The Tavistock and Portman
NHS Foundation Trust

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Quality Account 2024/25

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Statement on Quality from our Chief Executive Officer

At the Tavistock and Portman, we are committed to continually making the care we provide better – focusing our quality improvement lens on how we can make care safer, more efficient, and patient-focused to see real and measurable results.

Alongside the continued importance of Quality Improvement methodology, co-production and clinical leadership, our Quality Accounts this year reflect the ongoing 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 to improve the quality of our services.

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 2024/25 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.

Through the work of the strategic objective of 'Outstanding Patient Care' and the Patient Carer Race Equality Framework (PCREF), we will continue our work in the year ahead to develop greater insight about the experiences of our service users and communities and use this understanding to address inequalities in access to our services.

The wellbeing of our staff is intrinsically important to delivering high quality care. The Trust were the most improved across the country in the NHS Staff Survey for 2024, with improved results in seven out of the nine survey areas, which is positive, but we know there is still more to do. The Board and the Executive Leadership Team are committed to working to address the themes and issues identified in the findings.

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

Chief Executive Officer

Introduction from our Chief Nursing Officer

I am pleased to introduce the Quality Account for the Tavistock and Portman Foundation Trust for 2024/25. 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 ongoing improvements that we have made in many areas of quality and safety in the Trust this year. Our clinical and corporate teams have been working extremely hard to continuously improve the quality of care we provide to our patients and their families. This is particularly evident in the progress made against the quality priorities we set in 2024/25 – linked to the core domains of quality – and the work of the quality improvement projects underpinning the Trust's strategic objectives.

Listening to patients' experiences of the care they receive is crucial to delivering services that are safe, effective and continuously improving and that make a meaningful difference to people's lives. Improved patient experience leads to better outcomes - when patients feel listened to and valued as a partner in their care, this contributes to their overall health and wellbeing. Our strategic objective of 'Outstanding Patient Care', which supports our quality priorities related to patient experience, has made significant progress this year including increasing the ways and opportunities that patients and their families can provide feedback on their experience.

Our Quality Account also outlines the developments that we have made in our Complaints & Enquiries management processes, and the tangible improvements we have made to the number of outstanding complaints. This will continue to be an area of focus in 2025/26 through a quality improvement project, so that the process for patients is even more efficient and compassionate.

During the year, we successfully implemented the Patient Safety Incident Response Framework which has increased the strength of how we review and learn from incidents. The recruitment and introduction of two Patient Safety Partners has been a positive step to involve the voice of patients in our safety culture. Our incident reporting culture and processes are a continuing area of focus alongside compassionately engaging patients and staff in learning responses.

Clare Scott

Chief Nursing Officer

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 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.

Our vision, mission and values

➢ Our vision

Our vision is to be a leader in mental health care and education, using talking and relational therapies to make a meaningful difference to people's lives

➢ Our mission

Our mission is to work in partnership with people, families and communities to provide high-quality specialist mental healthcare, alleviate emotional distress and pioneer innovative education and research

➢ Our values

We strive for **excellence**

We champion **inclusivity**

We place **compassion** at our core

We have **respect** for each other

A review of our services

During the reporting period 2024/25 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 205 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)

The Trust continues to embed a culture of continuous improvement through a structured, inclusive, and data-driven Quality Improvement (QI) approach, grounded in the NHS IMPACT framework and Lean methodologies. Our aim is to improve outcomes for patients, students and service users, enhance operational efficiency, and support staff in delivering high-quality care and education.

This year has seen significant development in how Quality Improvement (QI) is led and delivered across the Trust:

- **Adoption of Lean and A3 Methodology**

The Trust consolidated the A3 problem-solving approach as the core QI method, providing a clear, visual structure for identifying problems, analysing root causes, and delivering measurable improvements. More than 30 A3 documents are currently in use across the clinical, education and corporate areas, including Trust-wide A3s focused on waiting lists, patient experience and outcome monitoring.

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.

- **Kaizen Events**

Whole-team Kaizen events were held in the Autism Assessment and Adult Trauma services, each spanning more than 5 months of engagement. These service-wide improvements have delivered change in areas including waiting list management, pathway flow and minimisation of missed appointment slots. Each Kaizen produced 30/60/90-day action plans, monitored and sustained through working groups and huddles.

The Kaizen events are a Japanese concept that translates as 'good change' and refers to business activities that continuously improve all functions and involve all employees.

- **Quality Improvement Forums and Huddles**

Monthly QI Huddles were reintroduced and expanded to now include one for Clinical Services and another in the Department of Education and Training (DET), creating collaborative spaces for shared learning, live problem-solving, and support for new improvement ideas.

- **Training and Capability Building**

18 staff members were trained to Green Belt level in Lean Six Sigma, with additional A3 and Kaizen training embedded into staff inductions and available via 1:1 coaching and group workshops as required.

- **Lived Experience and Co-Design**

Service users were actively involved in co-design efforts, particularly in the improvement of the Waiting Room platform, which is a website that provides mental health and wellbeing information for children and young people, adults, parents and carers, and professionals based in North Central London. Service users were also involved in the redesign of trauma-informed pathways and the improvements made to the collection of patient feedback. This marked a step toward our goal of embedding lived experience in strategic improvement priorities.

- **Governance and Structure**

QI now sits within the Strategy and Transformation function, providing alignment between improvement work and organisational strategy. A Quality Improvement RACI (Responsible, Accountable, Consulted, and Informed) has been developed to clarify roles and responsibilities, and a consistent and transparent reporting structure for QI projects has been established and woven into clinical and academic governance meetings.

Quality Improvement Priorities for 2025–2026

Looking ahead, the Trust will continue to deliver against the five domains of the NHS IMPACT (Improving Patient Care Together) Framework through the following priorities:

1. **Building a Shared Purpose and Vision**
    - Launching the "Vision into Practice" toolkit to help teams align their day-to-day work with the Trust's strategic goals.
    - Conducting quarterly alignment audits and introduce surveys to assess staff ownership of the Trust vision.
2. **Investing in People and Culture**
    - Expanding QI Forums to include Corporate and Administrative teams.
    - Developing a Trust-wide QI engagement register to monitor participation and support.
    - Partnering with Tavistock Consulting to embed coaching styles of leadership into QI training and management development.
3. **Developing Leadership Behaviours**
    - Publishing the Leadership Behaviour Framework and embed it in performance expectations.
    - Strengthening cross-organisational partnerships with North Central London (NCL) partners.
    - Standardising leadership "Go and See" visits to enhance visibility and trust.
4. **Building Improvement Capability and Capacity**
    - Scaling up tiered QI training across all staff levels, including clinicians, admin, and the Department of Education & Training (DET).
    - Establishing a network of QI Coaches and Lived Experience Partners.
    - Expanding the use of dashboards and Statistical Process Control (SPC) charts to monitor progress in real time.
5. **Embedding Improvement into Management Systems and Processes**
    - Develop a goal-tracking system to link team-level objectives with QI work.
    - Increase QI integration across enabling services through cross-functional planning sessions.
    - Strengthen alignment with regional priorities by embedding QI into ICS-level (integrated care system) collaboratives.

