

# Tavistock and Portman NHS Foundation Trust

## Quality Report

The Tavistock Centre  
120 Belsize Lane  
London  
NW3 5BA

Tel: 02074357111

Website: [www.tavistockandportman.nhs.uk](http://www.tavistockandportman.nhs.uk)

Date of inspection visit: 25 - 29 January 2016

Date of publication: 27/05/2016

Core services inspected	CQC registered location	CQC location ID
Specialist psychological therapy services	The Tavistock Centre	RNK01
Other specialist services (Gender identity development service)	The Tavistock Centre	RNK01
Specialist community mental health services for children and young people	The Tavistock Centre	RNK01
Other specialist services (Gender identity development service)	Gender Identity Development Services (GIDS) Leeds Base	RNKX1

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for services at this Provider

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



### Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	4
The five questions we ask about the services and what we found	6
Our inspection team	11
Why we carried out this inspection	11
How we carried out this inspection	11
Information about the provider	12
What people who use the provider's services say	13
Good practice	14
Areas for improvement	15

---

### Detailed findings from this inspection

Mental Health Act responsibilities	17
Mental Capacity Act and Deprivation of Liberty Safeguards	17
Findings by main service	18
Action we have told the provider to take	41

---

# Summary of findings

## Overall summary

We have given an overall rating to Tavistock and Portman NHS Foundation Trust of **good**.

We have rated the three services that we inspected as good.

The trust has much to be proud of and also some areas that need to improve. The trust was well-led by the senior leadership team and board. There were many committed and enthusiastic senior staff throughout the organisation working hard to improve the delivery of psychological therapies, provide innovative services and national specialist services to children, young people and adults in out-patient and community settings.

The main areas which were positive were as follows:

- We spoke with very caring staff in all of the services and teams we visited. They were clearly sighted on and understood the needs of patients they worked with. We received a lot of very positive feedback from patients and parents about staff.
- There were several excellent examples of staff working in partnership with other organisations such as local schools, GPs and health visitors.
- Staff were receiving very regular supervision, which they felt was of high quality. Staff were up to date with mandatory training and described significant opportunities for further professional development. All staff received an annual performance appraisal.
- The staff provided patients with good quality psychological therapies. The psychological therapies provided were evidence-based. Some teams were undertaking innovative projects to enhance patient care and treatment or were involved in research.
- Most staff had a good understanding of safeguarding policies and procedures in respect of both children and vulnerable adults.
- The trust had recognised particular areas of local need and developed services to help meet those needs. For example, the excellent work with refugee communities.
- Staff and managers had worked to address equality and diversity issues in the trust work force as well as improve access to psychological therapies for under-represented groups.

- The trust had developed a number of creative and innovative initiatives aimed at involving patients in services and service development.
- There were very high levels of job satisfaction amongst staff in all teams we visited and in the trust as a whole.

There were some areas which needed improvement. The main areas for improvement were as follows:

- The documentation in relation to the risk assessment and risk management of patients was sometimes poor, particularly in the Portman clinic. Assessments did not always reflect actual risks. The local network involved in managing risks affecting patients was not always identified. Patients did not always have clear crisis plans in place that staff could find quickly in an emergency. Risk registers did not extend to team level which meant there was a risk that not all risks were being captured and reported at board level. In the Portman clinic adults and children and young people shared a waiting room. Despite mitigating action taken by the trust, this was not appropriate and potentially unsafe, especially given the risk histories and previous experiences of patients attending the clinic.
- Services were struggling to implement the new electronic patient records system. Some services were keeping both paper and electronic records for the same patient, some paper records were poorly scanned making them difficult to read, and one service had not yet implemented the electronic patient record system. There were risks to patient care from running paper and electronic records systems side by side. The quality of data extracted from the system was unreliable.
- The physical health needs of patients were not made a high priority. We noted the trust had recruited a physical health nurse one day a week, and was recruiting another, to improve the support offered to patients around smoking and alcohol use in particular. However, it was not clear that staff always considered the wider physical health needs of patients.
- The trust had not carried out infection prevention and control risk assessments in all premises where patients were seen. This meant the trust could not be confident that all infection risks were being managed appropriately.

# Summary of findings

- The trust had recently contracted a new independent advocacy provider. However, staff and patients were generally unaware of the service and we saw no advertising of the service in the areas we visited.
- There was much creative and innovative work taking place in the trust. However, there was a lack of agreed strategy or frameworks in place to support continuous improvement and ensure sustainability.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

# Summary of findings

## The five questions we ask about the services and what we found

We always ask the following five questions of the services.

### Are services safe?

We rated safe as **requires improvement** for the following reasons:

- Not all patients had an up to date, comprehensive risk assessment and risk management plan detailing how risks were being managed or mitigated. This was particularly the case in the Portman clinic where patients tended to be at higher risk than patients using other services. I
- Adults shared a waiting area with children and young people in the Portman clinic. This put children and young people at unnecessary risk.
- Not all patients had up to date, personalised crisis plans in place that reflected their individual circumstances and were easily accessible to all staff caring for them in specialist psychological therapy services.
- The trust had not carried out infection prevention and control risk assessments in all premises where patients were seen. There was no system in place to monitor and record when staff cleaned toys used by children. This meant the trust could not be confident that all infection risks were being managed appropriately.
- Medical equipment, including blood pressure monitors and weighing scales, had not been serviced and calibrated at regular intervals to confirm that the readings were accurate.
- Services and teams did not have their own risk registers. There was a risk that the risks identified in teams and services were not brought to the attention of the trust board via the organisational risk register and would not be managed appropriately.
- Fire safety checks and fire alarm tests were not always carried out regularly and documented.

However:

- Staff were up to date with mandatory training.
- Most staff had a good understanding of safeguarding policies and procedures in respect of both children and vulnerable adults.
- Most services were fully staffed and there were few staff vacancies across the trust. Staff sickness rates were very low.
- The trust had a good record on safety. There had been very few serious incidents. Incidents were investigated and the lessons learned were shared with staff.

**Requires improvement**



# Summary of findings

- The trust was open with people when things went wrong. Most staff understood their responsibilities under the duty of candour.

## Are services effective?

We rated effective as **good** for the following reasons:

- Staff used recognised tools to measure patient treatment outcomes.
- The trust had national institute for health and care excellence (NICE) champions in most teams. The champions took new NICE guidance and updates on guidance back to their teams for consideration. Staff undertook training in new psychological therapies in response to evidence of effectiveness and NICE recommendations.
- The gender identity development service had a strong focus on developing research within the field and working with partners internationally to ensure that best practice was developed in an area where there was not a strong evidence-base currently.
- Despite the lack of a formal audit programme in the trust, clinicians were active in completing clinical audits in a range of areas.
- Staff were receiving very regular supervision and had received an annual performance appraisal. Staff described significant opportunities for further training and professional development. Staff were generally experienced and well qualified.
- The trust worked very well in partnership with other organisations. For example, with schools, GPs, health visitors, other health organisations and the voluntary sector. Feedback from partners about joint working and communication with the trust was very positive.
- Most staff had received training in the Mental Capacity Act 2005. The trust had a detailed consent policy in place. Staff working with children and young people in most services understood the concept of Gillick competence and recorded assessments of Gillick competence in the records of young people.

However:

- Staff in many services did not effectively record information about patients in the electronic patient records system. Some services kept both paper and electronic records about the same patient. This meant there was a risk that records might hold conflicting information or staff may not look at the most up to date record.

**Good**



# Summary of findings

- The trust did not have a physical health care strategy to support staff to assess patients' physical health needs, deliver actions to address the needs identified and promote physical health as an important part of mental health and well-being. Staff did not routinely assess the physical health needs of young people other than those related to smoking and alcohol intake.
- Young people, particularly in the family mental health service did not always have a clear plan of care and treatment, or equivalent, in their care records.

## Are services caring?

We rated caring as **good** for the following reasons:

- Staff were very caring in all of the services and teams we visited. They were clearly sighted on and understood the needs of patients they worked with. Patients and parents were very positive about the staff.
- The gender identity development service had developed user/peer support groups which provided additional support to young people and their families.
- The trust routinely collected feedback about services from patients, parents and carers in a range of different and creative ways. Feedback was used to make improvements in services. Patients were trained to take part in the recruitment of new staff.

However:

- Staff and patients were generally unaware of the independent advocacy service that was available to them. The service was not clearly advertised in the areas and services we visited.

**Good**



## Are services responsive to people's needs?

We rated responsive as **good** for the following reasons:

- Patients were able to access services promptly. Services were generally meeting target times from referral to assessment and there were few breaches. There were waiting longer waiting times from assessment to treatment in some services. Where this was the case staff contacted patients regularly while they were on the waiting list to check on their progress.
- Managers and staff had worked hard to address equality and diversity issues in the trust work force as well as improve access to services for under-represented groups.
- The City and Hackney primary care psychotherapy consultation service had set up specific projects to meet the needs of

**Good**





# Summary of findings

minority communities less likely to engage with more ‘traditional’ psychotherapeutic approaches. The service was named as the British Medical Journal mental health team of the year 2015.

- The trust employed community mental health practitioners who spoke local languages and were from the largest refugee communities in Camden. Staff co-led groups with Somali and Congolese communities to produce leaflets in different languages. The refugee service had provided outreach projects including narrative groups for children and their parents in schools, youth clubs and sports centres and mental health awareness raising sessions.

However:

- The room allocated as the multi-faith room at the Tavistock Centre was also the designated clinic room. People using the room for prayer or contemplation were sometimes interrupted by staff and patients wanting to use the room, which was not appropriate.
- Patients with physical disabilities could not easily access group therapy at the Portman clinic because of the stairs and this therapy was not provided in an alternative accessible venue.
- Some parents in the gender identity development service were concerned that if they made a complaint about the service this could impact negatively on the care and treatment their child received, although we found no evidence of this.
- Parents and young people using the gender identity development service said they did not always have sufficient information about the pathways and options for treatment throughout the period of care provided.
- Information on how to complain was not available in the waiting rooms used by young people. Information was not displayed in accessible formats for younger children and children with learning disabilities.

## Are services well-led?

We rated well led as **good** for the following reasons:

- The trust had a clear governance structure in place and this supported the provision of effective psychological therapies to children, young people and adults.
- Staff were up to date with mandatory training, received regular supervision and appraisal and had access to specialist training and professional development opportunities.

**Good**



# Summary of findings

- The trust learned from incidents and complaints and improved service delivery as a result, although staff in some services were not aware of incidents in other parts of the trust.
- Appropriate systems were in place to ensure the trust met its responsibilities in relation to the fit and proper persons test.
- The trust understood the diversity of the work force and had taken action to improve race equality, develop an LGBT friendly environment and support staff in terms of their mental health.
- The trust looked actively to increase patient and public involvement in services, obtain feedback from patients on their experiences of care and treatment and improve the patient experience. The trust had initiated a number of different groups and projects for this purpose. Patients were trained and supported to take part in staff recruitment panels.
- The trust scored in the best 20% of trusts nationally in the annual staff survey on a whole range of measures. There were exceptionally high rates of job satisfaction amongst staff. There were low rates of staff sickness and low staff turnover. The trust had no difficulty recruiting new staff.

