday was on 10<sup>th</sup> August. He found it hard to accept that his youngest son might need time to deal with mixed feelings. Clinician A noted that patient B was determined to open a new chapter and move on with his life after 10 August 2016 with or without his son. Clinician A and patient B agreed to meet on 11 August 2016 despite a planned break in therapy occurring on 4 August 2016. This meeting never took place. The cause of death remains unknown until the inquest but it is believed that the patient took a fatal overdose.

Many examples of good practice were noted in this case and there was no implication that any action or failure to act contributed significantly to the patient's death. The lessons learned are indicated in the attached action plan emerging from our investigation and mainly involve the role of honorary clinicians in the Trust and the obligations on them and on service managers and clinical directors.

## Action Plan

Objective	Success criteria	Plan	Timescale	Lead
1. To establish an updated list of honorary clinicians, with status, activities and adherence to points 2–4 below, kept up to date	Evidence of an update to date Database – audited annually for completeness	Identify all honorary clinicians and update HR database on mandatory training compliance	June 1st 2017	Designated individual in CYAF, AFS and DET JS/SH/BR
2. All clinicians with honorary contracts in the Trust to have risk assessment training, at least every 2 years	Evidence of risk assessment training, at least every 2 years in >80% of the cohort	Identify last date for risk assessment training for clinicians with honorary contracts	September 1st 2017	JS/SH/BR/ Clinical Governance Team
3. All clinicians with honorary contracts in the Trust to have training on the Electronic records system before starting to see any patient	Evidence of ERS training, at least every 2 years in 100% of the cohort	Determine Care Notes training requirements of all clinicians with honorary contracts and liaise with IT to deliver training.	September 1st 2017	JS/SH/BR
4. All clinicians with honorary contracts in the Trust to have at	Clinicians with honorary contracts meeting with	Confirm all clinicians with honorary contracts have a	September 1st 2017	JS/SH/BR

Objective	Success criteria	Plan	Timescale	Lead
least a termly meeting with a designated supervisor or consultant, and where possible to be attached to/ attending meetings of a designated, relevant clinical unit	a designated supervisor termly, and attending relevant clinical unit meetings (where possible)	designated supervisor / consultant and  Update Honorary Contracts Procedure (due June 2017) and ensure full implementation across directorates and to all clinicians with honorary contracts		
5. All clinicians with honorary contracts in the Trust to ensure that evidence of supervision on their cases is inputted into the ERS in a timely manner.	Evidence of inputting of some note on supervision in at least 80% of relevant clinical staff at least every 2 years in >80% of the cohort	Designated individual to assess	September 1st 2017	JS/SH/BR

## Board of Directors : 23 May 2017

**Item** : 16

**Title** : Human Resources and Organisational Development 2016/17 –  
Year End Report

**Purpose:**

This paper outlines progress made against the strategic HR and organisational development business plan for 2016/17.

Incorporated within this report are the full year workforce key performance indicators and metrics.

**This report focuses on the following areas:**

*(delete where not applicable)*

- Quality
- Workforce

**For** : Noting

**From** : Craig de Sousa, Director of Human Resources

# **Human Resources and Organisational Development Year End Report**

## **1. Introduction**

At the beginning of 2016/17 a comprehensive business plan was developed setting out a number of key activities needed to change the way that the HR directorate supports the organisation.

This papers sets out progress that has been made against each of the activities and provides narrative about the successes and some of the challenges that have arisen throughout the year.

## **2. HR directorate and structure**

Not long after the new director of HR starting in post a number of structural changes were made to the HR directorate. These reflected the need to strengthen a number of our operational processes and draw on best practice from other NHS organisations pan-London.

The new HR structure was formally introduced in May 2016 which established two HR business partners aligned to the clinical, education and corporate directorates. The roles were designed to be proactive and support managers to implement complex change and also to use organisational development skills to develop the wider workforce. Feedback from managers has been that the roles have been a great support over the last year and they are seeing the benefits of having accountable senior resources aligned to their services.

Alongside the business partners the recruitment, HR administration and learning and development functions have been strengthened with a senior level appointment who has ensured that robust systems and processes have been put in place to ensure both consistency in approach and that we are reshaping our services to provide a better recruitment experience. Again, the changes have been received positively throughout the organisation.

To support all of the above a number of the core HR procedures have been substantially reviewed and amended to make them easier to use.

### 3. The organisational development and people strategy

One of the Trust's strategic priorities was to develop and implement a comprehensive people strategy that brings together good work that has already been developed and create a systematic approach to how we develop these initiatives further.

The strategy has been well received and staff from across the organisation have engaged with the rhetoric set out in the document.