Measuring Progress

In 2024/25, the Trust progressed in 14 of 22 NHS IMPACT goals, with particular advancement in Building Improvement Capability and Capacity, where all five sub-domains were assessed as progressing. This self-assessment, alongside our refreshed QI Plan, will guide continued development in 2025/26 and support annual reporting of improvement impact.

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities.

Care Quality Commission (CQC)

The Trust has not been inspected by the CQC in 2024/25. The Trust's rating from the CQC's inspection in November 2018 are detailed below. The Trust has not been subject to a full Trust inspection since that time and these ratings remain.

Full details of all previous inspections can be found here

The CQC has not taken enforcement action against the Trust during 2024/25.

CQC Improvement Group

The CQC Improvement Group is a formally constituted Group within the Trust's governance structure and reports to the Quality and Safety Committee as part of this framework. 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 CQC's assessment framework and any developments in relation to that. The plan to monitor progress against the must and should do recommendations from past inspections is monitored at each meeting.

The Group undertook a self-effectiveness review in line with its Terms of Reference. The survey was commissioned by the Group's Chair and conducted electronically via an online platform. The feedback received was positive overall, with a focus on the recent improvements in the Group's effectiveness and focus. An improvement point was noted about how teams learn from each other and how improvements made are embedded for long term sustainment. This will be an area of focus for the Group in 2025/26.

In 2024/25 the Group has reviewed draft processes to undertake internal quality reviews, linked to the CQC's assessment framework, key questions and quality statements. A plan for quarterly reviews has been discussed and developed with the Group and will be launched in Quarter 1 2025/26.

The Trust has been involved in the stakeholder work that the CQC has undertaken in the year including workshops about the assessment framework and the adult community mental health programme. The Trust has also continued to hold quarterly meetings with the CQC's Operational Manager assigned to the Trust.

Part 2

This section contains information on the quality of services provided by the Tavistock and Portman NHSFT during 2024/25. Where possible, we have included historical data demonstrating how we have performed at different times.

The Trust Board, the Quality & Safety Committee, along with our clinical commissioners, have played a key role in monitoring our performance on these key quality indicators during the year. Monitoring is also led through our Integrated Quality & Performance Report (IQPR) process, clinical governance, senior leadership and other meetings in the Trust's corporate governance framework.

Progress Against Quality Priorities from 2024/25

During the 2024/25 financial year, the Trust identified three areas of focus for Quality Priority workstreams:

- Strengthening our Patient Safety Culture
- Clinical Effectiveness
- Patient Experience

A number of individual workstreams have been active over the course of 2024/25 and progress against these is outlined in the table below.

Strengthening our Patient Safety Culture	**85% of staff will be trained in the Level 1 Essentials of Patient Safety syllabus**	The Trust's overall compliance for the Level 1 Patient Safety syllabus increased each quarter, starting at **66.38%** at the end of Quarter 1 (June 2024) and ending at **81.04%** in Quarter 4 (March 2025). This learning is part of mandatory and statutory training for all Trust staff and so compliance against the target will continue to be monitored.	Partially achieved
	Training for staff in new PSIRF investigative techniques	Over the course of 2024/25, the patient safety team have continued to develop the Trust's processes for new learning responses as part of our implementation of the Patient Safety Incident Response Framework (PSIRF). As part of this, thirteen staff, including our Patient Safety Partners, have been trained as After Action Review (AAR) conductors. The AAR is a significant change in the way in which we review and learn from our incidents and the process been received well by our staff. Funding for Compassionate Engagement and Duty of Candour with Empathy training has also been secured and will be delivered to a number of staff in the coming year. Moving into 2025/26 the Patient Safety Team continues to deliver targeted training sessions at team level, aimed at enhancing staff understanding of incident reporting, response processes, and learning in line with the PSIRF.	Achieved
	100% of patients/families involved in Patient Safety Incident Investigations are included in the investigation process	Compassionate engagement of service users has continued to be a priority in our PSIRF implementation. This has included that the principles of transparency, compassion, and collaboration are upheld throughout the review process. As the After Action Review is considered to be our primary learning response, developing a co-produced process for involving service users, and their families as appropriate, in the AAR process will be a Quality Priority for the Trust moving forward into the coming year.	Partially achieved

Clinical Effectiveness	**Implementation of PCREF (Patient and carer race equality framework)**	Over the course of the year, our implementation of the framework was developed via an implementation group which grew over the year, with the framework officially being launched during Quarter 4. The ambitions and expectations about this were presented via the Trust's 'All Staff Briefings' and at the Senior Leadership Forum. We are committed to building support and fluency across the Trust and thus continue to work towards local ownership of our data and bespoke improvement strategies. Clinicians and teams with exemplary practice that will enhance our PCREF journey are invited to share good practice formally. We have also identified key members of the community that we intend to use for our awareness events. This will continue to be a Quality Priority in the coming year.	Achieved
	Outcome Measures: Performance that meets NHSE standards and includes matched pairs of outcome measures	Initial plans and goals were introduced and socialised at Clinical Governance meetings across the Trust early in the year. A plan was agreed for a suite of standardised Trust-wide outcome measures to be developed and for the associated processes around form generation and collection to be centralised and standardised where possible. Trust-wide training was undertaken on the new NHS Waiting Time Metrics, incorporating broader Outcome Measure (OM) training, with easily accessible training videos also created to increase reach. New measures were added to our clinical software and rolled out effectively. Reporting was also updated alongside these changes to ensure changes in focus are reflected in ongoing reports.	Achieved
Patient Experience	**Increase ESQ feedback received by 200% per service line (based on previous baseline rates)**	Whilst the target was unfortunately not met, a significant amount of work was undertaken over the year to work with teams on developing bespoke targets and to co-produce process maps to better understand processes of ESQ form collection and where improvements can be made. Teams are now receiving both quantitative and qualitative feedback monthly. Targeted support will continue to be offered at team level to increase feedback in addition to service user input to increase patient awareness of the feedback process.	Partially achieved
	Reporting experience metrics by protected characteristics / demographics	Reporting was developed over the course of the year to enhance ethnicity data capture on the Experience of Service Questionnaire (ESQ) forms. An updated electronic ESQ form was launched during Quarter 3 which should assist with increasing return rates. During Q4 an ESQ dashboard was developed which incorporates an ethnicity filter. With this feature we will be able to monitor if there is a difference in patient satisfaction scores based on ethnicity.	Achieved
	Developing a digital drop box for 'live feedback'	A QR code was launched during Quarter 3 and was widely shared within Trust buildings and on communications. The codes are displayed in reception areas and we have started including the codes in patients' correspondence. With the Digital Dropbox system now live, work will continue in 2025/26 to support teams in increasing the volume of feedback that is being received, including implementing an automatic text message system to service users.	Achieved
	Innovative ways of collecting feedback from children & young people	This workstream worked closely with the above as the Digital Dropbox was identified as a key method of enhancing the feedback reach for our child & young patient cohort. Young patients from the 'Growing with You' clinical team were recruited to support obtaining feedback via opportunities to lead workshops with peer groups. Emojis were implemented on the paper version of ESQ forms during Quarter 4. Moving into the new year, there is ongoing work to further enhance the accessibility of ESQ forms as well as to engage young people in this process, potentially via focus groups.	Partially achieved