However:

- The quality and reliability of management information and outcome data was compromised by difficulties implementing the electronic patient records system. The trust had recognised this and allocated additional resources.
- Quality improvement was not yet clearly embedded across the trust. There was much creative and innovative work taking place in the trust. However, there was a lack of agreed strategy or frameworks in place to support continuous improvement and ensure sustainability. The trust had only recently presented a draft quality strategy to the board.

# Summary of findings

## Our inspection team

Our inspection team was led by:

**Chair:** Professor Tim Kendall, Director, National Collaborating Centre for Mental Health, Royal College of Psychiatrists; medical director and consultant psychiatrist, Sheffield Health and Social Care NHS Foundation Trust; visiting professor, UCL.

**Team Leader:** Judith Edwards, inspection manager for mental health, learning disabilities and substance misuse, Care Quality Commission

The team of **23** people consisted of:

Five CQC inspectors

Two CQC assistant inspectors

One CQC observer from the mental health policy team

Two analysts

Two experts by experience who have personal experience of using services we were inspecting

One inspection planner

Four psychologists

Two nurses with specialist experience of the services we inspected

One pharmacist

One consultant psychiatrist specialising in child and adolescent mental health

One social worker

One person with experience of governance and senior management in health care

## Why we carried out this inspection

We inspected the trust as part of our comprehensive mental health inspection programme.

## How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received

- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, Health Education England, the Royal College of Psychiatrists, and other professional bodies
- Sought feedback from patients, parents and carers by attending three focus groups and meetings and speaking with 16 patients and a carer.
- Met with five trust governors and the company secretary
- Received information from patients, carers and other groups through our website
- Met with three link workers from a local school

During the announced inspection visit from the 25-29 January 2016 the inspection team:

# Summary of findings

- Spoke with **72** patients, parents and carers
- Collected feedback from **115** patients, parents, carers and staff using comment cards
- Spoke with **74** staff members
- Attended and observed **8** team, multidisciplinary and research meetings
- Attended **four** focus groups attended by **25** staff
- Attended **three** focus groups for patients
- Interviewed **seven** senior executive and board members
- Spoke with other senior managers including the leads for quality and safety, audit, research, safeguarding, human resources, training and development, public and patient involvement, equalities and diversity, patient advice and liaison service, complaints, duty of candour and health and safety
- Looked at **70** treatment records of patients
- Spoke with the medical director about medicines management
- Spoke with **four** trust governors
- Spoke with **one** general practitioner and **nine** staff from local schools
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Observed a trust board meeting
- Requested and analysed further information from the trust to clarify what was found during the site visits

The team inspecting the mental health services at the trust inspected the following services:

- Specialist community mental health services for children and young people
- A national gender identity service for children and young people
- Specialist psychological therapy services

These services included the following specialist teams and services:

- Adolescent and young adult service
- Refugee service
- Family mental health service
- Community CAMHS Camden (North)
- Community CAMHS Camden (South)
- Fitzjohn's service
- Lyndhurst unit
- Portman clinic
- City & Hackney primary care psychotherapy consultation service
- Trauma unit
- Gender identity development services for children and young people in London and Leeds

We did not inspect substance misuse services or educational services provided by the trust as part of this comprehensive inspection.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

## Information about the provider

The Tavistock and Portman NHS Foundation Trust provides specialist mental health services some of which are national services. The trust supports adults and children in several London boroughs, including the London borough of Camden where it is located. They provide the specialist community child and adolescent mental health services in Camden, the national gender identity development service

for children and young people under the age of 18, and several specialist children's out-patient and community services. The trust has an international reputation in respect of the provision of specialist psychological therapies and in delivering training and education at undergraduate and post-graduate level in psychotherapy, family therapy and child and educational psychology.

# Summary of findings

The trust has an annual income of around £41 million and achieved a financial surplus of £544,000 in the previous year. The trust employs 578 staff, of which 440 are clinical staff. Staff provide mental health care and treatment for more than 6000 adults and children each year. In total the trust has more than 25 services including outpatient and community services. The trust provides a number of educational services, specialist drug and alcohol services, and services delivered in partnership with other agencies, such as the family drug and alcohol court and the provision of clinical expertise to a pain clinic at a local acute hospital. We did not include these services in the inspection.

The trust has one main site, the Tavistock Centre. In addition the trust provides services from 22 other community sites.

The services provided by the trust are organised into two directorates. Each has a directorate lead who is also a trust board member.

The trust has one location registered with CQC. The Tavistock Centre has been inspected three times since registration in 2010, in January 2012, March 2013 and March 2014. All three inspections found the trust compliant with essential standards, now known as fundamental standards, for all areas inspected.

## What people who use the provider's services say

Before the inspection took place we met with three different groups of patients, carers and other user representative groups as follows:

- Lyndhurst unit therapy group
- Pizza night group
- Adult patient reference group

Through these groups we heard from 17 patients, parents and carers. In addition we received feedback from an independent mental health advocacy service and a local Healthwatch.

We also met with link workers at staff at a local school.

During the inspection the teams spoke to 72 people using services or their relatives and carers, either in person or by phone. We received 115 completed comment cards of which 111 were positive, three negative and one was neither positive nor negative. We also received individual comments from people through our website or by telephone.

Most of the feedback we received was very positive as follows:

- Some patients spoke of working with the same therapist for many years and said how beneficial this had been in terms of continuity and consistency.

- Patients, parents and carers told us staff were very friendly, caring, professional and knowledgeable. Young people we spoke with said staff listened to them very well and offered support without judgement.
- Some patients described staff as flexible in their approach.
- Patients and carers in most services felt included in their care and treatment.
- Young people said that staff spoke in a way that was understandable.
- Parents and carers said staff were very accessible. Several parents gave examples of how they felt the support received from the service had saved their child's life.
- Some patients described their therapy as "life-saving".

Some of the challenges patients told us about were as follows:

- Some patients were unhappy that they had not been given the opportunity to choose between individual therapy and group therapy.
- Some patients felt that at times staff had been rude to them.
- Some parents in the gender identity development service were worried that if they made a complaint this would impact negatively on the care and treatment of their child.

# Summary of findings

## Good practice

### Trust wide

- The trust looked actively to increase patient and public involvement in services, obtain feedback from patients on their experiences of care and treatment and improve the patient experience. The trust had initiated a number of different groups and projects for this purpose. For example, the trust had awarded five services with grants through a “bid for better” programme to improve patient experience. Some of these grants went towards a Somali social kitchen and patient film nights. A competition had been held to rename the Camden child and adolescent mental health service, and the trust had implemented a mystery shopper initiative to obtain feedback on the trust’s telephone and email communications, website and visitors experience. Patients were trained and supported to take part in staff recruitment panels.
- The trust scored in the best 20% of trusts nationally in the annual staff survey on a range of measures. There were exceptionally high rates of job satisfaction among staff.

### Specialist psychological therapy services

- The City and Hackney primary care psychotherapy consultation service was named as the British Medical Journal mental health team of the year 2015. The set up specific projects to cater for ‘hard to reach’ and black and minority ethnic groups. These included a horticultural therapy group for Turkish speakers and a community photography group. The aim was to develop therapeutic interventions tailored to the needs of those less likely to engage with more ‘traditional’ psychotherapeutic approaches.
- The Trauma unit had set up a link with the British Red Cross. This involved graduate trainees from the trust providing individual and group therapy to people who had experienced trauma and had symptoms of post-traumatic stress disorder. The service was created by the trust to address the difficulty of specific groups in the community not being able to access mental health services. The service was predominantly offered to war veterans and asylum seekers.

- The Portman clinic was a part of a pilot study implementing mentalisation-based treatment for anti-social personality disorder. The study was conducted in partnership with University College London.

### Gender identity development service

- Staff in the gender identity development service were very positive about their experiences of working for the trust. All staff, without exception, told us that they felt well-supported with supervision and access to specialist training, and attendance at relevant conferences and internal professional development events and meetings.
- The gender identity development service had a strong focus on developing research within the field and working with partners internationally to ensure that best practice was developed in an area where there was not a strong evidence-base.
- The gender identity development service had developed some very strong relationships with individual child and adolescent mental health services around the country
- The gender identity development service had developed user/peer support groups, which provided additional support to young people and their families.

### Specialist community mental health services for children and young people

- The child and family refugee team offered multidisciplinary interventions to children and families from refugee and asylum seeking communities to improve their emotional and mental health. The trust employed three community mental health practitioners in the team who spoke local languages and were from the largest refugee communities in Camden. Staff co-led groups with Somali and Congolese communities to produce leaflets in different languages. Work with these communities led to the training and employment of people from the communities as child and adolescent mental health workers. The service had provided outreach projects including narrative groups for children and their parents in schools, youth clubs and sports centres and mental health awareness raising sessions.

# Summary of findings

- The trust had established close links with local schools. Trust staff provided training to school link workers, who could directly refer pupils to child and adolescent mental health services. The school and trust staff ran several interactive projects together. School link workers reported that staff were easy to contact, informed the school when they were about to discharge a young person, always attended safeguarding meetings and sent reports on time. Trust staff had good cultural knowledge and understanding and readily offered support on social issues, such as housing. One link worker said, “I would like to work with everyone the way we work with the Tavistock.”
- The trust was involved in a project to provide services to young people aged between 16 and 24 who may have experienced difficulty transferring from one service to another, for example, from child and adolescent mental health services to adult mental health services. This project was called Minding the Gap and included two outreach teams of staff operating out of a community youth base. This base was co-designed with young people and the project was co-created with a young people’s board.
- The community child and adolescent mental health teams provided support to GPs and health visitors. Partnership working with these groups was excellent. Feedback about joint working and communication from partners was very positive and complimentary.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Specialist psychological therapy services

- The trust must ensure that all patients have a comprehensive risk assessment completed and a risk management plan detailing how risks are being managed or mitigated.
- The trust must ensure that adults have a separate waiting area from children and young people at the Portman clinic.
- The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and are up to date. These must be kept where they can be found quickly by all staff.

