The Tavistock and Portman
NHS Foundation Trust

The Tavistock and Portman NHS Foundation Trust

Quality Account 2023/24

Excellence Inclusivity Compassion Respect

Contents

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Statement on Quality from Michael Holland – Chief Executive

Alongside the continued importance of Quality Improvement methodology, co-production and clinical leadership, our Quality Accounts this year reflect the steps that have been taken over the year to improve the availability and use of data to try and improve services. This has led to real improvements in information available to teams, that can be used alongside our own observations, and the experience of our service users.

Tavistock and Portman published Strategic Pillars this year, with the first pillar committed to delivering 'Outstanding Patient Care'. It has been pleasing to see the energy in the Trust to use improvement methodology, bringing some exciting innovation and focus on improving experience and outcomes.

Service users, patients and carers are key in helping us to get it right, to understand and accept when something isn't working, and seek to do better. To make sure that patients, local community representatives and our staff shaped our Quality Priorities, we held an engagement event in March 2024. Together we developed our Quality Priorities for 2024-2025 and you can read about these in this report, as well as finding out more about what we've been doing over the last year.

I want to thank staff and service users who have worked collaboratively to improve our provision of safe, effective and positive experience of services.

Michael Holland

CEO

Introduction from our Chief Nursing Officer

I am pleased to introduce the Quality Account for the Tavistock and Portman Foundation Trust for 2023/2024. The report summarises our work to provide assurance about quality of care through a variety of mechanisms, including the strengthening of the quality framework and governance to evidence this.

I am very proud of the improvements that we have made in many areas. The North Central London Integrated Care Board (NCL ICB) recognised the positive work we have progressed in the quality domain and this is now rated green under the System Oversight Framework segment 3 scrutiny that the Trust is under.

The focus on patient experience and outcomes featured heavily this year with the launch of the Trust's Strategic Pillars with a particular focus on delivering 'Outstanding Patient Care'. The application of quality improvement to tackle the immense challenge of reducing waiting lists in three services, along with increasing and improving service user feedback has been driven locally by teams.

The development of available and accessible data and information at all levels of the organisation, from teams, service lines and the Trust board, enables each level of the organisation to understand and investigate causes of unusual variation and respond appropriately. The strengthening of the integrated quality and performance report at service line level and to the Trust board includes an A3 problem solving report on a page for each area under the outstanding patient care strategic pillar and a dashboard of key quality metrics, together with narrative, to ensure we are alert to the key quality indicators on a routine basis.

Our Annual Account contains details of how the organisation is implementing the patient safety incident response framework (PSIRF) and how we plan to approach safety differently in future, including the appointment of our three patient safety partners. The year ahead includes ambitious plans to apply our quality improvement approach to further embed PSIRF, work with people who access our services collaboratively to make improvements led by those most affected and our approach to our work on equity through the Patient and Carer Race Equality Framework (PCREF).

Clare Scott

Chief Nursing Officer

About our Quality Account

Organisations are required under the Health and Social Care Act 2012 to produce an annual Quality Account if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. The information included is required by law to provide so that people can see how the quality of our services compares to those of other NHS trusts. We have also included some areas of positive quality, safety and governance undertaken during the year.

The Quality Account is an important and positive way to reflect on the services we have provided in the previous year, and to outline our plans to improve the quality of our services in the year ahead. This report will outline our highlights and challenges of the year, and where we have put actions in place to improve the care we provide.

This Quality Account has been reviewed by the following:

- The Trust's Quality & Safety Committee
- The Trust's Board
- The Trust's Executive Leadership Team

As part of our external engagement, the draft version of this report has also been shared with our stakeholders, including;

- The Trust's Council of Governors
- North Central London Integrated Care Board
- Healthwatch Camden
- London Borough of Camden Health and Adult Social Care Scrutiny Committee

Our external stakeholders were asked to review the report and provide feedback to be considered in the final version. Stakeholders are also asked to provide a statement on the report. Where received, these are included in Part 4.

About our Trust

We are a specialist NHS mental health trust with a focus on training and education as well as providing a full range of mental health services and therapies for children and their families, young people and adults.

We are also a global centre of excellence in clinical practice, training and education, and innovation in the fields of mental health and emotional wellbeing. Our distinctive approach to mental and emotional wellbeing focusses on the importance we attach to developmental, psychological and social experience at all stages of people's lives across three key areas:

- **Education:** the Trust is a pioneer in mental health, social work and leadership education. We train clinicians, social workers, nurses, teachers and many other professionals. Our clinician-tutor model and multidisciplinary approach ensures our courses are relevant, transformative and empowering.

- **Clinical services for children and adults:** we provide over 30 specialist and community services in Camden, across London and nationally.

- **Research:** our research and innovative approach began just after the First World War following successful recovery of military personnel using the Tavistock model, leading to extensive global trials and proven inquiry for a century. Since our inception, we have built a reputation as a testing ground for fundamental new ideas and practices. For decades our work has helped shape how we see ourselves, as people and as a society. Much thinking that has entered the mainstream emerged from its challenging interdisciplinary research and practice.

Our vision, mission and values

Our new strategy signals our values and sets out a plan to support all of us in coming together to deliver its ambition via a consistent way of working on quality improvement over the next three years. At its core is strengthening our relationship with service users, carers, students, all our partners and each other. This is our plan to ensure services, education, training and research are contemporary and fit for the future as we consider merger partners.

A review of our services

During the reporting period 2023/24 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 212 contracted services, across three Clinical Directorates, covering 34 clinical teams.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to it on the quality of care in these contracted services.

Quality Improvement (QI)

Quality Improvement (QI) at the Trust is focused on improving patient outcomes, system performance and professional development. At the heart of our approach is our strong commitment to improving patient experience and outcomes, and our belief that QI is about both relationships and the effective use of proven methodology. QI support structures are in place to enable staff to become actively involved in this approach and for it to become part of everyday work across the organisation. With an ever-changing health and social care landscape, this approach has been helping us to continue to deliver high quality clinical services which are tailored to our patients 'needs.

An A3 Report is a pioneered practice of getting the problem, the analysis, the corrective actions, and the action plan down on a single sheet of large (A3) paper, often with the use of graphics.

QI draws on a wide variety of methodologies, approaches and tools. The Trust had previously primarily been using the **IHI Model of Improvement** with its Plan, Do, Study, Act (PDSA) approach of small scale testing and change. In 2023-24, this has been developed further to use the A3 problem solving approach to reporting issues and presenting ways of addressing them. This way we keep the same view on issues we face and how we are delivering improvement. Many staff, from frontline teams to Board level, have been trained in the use of the A3 methodology, and this is becoming well-embedded in work across the Trust, as a method of analysing problems, and implementing and measuring improvements.

The Trust's new strategic pillars are being progressed using this A3 methodology. The two sub-objectives under Outstanding Patient Care - waiting lists and patient experience - each have Trust-wide A3 documents in place with local teams owning and progressing the work. The Kaizen events (a Japanese concept that translates as 'good change' and refers to business activities that continuously improve all functions and involve all employees) are underpinned by the problem statements in these A3s.

There are Associate QI Leads across areas of the Trust, including clinical services and the Department for Education and Training (DET), who are supported by Associate Directors. Staff vacancies have affected the delivery and impact of QI work across the Trust during the year, but the QI workforce has also significantly expanded with the addition of staff from the Strategy and Transformation Team actively supporting QI work across the Trust. This portfolio of work has moved under the leadership of the Director of Strategy and Business Development.

There have been continuing improvements and growth in delivering QI across the Trust over the past year. There are a number of active QI projects across the Trust and there are QI forums across the Trust to support these. Some of the recent projects include:

- DET – improve student satisfaction via the use of Moodle, an online Learning Management System (LMS)
- South Camden child and adolescent mental health services (CAMHS) – improving assessment processes, equality of access to services, and improving outcomes
- Gender services – improving staff morale and wellbeing

There is also a newly established dedicated QI space in the Tavistock main building and weekly huddles are held to monitor progress of projects and provide coaching and support to staff.

In addition, in 2024, two Kaizen events have been held in the Trust: so far, in our adult gender identity clinic (GIC) and our primary care psychotherapy consultation service (PCPCS). These have been team-wide QI events across several days, which have systematically analysed service-level problems and identified solutions through the A3 methodology. From these, several QI projects have been developed and are ongoing, including increased collection of patient outcome measures, clearer DNA (did not attend) processes, and optimising staff wellbeing and retention. Further services will participate in Kaizen events over the coming year.

Care Quality Commission (CQC)

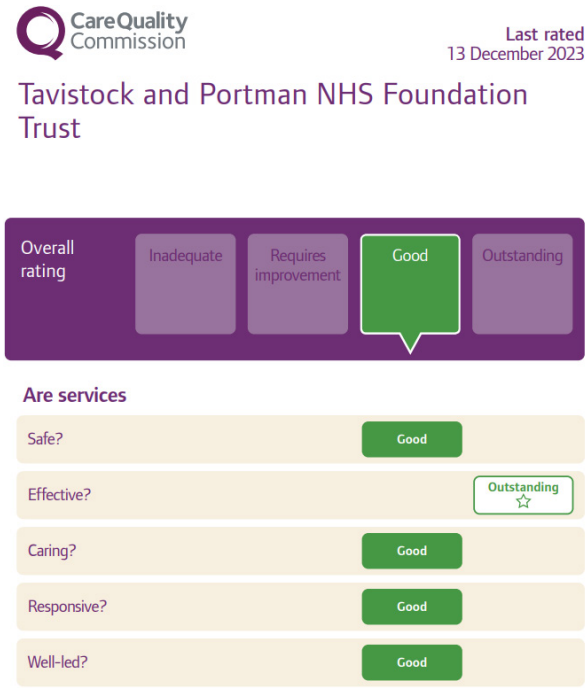
2023/24 Inspection
In September 2023, the CQC undertook a revisit to the GIDS (Gender Identity Development Service) team to reinspect the service following their inspection in 2020. The focus of the follow-up inspection was to review progress against recommendations made in 2020 with a focus on 'safe 'and 'well led 'domains. This was a short, focused inspection and the CQC did not re-rate the service. The revisit acknowledged the considerable improvements made.