Clinical Audit

Local Clinical Audits

In June 2024, we moved to a new quality and risk management system, with the previous system being decommissioned in July 2024. The new system, Radar, integrates a number of quality and risk data capture and management, and includes a new audit module which went live in November 2024. During the five-month transition gap, all service lines were asked to document all audits and save them locally. Several Trust-wide and small group training sessions on how to use the new audit module have been delivered, and will be supported by training materials.

There has been a change in clinical audit leadership since January 2025 and therefore this post has been vacant since this time. However, once the new role is in post, a priority will be for an agreed clinical audit plan for 2025/26 to be in place that is co-developed with clinical services.

Local clinical audits were undertaken during 2024/25, with 3 of these audits still in progress, as detailed below.

- **Portman Clinic Audit on Referral Rejections & Service Criteria Review**

This audit analysed referral rejections over the past year to identify key reasons for rejection. This has led to a review of service criteria to enhance clarity and reduce inappropriate referrals and the redevelopment of Portman Clinic brochures and posters to better communicate referral guidance to professionals.

- **Portman Clinic Female Referral Audit & Service Adaptation ongoing**

This was undertaken to audit a 20-year retrospective review of all female referrals to the Portman Clinic to better understand why referral numbers remain low and whether this reflects broader population needs.

- **Portman Clinic Large-Scale Intake Audit (Portman Activity Analysis) ongoing**

This audit aims to identify trends, inform service improvements, and enhance patient engagement strategies and leads a comprehensive review of Portman intake data, analyzing variables such as criminal history, substance use history, self-harm patterns, referral pathways, engagement outcomes and themes in referral rejections.

- **Audits of Electronic Patient Records**

Local 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 notes to patient appointments. 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 regular cycles and are undertaken both locally within teams and Trust-wide.

- **Prescribing Audits**

These audits are undertaken to review the adherence to the Trust's prescribing procedure including prescribing of controlled drugs. 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).

- **Safeguarding Audits**

Issues in relation to documentation of safeguarding consultations and supervision had emerged previously. An adult safeguarding audit was undertaken which revealed that there remains an

issue of under-recording of adult safeguarding concerns. This audit was requested by the Trust's external auditors and the report is ongoing. For children's safeguarding audit, the Trust children's safeguarding lead has participated in actions from the external audit and there are further plans to re-audit in 25/26.

- **Quality Audits in Relation to Waiting Times**

These audits are performed locally within teams and review 11–18-week breeches, appointment cancellations and referral received date.

- **Audit of Compliance with NICE Guideline NG 225 Self Harm**: **Assessment, management and preventing recurrence.**

This audit has been completed and the results disseminated to all services.

- **Trust-wide Duty of Candour Audit**

The new incident module on Radar has been implemented so that the processes around Duty of Candour management has improved. This audit will be completed as a priority in 2025.

Future plans for 2025/26

- Refreshing the Clinical Audit and Effectiveness Group
- Trust to take part in Clinical Audit week 2025
- Learning lessons event programme to include relevant audit findings
- Areas of good practice from audits to be highlighted in Trust wide learning events
- Enhancing processes needed to evidence improvement from audits
- Ongoing work to integrate clinical audit and Quality Improvement and to consider how they work best together at a local level, and to develop improvement plans from audits
- Further training for staff on the new electronic audit module in Radar

Participation in national clinical audits and national confidential enquiries

During 2024/25 there were no National Clinical Audits directly relevant to services provided by the Tavistock and Portman NHSFT.

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 2024 and the end of March 2025, **39 participants** have been recruited to **2 research studies** in the Trust.

The recruiting studies for the Trust during the 2024/25 financial year were as follows:

Recruiting Study Name	IRAS	Recruitment Numbers
MAGIC (Markers of autism and gender incongruence in children)	312288	6
Personalised Programmes for Children RCT	268597	33

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)

The Tavistock and Portman NHS Foundation Trust's income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because the framework had been paused by NHS England.

Data Security & Quality

The Tavistock and Portman NHSFT did not submit records during 2024/25 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 Tavistock and Portman NHSFT was not subject to the Payment by Results clinical coding audit during 2024/25.

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.

DQMI – Data Quality Maturity Index	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Tavistock and Portman NHS FT	**97.2%**	**96.9%**	**96.9%**	*Not available yet*
National Average	**80.1%**	**77.2%**	**76.7%**	*Not available yet*

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.

In terms of technological developments, there are some exciting projects being developed that are scheduled over the coming year.

- To continue to develop and improve the Power BI Dashboard, both to support senior management with performance data and teams to manage workloads.
- To improve the process and quality of reports shared with teams so they can access real-time data for improvement.
- To design a reporting framework for the quality and safety data, including complaints, compliments, incidents and audits, which will improve awareness, procedures and access to data.
- To continue improving Care Notes forms and interfaces to improve patient safety, time efficiencies and data quality.

System Oversight Framework Indicators

The Trust has a range of NHS targets on which we report throughout the year and which form part of the Single Oversight Framework (SOF), used by NHS England and our commissioners to detect possible governance issues and identify potential support needs. Such information, including the Mental Health Services Data Set (MHSDS), and operational performance information is presented quarterly to the Board alongside formal complaints, staff Friends and Family Test (FFT) findings and actions and patient safety incidents.

MHSDS System Oversight Framework Indicators	Target %	Q1	Q2	Q3	Q4
Valid NHS Number	95%	99.61%	99.69%	99.79%	99.76%
Valid Postcode	95%	99.75%	99.74%	99.76%	99.76%
Valid Date of Birth	95%	100%	100%	100%	100%
Valid Organisation Code of Commissioner	95%	99.39%	99.50%	99.51%	99.48%
Valid Organisation Code GP Practice	95%	99.15%	99.95%	99.17%	99.29%
Valid Gender	95%	99.96%	99.95%	99.98%	99.96%
Ethnicity	95%	92.06%	92.28%	92.14%	92.85%
Employment Status (for adults)	85%	67.16%	66.40%	67.35%	72.25%
Accommodation Status (for adults)	-	64.97%	64.06%	65.00%	69.03%
Primary Reason for Referral	-	100%	100%	99%	99%
Ex-British Armed Forces Indicator	-	92%	93%	93%	94%

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 formally launched the new Patient Safety Incident Response Framework (PSIRF) in April 2024. During the launch week, a series of lunch and learn sessions were held over the course of four days themed under the four PSIRF pillars.