### Action the provider **SHOULD** take to improve

#### Trust wide

- The trust should ensure that infection prevention and control risk assessments are carried out in all premises where patients are seen.
- The trust should ensure that medical equipment, including blood pressure monitors and weighing scales, is serviced and calibrated at regular intervals so that staff can be confident that the readings are accurate and patients are protected against potential risks.
- The trust should ensure that the process for services to enter risks on to the trust risk register is embedded and well understood by staff. Staff should have a clear view of risks affecting their own services.
- The trust should ensure that staff are able to effectively record information about patients in the electronic patient records system and that services do not keep paper and electronic records that can potentially hold conflicting information.
- The trust should develop a physical health care strategy to support the assessment of patients’ physical health needs, deliver actions to address the needs identified and promote physical health as an important part of mental health and well-being.
- The trust should ensure all staff are aware of the advocacy services available for patients and this should be advertised to patients, parents and carers.
- The trust should ensure the room allocated to the multi-faith room is not shared with the clinic room.
- The trust should ensure that quality improvement becomes embedded across the trust and leads to the systematic assessment and monitoring of performance and continuous improvement in the safety and quality of the services provided.



# Summary of findings

## Specialist psychological therapy services

- The trust should ensure that fire safety checks and fire alarm tests are carried out at regular intervals and documented. This includes ensuring that designated fire exits are kept completely clear.
- The trust should ensure that staff in all teams effectively record information about patients in the electronic patient record system.
- The trust should ensure that staff routinely consider patients' physical health needs when conducting assessments.
- The trust should ensure that there is access to group therapy for people with physical disabilities using the Portman clinic in order to provide fair access to treatment.
- The trust should continue to work to address the long waiting times for treatment in the PCPCS so that patients are able to receive treatment more quickly.

## Gender identity development service

- The trust should ensure that staff take a proactive attitude to complaints and sharing information with young people and parents about what will happen to complaints when they are made.
- The trust should make sure that staff continue to involve and share information with all young people and parents or carers so that they are aware of the pathways and options for treatment throughout the period of care.

## Specialist community mental health services for children and young people

- The trust should ensure that toys used by children are cleaned after use and staff keep cleaning records.
- The trust should ensure that staff complete and record risk assessments for all young people, review these regularly, and share information on risk with other health professionals involved in young people's care and treatment.
- The trust should ensure that staff share crisis plans in writing with young people and their parent or carer.
- The trust should ensure that staff in children and young people's services are able to record information about young people in the electronic patient records system effectively.
- The trust should ensure all young people have a clear plan of care and treatment, or equivalent, in their care records, particularly in the family mental health service.
- The trust should ensure that staff routinely assess the physical health needs of young people other than those related to smoking and alcohol intake.
- The trust should provide information on how to complain in the waiting rooms used by young people.
- The trust should ensure that information provided to patients is also made available in accessible formats for younger children and for young people with learning disabilities.



# Tavistock and Portman NHS Foundation Trust

## Detailed findings

### Mental Health Act responsibilities

The trust provided out-patient and community based services only. The trust was not registered to provide the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983. We did not inspect or report on Mental Health Act responsibilities.

### Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff attended mandatory training on the Mental Capacity Act 2005 (MCA), although understanding of the Act varied between staff. Some staff providing specialist psychological therapies to adults were less clear about how the MCA affected their practice. Staff were unsure where to get advice on MCA matters within the trust.
- The trust had a detailed consent to treatment policy and procedure that included guidance for clinicians on competence, consent, and refusal of treatment for children and young people; the procedure for obtaining consent for people aged 16-18; and the procedure for obtaining consent for people under 16.
- The Mental Capacity Act 2005 applies to young people aged 16 and 17 and mental capacity assessments should be carried out to make sure the patient has the capacity to give consent. The Mental Capacity Act (MCA) does not apply to young people aged 16 or under.
- For children under the age of 16, the young person's decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may be mature enough to make some decisions for themselves. When working with children, staff should assess whether a child has a sufficient level of understanding to make decisions regarding their care.
- Young people, parents and carers told us that staff asked for their consent to treatment. We found records of appropriate assessments of Gillick competence in the care records of young people. Staff in the child and adolescent services and the gender identity development service showed good understanding of competence and how this would be considered and assessed. However, competence, capacity and consent was not always well documented in the records of young people using the Portman clinic.

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Summary of findings

### Our findings

#### Safe and clean care environments

- The trust completed regular estates risk assessments for all of their service locations and followed up on outstanding actions in a timely manner. The trust had carried out a ligature risk assessment at the Tavistock Centre and Portman clinic in November 2015. The risk assessment highlighted a number of ligature anchor points throughout both premises. The trust acknowledged that the number of ligature points presented a risk but the risk associated with patients attending for appointments was low. In addition, patients were not usually left unsupervised. An action plan had been put in place to monitor the implementation of identified remedial work including the removal of ligature anchor points in toilets and actions to restrict access to some areas for children. The action plan was being monitored by the patient safety and clinical risk work stream. The trust planned to conduct similar ligature risk assessments in other services where patients were seen on site. These assessments were due for completion by the end of August 2016.
- The Tavistock Centre was visibly clean and well maintained. Furnishings were in good condition. There was artwork displayed in all communal areas, which made the environment welcoming. Waiting areas for children and young people were bright and colourful.
- The trust had a policy on infection control and procedures for the prevention and management of blood borne viruses, which were due for review in April 2016. Staff received basic infection control and handwashing guidance as part of their mandatory in-service training and clinical induction. Alcohol hand gels were provided on each floor at the Tavistock Centre. The trust conducted an annual flu campaign that stressed the importance of careful disposal of tissues and other basic measures to prevent the spread of infection. However, the trust had not carried out any

infection control and prevention risk assessments or audits of premises where patients were seen for appointments. This was not in accordance with the 'Health and Social Care Act 2008'. The infection control policy dated May 2013 had not been reviewed to ensure it was in line with updated national guidance published in July 2015.

- There was a clinic room that all staff at the Tavistock Centre could use to carry out physical examinations, for example measuring the blood pressure of patients who were prescribed medication. This room had an examination bed, weighing scales and three blood pressure monitors. However, there was no evidence to show when staff had calibrated the blood pressure monitors or weighing scales to make sure they took place. Uncalibrated equipment may give readings that are not fully accurate, which in turn could affect the safety of patients.
- There was open access to the Tavistock Centre and there was no formal sign-in system for visitors. Staff at reception monitored who entered the building but did not record their names. Reception staff were informed of patient appointments, including appointments held out of the main office hours. They kept a daily list of patients attending the centre so that they knew who was in the building. However, administrative staff told us that some clinicians had to be given regular reminders to ensure that reception staff were aware of patient appointments. Students regularly accessed the building for the trust's training and education services. Reception staff monitored the CCTV that was fitted throughout the building.
- Interview rooms were not fitted with alarms. However, staff had access to personal alarms when they needed one. Each room where staff met patients individually had a telephone and staff could phone reception using a code word in an emergency.
- The Portman clinic did not offer separate waiting rooms for children and adults using the service. The team manager told us that all children and young people were required to attend an appointment with a parent or carer. However, this did not fully mitigate the risks to children

## Are services safe?

waiting in the same room as adults. Due to the nature of the service and the background of the patients that attended the clinic, a shared waiting room put children at risk of harm.

- Fire wardens allocated on each floor in the Tavistock Centre were responsible for evacuating the floor when the fire alarm sounded. The Tavistock Centre completed weekly fire checks and annual fire evacuation drills. However, at the Portman clinic fire log books were not completed to show that the fire alarms had been checked every week and there were no checks recorded between May and October 2015. We found that fire exits were partially blocked by a desk and chair, which may have caused a delay in evacuating the building in the event of a fire. These issues were raised with the manager of the Portman clinic on the day of the inspection for them to take immediate action.

- The trust had not conducted any patient-led assessments of the care environment, known as PLACE assessments. These assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The PLACE assessment focuses entirely on the care environment and is applicable to out-patient as well as in-patient environments.

### Safe staffing

- At the time of the inspection there were 41 whole time equivalent staff vacancies across the trust. The trust was actively recruiting to vacant posts. Bank and agency staff were used to cover shortfalls, mostly in administrative and clerical roles. At the time of the inspection there were 11 agency staff covering posts in the trust. These were mostly administrative staff. There was one agency nurse employed in the child and adolescent mental health service. The head of human resources at the trust stated that no posts in the trust were difficult to fill.

- There were 26 whole time equivalent consultant psychiatrists working in the trust. There were 34 nurses working in clinical, teaching and supervisory roles. The majority of clinical staff in the trust were clinical psychologists and psychotherapists. Teams reported that they had manageable caseloads. Most services were meeting referral to assessment targets. The gender identity development service had received a large increase in referrals over the last few years that was putting pressure on staff.

- Staff sickness in the trust was very low. In quarter 2 of 2015/2016 the staff sickness rate across the trust was less than 1%. Similarly, the trust reported very low staff turnover rates and very high staff retention.

- The trust did not have a specific recruitment strategy. The trust reported this was due to their low vacancy rate and low staff turnover.

- Staff were up to date with mandatory training. In quarter 1 of 2015/2016, 93% of staff had completed mandatory training. In quarter 2 this rose to 94% of staff and in quarter 3 was 91%.

- The trust managed employee issues through performance or disciplinary procedures. These incidences were few. The trust reported on the number of staffing issues to the board so that they were aware.

- The trust carried out enhanced criminal records checks on all relevant staff. These checks were renewed every three years for all staff in direct contact with adults at risk, children and patient data. This included locums, temporary staff and sub-contractors. The trust achieved completion of checks for 98% of staff in quarter 1 of 2015/2015 and 96% in quarter 2. In quarter 2 there were 20 outstanding staff criminal records checks. The reasons for these were: two staff on career breaks, eight staff on secondment, five staff on maternity leave and five new staff for whom risk assessment forms had been completed.

- We reviewed the personal records of ten trust employees. Records showed that checks had been carried out on staff before they started working in the service, to confirm that they were suitable to work with patients, particularly vulnerable adults and children. These checks included enhanced criminal record checks with the disclosure and barring service, two references were obtained from previous employers and staff provided photographic proof of identity. For nine of the ten records we checked the reasons for any gaps in the employment history of the prospective employee were explained in their application form or explored at interview. The service checked the professional registration of clinical staff before they were employed and monitored this on an on-going basis.

### Assessing and managing risk to patients

- The completion of patient risk assessments varied across services. At the Portman clinic the care records of three of patients under the age of 18 years, did not demonstrate

## Are services safe?

that full risk assessments had taken place and were updated in line with changes in risk. Risk management plans were limited in detail and did not clearly demonstrate that staff were appropriately documenting risk. All three individuals had histories of serious risks affecting them. The trust assured us that risk was taken seriously by the service. Staff worked in partnership with other agencies to manage the risks affecting the young person but the current risk management arrangements were not recorded and therefore could not be considered robust. Information on the level of risk and risk management was not readily available to staff not working directly with the young person. Any staff unfamiliar with the young person would not be able to understand the level of risk if they relied on the care records for each of these three young people for information about them. The lack of risk assessment and management plans meant that the risk had not been monitored and managed in a safe way. This put staff, patients and others at risk of potential harm.