Work has already begun implementing the strategy and progress will be reported to the board on a quarterly basis.

### 4. The NHS staff survey – 2016

In March we received the results from the most recent NHS staff survey. The findings were positive in most parts and placed us in the upper quartile for staff engagement.

There are still a number of areas where we need to improve and actions that need to follow.

The table below details the key actions and where they will be managed through.

Improvement Area	Method of Managing Actions	Responsible	Timescale
Bullying and harassment	Review the methods of raising concerns and draw on best practice from other organisations.	Chair, chief executive, director of HR and freedom to speak up Guardian	Q1
	Develop a confidential mechanism to raise concerns with action following		Q2-3
Staff working extra hours and workplace stress	Implement reducing the burden initiative	Director of technology and transformation	Q1-4
	Ensure that there is adequate coverage of reflective practice groups like Thinking	Director of HR	Q2

Improvement Area	Method of Managing Actions	Responsible	Timescale
	<p>Space, coffee mornings and other initiatives.</p> <p>Continue to implement the living well programme</p>	Director of HR & director of quality and Patient experience	Q1 –4
Incident reporting and learning from lessons	<p>Implement an electronic system for reporting incidents</p> <p>Review existing arrangements for incident management and how lessons learned are communicated</p>	Director of quality and patient experience	Q4
Quality of appraisal discussions	Review the revised appraisal process	Director of HR	Q2
Teams with concern areas arising from the staff survey	Commission a bespoke and focused organisational development programme for middle managers across the organisation.	Director of HR	Q2
Diversity and inclusion	Develop and implement a comprehensive workforce race equality strategy	Director of quality and patient experience	Q2



## **5. Health and wellbeing**

Throughout the year we have increased our focus on health and wellbeing working in partnership with the quality and patient experience directorate and taken a number of steps to implement a range of programmes that aim to support our staff to make healthy life style choices.

During the year we hosted two health and wellbeing promotion days each having in excess of a hundred attendees. Both involved promotional stands but also ways for staff to contribute to what is working well and what they would like to see more of. As a result of our programme of work we now offer or have launched:

- Onsite chair massage
- Yoga sessions during and after work
- A cycle to work scheme
- A staff walking challenge
- Healthier eating options in our canteen
- Access to an NHS gym and fitness centre
- Fast track physiotherapy services

In the coming year we will be using the people strategy as the vehicle for taking this work further forward and specifically focusing on how we support our staff.

## **6. Management and leadership development**

In quarter 4 we launched our new internal leadership programme which aims to improve management capability across the middle tiers of the organisation. The programme was well subscribed to and attracted a good mix of participants from BAME backgrounds.

The programme uses national NHS Leadership Academy e-learning material supplemented by master classes. The first cohort of participants are due to complete

their leadership journeys in May and the second cohort just before the end of the term.

Feedback between each master class has been positive with participants explaining that the programme has been stretching and they have valued the opportunity to work through key skills like managing conflict, difficult conversation and understanding themselves as a leader.

A full evaluation will be completed at the end of the first cohort with results being shared with the staff training committee and management team.

## 7. Strategic HR business plan for 2016/17 – year end position

The table bellows sets out the activities described in the annual business plan and highlights the current status of each deliverable.

	On target / complete
	Progressing but behind target
	Significantly behind target
	Not started

Activity	5 Year Ambition Alignment	Responsible	Q1	Q2	Q3	Q4
Organisational development and workforce strategy						
Commence the narrative activities for the strategy	Reinforce our reputation as one of the best places to work in the NHS	HR Director	X	X		
Draft strategy consultation process		HR Director			X	
Final strategy for board approval		HR Director				X
Health and Wellbeing						
Finalise the health and wellbeing strategy	Enhance the capability of our organisation	HR Business Partner	X			
Re-procure the occupational health contract		HR Business Partner	X	X	X	

Staff engagement						
Managers to implement immediate actions to the staff survey and HR report on progress	Reinforce our reputation as one of the best places to work in the NHS	HR Business Partner	X			
Plan for launch of 2016 survey and agree granular reporting levels		HR Business Partner		X		
Launch the staff survey promoting actions taken to respond		HR Business Partner  Head of Communications			X	
Report on findings from 2016 survey and re-engage with staff		HR Business Partner				X
Employee relations						
Review key HR policies – disciplinary, grievance, capability, sickness management and change management	Reinforce our reputation as one of the best places to work in the NHS	HR Director & HR Business Partner	X	X		
Medical Staffing						
Support the Trust’s training programme directors to map existing rotas against the proposed revised rules	Enhance the capability of our organisation	Resourcing and Development Manager and HR Business Partner	X			
Appoint a rota guardian to oversee the safety		Resourcing and Development Manager	X	X		