Key areas of improvement following implementation include:

- The recruitment and introduction of two Patient Safety Partners who have been with the Trust since February 2024
- A refreshed and approved Trust PSIRF policy and plan (PSIRP) which outlines the Trust's approach to implementing, embedding and continuing the new framework
- Ongoing training and communication about the new framework and ways of working across the Trust
- Training and information sessions Trust-wide and for individual teams on incident reporting and safety culture
- New incident reports and data for corporate and clinical governance meetings which improve oversight and accountability
- A reviewed and refreshed Clinical Incident & Safety Group that is accountable to ensure that all incidents with learning are investigated and actions evidenced
- Training for Trust staff on the new learning response methods available e.g. After Action Reviews. Further training in compassionate engagement is planned for 2025/26

To ensure that the actions taken in implementation are thoroughly embedded, an A3 Quality Improvement plan focusing on PSIRF has been developed. This approach has helped us to formally document progress against the framework, monitor progress and clearly articulate the success criteria that will be met.

Patient Safety Incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. The number of patient safety incidents reported within the Trust during 2024/25 are below.

There has been a significant piece of work throughout that last two years, 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.

	2020/21	2021/22	2022/23	2023/24	2024/25
Total reported incidents	298	379	332	365	339
Patient Safety Incidents	38	48	19	123	131

Our new local risk management system, which was officially launched for incident reporting at the beginning of June 2024, has enabled automatic upload of the reported patient safety incidents to the Learn from Patient Safety Events (LFPSE) service.

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

- The organisation provides outpatient 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 daily patient safety huddle which triage 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 undertaken if additional learning is indicated
- 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 PSIRF quality improvement A3 project

Work will continue throughout the next year to ensure that safety is at the forefront of all that we do. During the year, a Trust-wide learning poster has been developed to share learning from the learning responses we undertake widely across the Trust. This process of sharing learning will be expanded to ensure reach and support from all Trust staff.

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.

In 2024/25, the Trust was notified of the deaths of 39 patients known to its services, in line with the definitions outlined above. No deaths were recorded among patients with a diagnosed learning disability. A quarterly breakdown and details of the investigations conducted are provided below. The Trust does not have any inpatient services and therefore there were no inpatient deaths reported.

Quarter	Breakdown
Q1 24-25	8
Q2 24-25	12
Q3 24-25	7
Q4 24-25	12

All notified deaths are recorded via the Trust's incident reporting system and trigger a learning review, including a mortality review where appropriate. Due to the nature of services provided, notification of a patient's death and cause may be delayed. During the year there has been a significant amount of work undertaken to complete mortality reviews in a timely manner, and a piece of work undertaken to ensure that reviews from previous years have also been completed and reviewed through governance processes.

All completed learning reviews are reviewed by the Clinical Incident & Safety Group with discussion on any learning, positive practice identified, and a call to action for the reviews to be discussed at the Unit Clinical Governance meetings. The Group may also determine whether a further learning response is required. Learning from all reviews is shared across teams and disseminated Trust-wide through meetings and learning events where appropriate.

In response to learning that has arisen following reviews, the Trust has introduced a revised screening and triage system in the adult Gender Identity Clinic to ensure timely review and appropriate follow-up. The risk grading (RAG) matrix and process has also been updated following learning from reviews.

The Trust's Learning from Healthcare Deaths policy was reviewed and updated in the year in response to internal governance changes and the principles of the Patient Safety Incident Response Framework (PSIRF).

Duty of Candour obligations are fulfilled with sensitivity to the needs of bereaved families, particularly in cases where suicide is suspected. Where appropriate and required, the deceased's GP is informed and relevant external organisations are notified.

Infection Prevention & Control (IPC)

The Trust's priority is to meet the required standards of Infection Prevention and Control (IPC) and environmental cleanliness, with the goal of minimising the risk of Healthcare Associated Infections (HCAIs) as much as possible. The Trust is dedicated to ensuring that patients receive care and staff work in a safe, clean environment where the risk of HCAIs is minimised. Infection prevention and management is the responsibility of all staff at our Trust and is a key part of everyday practice. We are committed to upholding the highest standards of hygiene and infection prevention practices. This is tailored to the uniqueness of the trust as a mental health care facility and done through continuous education, effective infection surveillance, and collaboration with all stakeholders.

Through partnership within North Central London, we now have a Infection Control specialist working with us who is collaborating with teams throughout the organisation to ensure compliance and provide assurance for effective governance.

The completion of the National Infection Prevention and Control Board Assurance Framework (NIPC BAF) is done in accordance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015, 2022); as well as other National Guidance: National Standards of Healthcare Cleanliness 2021 and the National Infection Prevention and Control Manual (NIPCM) for England (2022). Six areas were identified as partial compliance which are being addressed.

Patient Experience

Under the Trust Strategic Pillar of 'outstanding patient care' sits the service users experience annual priority. We have made improvements in the way that service users and carers can provide feedback by expanding the ways in which this can be done, through QR codes and hyperlinks, allowing service users to give feedback on their experience at any time during their care. The feedback we receive from service users, carers and families allows us to broaden the way that we hear their voices, and how we respond to what we hear to make continuous improvements.

To support the services with accessing and responding to the feedback significant work has been caried out to create clear processes around collating, recording, and reporting on the feedback from our service users. We have standardised and improved the way qualitative and quantitative feedback is communicated to teams, allowing more timely access to data to inform service-level improvements. Improvements include:

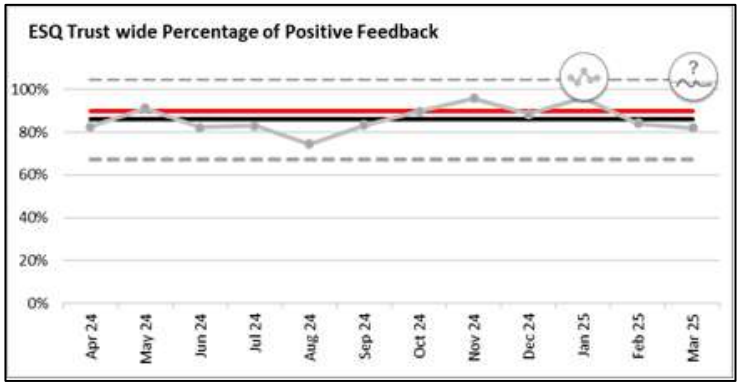
- Feedback is now shared monthly (previously quarterly)
- Feedback is anonymised
- Improvements have been made to categorising and capturing themes (allowing us to review and triangulate with other quality data)
- Ethnicity and protected characteristics are linked to feedback
- Reporting on service user feedback is clearly embedded in our governance structures to provide assurance that patient voice is present in the development and improvements of our services.