- Many patients using specialist psychological services did not have clear crisis management plans in place. Their care records did not contain accessible, comprehensive information for patients or staff about what to do if an emergency arose and who to contact. In the child and adolescent mental health services crisis plans were developed for young people, but some young people we spoke with were unsure whether a copy of the crisis plan had been provided in writing or shared verbally with them. There was no clear, service-wide process for the sharing of written crisis plans with young people and families.

- The trust had recorded 15 incidents involving the restraint of people, none in the prone position, in the last year. These had occurred in an educational service provided by the trust and all involved staff intervening in fights and aggressive incidents between pupils. The educational service was not part of this inspection. It was rated as outstanding by Ofsted in February 2014

- The trust had mandatory child and adult safeguarding training for staff. In quarter 2 of 2015 – 2016, 98% of staff had completed level 2 safeguarding training and 93% had completed level 3 training. Female genital mutilation was included in safeguarding training at all levels. All clinical staff working with children were expected to complete safeguarding children level 3 training every three years. Administrative staff completed safeguarding training every two years.

- The trust had policies for safeguarding children and safeguarding adults at risk. The trust had introduced a policy on admitting important persons and celebrities to the trust premises in response to recommendations in the recent Lampard report (Lampard and Marsden (2015) 'Themes and lessons learned from NHS investigations into matters relating to Jimmy Savile.')

- The trust had named professionals for safeguarding children and adults at risk who reported to the patient safety and clinical risk team. The trust had a safeguarding committee that was attended by the trust chair. The trust had good working relationships and regular liaison with local safeguarding teams. Local stakeholders commented that the trust had made improvements in safeguarding adults practice and engagement with partners. The trust safeguarding lead attended the quarterly multi-agency safeguarding meeting hosted by Camden social services.

- The named clinician and named professional were responsible for making a child safeguarding referral to the local authority and following up to ensure they took action. The professional leads also provided support and advice to staff.

- Between April 2015 and the end of December 2015 the trust had raised six adult safeguarding alerts and 51 child safeguarding alerts with the appropriate local authority safeguarding teams.

- The trust was improving its safeguarding documentation in patients' clinical records and addressed safeguarding in staff supervision. For example, not all children subject to child protection plans in Camden had the relevant box ticked in their care records. The new electronic patient record system did not have a banner alert system to highlight if a patient was subject to a safeguarding referral. This was being addressed.

- The trust reported adult and child safeguarding referrals at management team and board level. However, they did not have formal systems to cascade information to staff at team level.

- In the services and teams we visited staff and at team meetings and took decisions to make appropriate safeguarding referrals to the local authority safeguarding team.

- There were no medicines stored at or supplied from the trust. Medicines were prescribed by doctors to be supplied

## Are services safe?

by the patient's choice of community pharmacy. The trust had a prescribing and administration of medication procedure dated March 2015, which set out the responsibilities of any staff involved in the prescribing or administering of medicines. This procedure clearly set out how prescription pads must be stored to prevent misuse. Prescribing was audited quarterly by the medical director to ensure that the medicines prescribed were within the doctors' competency.

- Medicines incidents were reported through the patient safety and clinical risk workstream where it was a standing item. No medicines incidents were reported in the last quarterly meeting. Central alerting system alerts were a standing item on the agenda of this workstream and there was evidence that the trust had acted promptly in response to these alerts.
- No emergency medicines were held on trust premises and there were no automated external defibrillators. The trust has not completed a risk assessment in regard to the decision not to keep emergency equipment on trust premises. The decision not to have emergency equipment had been taken by the medical director and the health and safety manager, on the basis that patients using trust services were generally in good physical health. However, the trust had recently decided to expand the number of staff trained in basic life support techniques including the use of a defibrillator. The trust was proposing to purchase defibrillators and install them in trust premises from April 2016.
- The trust had central operational and corporate risk registers but only some services, such as IT, estates and the family nurse partnership had local risk registers. When managers wanted to escalate a risk from their individual service onto the trust's operational risk register, they complete a structured risk assessment form and liaised with a service director. This was a recent development and as a result not all current risks on the register had a corresponding completed structured risk assessment form. All staff were not aware of the central risk register and risks within their own services and across the organisation. Consequently there was a risk that the trust had not captured all risks on the central register and staff in local services were not able to take appropriate actions to address risks as they were unaware of them.

### Track record on safety

- The trust had a good track record on safety and there had been very few serious incidents. The trust attributed this to the low risk nature of the community and outpatient services provided.

- In last 12 months there had been two serious incidents. They both related to deaths of patients who had been seen in trust services, although neither person was in receipt of a service at the time of their death. The trust had investigated the circumstances around the deaths. The root cause analyses of these incidents had been shared with the trust board.

- The trust reported 15 incidents in the last 12 months. Eleven of these (73%) were categorised as low harm and four as no harm. Five of these were accidents.

### Reporting incidents and learning from when things go wrong

- The health and safety manager managed incident reporting for the trust. Incident forms were available on the trust's intranet. Staff sent a completed incident form to the health and safety manager who recorded these on a spreadsheet. The trust did not have an electronic database to report and manage incidents although was considering the introduction of such a system. The health and safety manager provided support and advice to staff on incident reporting and recording.
- The trust had very few serious incidents and these were investigated by an identified serious incident investigation team who produced a report using an agreed report template. Any recommendations made by the investigators were reviewed by the medical director. If the recommendations were approved an action plan was developed by the relevant team. The action plan was monitored by the patient safety work stream reporting to the clinical quality, safety and governance committee (CQSG) to ensure learning took place, lessons were shared and, where required, practice changed. Lessons learnt from all incidents were reported to the clinical quality and risk committee quarterly.
- The trust board discussed the root cause analyses of two serious incidents at the January 2016 board meeting. Both investigations had identified a number of lessons learned and recommendations which were addressed via an action plan. Progress against the plans was monitored by the patient safety work stream and reported to the trust's CQSG.



## Are services safe?

- The trust highlighted lessons learned from incidents in the quality newsletter, which was sent to all staff every three months, at mandatory in-service training sessions and at team meetings. The quality newsletter sent to all staff in July 2015 highlighted five incidents that had occurred in the trust, summarised the action taken and the lessons learned from the incidents. However, staff in the specialist child and adolescent mental health teams and gender identity development service were not all able to tell us of incidents that had occurred in other trust services and any lessons learned.
- Health Education England stated in a recent quality visit report that trainees in the trust were encouraged to report clinical incidents and that learning and feedback from incidents was 'excellent'.
- Senior managers were confident the level of incident reporting was an accurate reflection of actual numbers of incidents in the trust.

### Duty of candour

- The trust was working to fulfil its responsibilities under the regulation relating to the duty of candour. The duty of candour means that providers must operate with openness, transparency and candour, and if a patient is harmed they are informed of the fact and offered an appropriate remedy. Staff completed duty of candour training as part of their induction and three yearly mandatory training. The trust also included information on duty of candour in their quarterly quality newsletter distributed to all staff.
- The trust recently added a section to their reports for staff to indicate whether they had followed the duty of candour but did not provide details about what this included. The health and safety manager was responsible for assessing whether incidents qualified for the duty of candour.
- Staff described incidents where patients were informed when things went wrong, apologised to and offered the opportunity to make a complaint.

- The trust had a 'being open and candid with patients involved in an incident policy', dated March 2015. This set out the duties and responsibilities of staff in respect of the duty of candour.
- Between October and December 2015 two patient safety incidents had been categorised as medium harm or incident above. Both incidents involved confidential information being stolen from clinicians' cars. In both cases the patients were informed promptly and the trust sent letters of apology in both cases.
- Many staff had a clear understanding of their responsibilities under the duty of candour, although some did not. Most staff were able to describe how they were open and transparent and provided an apology when things went wrong.

### Anticipation and planning of risk

- The trust had plans in place for emergencies and major incidents. The medical director presented a paper to the trust board in January 2016 on the emergency preparedness, response and recovery (EPRR) and work plan for 2015-16. The trust assessed itself as compliant or working towards full compliance with all relevant standards and this was confirmed by NHS England. The work plan for 2015-16 addressed all areas that were assessed as 'amber' (evidence of progress towards full compliance with a core standard). The work plan listed action to be taken, which included carrying out a range of exercises aimed at delivering an effective response to emergencies and business continuity incidents. There were clear dates for the delivery of actions.
- The trust had a contingency plan to address IT failures, and a major incident plan and a business continuity plan, both of which had been updated in January 2016. The business continuity plan addressed issues such as the potential adverse effects on the provision of trust services of severe weather, disruption to transport, loss of communication systems and loss of access to buildings.

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Summary of findings

### Our findings

#### Assessment of needs and planning of care

- The trust had recently implemented a new electronic patient records system. Staff had been involved in choosing the system and the trust had provided training to staff on how to use the system. However, many staff said they found the records system difficult to use. A Health Education England quality visit report from September 2015 noted that the trust needed to ensure a robust process was in place to allow trainees timely access to the electronic patient record system.
- The electronic patient records allowed for the recording of outcome measures and other performance and management information in a consistent way across services. However, staff were not always entering data into the patient records effectively. This was because of unfamiliarity with the system or because they were not using the electronic records system at all. There were some issues with the functioning of the system that were still causing problems. As a result the trust did not have confidence in management information generated from electronic patient records system as it was not being used consistently by all services. This undermined the trust's ability to use patient information to measure outcomes, confirm targets were being met, compare performance between teams and have good oversight of service delivery.
- The Portman clinic staff were not using the electronic system at all while other services were running two records systems, one paper based and one electronic, alongside each other. There was a risk that staff would not know which of the patient records was up to date. In one service staff continued to write patient notes on paper, which were then scanned into the electronic system. Historic paper patient records had also been scanned in to the electronic record. We saw examples of records that had been scanned upside down. Scanned records were generally difficult for staff to read.
- The trust board were aware of the difficulties implementing the electronic records system and the impact of this on data quality. The issues had been raised at the last two board meetings and a clinician had been identified to lead full time on the implementation. More training on how to use the system was on offer to staff. Senior trust managers acknowledged they had underestimated how difficult it would be and how long it would take to implement the electronic patient record system and make sure it was being used effectively by all staff and teams.
- Staff carried out comprehensive assessments of patients. The trust told us that patient care plans were completed following assessment and that the plan was co-produced with the patient. The electronic patient record contained a field where the care plan was recorded and a consent box was ticked confirming that care and treatment options had been discussed. However, information on how many patients had care plans in place was not reported to the board in January 2016 because of difficulty in extracting the information from the electronic records and a lack of confidence in the reliability of the data. There was a plan to provide this information to the board before the end of March 2016.
- In most services we inspected patients had plans of care, or equivalent, in their records, although this varied between teams. For example, we could not find a plan of care in five of seven records we reviewed in the family mental health service. In addition the level of detail in plans of care varied considerably. Some were holistic and covered a range of identified needs, while others contained information on the assessment formulation of the patient and a description of the therapy they were receiving. Young people using the gender identity development service and their parents, received copies of letters written by clinicians when information was shared with other services, such as GPs. However, the service did not have a system of providing a distinct

## Are services effective?

'care plan' to young people and it was not clear in the patient records whether children, young people and families had agreed to the plans outlined. In the specialist psychological services care records did not always show that plans were created in collaboration with the patient. Plans of care generally lacked the 'patient voice'.