monitoring process for the new contract		Medical Director				
Work with training programme directors to explore the impacts of the new contract		Resourcing and Development Manager			X	X
Recruitment and sourcing						
Review the trust's recruitment and HR administration procedures with involvement from line managers and introduce KPI metrics	Reinforce our reputation as one of the best places to work in the NHS	Resourcing and Development Manager	X	X		
Explore opportunities for enhancing our e-recruitment solution	Enhance the capability of our organisation	Resourcing and Development Manager		X	X	
Review our branding and marketing information for prospective applicants	Improve our use of information and technology	Resourcing and Development Manager			X	X
		Head of Communications				
Learning and organisational development						
Finalise organisation learning needs analysis and commission educational requirements	Reinforce our reputation as one of the best places to work in the NHS	Resourcing and Development Manager	X			
	Enhance the capability of our organisation	Organisational Development Consultant				
Scope and develop a trust wide management development programme harnessing the	Improve our use of information and technology	Organisational Development Consultant	X	X		

resources from the NHS Leadership Academy Programmes						
Launch cohorts 1 – 4		Resourcing and Development Manager			X	X
Transition all training records on to Oracle Learning Manager		Resourcing and Development Manager		X	X	
Develop a succession planning framework		HR Director			X	
Review and revised the Trust's appraisal process		Organisational Development Consultant		X		
Reward and recognition						
Explore the flexibilities that existing with Agenda for Change and whether we ought to explore local terms and conditions of service	Reinforce our reputation as one of the best places to work in the NHS	HR Director and Chair of Staff Side		X	X	
Assess the existing mechanisms for recognising and rewarding staff	Reinforce our reputation as one of the best places to work in the NHS	HR Business Partner			X	
Develop a recognition framework and process		HR Business Partner				X

## Key workforce indicators

Workforce Metrics – April 2016 – March 2017																
	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
<b>Staff in Post</b>																
Full Time Equivalent Staff in Post (FTE)	495.39	492.97	495.29	494.55	498.42	500.8	514.65	504.62	527.02	541.19	539.39	535.87	543.1	540.28	547.68	543.69
Secondments (FTE)	16.24	16.24	16.24	16.24	16.24	16.94	16.64	16.61	16.94	16.94	16.94	16.94	16.94	16.94	16.94	16.94
Bank (FTE)	34.1	37.6	36.5	36.07	38.9	38.5	35	37.47	36.8	40.5	32.2	36.50	42.5	43.7	43.7	43.30
Agency (FTE)	10.25	19.7	22.3	17.42	20.2	18.9	17.7	18.93	15.1	12.4	13	13.50	12	12.68	12.68	12.45
Total (FTE)	555.98	566.51	570.33	564.27	573.76	575.14	583.99	577.63	595.86	611.03	601.53	602.81	614.54	613.6	621	616.38
Headcount	594	594	598	595.33	595	595	611	600.33	626	639	638	634.33	644	642	650	645.33
Vacancy Rate	13.56%	14.69%	14.86%	14.37%	14.32%	14.83%	13.50%	14.22%	15.68%	13.41%	13.70%	14.26%	13.10%	13.56%	12.37%	13.01%
Turnover	19.74%	19.69%	19.47%	19.63%	17.53%	18.46%	19.26%	18.42%	20.02%	20.25%	19.49%	19.92%	19.01%	18.89%	19.89%	19.26%
Stability Index	81.31%	81.42%	81.25%	81.33%	81.57%	81.80%	82.50%	81.96%	81.40%	81.61%	81.76%	81.59%	80.60%	81.44%	83.14%	81.73%
<b>Health, wellbeing and morale</b>																
Sickness Absence Spot Month	2.18%	1.81%	1.56%	1.85%	1.62%	1.28%	1.42%	1.44%	1.52%	1.37%	1.22%	1.37%	1.21%	1.64%	1.36%	1.40%
Sickness Absence 12 month rolling average	1.42%	1.49%	1.98%	1.63%	1.63%	1.66%	1.71%	1.67%	1.73%	1.62%	1.73%	1.69%	1.70%	1.74%	1.67%	1.70%
<b>Training and compliance</b>																
DBS Compliance	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	96%	98%	96%
Appraisal Compliance	98%	99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	100%	100%	100%	100%	100%

\* data definitions are included in Appendix A of this report.