The Trust collects Experience of Service Questionnaires (ESQs) forms which include the Friends & Family Test (FFT) question 'Overall, how was your experience of our services?'.

During 2024/25, the Trust reviewed and improved the data collection process and brought consistency across services, as outlined in Part 2. The new system has also increased the opportunities a service user has to provide feedback and now includes digital forms as well as traditional paper forms.

In 2024/25, 86% 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) which is lower than in previous years. One of the main contributing factors for this is due to increasing the opportunities for service users to provide feedback and that teams with extended waiting lists now have feedback captured.

The chart below indicates the percentage of positive feedback received throughout the year by month, in the form of a Statistical Process Control (SPC) chart.



As part of the review of our ESQ processes, we will continue to increase the ways feedback can be provided, the forums where teams can reflect on the feedback received and how to support learning process and improvement of services.

Complaints

During the year 2024/25, the total number of formal complaints received by the Trust was 61, representing a reduction of 33 formal complaints on the previous year. As part of our ongoing quality improvement work in complaints management, we have prioritised supporting staff in achieving an earlier, informal resolution of concerns. This approach aims to provide a quicker and more responsive process for patients and their families when issues are raised, and the reduction of formal complaints is understood to be attributable to this. By empowering staff to address concerns promptly and empathetically at the point of care or service, we can enhance trust, reduce escalation, and improve overall satisfaction with the complaints experience.

By unit, the highest number of formal complaints was received by the Adult unit (51), followed by CYP and Families (6) and Camden (4). Within the Adult Unit, the highest number of formal complaints was received by GIC (34), followed by Psychotherapy (8) and Trauma (5).

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Formal Complaints Received	**166**	**116**	**144**	**103**	**94**	**61**

Source: Quality Portal and RADAR

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

Complaint Categories 2024/25	No. of Complaints
Access to Treatment or Drugs	**16**
Admissions and Discharges	**1**
Appointments	**5**
Communications	**22**
Other	**1**
Patient Care	**6**
Prescribing	**1**
Privacy Dignity Wellbeing	**1**
Restraint	**1**
Trust Administration	**3**
Values & Behaviours	**1**
Waiting Times	**3**

Source: Quality Portal 04/2024

Communications was the highest category of complaints recorded (22) and, within that group, the highest sub-category is 'Communication with Patient (11). 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 outcomes and actions plans that can be taken from complaints in these categories.

The complaints policy states that all complaints are to be acknowledged within 3 working days of receipt. For 2024/25 the percentage of complaints that were acknowledged within 3 days was 86%. The timely acknowledgement of Complaints and Enquiries is being addressed as part of the Complaints Quality Improvement project.

Complaints Quality Improvement

A review of the complaints process is currently being undertaken through the Trust's Quality Improvement team to address a number of key priorities including ensuring the investigation and response are prioritised, and the way in which the Trust learns from complaints and enquiries.

The Quality & Safety Committee approved a new complaints process in January 2023 and one of the key changes was the extension of the Trust's timeframe for responding to complaints from 25 to 40 working days. Trust-wide training in effective complaints investigation and management was completed in May 2024 and September 2024. A further update is planned for Quarter 1 2025/26 to support the outcomes of the Complaints Quality Improvement project. Senior clinical and operational staff have been involved in the improvement process.

In June 2024, the introduction of a new complaints management portal, Radar, improved oversight, escalation, support and monitoring of complaints for managers and investigation leads as well as other Trust stakeholders. In addition to the priorities noted above, the Complaints Quality Improvement project seeks to ensure:

- Prioritising an early and local resolution process where possible.
- Reducing the length of time a new complaint is allocated to the Investigation Lead.
- The number of Investigating Leads within the Trust is increased.
- Investigation Leads are supported throughout the investigation process, including the drafting of the complaint investigation report.
- Complaint investigations are completed on time and within the 40 working-day time frame.
- Complaint quality assurance, and sign-off process is improved.
- Complainants receive regular updates throughout the complaints process.
- Complaints Managers can manage the complaints process flow more efficiently.

Overdue Complaints

Since the beginning of 2024/25 the number of open and overdue complaints has significantly reduced. The number of open complaints at the end of the year was 21 of which 4 were overdue i.e. outside of the 40-day time limit.

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 2024/25, the PHSO did not formally investigate any Trust complaints.

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 unit 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.

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.

Over the past year the team has been focussed on engaging with clinical and education leads to develop shared understanding of the benefit of working in partnership with service users and experts by experience to develop and improve services. Underpinning this is new PPI policy, documentation and leaflets. These have been developed through partnership with service users, consultation with service user forums and approved though our Service User Involvement Group (SUEG).

Service User involvement work can be seen at various levels across the Trust for example in Recruitment, Governance Groups, Patient Safety, external reviews and patient-led forums. We have been working on ensuring service user involvement is valued and respected. Feedback from service users on interview panels has highlighted the shift to a more inclusive and collaborative process embedded into the principle of shared decision-making. Furthermore, service users regularly feedback on their experience directly through presentation to the Board of Governors and Board of Directors.

We have maintained and developed the Patient Safety Partners, a new role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety, and Experts by Experience for the Service User Experience Group, a sub-group of the Quality and Safety Committee. There are also service users involved in each strategic priority Quality Improvement group.

We are increasing the number of service user representatives from a range of services across the Trust by 100%. This allows us to ensure we have a wider, more diverse group to support our continued efforts to ensure service user voice is central to the development of our services.

Public Involvement

We have continued the development of our external relationships through the Art Board by further defining how it relates to the work of the Trust. The aim of this is to support greater community engagement, making art at the Tavistock more accessible to the wider community. Our relationship with Camden HealthWatch is now embedded into our work through the Service User Experience Group and allows us to identify opportunities to involve them more in work across the Trust.

Next steps

The team will continue to build on the foundations set over the past year. We have identified an annual plan of work which clearly sets out our priorities and how we will achieve these. These are:

- increase service user / carer engagement and involvement across the Trust by 50% – to improve service delivery and design.
- Service User Voice to be captured at all levels. Develop a culture that proactively seeks patient experience feedback to support the Trust to develop and improve services based on service user feedback

- Develop the Art Board and community engagement work through this forum
- Support Merger work across the Trust to ensure Service Users, carers and local networks are fully informed and engaged in the process
- Patient and Carer Race Equality Framework (PCREF) Involvement – support engagement of service user/expert by experience and local service user/carer groups.