The revisit report, published in December 2023, acknowledged the de-commissioning of the service provided by the Trust and the subsequent transfer of the waiting list in October 2022 to the new provider model. Therefore, the CQC removed the condition of registration placed on the Trust in January 2021 as it was no longer applicable.

The Trust does not have any other conditions of registration.

The CQC has not taken enforcement action against the Trust during 2023/24.

2018/19 Inspection
In November 2018, the Care Quality Commission (CQC) rated the Trust as illustrated below. The Trust has not been subject to a full Trust inspection since then and therefore these ratings remain.



Full details of all previous inspections can be found here
https://www.cqc.org.uk/provider/RNK

CQC Improvement Group
The CQC Improvement Group is a formally constituted Group within the Trust's governance structure which reports to the Quality and Safety Committee. The Group has delegated authority to oversee and monitor the improvement plans developed from the 'must do' and 'should do' recommendations from CQC inspections and for planning for future inspections. The Group also has delegated authority for preparing the Trust for the new CQC Single Assessment Framework.

The plan to monitor progress against the 'must' and 'should' do recommendations from past inspections is monitored at each meeting. It has been agreed that, where work is underway and covered at a Trust-level e.g. A3 improvement projects, strategic objectives, it will be monitored through that process to streamline assurance.

Another key area of work has been to thematically review all previous recommendations, including those which had been closed, to ensure that improvement work has been embedded to full effect.

A successful learning lessons event called 'CQC Demystified 'was held in October 2023 for all staff. The event was developed in collaboration between the Chief Nursing Officer's team and clinical services to understand how staff are feeling in relation to past and future inspections and to share some valuable experiences of recent inspections by teams who had experienced this. The workshop also included some key information for staff in respect of the CQC's key areas of focus and evidence categories and a focused look at what a Well Led inspection may look like. Additionally an interactive session with members of the services that were inspected in January 2023 (The Portman and Camden CAMHS) shared what they felt went well, and what could be improved for future preparation.

The Trust and the Board has been kept apprised of the CQC's work in relation the new Single Assessment Framework, and this is a key area of focus of the Improvement Group. This has included outputs of a self-assessment against the new quality statements.

Part 2

This section contains information on the quality of services provided by the Tavistock and Portman NHSFT during 2023/24. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other trusts. Indicators include those reported in the past three years.

The Trust Board, the Quality & Safety Committee, along with North Central London Integrated Care Board (ICB) and our clinical commissioners from other boroughs, have played a key role in monitoring our performance on these key quality indicators during 2023/24. Monitoring has also been undertaken through our divisional Integrated Quality & Performance Report (IQPR), clinical governance and senior leadership meetings.

Progress Against Quality Priorities from 2023/24

During the 2023/24 financial year, the Trust identified six areas of focus for Quality Priority workstreams. Progress against these is outlined below. Where they have not been achieved in full, the priorities are planned to be taken forward through the work of the strategic objectives, separate quality improvement projects or to be continued as quality priorities for 2024/25.

Equalities to increase collection of demographic information as possible and to understand variations in access and experience of service users with protected characteristics	The collection of protected characteristics, and other associated metrics, data has increased throughout the year however there is still room for improvement to meet targets. As part of the Trust's new strategy launched in 2023/24, under the 'Outstanding Patient Care' Pillar, a strategic aim was identified for service user experience. This quality priority has been absorbed into the work to progress the strategic aim which is being progressed through quality improvement approach, with an A3 plan in place. The implementation of the new NHS Patient and carer race equality framework (PCREF) will be a new quality priority for 2024/25.
Waiting Times to develop harm policies and protocols for patients on long waiting lists and to improve and develop communications and support/advice provided to patients on long waiting lists	The further development of the NCL Waiting Room has been integral to improving support to patients and their families whilst waiting for treatment. A new interactive patient platform for the adult Gender Identity Clinic has been designed throughout the year. This will be launched in 2024/25. The development of a harm review process will be continuing as a quality priority into 2024/25. Work has progressed in the adult gender services to implement clinical harm reviews, with new nursing roles being recruited to. The work started in GIC will be expanded to other areas with waiting lists.

Gender Services to continue to support our children and young people in GIDS whilst awaiting transfer of care to the new regional hub model.	The GIDS Demobilisation working group, and the sub-groups of that, focused on ensuring a safe transfer of all patients to the new models of care for children and young people. The CQC undertook a reinspection of GIDS in September 2023. The report acknowledges the Trust's work undertaken to improve safety since their previous inspection. Patients and carers spoke of feeling supported and positive experiences of care.
Outcome Measures *to increase overall OM completion rates across the Trust, to establish and embed meaningful information sharing internally and to develop the use of digital systems to aid the collection of data*	A quality improvement project has been convened to focus on reviewing our processes for collecting and reporting outcome measure forms. Improvement in collection of data has been evidenced through the year, as outlined in the Outcome Measures section of this account, alongside an increased use of digital systems to support this. This will continue to be an area of focus in 2024/25 through the quality improvement project.
Endings *co-designing and co-producing what an 'Endings' strategy looks like with patient groups, making sure our processes and approaches around discharge are correct and consistent*	This Quality Priority was paused as a project in light of priority work around the strategic objectives. However, the Trust has undertaken some separate but linked pieces of work in relation to supporting those exiting care. This included a project with the Fitzrovia Youth in Action group for those young people leaving CAMHS services. The GIDS demobilisation programme also included an Endings area of work.
Learning *to review existing processes in place relating to the sharing of learning, including triangulation of key quality metrics*	New reports for incidents and complaints have been developed to thematically review trends and demonstrate how learning is being taken forward. A new Quality & Safety report is now in place that triangulates trends from key quality and safety metrics. This will further be developed in 2024/25 through the work of PSIRF implementation (further outlined on page 18), and the related A3 quality improvement plans. We will continue to focus on ensuring that our processes for sharing and embedding learning are robust – through existing groups such as the Clinical Incident & Safety Group, the Quality & Safety Committee and divisional Clinical Governance meetings and processes.

Clinical Audit

Local Clinical Audits

31 local clinical audits were undertaken during 2023/24 with 3 audits still in progress. The reports of 30 clinical audits were reviewed by the Trust in 2023/24 and we have taken or intend to take the following actions to improve the quality and safety of the healthcare we provide:

- **Audits of Electronic Patient Records:** Multiple case notes audits were undertaken across the Trust in relation to completion of sections of electronic patient records, particularly completion of risk assessment summaries, crisis plans, care plans, review summaries and matching clinical note to patient appointment. The purpose of the audits is to review case note completion, to identify areas for improvement and to ensure there are plans to re-audit. These case notes audits are scheduled to continue on a quarterly cycle.

- **Prescribing Audits:** These audits are undertaken to ensure adherence to Trust prescribing procedure. The Trust does not have e-prescribing and the main recommendation from our audits remains that the Trust should explore the option of adding e-prescribing to its electronic patient record (EPR).
    - Biannual prescribing audit to review adherence to prescribing procedure including prescribing of controlled drugs.

- **Trustwide Mortality Audits:** These include both deaths of patients open to Trust services as well as deaths of patients on waiting lists. The audits are a means to document, where possible, the cause/likely cause of death, any contributing factors and modifying actions that could prevent future deaths, reviewing action plans and outcomes.

- **Trustwide Duty of Candour Audit:** Audit compliance with the Trust Duty of Candour policy. From this audit it has been recommend that Trust wide quarterly compliance audits are completed regularly.

- **Audit of Compliance with NICE Guideline NG 225 Self Harm**: Assessment, management and preventing recurrence. This is due to report in Q1 2024/25

- **Safeguarding Audits:** issues in relation to documentation of safeguarding consultations and supervision have emerged and actions is underway to remedy these areas to strengthen safe practice.

- **Quality Audits in Relation to Waiting Times:** 11–18-week breeches, appointment cancellation and referral received date audits.

- **Retrospective Audits:** Several audits were completed in the previous year (2022-23) but due to delay in reporting on the Trust wide system (due to the malware attack experienced by our EPR system provider in 2022) they are included in this year's report for completeness and include multiple audits of case notes in gender services, audits of ethnicity, cultural and broader needs, physical health needs audit and quality of notes

The following actions have been/are being taken to improve quality of health care provided:

- Procurement of a new integrated risk management system which will be functional for clinical audit during 2024/25.
- Establishing a new Clinical Audit and Effectiveness Group to meet quarterly 2024/2025
- Trust to take part in Clinical Audit week 2024.
- Raising awareness and promotion of the principles of Duty of Candour plan.
- Learning lessons event programme to include relevant audit findings.
- Areas of good practice from audits to be highlighted in Trust wide learning events.
- Enhance processes needed to evidence improvement from audits.
- There is an ongoing programme of case notes audits which can be targeted depending on findings.
- Work is ongoing to integrate clinical audit and QI and to consider how QI and clinical audit work best together at a local level.

Participation in national clinical audits and national confidential enquiries

During 2023/24 there were no National Clinical Audits directly relevant to services provided by the Tavistock and Portman NHSFT.

During that period, the Tavistock and Portman NHSFT participated in 100% of the national clinical audits and of national confidential inquiries that it was eligible to participate in.

Participation in Clinical Research

The Trust has a significant programme of research and its performance across key research domains are highlighted below.

Between the beginning of April 2023 and the end of March 2024, **138 participants** have been recruited to **3 research studies** in the Trust.