### Best practice in treatment and care

- The trust had national institute for health and care excellence (NICE) champions in most child and adolescent service teams and some in the adults and forensic teams. The champions took new NICE guidance and updates on guidance back to their teams for consideration. The NICE champions had received training in how to identify relevant guidelines and apply them to the work of their teams. Where gaps were identified action was taken to address them. For example, when new evidence based therapies had been identified the trust had bought in training to enable staff to provide them. Staff from the Camden child and adolescent mental health teams had undertaken training in dialectical behavioural therapy to better manage self-harm behaviours. A core group of staff had been training in interpersonal psychotherapy in response to evidence of its effectiveness in the treatment of depression, anxiety and eating disorders.
- The trust had traditionally provided more long term individual and group psychotherapy services. In recent years the trust had expanded the number and types of specialist psychological therapies they were able to offer. These included cognitive behaviour therapy, mentalisation based therapy and eye movement desensitisation and reprocessing therapy, an integrative psychotherapy that has proven to be effective for the treatment of trauma.
- The trust used outcomes from research to improve services.
- The trust did not have an audit department or formal clinical audit programme. A senior child psychiatrist led on audit at the trust. Teams or clinicians sent proposals for audits to a virtual audit clinic where they were offered advice on their proposal. The audit lead was preparing an audit plan for 2016-2017 that would involve participation in national audits, and be linked to the trust's two year objectives as well as to the implementation of NICE guidance. This was a new initiative for the trust.
- Despite the lack of a formal audit programme clinicians had completed audits in a range of areas. These were not evenly spread across all teams and services but included a trust-wide audit of staff supervision arrangements, an audit of "intermittent" (less than once weekly) psychotherapy treatment, audits of self harm in young people using the gender identity development service and the adolescent and young adult service, and an audit of the management of children and adolescents with attention deficit hyperactivity disorder seen in the community child and adolescent mental health service clinics. In addition, the community child and adolescent service was undertaking an audit of compliance with NICE guidelines for the treatment of depression in children and young people. Staff took action to improve practice in response to audit results and there was some evidence of follow up audits to measure those improvements.
- The trust had participated in national audits such as the national audit of psychological therapies, and the green light tool kit audit in 2015, aimed at improving mental health for people with autism and learning disabilities. The trust had responded to recommendations in the national audit of psychological therapies in order to bring about improvements in care and treatment.
- Learning from audits was shared with teams. However, senior managers acknowledged learning and improvement could be better. Some audit results were circulated and cascaded to staff by the audit lead. The trust had introduced clinical audit and effectiveness presentations that were due to start in March 2016. The current approach to clinical audits was not well planned or systematic. The lack of overall planning of audit activity meant there was a missed opportunity for the trust in terms of improving its oversight of clinical performance in all services and improving the quality and effectiveness of care and treatment provided.
- The trust had joined the NHS Benchmarking Network and made use of benchmarking data for the child and adolescent mental health service.
- The trust measured outcomes for patients using a range of outcome measures. In 2014-2015 over 75% of patients receiving community child and adolescent mental health services, who completed the measure, achieved an improvement in their global-based measures score between pre-assessment and after six months or at the end of therapy, if sooner. For adults in the same period 53%, who completed the measure,



## Are services effective?

showed an improvement in CORE outcome measures scores between pre-assessment and the end of treatment. CORE outcome measures are derived from patient self-report questionnaires covering their subjective well-being, problems/symptoms, life functioning and risk/harm.

- The gender identity development service was committed to developing research and establishing best practice in an area of practice where there was little research evidence to support best practice for gender dysphoria in the UK. The service had employed research assistants and a full time research psychologist. They met monthly to discuss current research and policy updates. This was shared with the wider team. Clinicians were active in the newly formed British Association for Gender Identity Specialists and attended the World Professional Association for Transgender Health international conference to ensure that evidence and research was shared.
- The trust had not met physical health care commissioning for quality and innovation (CQUIN) targets in respect of smoking cessation in 2015-2016. Similarly, several physical health CQUIN targets in respect of alcohol misuse had not been met. For example, failure to achieve referrals to a physical health nurse, implementation of a system to report domestic violence, and referrals to local alcohol services. The nursing director acknowledged that the approach to patients' physical health needs was not well-developed in the trust. A smoking cessation nurse worked one day a week. The trust had taken a decision to employ a dedicated physical health nurse for a further two days a week. A domestic violence sub-committee has been set up and domestic violence was now being recorded on patient records, when applicable. A physical health care form was included in the new electronic patient record and all staff had access to this.
- The trust did not have a strategy in relation to the physical health needs of patients. The trust stated that it planned to develop a strategy and introduce a physical health CQUIN in 2016-2017. However, the trust was not very active in terms of addressing the physical health needs of patients, which meant they were failing to address an important issue facing people with mental health problems. People with long-term severe mental health problems have a life expectancy that is 10-20 years less than the general population. This is largely due to physical health problems, such as heart disease

and diabetes that can be prevented by a healthy lifestyle. In the services we visited the formal recording of physical health needs relating to smoking and alcohol intake had improved since the introduction of the new patient record system. Patients physical health needs were discussed at clinical meetings we attended. However, there was little evidence that staff routinely assessed the physical health needs of patients.

### Staff skilled to deliver care

- Staff in all teams were experienced and qualified. There were representatives from different disciplines but the majority of staff were psychologists or psychotherapists. The teams had many trainee staff. Trainees were all well supervised by experienced clinicians.
- At the end of quarter 3 2015-2016, 99% of staff, who required an appraisal and personal development plan had completed these. The trust annual appraisal cycle ran from April to March every year. Staff personal development plans informed internal training and development programmes. Staff had regular team meetings.
- All staff received regular supervision and this was considered a particular benefit of working for the trust. Staff had access to regular formal individual and group, case and personal supervision in addition to informal supervision as needed. The trust also offered clinical supervision groups across the organisation that staff could sign up for and attend for a year.
- The last national audit of psychological therapies showed that the trust scored below the national average in response to the question: "therapists are providing therapy under supervision, and have received formal training to deliver the therapy provided." The trust scored 34% on this measure against a national average of 80%. The trust explained that the apparent low figure was related to the way the question was phrased and low numbers of staff counted. Clinical trainees at the trust provided psychotherapy to patients but did so under the supervision of a trained and experienced therapist. We concluded that staff and trainees were trained and supervised to a high standard.
- Staff had access to a wide range of specialist courses provided by the trust. Post-graduate courses were subsidised for employees. Some courses such as the history of psychoanalytic theory were free for staff and well received. The trust provided specialist training in a range of psychological therapies and psychotherapy. It

## Are services effective?

provided post-graduate clinical training in family therapy. The gender identity development service gave staff the opportunity to develop professionally. Staff had access to specialist training and national and international conferences in the field of gender dysphoria.

### Multi-disciplinary working and inter-agency work

- There were staff from a range of different disciplines working in the trust. The majority were clinical psychologists and psychotherapists. There were smaller numbers of psychiatrists, nurses, family therapists and social workers employed in different services.
- The trust provided services in conjunction with a range of other agencies, including other trusts, local authorities and the voluntary sector.
- The trust had established close links with local schools. We met with three link workers based in a local school. The link workers had received training from Tavistock staff and could directly refer pupils to child and adolescent mental health services. The school and trust staff ran several interactive projects together. For example, the tree of life, an eight session programme that encouraged young people to talk about their culture. The school had Somali, Congolese, Bengali and Kosovan link workers. Over 20% of pupils at the school were first or second generation refugees. The link workers referred pupils directly to the refugee service when they identified a need. They commented that it was easy to contact the refugee service. Trust staff informed the school when they were about to discharge a young person from their service, always attended safeguarding meetings and sent reports on time. The link workers said that trust staff had good cultural knowledge and understanding and readily offered support on social issues, such as housing. They saw positive outcomes from treatment. One link worker summed up the views of others when they said, "I would like to work with everyone the way we work with the Tavistock."
- Child and adolescent mental health service (CAMHS) staff provided one session a week at local GP practices. A GP described the positive effects of input from the psychiatrist and described the working relationship with CAMHS as very positive. Young people who were referred to the service were generally seen within two to three weeks. The GP felt that having a member of CAMHS staff at the practice each week helped facilitate a

referral and reduced the stigma attached to having mental health difficulties. Staff recorded notes from consultations carried out at the GP practice on the trust electronic patient record.

- One team member from Open Minded CAMHS north supervised 12 health visitors from local community services. This was to encourage a focus on the child as well as the parent and the staff carried out joint visits with health visitors where appropriate. The 12 health visitors completed an evaluation of the supervision to develop this work further. The evaluation showed they found it valuable and said it had enhanced their relationship with the trust.
- In December 2015 the trust had conducted a survey of GPs to find out how effective they perceived the trust to be in terms of communication. Sixty three per cent of those who responded said they were satisfied with how well the trust communicated with GPs during a patient's treatment and knew who they could contact in order to gain further information about a referral. The primary care psychotherapy consultation service (PCPCS) had a joint working model with local GPs and many of the team were based in GP surgeries. Staff told us that the team had good working links with improving access to psychological therapies (IAPT), homeless charities and organisations providing asylum advice and support.
- Commissioners told us the trust took a flexible and collaborative approach to service delivery and innovation.

### Consent to care and treatment and good practice in applying the Mental Capacity Act

- Most staff had received training in the Mental Capacity Act 2005 (MCA). The MCA training lead had provided 11 training sessions for staff between March 2015 and January 2016. Further sessions were scheduled.
- Staff working with children and young people in most services understood the concept of Gillick competence and recorded assessments of Gillick competence in the records of young people. However, for three children using the services at the Portman clinic there were no records of assessment of capacity or competence.
- The trust had a detailed consent to treatment policy and procedure that included
- Consent audits had been undertaken in 2014/15 on the paper records, before the introduction of the electronic patient records. Six patient records had been audited in the Fitzjohn's unit. The audit showed that in four of the

## Are services effective?

six care records there was no narrative around the discussion of consent, although the box to show that consent had been discussed was ticked. The audit for 2015/16 was being undertaken but was not available at the time of the inspection.

- Staff we spoke with showed a good understanding of consent within the context of their work.