Clinical Effectiveness

Improving the Physical Health of Patients

Evidence shows that individuals with poor mental health often face poor physical health outcomes and may struggle to access the services they need. As a community mental health Trust, it is our responsibility to ensure that patients' physical health needs are explored alongside their mental health.

A Physical Health strategy was approved by the Quality and Safety Committee last year. It was informed by work carried out in collaboration with an Expert by Experience (EbE) who scoped the needs of a future service, enabling us to understand the needs of our diverse patient group. Scoping work included stakeholder workshops, staff survey, patient workshops and team deep dives.

The aim of the strategy was to ensure staff felt 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.

In December 2024 we launched a new physical health form attached to core assessments to enhance holistic patient care.

The form includes questions on:

- Long-term health conditions
- Physical health medications
- Allergies
- Alcohol intake, smoking/vaping, recreational drug use
- Eating habits and sleep patterns

These questions provide patients with an opportunity to raise physical health concerns, aiding a more comprehensive and holistic assessment and signposting to support their mental health care.

Outcome Monitoring

Outcome Monitoring A3 OMs work

The Trust has completed a review of the minimum set of Outcome Measures (OMs) required. This was a Quality Priority for us in 2024/25, as outlined in Part 2. The project's aim has been to bring consistency across teams and a better understanding of the Trust's expectations. This project has delivered an update to our reminder system, set a strong communications campaign and developed a power BI dashboard to support teams in actioning missing forms. The number of forms has recently increased as a result of this piece of work.

Goal-Based Measure (GBM) continue to be a mandatory outcome measure to be completed. CORE (Clinical Outcomes in Routine Evaluation) has been removed from the mandatory list which has had an impact on the data below.

Outcome Monitoring Data for under 18 year old services

The Trust uses the Goal-Based Measure (GBM) for our patients under 18 years old, 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.

Time 1 (T1) refers to the first time the patient agrees goals with their clinician. 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:

As part of the outcome measures quality improvement project, The trust now includes all Thrive Categories in the cohort which has had an impact on the number of forms due and completed for 2024/25.

We are pleased to see an improvement in both our completion rates both for T1 and T2. There has been focussed work with services, clinical governance groups, regular reminders and the quality improvement on project Outcome Measures which has had a positive effect.

Improvement rates	2020/21	2021/22	2022/23	2023/24	2024/25
% Qualifying CAMHS patients who reported an improvement in their GBM scores from first to last completed form	**36.6%**	**50.0%**	**60%**	**67%**	**63%**

The improvement rates are taken from the first form (T1) to the last completed form (TL) on qualifying discharged patients during 2024/25 - 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 -> -2.45 to +2.44
- Negative change in goal progress -> -2.45 or less

Outcome Monitoring Data for adult services

The main outcome measure used across all adult services (patients over 18 years old) has been 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.

As noted above, over the course of 2024/25 the set of mandatory forms was reviewed and as a result CORE is no longer in the set of mandatory outcome measures which explains the drop in usage.

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

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.

Improvement rates	2020/21	2021/22	2022/23	2023/24	2024/25
% of Discharged patients who reported an improvement in CORE score from first to last completed form	**62%**	**63%**	**53%**	**61%**	**60%**

For 2025/26 we are planning to replace our CORE data with one of the outcome measures now required for patients over 18 years old. The Outcome Measure quality improvement project remains active and will review this.

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 expansion of our staff engagement opportunities to listen to staff voices and act accordingly, introduction of behaviours that echo our values, creation of opportunities to celebrate our people living the values at work, provision of transparent processes for applying for training and career development, the implementation of commitments within our EDI priorities and strategic pillars, or the introduction of additional health and wellbeing initiatives.

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 2024

There were 417 questionnaires completed by the Tavistock and Portman staff, a 54% response rate which is an improvement from the level of participants the previous year (53% in 2023). The Trust is benchmarked in the Mental Health and Learning Disability and Community Trusts section, and the results show improvement where we are no longer recorded at the bottom of the benchmark group.

The staff survey participation rate had been declining over the past few years so the continued 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 compared to the 2023 survey. Although not statistically significant, the table shows that we have improved in all except one area for this year's survey. We have slightly declined on the 'we are a team' element.

Appendix B: Significance testing – 2023 vs 2024

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 2023 and 2024*. For more details, please see the technical document.

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.14	435	7.23	415	Not significant
We are recognised and rewarded	6.05	434	6.18	417	Not significant
We each have a voice that counts	6.23	429	6.41	415	Not significant
We are safe and healthy	5.84	424	5.97	415	Not significant
We are always learning	5.18	413	5.29	391	Not significant
We work flexibly	6.38	433	6.49	411	Not significant
We are a team	7.05	434	6.97	416	Not significant
Themes					
Staff Engagement	6.46	435	6.64	417	Not significant
Morale	5.21	435	5.46	417	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.
Note: 2023 results for 'We are safe and healthy' are now reported using corrected data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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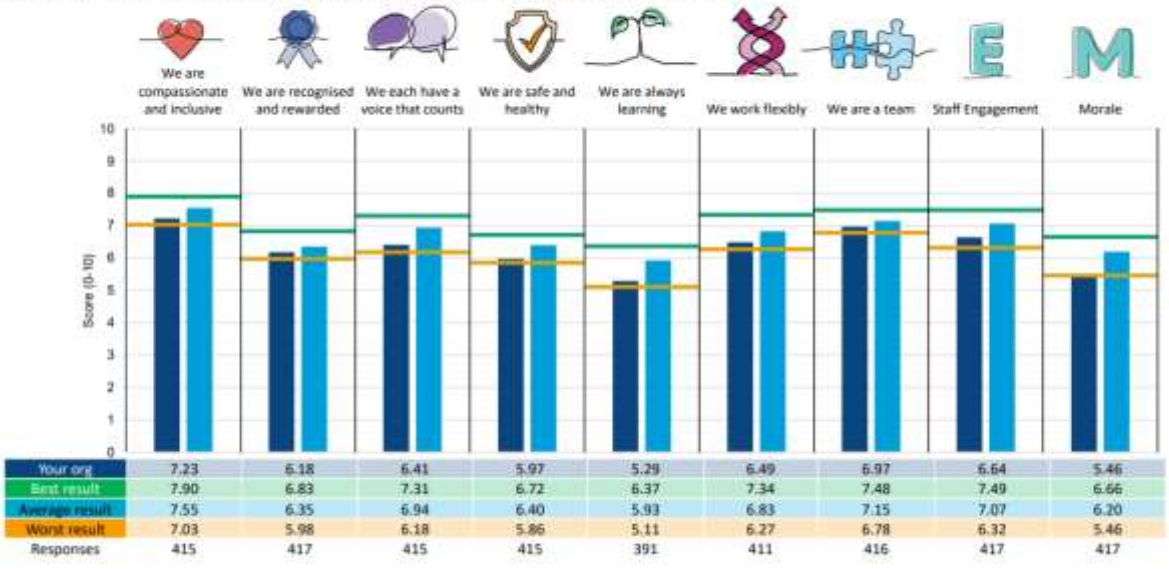
The Trusts results for 2023 showed that the experience of our people at The Tavistock and Portman is still below the average of that experienced by staff in the Trusts we were compared against. However, in 2023 we were the lowest score across seven of the nine themes, whereas for 2024 we are the lowest in only one of the nine themes - staff morale. Although the results show that we have made improvements there is still significant further improvement that we need to make for our people. In the context of upcoming changes, it is important we consider how to engage staff and increase morale with that in mind.