The recruiting studies for the Trust during the 2023/24 financial year were as follows:

Recruiting Study Name	IRAS	Recruitment Numbers
MAGIC	312288	113
Personalised Programmes for Children RCT	268597	24
REDUCE-Carbon	285768	1

More information on the details behind these studies can be found on our Trust website at https://tavistockandportman.nhs.uk/research/research-projects/

Commissioning for Quality and Innovation (CQUIN)

A proportion of Tavistock and Portman NHS Foundation Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between the Trust and our commissioners. In line with the national guidance, the Trust reported against all applicable national and local CQUINs. Commissioners will pay the CQUIN at 100% upfront as part of the monthly contract payment. Commissioners guarantee that the Trust will receive no less than 90% of CQUIN monies and the Trust will retain the additional variable 10% of CQUIN monies if it is able to demonstrate that it has reported on all National and Local CQUINs set out in Schedule 3 Part F of the NHS Standard Contract 2023/24 .

Data Security & Quality

The Tavistock and Portman NHSFT did not submit records during 2023/24 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHSFT is not a consultant-led, nor an in-patient service.

The last Data Security & Protection Toolkit submission was made in June 2023. The resulting status following that submission was 'Standards Not Met', with an amended status (on approval of the Data Security Improvement Plan') of 'Approaching Standards'. The next Data Security & Protection Toolkit submission is due in June 2024.

The Tavistock and Portman NHSFT was not subject to the Payment by Results clinical coding audit during 2023/24.

Data Quality Maturity Index (DQMI)

The Data Quality Maturity Index (DQMI) is a monthly publication from NHS Digital about data quality in the NHS and is intended to raise the profile and significance of such matters. It is based on the completion of agreed data items which include NHS number, date of birth, gender, postcode, specialty and consultant. This data is published three months in arrears.

DQMI – Data Quality Maturity Index	Q1 2023/24	Q2 2023/24	Q3 2023/24	February 2024
Tavistock and Portman NHS FT	**96.3%**	**96.9%**	**96.8%**	**97.2%**
National Average	**81.1%**	**82.1%**	**81.8%**	**81.4%**

The importance of having high quality data on which to base decisions, whether clinical, managerial, or financial, is recognised by the Trust. An ongoing focus on having robust systems, processes, data definitions and systems of validation helps assure us of our data quality. Whilst the Trust has key processes in place for assuring the quality of data it recognises that further work is required, particularly in respect of timely data submissions by staff, and further improving data validation and completeness.

Data Quality

Significant work has been undertaken over the last few years to improve data validation across the Trust. This has included changes to Carenotes, the Trust's electronic patient record system, forms, the updating of protocols and data collection tools in order to support communication and information requirements of staff and service users. One of the areas of focus during 2023/24 was improving governance processes around the completion of Care Plans for under 18s and Clinical Notes entries.

In recent years we worked on improvements around Assessment Summaries and Review Forms and Care Plans processes. The result has been a more efficient system to produce Care Plans, supported by easy-to-use reports. This year we continued with the operational implementation and training. Consequently, we have seen another significant improvement in completion rates on Care Plans - 25% increase for Initial Care Plans and 45% for Review Care Plans compared to 2022/23.

	2019/20	2020/21	2021/22	2022/23	2023/24
Initial Care Plans	47%	52%	52%	63%	88%
Review Care Plans	24%	38%	25%	33%	78%

During 2023/24 we also focused on Clinical Notes Entries. As we were recovering from the Care Notes outage (from August 2022 to December 2022 in which our electronic patient record provider suffered a malware attach) we invested many efforts on reinforcing process, awareness, and training around Clinical Notes entries. The result has been a significant improvement in understanding and in completion rates. It is difficult to report on last year's data, due to the outage, but we estimate an improvement of 20%.

The Trust also started two key quality improvement projects, one on Experience of Service Questionaries (ESQs) and one on Outcome Measures. These projects are starting to deliver improvements in understanding and involvements. When looking at the ESQ we have now benchmarked our performance and started to define action plans on how to collect more questionnaires and feedback. With regards to OMs the trust is assessing the most suitable OM for our services and methods to support collection of forms.

In terms of technological developments, we have some exciting projects being developed that are scheduled over the next financial year:

- To continue to develop and improve the Power BI Dashboard.
- To improve the number of targeted and automated reports to allow teams to have real-time access to their own data on a number of metrics
- To implement a new system to record complaints, compliments, incidents and audits, this will improve our operational procedures and access to quality data.
- To continue improving Care Notes forms and interfaces to improve the administration process and data quality.

Quality Assurance Work

- The Quality Assurance Team maintain a presence at Clinical Governance Meetings across the Trust to ensure that data quality and reporting considerations are factored into conversations where appropriate. Key performance and quality reports are presented on a monthly basis, assessing progress achieved or highlighting areas for improvement.

- There are a series of scheduled notifications sharing information on data quality performance with general management and other key staff.
- The validation of data and checks on the completeness and accuracy of data as outlined in the Trust's Clinical Data Quality Management Procedure.
- The use of standard operating procedures (SOPs) for data collection, validation and reporting to support the quality of data by the Quality Assurance Team and services.
- To expand Qualitative Audits on themes like Clinical Notes.
- To continue implementing SPC charts to monitor compliance rates.

Training and Education

- New training materials in Clinical Notes that have been key to enable improvements and engagement with services.
- Mandatory training in our electronic patient administration system (Care Notes) and outcome monitoring.
- The informatics department shares with all Care Notes users 'Top Tips' on how best to use the system on a regular basis.
- Ongoing support of services by the Quality Assurance Team to deliver improvements in relation to CQUINs, KPIs, locally agreed targets and where data quality issues are identified. This includes the provision of monthly team reports on missing data in order to improve data completeness for reporting purposes.

System Oversight Framework Indicators

The Trust has a range of NHS England (NHSE) targets on which we report throughout the year and which form part of the System Oversight Framework (SOF), used by NHSE to detect possible governance issues and identify potential support needs.

MHSDS System Oversight Framework Indicators	Target %	Q1	Q2	Q3	Q4
Valid NHS Number	*95%*	99.53%	99.65%	99.64%	99.66%
Valid Postcode	*95%*	99.68%	99.76%	99.81%	99.73%
Valid Date of Birth	*95%*	100%	100%	100%	100%
Valid Organisation Code of Commissioner	*95%*	99.21%	99.21%	99.33%	99.33%
Valid Organisation Code GP Practice	*95%*	98.89%	99.03%	99.23%	98.09%
Valid Gender	*95%*	99.96%	99.96%	99.94%	99.95%
Ethnicity	*95%*	87.59%	89.50%	90.76%	91.83%
Employment Status (for adults)	*85%*	59.74%	58.81%	61.21%	64.88%
Accommodation Status (for adults)	-	58.55%	57.43%	58.64%	62.54%
Primary Reason for Referral	-	100%	100%	99%	100%
Ex-British Armed Forces Indicator	-	88%	89%	90%	91%

MHSDS Data is published monthly. Quarterly data is represented by April, July, October and January figures.

Patient Safety

Implementation of the Patient Safety Incident Response Framework (PSIRF)

The Trust has undertaken a significant amount of work during the year in preparation for implementing the new incident framework. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

For our Trust, this represents an exciting and innovative opportunity to respond to the incidents we see and embed learning throughout individual services. The highlights of our work are outlined below. An A3 plan has also been developed to further guide our implementation through 2024/25.

- The recruitment of three Patient Safety Partners, who will be integral to strengthening our governance and management processes for patient safety. There is a significant shift in focus with the new framework on the full inclusion of carers and families within investigations and the Trust will monitor for improvement specific areas involving families and carers.
- The introduction of new investigative tools to review incidents in a timely, proportionate and systematic way, enabling clear and prompt learning to be taken forward
- The implementation of a safety huddle that ensures all incidents are reviewed on a timely basis and appropriate follow-up is assigned
- A number of presentations to the Board, senior leadership and wider Trust on what PSIRF is and what it means for our Trust and the wider NHS system
- Formal accredited PSIRF training delivered to 30 senior operational and clinical staff
- The review of our incident panel, and the implementation of the new Clinical Incident & Safety Group, a sub-group of the Quality Safety Committee. The group is tasked to give strategic oversight and challenge on incidents with a clinical and/or patient safety implication as well as ensuring that correct process is followed for recording and investigating patient safety and clinical incidents

The Trust's Quality & Safety Committee receives regular updates on the implementation of the new framework, as well as regular thematic and action-focused updates related to reported incidents.

Patient Safety Incidents

The number and rate of patient safety incidents reported within the Trust during 2023/24 are below. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

There has been a significant piece of work throughout the year, in line with our implementation of PSIRF, about the classification and recording of patient safety incidents. Therefore, our numbers of recorded patient safety incidents has increased. This has, in turn, supported greater opportunities for review and learning.

	2019/20	2020/21	2021/22	2022/23	2023/24
Total reported incidents	469	298	379	332	**365**
Patient Safety Incidents	37	38	48	19	**123**

When considering this data, it is important to note the following;

- The organisation provides outpatient psychological therapy services only, with no physical interventions and no inpatient services
- Our work to implement the new PSIRF has strengthened our oversight of classifying, recording and reporting patient safety incidents. This includes the work of the new daily patient safety huddle which reviews all incidents to confirm content and appropriate next steps.
- The majority of patient safety incidents reported resulted in no harm
- All deaths of Gender patients are subject to a mortality review as a minimum, and further investigation if indicated not discharged are reviewed
- The importance of incident reporting and learning is promoted across the Trust in order to support the management, monitoring and learning from all types of incidents. Staff are reminded of this at induction and training events and lessons are shared using a variety of methods. This will be further embedded through the work to transition to PSIRF.