## Mandatory and Statutory Training Compliance

Description	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Mandatory Training Compliance – INSET Attendance	94%	94%	85%	100%

Mandatory training compliance fell significantly in quarter 3 due to a high number of staff being unwell on the day of the last Inset. To address the reduction in compliance all those who did not attend were offered the opportunity to undertake e-learning to bring them back up to compliance, which has resulted in 100% compliance.

Description	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Basic Life Support	99%	99%	99%	99%
Conflict Resolution Training	100%	100%	100%	100%
Ladder Safety	100%	100%	100%	100%
Manual Handling	100%	100%	100%	100%
Online Safer Recruitment Training	45%	**	**	**
Safeguarding Children – Level 2	92%	92%	80%	94%
Safeguarding Children – Level 3	93%	93%	90%	94%
Clinical Risk Training	7%	10%	13%	16%

Following a review of the online safer recruitment training it has been established that the course is not fit for purpose. A new, taught, recruitment and selection training has been designed and is being rolled out from January 2017. Work is being undertaken to determine who is required to have the training and reporting on compliance will commence from 2017/18.

Formal clinical risk training was introduced as a result of the January 2016 CQC inspection. Working is currently being undertaken to implement the best solution for delivering this training requirement and increase the overall compliance rate.

## **8. Conclusions and recommendations**

Members of the relevant committees are asked to note the contents of this report.

Craig de Sousa  
**Director of Human Resources**  
April 2017



## Appendix A – Workforce KPI Data Definitions

<b>Full Time Equivalent Staff in Post (FTE)</b>	The number of staff employed by the Trust relative to the hours that they work each week
<b>Headcount</b>	The number of people employed by the Trust
<b>Vacancy Rate</b>	The % of FTE staff employed compared to the funded establishment
<b>Turnover (Annual)</b>	The % of staff which have left the organisation in the last twelve months
<b>Stability Index</b>	A % indicator which demonstrates the retention rate of staff employed with more than twelve months service
<b>Sickness Absence Spot Month</b>	The number of FTE days lost as a result of sickness compared to those available for one given month
<b>Sickness Absence 12 month rolling average</b>	The number of FTE days lost as a result of sickness compared to those available over the last twelve months
<b>Appraisal Compliance (Annual)</b>	The % of staff with a completed appraisal and personal development plan

## Board of Directors : May 2017

**Item : 17**

**Title : DET Annual Complaints Report 2016/17**

**Purpose:**

The purpose of this report is to provide a summary of the complaints received by the Department of Education and Training in 2016/17 and to outline the work done to improve processes and implement learning from complaints.

This is a slightly amended version of the paper that was reviewed at the Training and Education Programme Management Board on 8<sup>th</sup> May 2017.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that complaints have been managed in line with requirements.

**This report focuses on the following areas:**

- Student / User Experience

**For : Noting**

**From : Brian Rock, Director of Education & Training / Dean of Postgraduate Studies**

## Annual DET Complaints Report

### 1. Introduction

- 1.1 Over the past year the Department of Education and Training have implemented a number of improvements and changes in our systems for managing complaints. These have enabled us to respond to complaints more quickly, monitor patterns in complaints and consider where other improvements need to be made.
- 1.2 The Trust is now a member of the Office of the Independent Adjudicator (OIA) which means it is able to manage all complaints internally without requiring as much direct support from University partners. Therefore, we have reviewed our complaints process and now have one process for all complaints whereas in the past we had 4 (1 with each University partner and another for internal courses).
- 1.3 This process is much clearer, is easily accessible to students and tracking is now a simpler process. We have also created a number of forms and templates to be used by the Complaints Liaison Officer and those investigating complaints to ensure a consistent and complete response is made.
- 1.4 Membership of the OIA allows us to access training and guidance materials that have already assisted us in developing the procedure itself and in responding to complaints.

### 2. Complaints received

- 2.1 In financial year 2016/17 DET received 7 formal and 13 informal complaints. This was compared to 6 formal and 2 informal in 2015/16.
- 2.2 We would usually deal with all complaints as informal in the first instance. These complaints are managed without formal investigation. A complaint would be treated as formal in the following circumstances:
  - 2.2.1 If the student expressly states that they wish to make a formal complaint.