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	7.23	6.18	6.41	5.97	5.29	6.49	6.97	6.64	5.46
Best result	7.90	6.83	7.31	6.72	6.37	7.34	7.48	7.49	6.66
Average result	7.55	6.35	6.94	6.40	5.93	6.83	7.15	7.07	6.20
Worst result	7.03	5.98	6.18	5.86	5.11	6.27	6.78	6.32	5.46
Responses	415	417	415	415	391	411	416	417	417

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We are developing quality improvement plans focusing on the locality reports within each of the teams to focus on the improvements that can be made on a local team level as well as across the organisation.

Reported Raising of Concerns: Whistleblowing & Freedom to Speak Up (FTSU)

The Trust is committed to creating and maintaining a learning culture where staff and students can speak up about anything that they feel may be getting in the way of good patient care and staff wellbeing, without fear of detriment. The Trust is also committed to ensuring that people are listened to when they speak up, and that things they speak up about are followed up on.

In most cases, staff and students will speak up to their line manager or someone else senior in their team or department. The Trust also has two Freedom to Speak up Guardians (FTSUGs) for support, advice, and guidance with speaking up, including in situations where staff do not feel able to speak up within their local team - Sophia Shepherd and Sarah Stenlake who both undertake the FTSUG role on a part time basis. They are supported by Professor Mark Freestone, Chief Education and Training Officer, who is the Executive FTSU lead. The FTSU team meet regularly with the Chief Executive to ensure that there is ongoing dialogue about speaking up topics that staff are raising and to enable appropriate actions to be taken to address the concerns and learn from these.

The Executive FTSU lead maintains the register for FTSU cases raised to the Trust that require formal investigation. In 2024, there were 32 new cases entered on the speaking up register. Positive learning from register cases has contributed to outcomes such as the new Continuing Professional Development (CPD) procedure with specific EDI representation, and the Board training and reflection session on reducing detriment and improving the FTSU culture in the Trust.

FTSUG support is promoted across the Trust in a number of ways: a prominent ‘speaking up’ link on the intranet front page; monthly speaking up drop-in sessions for all staff; FTSUG presence at new staff inductions; refreshed posters around Trust buildings, and FTSUGs are featured regularly in all-staff meetings and announcements.

The average number of instances of individuals seeking confidential support, advice or guidance from a FTSUG about something per quarter in 2024 was 8, with an increase in cases in the most recent quarter (to 15). The four most common reasons for people seeking FTSUG support were Bullying and/or Harassment (26%), Worker Safety or Wellbeing (26%); Inappropriate Attitudes or Behaviours (24%) and Patient Quality/Safety (23%).

In progress initiatives for the year ahead include recruitment, training and supervision of FTSU champions (who promote FTSU principles within their teams, and signpost people to the FTSUGs); a review of the FTSU policy and procedure; an anonymous reporting box introduced at the Tavistock Centre; introduction of FTSU training workshops for managers and leaders; increased “you said, we did” communication to all staff about FTSU feedback/learning;

improvements in FTSU procedures and register monitoring; the completion of a FTSU self-reflection tool by the Board/ for FTSU.

In 2025/26, the FTSU team will also be contributing to a new People & Organisational Development program around Staff Experience, ensuring that FTSU objectives are part of a discussion with all staff across the organisation to improve on themes identified from our 2024 staff survey results.

Mandatory Training 2024/25

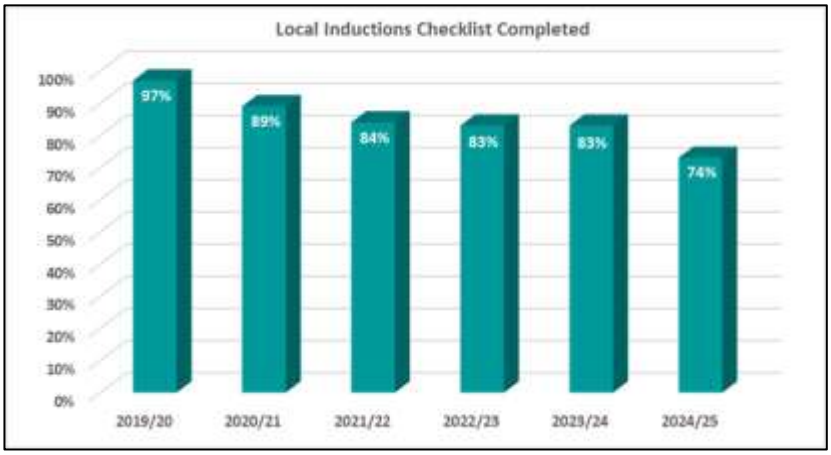
Every member of staff employed by the Trust is required to be compliant with a range of mandatory and statutory training requirements. The organisation has a consistent approach and has adopted the requirements and curriculum for each topic area in line with our partner Trusts in North Central London. 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	2024/25 Overall Figures
Core Subject Mandatory Training Compliance	*80.11%*	*80.22%*	*76.78%*	*80.78%*	**79.47%**
Local Induction Checklists Completed	*74.52%*	*74.20%*	*73.70%*	*71.98%*	**73.60%**

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 with 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 compliance enables the team to respond and act on this information.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2024/25 Overall Figures
DBS Compliance Checks Completed	*97.72%*	*98.16%*	*97.79%*	*98.25%*	**97.98%**

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 2025/26

This section of our Quality Account outlines our priorities for improvement for the coming year.

In March 2024, the Trust held a stakeholder event to discuss the successes and challenges from 2024/25 and to engage stakeholders in developing quality priority proposals for 2025/26. The event was well attended and included representation from service users, the Board, Executive Leadership team and staff. Feedback was received on the proposed quality priorities for 25/26 and has been incorporated where appropriate. The event also included a rich discussion about safety culture. The proposed Quality Priorities were also presented and discussed with the Joint Board and Council of Governors meeting in April 2025.

Our quality 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 2025 meeting. As outlined in Part 2, some of these quality priorities are a continuation of last year's priorities. Progress on achievement of these priorities will be monitored during the year and reported to the Quality & Safety Committee on a quarterly basis.