Work will continue throughout 2024/25 to ensure that safety is at the forefront of all that we do. We will focus on ensuring that our processes for sharing and embedding learning are robust – through existing groups such as the Clinical Incident & Safety Group, the Quality & Safety Committee and divisional Clinical Governance meetings and processes.

Learning from Deaths

The Trust reviews all patient deaths under the following categories:

- Patients currently active/open to Trust services
- Patients on waiting lists for Trust services
- Patients who have died within 6 months of discharge from Trust services.

During 2023/24 the death of 50 patients known to Trust services, as per the definitions used above, were reported. There were no deaths of patients recorded as having a learning disability.

All deaths that the Trust is notified of are recorded via the Trust's incident reporting system and are subject to a learning response, including a mortality review where appropriate. The outcomes of these are discussed at the Clinical Incident and Safety Group meeting.

Due to the nature of the services we provide, there is sometimes a delay in the Trust being informed of a death of a patient. During 2023/24, there has been a focus on working with GPs, Coroners Officers and other health services to ascertain causes of death and any contribution that the Trust can make to a mortality review where this is led by another organisation, with the aim of enabling shared multi-agency system wide learning.

Duty of Candour obligations are carried out with careful consideration of the needs of family members, particularly when suicide is the suspected cause of death. The Trust ensures that the deceased person's GP is aware of the death. In addition, the death is reported to other relevant organisations that may have an interest.

Trust wide learning lessons events continued throughout the year. Mortality audits during 2023/24, along with the preparation for PSIRF (patient safety incident response framework), have identified some themes that can be used to guide learning events during the year 2024/2025.

Infection Prevention & Control (IPC)

It is a Trust priority to deliver the required standards of infection, prevention and control (IPC) and environmental cleanliness, to reduce, as far as possible, the risk of Healthcare Associated Infections (HCAIs). The Trust's objective is to ensure that patients are cared for, and staff work in, a safe and clean environment in which the risk of HCAIs are minimised.

The Trust is a mental health Trust that is quite unique in the services it provides, all of which are community based with no inpatient services. The Trust aims to adhere to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015); as well as other National Guidance: National Institute for Clinical Excellence (NICE); Infection & Prevention Control Quality Statement 61 (2014). This year the Trust completed the national Infection Prevention and Control Board Assurance Framework. This identified that many of the areas, such as tackling antimicrobial prescribing, were not applicable to the Trust, however it did identify the requirement for greater IPC expertise in the Trust. Innovative work has progressed in the North Central Lonon Integrated Care System for a local provider to work in partnership with Tavistock and Portman to provide this.

Patient Experience

In 2023/24, 95% of patients reported positive feelings about their experience of care/treatment, as reported by service users and/or their families in the Trust's Experience of Service Questionnaire (ESQ). This is consistent with the averages from previous reporting years.

	Yearly Averages					2023/24			
	2019/20	*2020/21*	*2021/22*	*2022/23*	*2023/24*	Q1	Q2	Q3	Q4
Positive responses relating to experience of care/treatment	**97%**	**98%**	**95%**	**95%**	**95%**	**97%**	**90%**	**100%**	**96%**

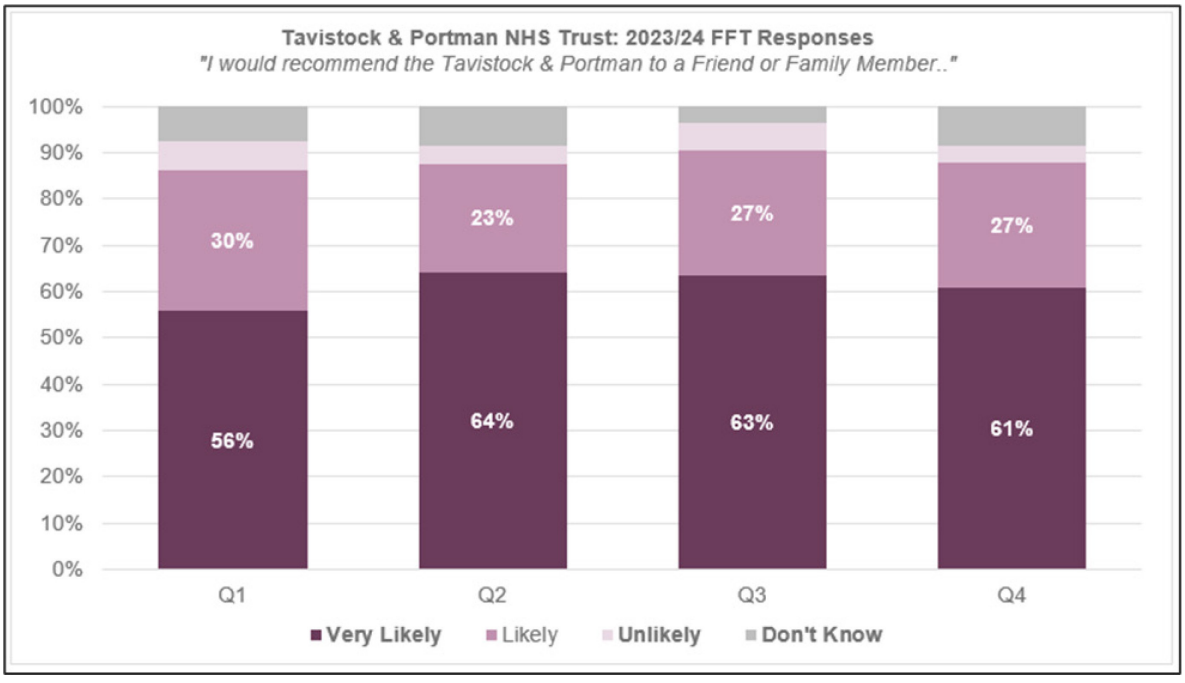
Numerator = 'Good + 'OK' Denominator = 'Good' + 'OK+ 'Not Good' + 'Don't Know'.
Source: Quality Team, Data received and calculated: 05/04/2024

Friends & Family Test (FFT)

The Trust collects the Friends & Family data through a specific question included in the ESQ form. In 2023/24, the Trust reported a 88% positive recommendation rate for the FFT question.

	2019/20	2020/21	2021/22	2022/23	2023/24
% of patients who would recommend the Tavistock and Portman to a friend or family member if they required similar treatment	**94%**	**91%**	**88%**	**84%**	**88%**

The graph below illustrates the breakdown of responses for the FFT question responses received during 2023/24.



Patient & Public Involvement (PPI) & Service User Experience projects

The Patient and Public Involvement (PPI) team works collaboratively across our Trust departments and with community colleagues to embed involvement in clinical and educational work and in the business as usual of all departments. The team works with patients, family members, carers, local community partners and members of the public in various aspects of our work to help develop and improve the services we offer, in a meaningful and informed way. It is about empowering patients and the public to have a say and for professionals in the NHS, listening and responding to these views, creating actionable outcomes. We believe this promotes a cultural change that will improve patients' experiences of the NHS.

The team has undergone significant staffing changes during this period. Following a planning day in November 2023, an annual plan of activity for the year ahead was developed and approved by the Quality and Safety Committee in January 2024. This work plan is being held to account via the bi-monthly Service User Experience Group (SUEG), in line with the strategic ambition to provide outstanding patient care through user experience. The team has been working on this plan to meet our objectives in addition to adopting the new Trust vision, mission and values of excellence, inclusivity, compassion, and respect.

To achieve these ambitious goals, it was important to clarify our team function and communicate these updates across the Trust. The team has prioritised the review and refresh of policies, procedures and standardising processes as a core piece of co-produced activity with our service users. In addition to this we have focused on increasing internal engagement across all teams with the aim of identifying a ‘link person ’or champion to build on involvement activities in each service.

As part of the Trust’s newly established strategic pillars, user experience is a primary focus under outstanding patient care and the PPI team have been leading this piece of work. The use of Quality Improvement methodology has been implemented to focus our efforts in three main areas identified for improvement:

- Increasing patient experience response rates to our friends and family test
- Improving patient satisfaction of service scores
- Increasing service user involvement across all teams.

The team will continue to build on successful outcomes and seek to increase our engagement with clinicians. We aim to map out levels of service user involvement and share best practice in addition to supporting and developing service users’ skills. A great example of this is the recruitment of three service users into the role of Patient Safety Partners to support the implementation of the Patient Safety Incident Response Framework (PSIRF) for the Trust, as well as the recruitment of two Experts by Experience (EbE) for the Service User Experience Group (a subgroup of the Quality and Safety Committee).

Our external efforts at this time continue to be centred on the Art Board and the revolving exhibitions which are filled until Spring 2025. We have established a relationship with Health Watch Camden and will continue to work on this as we identify opportunities to involve them more into our work as we build relationships with teams across the Trust.

Complaints

During the year 2023/24, the total number of formal complaints received by the Trust was 94, representing a reduction of 9 complaints on the previous year. By service, the highest number of formal complaints was received in the following areas GIC (54), followed by Mental Health services (14) and GIDS (10).

	2019/20	2020/21	2021/22	2022/23	2023/24
Formal Complaints Received	**166**	**116**	**144**	**103**	**94**

Source: Quality Portal 04/2024

The illustration below demonstrates the breakdown of complaints according to subject categories recorded:

Complaint Categories 2023/24	No. of Complaints
Access to Treatment or Drugs	**10**
Appointments	**14**
Communications	**45**
Other	**1**
Patient Care	**1**
Privacy Dignity Wellbeing	**1**
Trust Administration	**1**
Values & Behaviours	**4**

Source: Quality Portal 04/2024

Communications is the highest category of complaints recorded (45) and within that group, the highest sub-category is 'Communication with Patient '(32). Within this sub-category, there was a diversity in topics including waiting times, disagreement with clinical outcomes, delays in communication and administration issues. A full chart of the sub-category breakdown is depicted in the diagram below. Most notable are the subcategories of 'Communication with Patient 'and 'Method/Style of Communication and work is currently being done to support service leads with the learning that can be taken from complaints to improve their service to patients.