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Summary of findings

### Our findings

#### Kindness, dignity, respect and support

- In all of the services we visited we saw staff treating patients, parents and carers with kindness and compassion. We received very positive feedback from most patients about the way they were treated by staff. For example, eight young people using the gender identity development service were all very positive. They described the service as “lifesaving” and said how much they valued being able to speak to “someone who understands”. In specialist services for children and young people patients, parents and carers said staff were open, positive and easily contactable, even at short notice. Most felt listened to. Young people said they felt supported and that staff did not judge them. All young people and parents we spoke with said they found the service very helpful and described positive changes that treatment had brought about. In other services for adults most patients praised staff for being professional and were grateful for the help provided. Patients felt that staff genuinely cared for them.
- However, in the gender identity development service nine family members and one young person raised concerns relating to a feeling of lack of involvement in or explanation of treatment pathways. Eight patients or their families raised concerns specifically about the attitudes of staff. Eleven family members or young people told us that they felt that the service was not adapted to meet the individual needs of their families.
- A recent friends and family test for staff (quarter 1 2015-2016) reported that 84% of staff would recommend the trust as a place to receive care. This was higher than the national average of 79%; The result of the friends and family test for patients in quarter 3 of 2015-2016 showed that 92% of respondents would recommend the trust as a place to receive care. This was higher than the national average of 86%. Eighty three

per cent of patients said they were extremely likely to recommend the trust to others. The trust received an overall score of 3.5 stars out of four ratings on the NHS Choices website

- A trust report from May 2015 outlined the results of an experience of service questionnaire filled in by 1001 parents and young people over 2014 and 2015. Results showed that 98% of people felt listened to; 96% felt it was easy to talk about their concerns; 99% felt well treated; 91% felt they were working together with the clinician; and 84% would recommend the service to a friend.
- In the weeks leading up to the week of the inspection we collected feedback from 115 patients, parents, carers and staff using comment cards. Of these 115 comments cards, 111 gave positive feedback about the trust’s services.

#### The involvement of people in the care they receive

- Patients had mixed views about the level of involvement they had in their care. Some felt very involved and said decisions were jointly made with their therapist. A few felt that decisions were made for them, particularly when they had not been able to access the type of therapy they wanted to.
- The trust routinely collected feedback about services from patients, parents and carers. They collected this information in a range of different ways in order to capture feedback from all people using the services, including young children. Experience of service questionnaires were used by all services to gain feedback.
- In 2014-2015 experience of service questionnaires showed that 88% of patients felt involved in important decisions about their care and treatment. Eighty six per cent of patients said care options were discussed with them.
- A new provider had taken over the advocacy contracts for the trust in October 2015. They provided independent mental capacity advocacy, independent Mental Health Act advocacy, advocacy in relation to the Care Act and generic advocacy. However, the advocacy

## Are services caring?

provider told us they were disappointed not to have received any referrals from the trust. We did not see any publicity or information advertising the advocacy service at any of the trust premises or sites we visited during the inspection. Many staff were unaware of the service.

- The trust involved patients, families and carers in improving the Open Minded CAMHS teams through focus groups. It also held a competition involving patients, families, carers, staff and trust visitors to rename the Camden CAMHS. The name 'Open Minded' was chosen. The Open Minded CAMHS south team held a 'feedback fete' which included a visual straw poll for younger children who were asked "does coming here help?" Eighty four children responded to the straw poll with 61% of them saying yes, coming here does help, 15% said no it did not. The service also displayed a comments box for private comments and put up brick wall wallpaper for young people to stick comments about the service. Fifty two private comments were received and a range of comments were stuck to the wall. As a result of the 'feedback fete' the patient and public involvement team produced a 'you said, we did' poster campaign. This identified the action taken in response to the comments received.
- The adult reference group met on a monthly basis and provided an opportunity for patients, people from the local community and former patients to meet. The group was recently asked to provide ideas to improve the waiting room environment at the Tavistock Centre. In the last six months, the group had run a successful film night group. This event provided a space for discussion about different topics including popular media articles, mental health issues and an informal space to chat with peers.
- The gender identity development service had a stakeholder reference group that included young people. The group met three times a year in London. There were plans to set up a similar group based in Leeds. The service also held 'family days' twice a year. These days were opportunities for young people, their main carers and siblings to meet separately and discuss issues, which had arisen, access support and meet each other. Families were positive about these family days.
- However, overall many care records in all services lacked evidence of patients' involvement in their care and treatment.

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

## Summary of findings

### Our findings

#### Service planning

- The trust understood the diverse needs of the local population and planned some services to meet those needs. Staff worked in partnership with other agencies in the delivery of local services. The trust provided services aimed at meeting the needs of refugee and asylum seeker communities.

#### Access and discharge

- The trust focussed on achieving waiting time targets from referral to assessment. There were few breaches of these targets. In the specialist community child and adolescent services the target for waiting times between initial referral and assessment was 11 weeks and all services were meeting this target. Children and young people waited between five and eight weeks to be assessed in the services we visited. In the specialist psychological therapy services most teams were also achieving the 11 week target. For example, the waiting time from referral to assessment in the Portman clinic was 10 weeks. Breaches were rare in all teams except the primary care psychotherapy consultation service (PCPCS). There had been 19 patient waiting time breaches in the PCPCS in the previous four months. Breaches were caused by delays in receiving additional pre-assessment information from the referrer and waiting for patients to respond and agree an appointment. The service was taking action to reduce the number of breaches.
- Services did not have set targets on waiting times from assessment to treatment. These waiting times were quite long in some services. For example, in the Fitzjohn's unit average waiting times from assessment to treatment was 13.6 weeks in quarter 1 of 2015-2016 and five weeks in quarter 2. In the PCPCS the average waiting time from assessment to treatment in quarter 2 was 23

weeks. The service had experienced an increase in referrals as GPs had become increasingly aware of the service. Where waiting times were long services focussed on managing waiting lists safely. In order to support patients on the waiting list they were seen and reviewed by therapists regularly while they waited for treatment.

- In the gender identity development service there had been an average of 50% increase in referrals each year since 2009. For example, in 2012-2013 there were 314 referrals, in 2013-2014 468 referrals and in 2014-2015, 697 referrals. In 2015, the current 18 week target between referral and assessment had been breached 156 times. These breaches all occurred in the London service. There had been no breaches of the target in the Leeds service. The average waiting time to be seen in the service was 17.4 weeks in quarter 1 of 2015-2016, 15.4 weeks in quarter 2, and 16.5 weeks in quarter 3. The service was part of the NHS England commissioned 'task and finish' group, which was currently reviewing the pathways for gender identity services across England. The service had good links with NHS England specialist commissioners, the lead commissioners.
- Many services took a flexible approach to referrals. Most services accepted urgent referrals. Young people were able to self-refer to the community child and adolescent mental health teams and a clinician would carry out a telephone screening. Open Minded CAMHS south also offered assessments to young people who walked in to the service on the day. The gender identity development service accepted referrals from child and adolescent mental health services nationally, GPs, schools and user-led groups. The service had made a specific decision not to restrict referrals to those already engaged with a local child and adolescent mental health service as it may have led to a further delay in them accessing treatment.
- Children and young people could be seen in school if they preferred. Staff in many services offered appointment times that suited the patient. At the adolescent and young adult service, staff offered 20% of appointments in the early morning and after 5pm in order to be more flexible.



# Are services responsive to people's needs?

- The refugee service had done work to engage with 'hard to reach' communities and families. The team had recruited specific staff with knowledge and experience of the local communities. The refugee service manager had written an article for a national newspaper in November 2015 about the mental health problems of refugees and the support they needed.
- The chief executive and board were aware of the waiting lists in the gender identity development service and in the PCPCS.
- In 2014-15 experience of service questionnaires completed by patients showed that 80% were satisfied with how quickly they were seen; 80% said appointments were usually at a convenient time; and 83% said it was easy to get to the place where they had their treatment.
- The trust took a proactive approach to reducing the numbers of patients that did not attend appointments. The did not attend (DNA) procedure had been recently revised. In the adolescent and young adult service, for example, staff telephoned patients and sent appointment reminders by text. In quarter 3 of 2015-2016 the adolescent and young people's service had a DNA rate of 16% and PCPCS had a DNA rate of 12%. The trust target for DNAs was 11%.

## The facilities promote recovery, comfort, dignity and confidentiality

- There were sufficient rooms available for individual and group therapy appointments. Therapy rooms included a couch and comfortable seating and the rooms were adequately sound proofed. The main waiting area at the Tavistock Centre was situated on the ground floor and patients would make the reception staff aware that they were attending an appointment. Waiting rooms for young people and adolescents across both sites were bright, colourful and spacious and had developmentally appropriate magazines available to read. All communal areas had artwork on the walls.
- In the London gender identity development service rooms had visual aids including child friendly pictures, which helped to illustrate and explain feelings and gender dysphoria, including for those young people

who identified as non-binary. This helped to put young people at ease. In the Leeds service, there was a dedicated waiting room area, which was decorated with pictures and drawings by young people.

- There was a range of information available about the services, the trust and local support groups in the waiting room areas of all services. However, there were no leaflets in accessible formats for younger children or for young people with learning disabilities.
- The trust website provided clear information about each service and provided links to other websites that young people and families may find useful as well as information on self-referral.

## Meeting the needs of all people who use the services

- The trust had carried out a detailed analysis of the race and ethnicity of people using its services compared with those in the local population. The trust has established that Black African and Asian patients were under-represented in the patient population compared with the general population. Black Africans were more significantly under-represented in several services while Black Caribbean people were sometimes over-represented. Asian people were significantly under-represented in all services, although the proportion in Camden child and adolescent mental health services was higher. The trust had started a number of initiatives to make its services more accessible to minority communities and groups considered 'hard to reach'. These included the development of the child and family refugee service. The trust had made links with local religious groups including Orthodox Jewish and Muslim groups.
- The trust collected information on the ethnicity of patients accessing talking therapies. Results from 2015 showed that in July 36% of patients were from black and minority ethnic backgrounds, in August this was 32% and in September 34%. These figures reflected the trust's provision of particular services for black and minority ethnic communities.
- The City and Hackney primary care psychotherapy consultation service had set up specific projects to cater for 'hard to reach' or black and minority ethnic groups. They included a horticultural therapy group for Turkish

# Are services responsive to people's needs?

speakers and a community photography group. The aim was to develop therapeutic interventions tailored to the needs of those less likely to engage with more 'traditional' psychotherapeutic approaches.