- 2.2.2 If they have already made an informal complaint and the issues have not been resolved.
- 2.2.3 If the issues raised are serious or complex a decision may be taken to move straight to the formal stage of investigation. This decision is taken by the Complaints Liaison Officer.
- 2.3 A significant proportion of this increase can be attributed to the improved tracking and management of complaints within the department. However there are still a number of students that are unhappy about some aspect of their experience studying with the Trust.
- 2.4 During this financial year we closed 3 complaints that had been held over from the previous year.
- 2.5 We have 1 complaint open which has been on-going since around 2014. This complaint have been complicated by progressing to a Complaints Review Panel at the University of East London and negotiations between ourselves, UEL and Human Development Scotland with regards to a resolution. No other complaints received in the last financial year remain open.
- 2.6 In the majority of cases our complaints ultimately come down to poor communication and a lack of knowledge around systems and procedures. There certainly appears to be a greater awareness of consumer rights by students and there is some evidence of a tendency to escalate complaints when the appropriate or desired response is not received.
- 2.7 There have been 3 complaints this year which have been more serious in nature than others and have resulted in threats of legal action, escalation to our University partners and/or significant financial settlements.
- 2.8 Each of these complaints were complex and had several strands to them and in 2 of the cases involved issues that had taken place over a number of years.
- 2.9 In all 3 cases decision making and process was not always well evidenced or clearly documented making investigation more challenging.
- 2.10 These 3 complaints are now closed.

### 3. Time to respond to complaints

- 3.1 Of the 7 formal complaints received 5 were responded to within the required timescales and 2 were delayed.
- 3.2 In one case the delay was the result of a student misconduct panel which was conducted alongside the complaint and delayed the response. The other was the result of the complaints liaison officer being away however an interim response was sent to the student to clarify her situation and to manage her immediate concerns.

### 4. Topics of Complaints

Topics of complaints received
Students incorrectly labelled as debtors and chased by credit agencies
Delays in receiving results and transcripts
Suggestions that a student was not provided with adequate supervision for their dissertation
Student given incorrect information regarding resubmission of work
Incorrect information given to a student regarding their Visa application
Suggestion that a student was given insufficient supervision for their Doctorate
Overpayment of fees not promptly returned to student
Student dissatisfied with content of a CPD course
Incorrect information printed in the graduation booklet and issues regarding the event itself

Data source: DET Complaints log

### 5. Complaint Responses

- 5.1 The table below outlines our responses to complaints received in the last year.

Was the complaint upheld?	2015-16	2016-17
Upheld in full	3	14
Upheld in part	3	5
Not upheld	2	1
<b>Total complaints</b>	<b>8</b>	<b>20</b>

Data source: Complaints log

## **6. Improvement measures**

- 6.1 In a number of complaints an issue arose that students wanted to complain or get information earlier and had not been able to do so. It is recognised that information around complaints needed to be improved and accessible, we have therefore taken the following steps:
  - 6.1.1 Updated information on the Trust website providing the complaints procedure and complaints form.
  - 6.1.2 Set up a complaints inbox that can be accessed by several staff so complaints are responded to in the absence of the Complaints Liaison Officer.
  - 6.1.3 A section on complaints is included in the student handbook.
  - 6.1.4 A poster is being created to put in the student reception area giving details on how to complain or give feedback. This will also include information on how students can get support through the Student Advice and Consultation Service.
- 6.2 The Complaints Liaison Officer along with our Senior Quality Assurance Officer have developed an hour long training on managing and responding to complaints which is available for all DET staff in professional support services and faculty.
- 6.3 This is promoted through the Trust Academy of Learning and Teaching and will be a requirement for all in DET. All professional support staff have now completed this training.
- 6.4 Last year a number of staff in DET undertook customer service training. This was well received by staff and provided them with skills and knowledge to provide a better experience for our customers. This is now mandatory for all DET professional support staff with all now having completed the training.
- 6.5 All formal complaints now have an action plan completed once they are closed. This sets out the recommendations of the investigator and detailed steps to implement these changes. These are held by the Complaints Liaison Officer, regularly reviewed, progress monitored and updates taken to the Education and

Training executive on a quarterly basis. The executive will also review patterns in complaints as a way of assessing the impact of these action plans as we would not expect to see multiple complaints of a similar nature were these successful.

- 6.6 Complaints are now investigated by Portfolio Managers rather than the Associate Deans. While this decision was undertaken to better distribute the burden of complaints investigation it is also hoped that they will be in a better position to share learning from complaints with course teams and to recommend changes or improvements that are workable.
- 6.7 The complaints Liaison Officer will attend the Portfolio Managers Group on a quarterly basis to share complaint action plans and to discuss the promotion of the learning taken from complaints.
- 6.8 We will include a quarterly complaints summary in our DET Newsletter to allow staff to see improvements that have been made and to remind them of key issues.

Report prepared by  
Fiona Hartnett, Dean's Office Manager/Complaints Liaison Officer  
On behalf of  
Brian Rock, Director of Education and Training/Dean of Postgraduate Studies

May 2017