Complaint Sub-Categories 2023/24	No. of Complaints
Access to Services	**2**
Appointment Availability	**1**
Appointment Delay	**7**
Attitude of Staff	**3**
Breakdown in Communication/Appointments	**2**
Communication with Patient/Carer/Relatives	**27**
Incorrect/Inaccurate Interpretation	**1**
Method/Style of Communication	**7**
Name Not on Waiting List	**2**
Other	**5**
Referral Delay	**2**
Service Provision	**2**
Treatment Cancelled/Delayed	**4**

The current complaints policy states that all complaints are to be acknowledged within 3 working days of receipt. For 2023/24 the percentage of complaints that were acknowledged within 3 days was 83%. The timely acknowledgement of Complaints and Enquiries is being addressed as part of the Complaints Improvement project.

Complaints Review and New Process

A review of the complaints process has been undertaken during the year to improve the process, ensure investigation and response is prioritised and to strengthen the way in which the Trust learns from complaints and enquiries. The Quality & Safety Committee approved a new complaints process in January 2023. Senior clinical and operational staff have been involved in the review process and training in effective complaints investigation and management is planned for Quarter 1 2024/25 to support the new complaints process. A key change in the complaints process includes the Trust's complaint response time from 25 working days to 40 working days, and, importantly, prioritising an early and local resolution process where possible. Alongside this, there will be the introduction of a new complaints management portal, Radar, that will integrate improved oversight, escalation, support and monitoring for complaints for Complaints Managers and Investigation Leads as well as other Trust stakeholders. The purpose of these proposed changes is to ensure:

- complaints investigations are completed on time and within the new 40-day time frame. The new time frame brings the Trust in line with national guidance around response times.
- Investigation Leads are supported throughout the investigation process.
- Complainants receive regular updates throughout the complaints process.
- Complaints Managers are able to manage the complaints process flow more efficiently.
- the complaints quality assurance and sign-off process is improved.

Overdue Complaints

Since the beginning of 2023/24 the number of open and overdue complaints has significantly reduced. Work to reduce the backlog of overdue complaints is continuing and the number of open complaints at the end of the year was 33 of which 26 were overdue i.e. outside of the new 40-day time limit. Work to the reduce the remaining overdue complaints continues and is expected to be complete by June 2024.

PHSO complaints

If a complainant is unhappy with the Trust's response to a complaint, they can ask the Parliamentary Health Service Ombudsman (PHSO) to review their case. If the PHSO decides to investigate formally, the Trust is notified whilst the PHSO carries out their own investigation. During 2023/24, the PHSO investigated 1 Trust complaint outcome; not further action was taken following the investigation.

Learning from complaints

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. Each complaint gives us a better understanding of the patient's experience of our services. To ensure that improvements to our services are made, we are able to create an action plan where applicable. Themes and actions following complaints are reported to the Quality & Safety Committee and the Service User Engagement Group (SUEG) and reports are provided to service leads to share within their clinical governance structures. Complainants are also invited to participate in the Trust's Patient Public Involvement (PPI) programme of work where they can use their knowledge and experience to help improve the Trust's provision of services to our patients.

Clinical Effectiveness

Improving the Physical Health of Patients

The Trust's physical health service, known as the Living Well Service, took the decision to review the needs of the population it serves. This was in response to challenges in recruitment and a recognition that the needs of the population and the way in which they engage with services has changed post pandemic. Between January and December 2023, the Associate Director of Nursing (ADoN) alongside an Expert by Experience (EbE) scoped the needs of a future service, enabling us to understand the needs of our diverse patient group. Scoping work has included stakeholder workshops, staff survey, patient workshops and team deep dives.

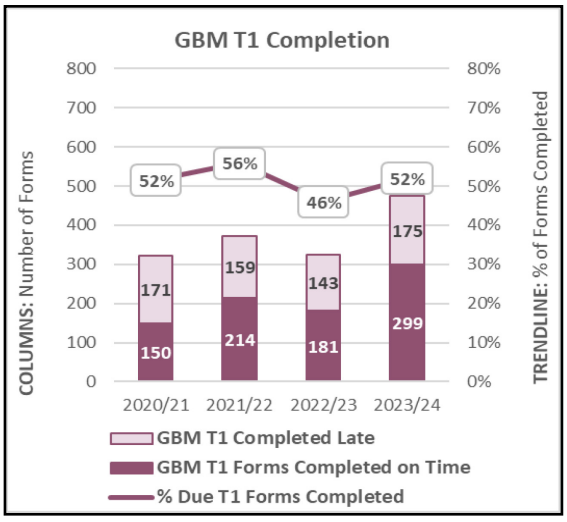
Based on the findings and evidence gathered from the scoping work, a physical health strategy was presented to the Quality and Safety Committee in January 2024 and the Committee approved this. There will be a phased approach to implement the strategy, with the aim of ensuring staff feel confident to ask relevant physical health questions during the assessment and treatment of service users and for basic physical health questions to be incorporated in all service user assessments in the Trust. Where physical health needs are identified the Trust will ensure up to date evidence-based information is available to clinicians and service users with the aim of enhancing service user experience and supporting them to choose how to access the information and what support they would like to benefit from.

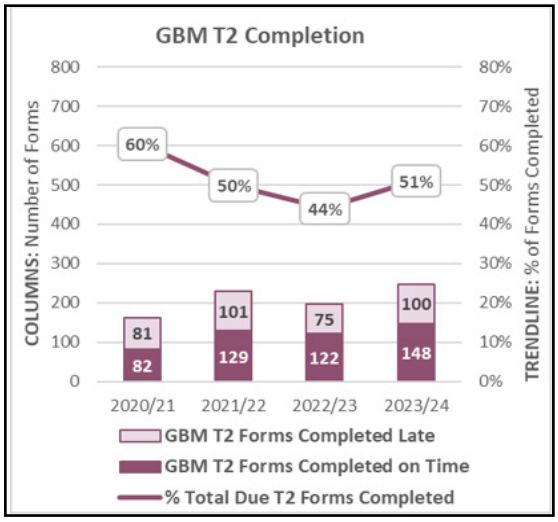
Outcome Monitoring Data - Goal-Based Measure (GBM) outcome data for Child and Adolescent Mental Health Services (CAMHS)

The Trust uses the Goal-Based Measure (GBM), for our under 18s service users and services, to enable us to know what the service user wants to achieve (their goal or aim) and to focus on what is important to them. The Goal-Based Measure tool is a way of evaluating progress towards goals in clinical work with children, young people, and their families and carers. This helps us to make adjustments to the way we work with the individual. GBMs are linked to the Thrive Category recorded in the assessment summaries and reviews. They are considered due when the thrive category is marked as Thriving, Getting Help and Getting More Help.

Time 1 (T1) refers to the first time the patient agrees goals with their clinician. This is expected to be completed within one month of the patient's second attended appointment. The GBM goals are agreed jointly between the clinician and the patient and are reviewed after three months, or earlier if clinically appropriate. This review is known as Time 2 (T2) and it is deemed as completed 'on time 'if recorded within four months of T1.

The completion rates for open patients with a due GBM T1 and T2 are outlined below:





We are pleased to see an improvement in both our completion rates and the timing of the completed forms during the year. We believe the work with the clinical governance groups, improvement in our reminders process and the quality improvement focused on Outcome Measures has had a positive effect. It is also important to note an increase in the GBM T1 and T2s due is likely to be linked to last year's cyber-attack and the backlog completing assessment summaries and review forms.

Improvement rates	2020/21	2021/22	2022/23	2023/24
% Qualifying Camden CAMHS patients who reported an improvement in their GBM scores from first to last completed form	36.6%	50.0%	60%	67%

The improvement rates are taken from the first form (T1) to the last completed form (TL) on qualifying discharged patients during 2022/23 - this allows us to evaluate the whole patient's pathway. We can then determine if there has been an improvement in score based on the following definitions:

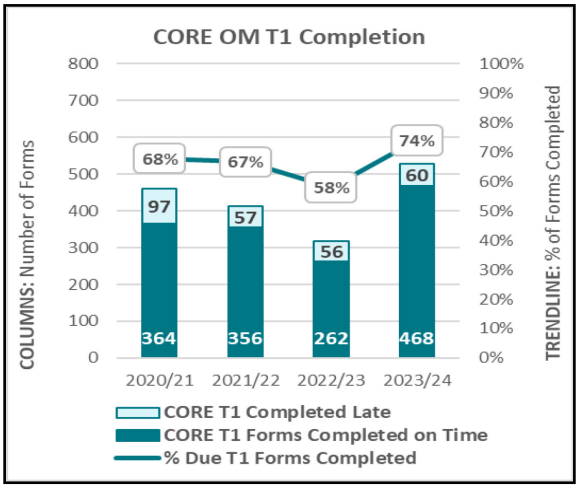
- Positive change in goal progress -> +2.45 or more
- No change in goal progress -> -2.44 to +2.44
- Negative change in goal progress -> -2.45 or less

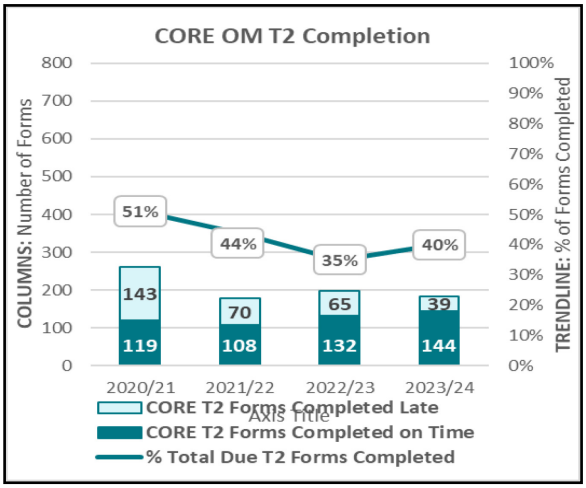
Outcome Monitoring Data - Clinical Outcomes for Routine Evaluation (CORE) outcome monitoring for adult services

The main outcome measure used across all adult services (patients over 18 years old) is the CORE. CORE (Clinical Outcomes in Routine Evaluation) is a session-by-session monitoring tool with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. This is designed to provide a routine outcome measuring system for psychological therapies covering four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm.