- The trust had sought to address perceptions that homophobia was inherent in traditional psycho-analytic psychotherapeutic approaches. The trust was a Stonewall LGBT health champion. The trust recognised the high rates of mental health problems amongst LGBT people and had worked with Stonewall to provide training to staff on this issue. The trust had started to routinely ask patients about their sexual orientation in 2015-2016 in order to determine take up of services from LGBT people. Staff had developed links with a local LGBT youth club. They also offered a service for adoptive parents, including same sex couples. In order to promote an LGBT friendly environment for staff, students and patients posters had been put up around the trust, leaflets provided in the adolescent and young adult service waiting room, and children's books with stories containing different types of family had been placed in the children's waiting room.
- The 2014/2015 staff survey indicated that many staff felt they had not received equality and diversity training. However, the trust provided training on equalities and diversity to staff at the twice yearly in-service training days.
- The trust provided interpreters where patients needed one to enable them to access services. Administrators told us interpreters were usually easy to find. The trust provided information in a range of languages. Administrators sent initial appointment letters in English with a leaflet in a number of other common local languages offering further support for those who did not speak English well. The trust had staff who spoke other languages. Trust leaflets about CAMHS had information on the back about how to access these leaflets in 10 different languages.
- The Life Span service offered a dedicated service for people with learning disabilities and autism across all ages. The Life Span team manager was carrying out the green light audit, the self-assessment tool for services for people with a learning disability and this was due to be completed in January 2016. The previous review was in 2014, and confirmed that the trust met all the access requirements for people with a learning disability. The trust had introduced a picture based system to ensure that correspondence was written in ways that fit the communication needs of patients with a learning disability. Life Span was also continuing to work on a phone application to assist with therapeutic support for people. This was initially being tested with people with an autistic spectrum condition.
- A room, which was the designated clinic room at the Tavistock Centre, was also used as the multi-faith room for staff and patients. This meant people who were using the room for religious purposes could be disturbed and asked to leave if the room was needed for clinical or medical reasons. During the inspection, we saw this taking place and staff told us this happened frequently. The dual purpose and use of this room was not appropriate.
- The trust asked patients about their access requirements before first appointments and could offer appointments in wheelchair accessible buildings with toilet facilities that could be accessed by people with physical disabilities. The Tavistock Centre had two toilets with disabled access and a lift between floors. There was a single cubicle gender-neutral toilet on ground floor. There was an induction loop system for those with hearing problems. However, it was not possible for patients at the Portman clinic to access group therapy if they were unable to manage to climb steps. This did not provide fair access to group therapy for all Portman clinic patients.
- The gender identity development service was a national service. The Leeds-based team had allowed the service to provide a more local service to young people in the north of England. The service also provided a regular outreach clinic in Exeter, as well as local arrangements to use the offices of specific CAMHS teams in Bristol and Gloucester. However, some families raised concerns about the distance that they needed to travel to access the service. Funding for travel was provided for people who had low incomes but this could be a barrier to access for some people.

## Listening to and learning from concerns and complaints

- The trust displayed information on how to complain in services and on their website. People submitted formal complaints in writing by post or email, in person or via



# Are services responsive to people's needs?

the trust's website. If a person complained verbally, the complaints manager transcribed the complaint and sent this back to the person for confirmation before forwarding to the appropriate manager to investigate.

- The trust had a complaints policy that was due for review in April 2018. Staff received training on complaints during their induction. The trust aimed to acknowledge complaints within three days and send a final response within 25 working days. The trust did not have first or second stages in their complaints process. If complainants were dissatisfied with the trust's response, the trust referred them to the parliamentary and health service ombudsman. This was confirmed by the complaint response letters we reviewed.
- The service director was responsible for managing the complaint and investigation where required. Once the service completed the investigation report, the complaints manager compiled a response letter. The chief executive officer checked and signed this letter.
- People could contact the patient advice and liaison service (PALS) based at the Tavistock Centre in person, by phone or email for concerns, complaints and feedback, which were often at an informal level. The service provided support to people to make a complaint and to resolve their concerns. Staff gave patients a leaflet about PALS with their initial appointment letters. PALS completed quarterly and annual reports on complaints including case studies and statistics, which they sent to the clinical quality safety and governance lead and patient safety and clinical risk lead and reported to the board. From October to December 2015, PALS received 256 telephone and email contacts and 17 face to face contacts across all of the trust's services.
- The complaints manager completed quarterly reports on formal complaints including lessons learned that were included in the corporate governance and patient safety and risk compliance report provided to the executive management team. The trust shared quarterly complaints summaries on their website.
- The trust reported 20 complaints up to January 2016 for 2015-2016, with 14 of these being from the children, young people and family services. This was a 43% increase compared to 2013-2014 (14 complaints received). The trust upheld six and partly upheld four of the complaints in 2015-2016. None of the complaints were referred to the PHSO. The board meeting in November 2015 noted an underlying theme of poor communication and failure to address unrealistic expectations.
- Over the first three quarters of 2015-2016 96% of complaints had been acknowledged within three working days and 100% had been responded to within 25 days or an explanation for the delay was given.
- We reviewed 10 complaints files. The trust acknowledged eight of these within three days and responded to seven within the 25 working day timescale. The three that the trust responded to outside of the timescale were due to several organisations being involved, complex complaints and need to obtain consent. Where the trust did not complete one on time, they sent an interim letter to the complainant informing them of the delay. Response letters offered the complainant a meeting with a manager or director to discuss their concerns and provided information about the PHSO.
- However, not all of the complaint files were complete. Two of the files did not indicate the date when the trust closed the file. The trust closed four files that were not clear on the action plan, final outcomes, lessons learned, whether they upheld the complaint or if the complainant took their complaint to the PHSO. Two files stated that the team would develop an action plan, which was not included in the files. Two files contained action plans. However, the actions identified were not specific or measurable. The trust did not have a formal audit system in place to ensure staff had completed actions identified in complaints responses.
- Most patients, young people, parents and carers we spoke with knew how to make a complaint, although several did not. There was information on display about how to contact PALS for support in making a complaint, but there was little information available in waiting rooms for children and young people on how to complain.
- In the gender identity development service some parents felt they could not make a complaint because of concerns it would impact negatively on the care of their child. There was no evidence that this was the case or

## Are services responsive to people's needs?

that anyone who had made a complaint had been treated any differently. However, the need to address this issue proactively had not been recognised and acknowledged by the service.

- Staff in all the services were able to give examples of complaints, which had resulted in changes in the way a service was provided. However, it was not clear how learning from complaints was shared across all trust services.

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary of findings

### Our findings

#### Vision, values and strategy

- The trust mission and values had been developed following consultation with staff. The mission of the trust was: “to make a measurable difference through what we contribute to the health and wellbeing of individuals and communities and the value we offer our commissioners; to be the UK centre of thought leadership and research in the application of psychological and social theory and practice; to be a pioneer in the development and delivery of effective clinical interventions which improve the mental health and wellbeing of children, young people and adults; to be a national and international centre of excellence for training and education; to be the champion of psychologically informed practice which improves the quality and efficiency of systems in the NHS and other sectors.”
- The trust values were: “we deliver education and training which meets the evolving needs of individuals and employers; we are outward facing, make an active contribution to the development of public policy work with others who share our values and can enable us to deliver our mission; we value all our staff and their wellbeing and foster leadership, innovation and personal accountability in our workforce.”
- Staff we spoke with, including some of the senior management team, could not always clearly explain the trust’s vision and values to us. However, their description of the values was not inconsistent with those stated by the trust.
- The board shared the vision for the organisation.
- The trust’s draft quality strategy was presented and discussed at the trust board meeting in January 2016.

The paper set out the trust’s clinical strategy for 2015-2017 in the context of the trust’s overall five year plan and two year strategic objectives to develop and extend clinical services.

- The trust had set its quality priorities for 2015/16 in the following areas: child and adolescent mental health service outcome monitoring programme; young people and adult service monitoring programme; access to clinical service and health care information for patients and public; patient and public involvement.
- The chair and non-executive members of the trust board visited different services, sat in on team meetings, and spoke with staff and patients on a regular basis. For example, at the trust board meeting in January 2016 the trust chair reported on his visit to the Fitzjohn’s service, Lyndhurst unit and the trauma unit. A non-executive director had visited the primary care psychotherapy consultation service. Services presented detailed reports to trust board annually. Staff reported that senior managers regularly visited services.
- The trust was beginning to develop clear strategies to underpin patient and public involvement initiatives, quality improvement and equalities and diversity. There were some excellent initiatives taking place in the trust but there was a risk to the sustainability of this work because underlying strategies were not yet embedded across the trust.

#### Good governance

- The trust had a clear system of governance in place. The trust board met monthly and received updates on quality and risk. Each clinical team or service provided a detailed report to the board every year. The report included information on performance, strategic direction, staffing, and risk and quality issues.
- The clinical quality, safety and governance committee (CQSG) reported to the board and provided assurance on the quality, safety and effectiveness of clinical services. The CQSG had four work streams: patient



## Are services well-led?

safety and clinical risk; corporate governance and risk; clinical quality and patient experience; and information governance. The CQSG reported to the trust board every quarter.

- The trust had appointed new governors in April 2015. The governors were positive about their experiences of working with the trust. They felt supported, involved, and encouraged to challenge agenda items during meetings. The trust invited governors to visit services and join trust committees, such as media, equalities and clinical quality, safety and governance. The governors attended the board of director's meeting on rotation as observers and received the meeting minutes.
- The system of governance supported the delivery of care and the small size of the organisation helped with communication from the board to the services and teams and vice versa. The trust had a good track record on safety. There had been very few serious incidents. Root cause analyses were carried out and shared with the trust board.
- Staff understood safeguarding children and vulnerable adults procedures and implemented them appropriately.
- Staff were up to date with mandatory training. They had received an annual performance appraisal and were receiving regular individual and/or group supervision. There were many opportunities for staff to develop their professional skills and expertise.
- There were few staff vacancies and the trust had little difficulty recruiting well-qualified and enthusiastic staff. There were high levels of staff satisfaction, low levels of sickness absence and low staff turnover.
- Services were developed in response to the needs of the local community, including black and minority ethnic and refugee communities. The trust worked well with partners to deliver a range of innovative and high quality services. Staff managed resources well.
- Staff in many services actively participated in clinical audits. However, the chief executive and other senior managers acknowledged that the audit programme was not well co-ordinated or clearly linked to the objectives of the trust. Plans were in place to improve this.
- The chair was very new to the organisation and had chaired only one trust board meeting prior to the week of the inspection. However, he was well-informed about the challenges facing the trust including difficulties implementing the electronic patient records system, long waiting times for treatment in some services, a lack of focus on patients' physical health and the need for a more systematic approach to quality improvement. He felt the board was strong and the non-executive directors were able to understand data presented to them and challenge effectively where needed.
- Senior trust managers and board members were knowledgeable about trust services and aware of the key challenges facing the trust and areas of concern. There was recognition that some clinicians and teams had struggled to implement the electronic patient records system. Recording issues had been identified and mostly rectified but there was significant resistance to using the new system in some services.
- The trust was aiming to develop clinical dashboards at a service level so that managers and teams could see their own performance and use the data to improve care. However, the accuracy of the clinical dashboards was reliant on the effective and consistent use of the electronic patient record system. The lack of confidence in the quality of data produced impacted on the development of effective performance and management information and was therefore not driving quality improvement as well as it should.
- The trust had a risk register. This was reviewed by the board and at directorate level. Directors were able to add risks to the register. Directors gave us examples of risks they had added to the register and raised with the board. However, below this level it was less clear how staff and services contributed to the risk register. There were no risk registers held at service or team level. A system had been introduced to allow staff to submit service level risks to the trust risk register but this was not well-known by staff. As a result it was not clear that all emerging risks at a team or service level were captured effectively on the trust risk register and brought to the attention of the board.
- The board assurance framework identified the key risks that could prevent the trust from achieving its strategic objectives. The framework identified the controls in place to address each risk identified, any gaps in controls and action plans in response to the gaps.