Patient Safety	Develop process to involve service users in After Action Reviews
Clinical Effectiveness	Implementation of PCREF (Patient and carer race equality framework) – Year 2
Patient Experience	Review and refresh of the Trust wide service user forum Develop innovative ways of collecting feedback from children & young people

Part 4: Stakeholder Statements

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 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.

Council of Governors

Lead Governor Statement

The leadership of the Trust continues to prioritise quality and safety, alongside achieving an improved financial position and a potential merger.

There has been focussed work and progress on the priorities and commitments made in last year's quality account. For example, there are improvements in the completeness and systems for data; quality improvement initiatives and expertise; and learning from other organisations and national best practice. In some areas there has been excellent progress, for example in complaints management.

Governors have had more opportunities to understand services and raise questions. They were involved in the development of this year's priorities.

I have seen year by year improvement in the Trust's work on quality and safety. For example, an initial focus on refreshing policies to now actively using policies to ensure consistent good practice in addressing concerns. I have seen increasing examples of welcoming feedback and supporting learning. Also, close working between the quality and safety team, and service delivery and corporate teams.

Going forward I'm pleased to see plans for focussed work to build on the progress to date on After Action Reviews; understanding access to our services and outcomes; ways we can more proactively seek patient experiences to improve services; and outcome measures to ensure we are making a difference.

I'm looking forward to another year of progress and learning as we move toward a merger both in my role as a governor observer on the Quality and Safety Committee and as Lead Governor.

Kathy Elliott

20.5.2025

Statement from North Central London Integrated Care Board (NCL ICB)

nclhealthandcare.org.uk

NHS
North Central London
Integrated Care Board

2 June 2025

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NHS North Central London Integrated Care Board Statement

Tavistock and Portman NHS Foundation Trust

North Central London Integrated Care Board (NCL ICB) has worked closely with the Tavistock and Portman NHS Foundation Trust throughout 2024/25, taking a pragmatic approach regarding assurance of commissioned services throughout the year; obtained through regular discussions with key staff within the Trust, and the Nursing Directorate at NHS region in relation to those services directly commissioned within the Specialised Commissioning portfolio.

We recognise, and are grateful for, your outstanding leadership and commitment to doing everything possible to keep service users safe, now and in the future, while navigating the signifianct changes within how the NHS currently operates.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to NCL ICB in May 2025). 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 has developed a robust model of Quality Improvement, underpinned by the NHS IMPACT framework, utilising the A3 problem-solving approach along with Kaizen events to lead service-wide improvements in areas such as waiting list management.

It is encourgaging to see the progress the Trust has made against the 2024/25 quality priorities, in particular, the work to implement the Patient Safety Incident Response Framework (PSIRF) and training staff, including the Patient Safety Partners, in undertaking 'After Action Reviews'. We recognise the work undertaken to improvent feedback on Exeperience of Service Questionnaires (ESQ) by 200%, based on the previous years baseline. While the target was not achieved last year, work is underway to support staff on the use of these forms.

We are supportive of the quality priorities that the Trust have identified for 2025/26 against the five domians of the NHS IMPACT framework, particularly those focused on building capacity and capability, investing in people and culture and developing leadership behaviours.

Yours sincerely,

Jenny Goodridge
Acting Chief Nursing Officer
NHS North Central London ICB

North Central London ICB Chief Executive Officer: Frances O'Callaghan

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 2024/25. 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.

The Trust has continued to demonstrate a strong commitment to patient-centred care throughout 2024/25. This is reflected in the prioritisation of compassionate engagement in Patient Safety Incident Investigations and the development of inclusive mechanisms for service user feedback. While the goal of 100% involvement of patients and families in investigations was partially achieved, efforts such as After Action Reviews and planned co-production approaches show a clear intent to embed patient voices in safety learning processes. The introduction of emoji-based feedback tools and youth-led workshops are good initiatives to engage children and young people in shaping their care experience.

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

The Trust has shown it is driven by a clear and consistent vision across its three Quality Priority areas: Patient Safety, Clinical Effectiveness, and Patient Experience. Each priority had defined, measurable objectives, and progress has been monitored throughout the year. While not all targets were fully met, especially around training compliance and Experience of Service Questionnaire feedback rates, the structured approach to planning, such as the phased rollout of outcome measures and targeted improvement plans, has enabled the Trust to achieve many of its targets.

Despite an improvement in the previous year's results, the National Staff Survey results remain a concern, particularly regarding staff morale.

3) Working collaboratively.

The Trust has taken positive steps to embed collaborative working across the organisation during 2024/25, particularly through the efforts of the Patient and Public Involvement (PPI) team. Service user involvement has grown, with contributions to recruitment, governance, and strategic improvement work.

It is encouraging that The Trust has strengthened roles such as Patient Safety Partners and Experts by Experience through structured involvement in the Service User Experience Group. The initiative to double the number of service user representatives reflects a commitment to broadening diversity and representation across Trust programmes and ensuring service user perspectives shape services.

Externally, partnerships like those with Camden Healthwatch and the Art Board continue to enhance community engagement.

The Trust's forward plan sets out clear priorities to further enhance collaboration and patient involvement, such as an ambition to increase service user and carer engagement and involvement across the Trust by 50% to improve service delivery and design.

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

The Trust has taken steps to be transparent in reporting progress, including acknowledging where targets were not met. The inclusion of protected characteristic data in experience reporting is a particularly strong example of accountable, inclusive practice.

The friends and family test results show in 2024/25 86% of patients reported positive feelings about their care, which is a reduction on previous years. However, the Trust explains this through expanded opportunities for service users to provide feedback, particularly in services with extended waiting lists.

The number of complaints the Trust received has declined by almost a third since the previous year. The Trust received the highest proportion of complaints related to communication (22 out of 61). I look forward to reviewing how the Complaints Quality Improvement Project will lead to improvement in that category in next year's accounts.

Kind regards

Councillor Larraine Revah

Chair of Camden Health and Adult Social Care Scrutiny Committee

Statement from Healthwatch Camden

Healthwatch Camden are pleased to see further year on year progress particularly in inclusivity and equality as an item that have met year on year targets. I'm particularly interested to understand your planning around collecting feedback, especially from young people. It's encouraging to see that many targets remain a focus to continue to build upon, too.

In light of this year's quality account we wanted to ask the following:

- How will you ensure that the targets relating to family involvement in patient safety investigations are met in future, given that there has been some high profile spotlight on this at various points across the last year (across Camden housing and Camden MH services as a whole, not at Tavi) but since its imperative nature has been highlighted will you do anything extra to ensure this is met, if so what?
- (As per last year) Could you please expand on how you will innovate in order to collate feedback from young people? Do you have a POA of who can support this workstream to ensure better future results?
- Is there anything that's changed as part of your recruitment and ongoing training programmes that has or may contribute positively to the achievement of one or more of your targets?
- Could you please outline what you do already to engage service users opinions and experiences?

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.

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.