Over the course of 2021/22 we successfully tested an online collection method (Qualtrics). In 2022/23 we started implementing this method in a wider range of services with the idea of increasing the number of patients we can reach and subsequently improving our return rates. Unfortunately, the database outage we experienced from August 2022 to December 2022 hindered the project. This is in the process of being restarted and ingrained in the service's routines. Over the course of 2023/24 several teams moved from CORE to CORE 10 which is a shorter form.

The completion rates for open patients with a due CORE T1 and T2 are detailed below:





Similar to the Outcome Measures form used for the under 18 services, the adult service have also seen an improvement in both our completion rates and the timing of the completed forms.

Improvement rates	2020/21	2021/22	2022/23	2023/24
% of Discharged patients who reported an improvement in CORE score from first to last completed form	**69%**	**66%**	**56%**	**61%**

Having patients complete multiple instances of the same Outcome Measure form means that we are able to directly compare changes in score between their first and last completed form, which gives us a good insight into the outcome of their treatment. Annual data for 2023/24 showed that 61% of patients who attended at least two appointments and had at least two CORE OM forms completed at discharge experienced an improvement in their CORE score.

Our People

Our ambition is to ensure that all our staff have a positive experience at work. Despite best efforts, we know from feedback and data that we must do more to make sure this is the case for everyone, and we are working hard to make this happen.

We share the NHS-wide ambition to make the People Promise a reality. This is reflected in our own People Plan and in the changes that we are making, be that the creation of new fora to listen to staff voices and act accordingly, transparent opportunities for training and career development, the commitments within our Inclusivity Action Plan, or health and wellbeing considerations.

We want our culture to be positive, compassionate, and inclusive – and we all have our part to play.

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

National Staff Survey 2023/24

There were 435 questionnaires completed by the Tavistock and Portman staff, a 53% response rate which is a significant improvement from the level of participants the previous year (45% in 2022). Although the Trust is the lowest scoring for the Mental Health and Learning Disability and Community Trusts it is also the most improved

The staff survey participation rate had been declining over the past few years; so the increase in response rate is a positive change in terms of staff engaging with the survey. The staff survey results reflect the feeling in the organisation and has highlighted the key areas that the organisation needs to prioritise and develop initiatives to ensure the organisation addresses the issues raised.

The table below highlights the key areas where our scores have improved significantly compared to the 2022 survey. Our scores for ‘We are always learning’, ‘We are a team ’and ‘Staff Engagement ’all show significantly higher results. There has been a reporting issue nationally with the scores for ‘We are safe and healthy ’and consquently we do not have a cumulative score for that element.

Appendix B: Significance testing – 2022 vs 2023

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.96	335	7.14	435	Not significant
We are recognised and rewarded	5.94	335	6.05	434	Not significant
We each have a voice that counts	6.08	332	6.23	429	Not significant
We are safe and healthy	5.73	335	-	-	-
We are always learning	4.63	315	5.17	413	Significantly higher
We work flexibly	6.34	335	6.38	433	Not significant
We are a team	6.73	335	7.04	434	Significantly higher
Themes					
Staff Engagement	6.19	335	6.46	435	Significantly higher
Morale	5.15	335	5.21	435	Not significant

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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

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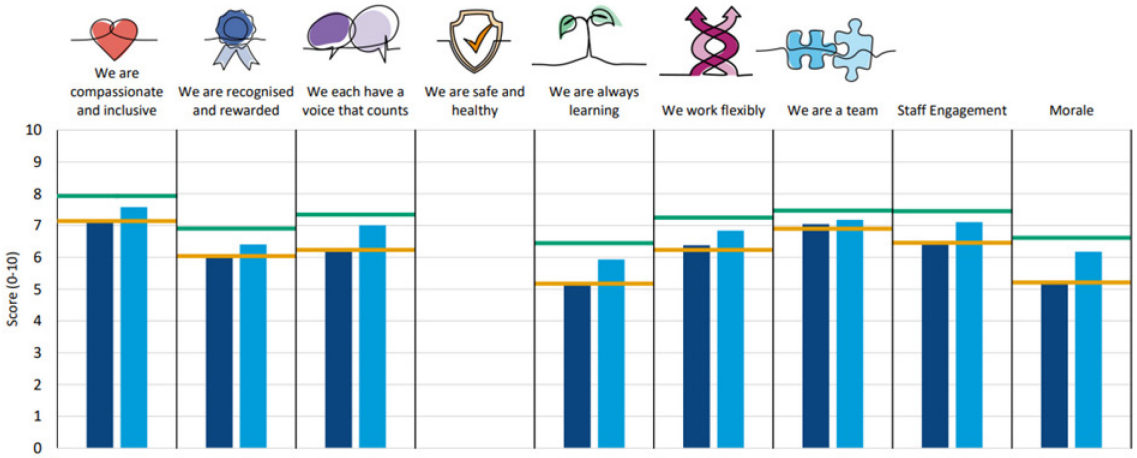
The Trusts results for 2023 showed that the experience of our people at The Tavistock and Portman is below that experienced by staff in the Trusts we were compared against. However, in 2022 we were the lowest score across all nine themes, whereas for 2023 we are the lowest in seven of the nine themes and this shows the progress we are beginning to make. The results place us as the second most improved Trust for staff engagement as compared to last year, however we are still at the bottom of our benchmark and we need to make significant further improvement for our people. The areas of greatest concern are in relation to staff feeling they have a voice that counts and staff morale.

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.14	6.05	6.23	-	5.17	6.38	7.04	6.46	5.21
Best result	7.93	6.90	7.34	-	6.45	7.25	7.47	7.45	6.61
Average result	7.58	6.41	7.01	-	5.93	6.84	7.18	7.11	6.17
Worst result	7.14	6.04	6.23	-	5.17	6.23	6.90	6.46	5.21
Responses	435	434	429	-	413	433	434	435	435

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Tavistock and Portman NHS Foundation Trust Benchmark report

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We are developing a Trustwide Staff Survey action plan which will focus on improvements which can be made on a local team level as well as across the organisation.

Reported Raising of Concerns: Whistleblowing & FTSU

The Trust takes the issue of staff being able to raise concerns by speaking up, or 'whistleblowing', very seriously. We continue to support and promote the formal Freedom to Speak up (FTSU) process, including the Guardian who was in post during 2023/24. The Guardian's role is to help ensure that staff are supported to raise concerns where this is needed, and to help remove any barriers to these being addressed.

The Trust's results of the 2023 NHS Staff Survey continue to show that there is a perception at least, not only that the Trust does not take concerns raised seriously, but also that those speaking up are not always supported or protected. The survey showed that only 61.2% of respondents felt "secure raising concerns about unsafe clinical practice" (well below the 74.7% average recorded at our comparator organisations). This was also slightly lower than the 60.5% of T&P staff who answered the same question positively in the 2022 survey, albeit on a smaller sample size.

Similarly, only 45.1% of respondents felt confident that the organisation would address concerns about unsafe clinical practice. Although this is an improvement on the 42.5% who answered this question affirmatively in 2022, it is well below the 60.2% average across the Trust's peer group. The Trust also scored poorly in responses given to questions about the extent to which staff were encouraged to report and learn from incidents and near misses.

However, in spite of the negative picture that these results present regarding the organisational attitude to raising concerns, on the positive side, staff do continue to speak up in good numbers. The most recent figures presented to the Board by the Freedom to Speak Up Guardian showed that they were involved in a total of 107 cases between April 2022 and March 2023 (a more than 100% increase from the 44 in the same period a year before). Staff illness has meant that the totals for 2023/24 were not available at the time of writing, but it is expected that the figures would have risen again. Also encouraging is the fact that none of the colleagues who raised concerns in 2022/23 felt that they needed to do so anonymously.

In terms of the sorts of issues that those speaking up were raising, the breakdown is as follows:

- worker safety or wellbeing – 50%
- patient safety/quality – 17%
- inappropriate attitudes or behaviours – 13%
- bullying or harassment – 12%
- disadvantage or demeaning treatment as a result of speaking up – 8%

It should also be noted that a number of recurring themes played out in the concerns raised in 2022/23 and subsequently. The first of these was that questions around equality, diversity and inclusion underpinned a significant proportion of the concerns, with many of the allegations of bullying and/or harassment including at least a perception of discriminatory treatment or behaviour. The second theme was the impact that often significant delays in completing investigations has had, not only on the colleagues who have raised concerns, but also the cohesion of the whole team.

Significant steps are being taken to address both the issues raised in the staff survey and the broader themes. Changes have been made to the Freedom to Speak Up support within the Trust, including the executive lead role passing from the Chief People Officer to the Director of Corporate Governance – this is with a view to addressing the perception of a conflict of interest that sometimes exists in relation to the People Team. In addition, with the previous non-executive lead coming to the end of their tenure as a non-executive director (NEDs), the role is

now being shared by two NEDs – one focusing on concerns of a clinical nature, and the other on those relating to managerial or HR issues.