# Are services well-led?

## Fit and proper persons test

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of health service bodies are fit and proper persons to carry out the role.
- The trust did not have a specific policy for FPPR. The board had ratified fit and proper persons action plans in July 2015. The trust extended their FPPR to include non-board directors such as the director of governance and facilities, the commercial director and director of human resources. The trust used a FPPR checklist for new appointments to ensure the necessary checks were completed.
- We reviewed the personal files of seven directors on the trust board. Three were non-executive directors and four were executive directors. All the files contained evidence of completed appropriate checks including disclosure and barring service checks, occupational health checks, employment references, identification and right to work, insolvency and bankruptcy checks and professional registration, where required.
- All the contracts of current directors had been amended to reflect the requirement for them to be compliant with the FPP test. Directors were required to make an annual declaration of their fitness in respect of the regulation.
- The trust had updated appraisal documentation for directors to highlight questions for the FPP test.

## Leadership and culture

- We met with staff in focus groups as well as those staff working in the services we visited. All staff were extremely positive and passionate about working for the trust and felt valued and supported by their teams and managers. Staff were proud of the innovative work of the trust with 'hard-to-reach' groups of people. Staff said they valued the opportunities available for training and professional development. The trust had been named as one of the Health Service Journal's top 120 NHS employers in 2014 and again in 2015.
- Staff felt the trust had an open culture and were comfortable raising issues and concerns, although some staff acknowledged that it could be difficult to speak up within a small organisation. Several senior staff told us

the trust had a culture of 'wanting to improve'. A local Healthwatch described the trust as open and easy to approach. The trust was very open to feedback throughout the inspection.

- The trust had recently appointed a freedom to speak up (FTSU) guardian. FTSU guardians help raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. The trust FTSU guardian had made links with guardians at other London trusts in order to share good practice. Information explaining the role of the FTSU guardian and their role had been sent with staff pay slips. The guardian had links to the trust board via a non-executive director. The guardian was due to take a paper on their work to the trust board meeting in March 2016.
- The national staff survey which took place between October and December 2013 and a confidential CAMHS survey undertaken in September 2014 identified some issues regarding bullying and harassment in the trust. An action plan to address these issues was brought to the trust Board meeting in November 2014. Actions included raising awareness of reporting concerns including bullying and harassment. This had been done in both in-service training and induction events with effect from 1 January 2015. The raising concerns and whistleblowing procedure was reviewed in February 2015 and included the process for raising concerns. In the 2014 national staff survey, the trust's scores in relation to bullying and harassment were significantly lower than the national average for mental health trusts. The trust had monitored this and conducted a pilot staff survey in the child and adolescent service, which did not identify any on-going issues. There was an externally provided bullying and harassment helpline for staff. We found no evidence of bullying or harassment during this inspection in any trust services.
- The trust had put in place initiatives to promote staff wellbeing including yoga classes, massage and mindfulness training. It was hoped this would help increase staff resilience and help them manage stress and the pressures of work more effectively. The trust had a staff advice and consultation service. Staff could

## Are services well-led?

self-refer to the service and access three sessions of counselling. The trust was challenging mental health stigma in the workplace and supported staff with mental health problems to remain in employment.

- The trust scored in the best 20% of trusts nationally against a number of areas of the annual staff survey including: the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; the percentage agreeing that their role makes a difference to patients; for effective team working; having well-structured appraisals; receiving support from immediate managers; a low number of staff witnessing potentially harmful errors, incidents or near misses; the percentage of staff feeling secure about raising concerns about unsafe clinical practice; very low numbers of staff experiencing physical violence from patients, relatives or the public; very low numbers of staff reporting experience of physical violence from staff in the last 12 months; and bullying or abuse from staff in the last 12 months. The trust also scored in the best 20% of trusts nationally in terms of the percentage of staff reporting good communication between senior management and staff, staff job satisfaction and staff motivation at work; and staff recommending the trust as a place to work or receive treatment. In quarter one of 2015-2016 79% of staff said they would recommend the trust as a place to work. This was better than England trust average of 63%. Similarly 84% of staff said they would recommend the trust as a place to receive care, which was better than the England trust average of 79%.
- The trust performed in the worst 20% of trusts nationally against the following findings: the percentage of staff receiving health and safety training in the last 12 months and the percentage of staff having equality and diversity training. However, we found during the inspection high levels of staff having completed this training.
- The chief executive of the trust had started a leadership development group involving the most senior managers in the organisation. The trust offered middle and senior management development training and practical human resources workshops for managers. It had also offered bespoke courses to middle managers on commercial matters and time management. The training linked to the personal development objectives of staff.
- The percentage of white staff believing that the organisation provided equal opportunities for career progression or promotion was 89% in both the 2014 and 2015 annual staff surveys. However, for black and minority ethnic (BME) staff 69% in 2014 and 61% in 2015 believed the organisation provided equal opportunities for career progression or promotion. This was lower than the national average for mental health trusts which was 75% for BME staff who believed their trust provided equal opportunities. The percentage of staff who had personally experienced discrimination at work from manager/team leader or other colleagues was 6% for white staff and 14% for BME staff in 2014. In 2015 6% of white staff and 5% of BME staff considered they had experienced discrimination at work. This was lower than the national average for mental health trusts, which was 13% for BME staff experiencing discrimination at work.
- The trust reviewed information about the staff it employed in terms of race and ethnicity. In order to increase the number of employees from black and minority ethnic communities the trust had held workshops for staff to raise awareness of unconscious bias. Unconscious bias refers to a bias that people are unaware of, and which happens outside of their control. It happens automatically and is influenced by people's background, cultural environment and personal experiences. The trust also planned to have an independent person sitting on all interview panels to reduce the possibility of bias affecting the recruitment of new staff.
- The trust had a five year plan and a set of objectives to be achieved over the next two years. A strategy to address equalities and diversity in the trust was being developed as one of these objectives.
- Trust policies underwent an equality impact assessment to make sure they did not disproportionately affect any particular group of staff or patients.
- Leaders were visible in the trust. Staff knew who the senior managers were.

### Engagement with the public and with people who use services

- The trust had a lead for patient and public involvement (PPI), clinical PPI leads and two full-time patient experience officers for the CAMHS and adult and forensic services. The trust's PPI strategy was included in



## Are services well-led?

their trust-wide two year objectives. The trust was working on embedding PPI into their practice across the organisation and produced annual PPI reports. In April 2015 a lived experience consultant completed a review of the trust's PPI and provided recommendations for improvement.

- Some of the PPI initiatives from 2014-15 included a visual straw poll in the reception area of the Tavistock Centre to get feedback from patients. The trust provided a comment book for patients to expand on their answers. The trust reported feedback to the board and stakeholders. A young people's pizza group for patients had been introduced to enable the young people to discuss their experiences of services. We visited the pizza group before the inspection and spoke with seven young people and a parent. The young people were positive about the group and liked the activities available. They liked being able to talk to other young people and feeling understood.
- The trust implemented a mystery shopper project to get feedback on the trust's telephone and email communications, website and visiting the Tavistock Centre.
- The trust gathered individual patient feedback through experience of service questionnaires. In 2014-2015 1047 completed questionnaires were returned. The majority of feedback was positive. For example, 96% of patients considered they had been treated well by the people who saw them; 92% felt that the help they had received was good; and 93% thought their views and worries were taken seriously.
- The trust involved patients and carers in their care and in service development and design. The trust had recently started involving patients in recruitment interview panels for new staff. Patients were offered honorary contacts to participate in this and were given training. During the course of the inspection we observed a training session for people who had volunteered for interview panels. The training was thorough and included discussion of equalities and diversity and not making assumptions about candidates based on personal characteristics.

### Quality improvement, innovation and sustainability

- The trust launched 'demonstrating quality' in February 2015, a trust-wide campaign designed to focus attention on providing evidence of quality and quality improvement across all services. The aims of the 'demonstrating quality' campaign were: to put the quality agenda at the forefront of all trust activities; to encourage staff to take personal responsibility in supporting and implementing this approach; to start an honest and open dialogue within the organisation on best practice and service improvement plus acknowledging issues and areas for improvement; to actively encourage participation and involvement from patients and wider stakeholders.
- The trust participated in national audits such as the greenlight toolkit and national audit of psychological therapies and acted on the findings. Learning from audits was shared with teams in order to bring about improvements in service delivery. The trust was aiming to benchmark its psychological therapy services against those of a local mental health trust.
- The trust collaborated with others in developing a research and evidence base for psychological interventions. The trust was involved in research in a number of areas such as the use of video feedback as an intervention with children under six years of age and their parents or carers and the use of evidence based interventions in children with conduct disorders who did not respond to conventional treatment. The trust had made links with international academics involved in research into medically unexplained symptoms which was a key focus of the City and Hackney primary care psychotherapy consultation service (PCPCS). The gender identity development service was committed to research and developing an evidence base for its work. Processes were in place to disseminate research, which took place within the service and relevant international research within the field. The service linked with other organisations and academics internationally.
- The PCPCS was named as the British Medical Journal mental health team of the year in 2015. The set up specific projects to cater for 'hard to reach' or black and minority ethnic groups. Projects included a horticultural therapy group for Turkish speakers and a

## Are services well-led?

community photography group. The aim was to develop therapeutic interventions tailored to the needs of those less likely to engage with more 'traditional' psychotherapeutic approaches.

- Senior trust staff acknowledged that while the trust was committed to quality improvement and had developed and introduced a number of highly innovative services, there was a lack of a clear approach and systems to support systematic quality improvement throughout

the trust. There had not been a clear focus on improving current services and outcomes. The trust understood the need to obtain reliable performance data to underpin quality improvement and was working towards this. Until this was achieved there was a risk to the sustainability of quality improvement and the trust's innovative and creative approaches to service delivery and development.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way.</p> <p>The trust had not ensured that all patients had a comprehensive risk assessment and a risk management plan demonstrating how risks would be managed.</p> <p>The trust had not ensured that adults had a separate waiting area from young adults and children at the Portman clinic. Potential risks to young adults and children were not sufficiently mitigated.</p> <p>Individual plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be found easily in a crisis.</p> <p>This was a breach of regulation 12(1)(2)(a)(b)(d).</p>