More importantly, with effect from 3 June 2024, a second Guardian has been appointed. It had become clear that the workload for one Guardian working 1.5 days a week was unsustainable and as such both Guardians will provide a combined 4 days of cover. This additional capacity will not only mean that staff wishing to raise concerns will be offered speedier appointments, but there will be more time for training, outreach and other proactive activities. In addition, there are plans in place to, in due course, appoint Freedom to Speak Up Ambassadors. Although these unpaid volunteers will not carry caseloads, they will work closely with colleagues across the organisation, helping to signpost appropriately, and they will be instrumental in helping to embed a culture of speaking up across the Trust, where raising concerns becomes a normal part of how we operate, and the real or perceived threat of adverse consequences becomes a thing of the past.

Mandatory Training 2023/24

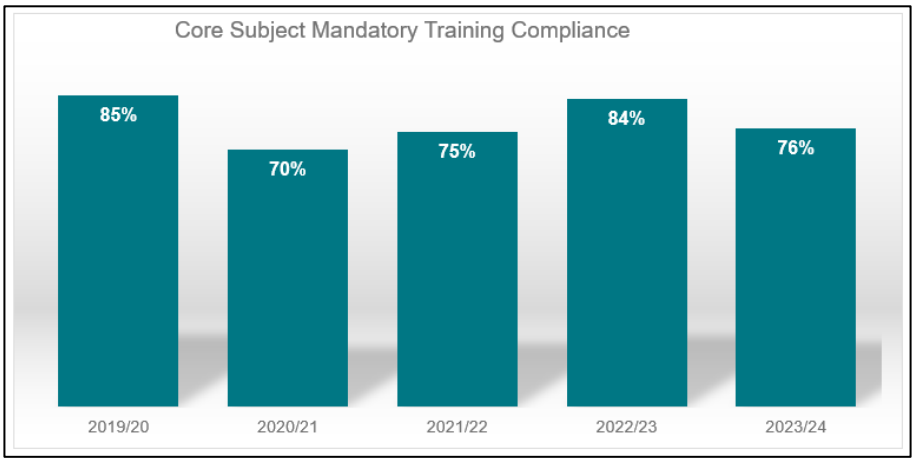
Every member of staff employed by the Trust is required to be compliant with a range of mandatory and statutory training requirements. The organisation has a consistent approach and has adopted the requirements and curriculum for each topic area in line with our partner Trusts in North Central London. The Trust has continued to accept training delivered at other NHS organisations for the purpose of consistency. The Trust, along with many other Trusts, has changed the method of training delivered from face-to-face (classroom based) to online e-learning modules through the Oracle Learning Management (OLM) module of the Electronic Staff Record (ESR). The staff member's personal ESR self-service account also provides data including current compliance rate and completion / expiry dates of modules. This approach has enabled staff members to complete training as and when required at their own pace and within the comfort of their own homes.

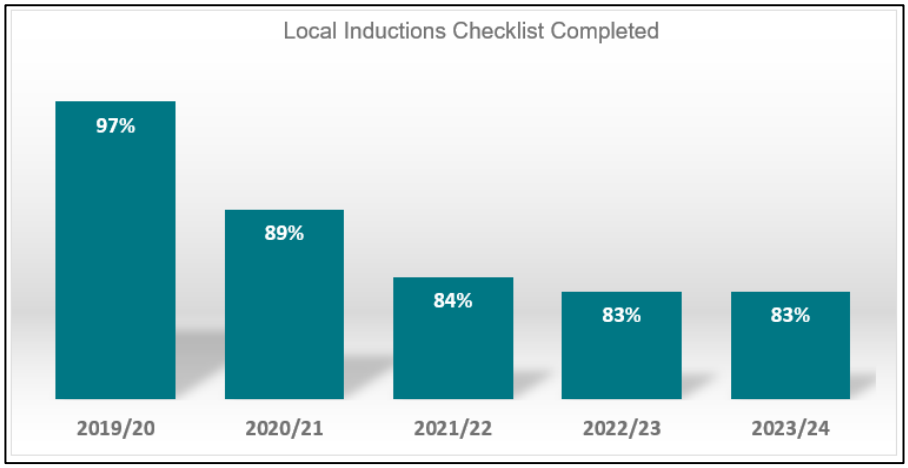
Compliance throughout the year reflects a downward and upward trend as observed in quarters 3 & 4. The Trust is in a process of implementing ESR Manager self-service aimed at improving overall Trust compliance.

The recent drop in mandatory and statutory training compliance is partly attributed to the closure of two key services with the Trust. This has resulted in increased sickness absence within those services, which in turn has significantly impacted the compliance for the service and Trust. Additionally, we have introduced new training modules – Oliver McGowan and Essentials of Patient Safety Level 1 – which we are still implementing. These new modules are also factors attributing to the drop in compliance.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023/24 Overall Figures
Core Subject Mandatory Training Compliance	*85%*	*56%*	*77%*	*86%*	**76%**
Local Induction Checklists Completed	*85%*	*82%*	*83%*	*81%*	**83%**

Source: Electronic Staff Record





Disclosure and Barring Service Compliance 2023/24

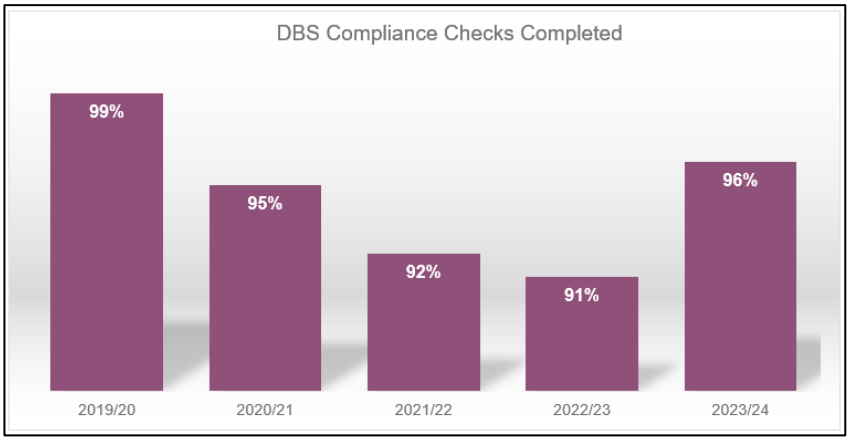
The Disclosure and Barring Service (DBS) helps employees make safer recruitment decisions. The DBS is an executive non-departmental public body of the Home Office.

The Trust continued to maintain a high level of compliance to the required standards. For the purpose of transparency, staff that are on maternity leave, or a prolonged absence are included in the denominator for this metric which accounts for the 5% who do not currently have an up-to-date check in place.

The Trust's recruitment and selection procedure requires that all staff that conduct regulated activity should undergo a disclosure check before commencing with the organisation. The Trust ensures that all staff are rechecked every three years. The Trust accepts DBS compliance from any staff member or potential candidate who is part of the update service which is an online subscription that allows the staff member to keep their certificate up to date on an annual basis. We have also taken the necessary precautions by implementing ESR notifications as part of our internal messaging / workflow systems within ESR. The workflow notifications relating to DBS compliance enables the team to respond and act on this information. Role-based notifications support internal processes and helps maintain the ESR system and its data.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023/24 Overall Figures
DBS Compliance Checks Completed	*95%*	*97%*	*97%*	*97%*	**96%**

Source: Electronic Staff Record

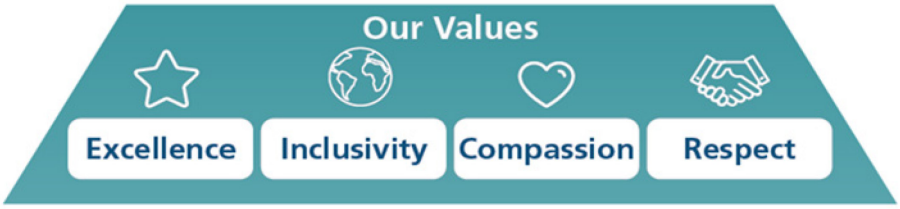


Staff Rota Information

The Trust has a dedicated Guardian of Safe Working Hours who supports the safe working of junior doctors including the coordination of collating exception reports and facilitates payments of fines.

The Trust has appointed to all trainee positions and is fully completed therefore there are no vacancies or staff gaps on the Rota.

Part 3: Our Quality Priorities for 2024/25



This section of our Quality Account outlines our priorities for improvement for the year 2024/25.

In March 2023, the Trust held a Quality Priorities stakeholder engagement event for the first time to engage stakeholders in developing quality priority proposals for 2024/25. The plan is to align the new quality priorities to the Trust's new values, strategic pillars and build on quality improvement work in these areas. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

For 2024/25 priorities are arranged under the three core domains of quality – patient safety, patient experience and clinical effectiveness. Our Quality & Safety Committee endorsed these areas of focus at its April 2024 meeting.

Strengthening our Patient Safety culture

- 85% of staff will be trained in the Level 1 Essentials of Patient Safety syllabus
- Training for staff in new PSIRF investigative techniques
- 100% of patients/families involved in Patient Safety Incident Investigations are included in the investigation process

Clinical Effectiveness

- Implementation of PCREF (Patient and carer race equality framework)
- Outcome Measures performance that meets the NHSE standards and includes matched pairs of outcome measures
- Reviewing the harm assessment process for services that have extended waiting times

Patient Experience

- Increase ESQ feedback received by 200% per service line (based on previous baseline rates)
- Reporting experience metrics by protected characteristics / demographics
- Developing a digital drop box for 'live feedback'
- innovative ways of collecting feedback from children & young people

Part 4: Stakeholder Statements

As part of our external engagement, the draft version of this report has been shared with our stakeholders, including;

- The Trust's Council of Governors
- North Central London Integrated Care Board
- Healthwatch Camden
- London Borough of Camden Health and Adult Social Care Scrutiny Committee

Comments received back have been incorporated where possible and the statements received on the Quality Account are detailed below.

The Tavistock and Portman Council of Governors - Lead Governor Statement

New Board Committees and ways of reporting have enabled Governors to understand more and gain confidence in the Board oversight of quality and safety. Governors have recently been invited to be observers on Board Committees. I indicated an interest in the Quality and Safety Committee and have been pleased, with a fellow Governor, to join the group. In my first meetings it has been good to see the engagement, team work and focus. Also to increase my understanding and confidence in how the lead non-executive director chairs and scrutinises the work.

There has been external recognition of improvement in the work on quality and safety from both the Integrated Care Board and the Care Quality Commission.

The focus on improving data is welcomed. It builds understanding and confidence that issues are being addressed and the impact of actions are being monitored. For example, the review, new systems, monitoring and improvement in responding to complaints. It also enables Governors to ask questions when there has been a deterioration or lack of improvement.
I have been concerned about the variability in some indicators between services. The availability of improved data gives greater clarity about where learning and action needs to take place. Governors have appreciated new opportunities to learn more about services, both through service visits and new communications. There has been team involvement, good feedback and early indications of change from projects, training and quality improvement initiatives.

I saw evidence of the Trust 'looking outwards' to learn from others, for example as part of the patient safety review and application of the Patient Safety Incidence Response Framework (PSIRF) including appointment of patient safety partners.

It is good to see that providing high quality specialist mental health care is at the heart of the new strategy with focused attention on waiting lists and patient experience. Also that important work such as audit continues to be valued, and issues where more work is needed, such as equalities, is acknowledged and planned. Governors are interested in understanding more about the targets for improvement on equalities and the results of audits. Other areas of interest are participation in clinical research, data security and patient safety incidents.

I am often asked if the work of the Trust 'makes a difference', and look forward to seeing more on the developing work on outcomes. I feel the priorities for the coming year build on the work that has been done, addressing issues that need further attention and focussing on improving care and outcomes for patients.

Kathy Elliott
Lead Governor
16.5.24

Statement Regarding Tavi Quality Account from **Stephen Heard, Director of Healthwatch Camden:**

"Healthwatch Camden are pleased to see ongoing progress and commitment to patient safety and inclusivity. As you are already aware, this is imperative for Camden residents in accessing your services and facilities and ultimately having good experiences and outcomes."

NHS
North Central London
Integrated Care Board

5th June 2024

Laycock PDC
Laycock Street
London
N1 1TH
0203 198 9743
northcentrallondon.icb.nhs.uk

NHS North Central London Integrated Care Board Statement

The NHS has continued to face significant challenges during 2023/24 as the system focused on recovery from the Covid -19 pandemic, while coping with the impact of Industrial Action, challenges with waiting times to access services, staff shortages and illness. We recognise, and are grateful for, your leadership and commitment to doing everything possible to keep service users safe, while undergoing significant changes within the senior leadership team at the Trust.

North Central London Integrated Care Board (NCL ICB) has worked closely with the Trust throughout 2023/24, taking a pragmatic approach regarding assurance of commissioned services throughout the year, obtained through regular discussions with key staff and attending the Trust's Quality and Safety Committee meetings.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to NCL ICB in May 2024). The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available a place holder has been inserted.

The Trust have established a clear strategy, signalling their vision and values with a clear focus on Quality Improvement incorporating five key strategic pillars and objectives, as set out in the Quality Account. We are pleased to see the Trust's strong commitment to improving patient experience and outcomes, moving away from small scale change models using Plan, Do, Study, Act (PDSA) cycles, to using the A3 problem structured problem-solving and continuous-improvement approach, to monitor and measure the effectiveness of mitigation.

Implementation of the Patient Safety Incident Response Framework (PSIRF) has been a key priority for the Trust this year. This is a key component within the national Patient Safety Strategy and is a requirement for all NHS Trusts to implement from 01 April 2024. The Trust have recruited three Patient Safety Partners and this is a positive step in strengthening governance processes and ensuring that the voice of the service user is heard and listened to.

The Trust have reviewed their process for managing complaints and introduced a complaints management response portal, to improve oversight of complaints, and allowing for prioritisation of early resolution where possible. The new process is designed to ensure that the complainant is communicated with regularly throughout the process, with greater support in place for the staff involved with investigating the complaint, as well as ensuring a robust process for sign off complaint responses.

North Central London ICB Chair: Mike Cooke
North Central London ICB Chief Executive Officer: Phill Wells

Services were severely impacted by the Care Notes outage that affected many providers of health in England from August 2022 to December 2022. Improving data quality and validation has been a key area of focus for the Trust, with work progressing on automated reports for teams to access in real time. Throughout the year, significant work has taken place to strengthen data and information shared with the Trust Board.

While the Trust have made some progress in relation to improving staff experience, based on the 2023 NHS Staff Survey compared to the previous year, the Trust acknowledges that more needs to be done, specifically in relation to improving morale and staff feeling that they have a voice.

We are supportive of the Quality priorities set out by the Trust for 2024/25, particularly those focused on strengthening Patient Safety Culture, fair and just culture and the implementation of the Patient and carer race equality framework.

Your sincerely

Phill Wells
Chief Executive Officer
North Central London ICB

North Central London ICB Chair: Mike Cooke
North Central London ICB Chief Executive Officer: Phill Wells

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Larraine Revah, and they should not be understood as a response on behalf of the Committee.

The report is well structured, and clearly sets out how the Trust performed against priorities in 2023/24. The report demonstrates the Trust acknowledges areas requiring improvement, and sets out plans to improve areas of concern.

The following observations were made in accordance with a set of core governance principles, which guide the scrutiny of health and social care in Camden.

1) **Putting patients at the centre of all you do**

Addressing waiting times was a carried over priority from the previous year, with the aim to develop harm policies and protocols for patients on long waiting lists and to improve and develop communications and support advice provided to patients on long waiting lists. It is positive that support has improved to patients and families who are waiting for treatment following development of the NCL Waiting Room, however I would recommend the accounts include more information on how improvements are being measured, to provide reassurance that patients are being consulted and able to feedback on the effectiveness of interventions.

I look forward to being updated on progress of the interactive platform for the adult Gender Identity Clinic in next year's quality accounts.

It is reassuring that 95% of patients report positive feelings about their experience of care.

2) **Focusing on a common purpose, setting objectives, planning**

The accounts acknowledge that more needs to be done to ensure staff have a positive experience at work. The National Staff Survey results remain a concern, particularly in relation to staff feeling they have a voice that counts and staff morale. Being the second most improved trust shows actions to improve are starting to work, however the Trust is still at the bottom of the benchmark. I hope the development of the Trustwide Staff Survey action plan will lead to significantly improved results.

3) **Working collaboratively**

The Patient & Public Involvement (PPI) and Service User Experience section showcases several initiatives that underline the Trust's commitment to working collaboratively. Notably, the recruitment of three service users as Patient Safety Partners to support the implementation of the Patient Safety Incident Response Framework (PSIRF) is a clear

example of integrating patient perspectives into safety protocols. Additionally, the involvement of two Experts by Experience (EbE) in the Service User Experience Group (SUEG) highlights the proactive steps taken to ensure that patient voices are represented at a strategic level. These roles are crucial as they bring firsthand patient insights into the decision-making process, potentially leading to more patient-centered care practices.

The relationship with Health Watch Camden and the ongoing Art Board exhibitions until Spring 2025 exemplify the Trust's efforts to foster external collaborations and engage with the community creatively.

4) **Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does**

In 2023/24 the Trust aimed to increase collection of demographic information and understand variations in access and experience of service users with protected characteristics. Although the Trust did not meet its targets on this, it is promising that collection of this data has increased. I look forward to understanding the impact of the implementation of the new NHS Patient and carer race equality framework in 2024/25.

Kind regards
Councillor Larraine Revah
Chair of Camden Health and Adult Social Care Scrutiny Committee

Glossary of Key Terms

CAMHS – Child and Adolescent Mental Health Services

Care Quality Commission – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

CareNotes – This is the patient administration system using, which is a 'live system' for storing information electronically from patient records.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) – The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, and isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

CQUIN (Commissioning for Quality and Innovation payment framework) – This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

CGAS – Children's Global Assessment Scale

CORE – Clinical Outcomes in Routine Evaluation

ESQ – Experience of Service Questionnaire. An internal experience measurement tool used to obtain feedback from patients.

ESR – Electronic Staff Record

Goal-Based Measure – These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc. to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 3 months, or at a later point in time).

Information Governance – Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

iTHRIVE - The National i-THRIVE Programme is a national programme of innovation and improvement in child and adolescent mental health that is being implemented in sites across the country. i-THRIVE was selected as an NHS Innovation Accelerator in 2016 and is now endorsed in the NHS Long Term Plan.

Key Performance Indicators (KPIs) – service indicators set either by commissioners or internally by the Trust Board.

Local Induction – It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

Looked After Children - A child who has been in the care of their local authority for more than 24 hours is known as a 'looked after child'.

MAST – Mandatory and Statutory Training

National Clinical Audits – Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

NCL – North Central London

OM – Outcome Measure.

Participation in Clinical Research – The number of patients receiving NHS services provided or sub- contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

Patient Safety Incident – A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

PPI – Patient & Public Involvement

Protected characteristics – These are defined in Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Quarter 1 23/24 – data from April to June 2023

Quarter 2 23/24 – data from July to September 2023

Quarter 3 23/24 – data from October to December 2023

Quarter 4 23/24 – data from January to March 2024

Standard Operating Procedures – A standard operating procedure (SOP) is a set of step-by-step instructions to help workers carry out complex routine operations. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply agreed processes.

TEL – Technology Enhanced Learning

Time 1 – Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.

Time 2 – Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.