The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 30th November 2021

Please refer to the agenda for timings.

Meeting held online

The Tavistock and Portman
NHS Foundation Trust

AGENDA Part 1

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 30th November 2.00pm – 4.25pm
Tavistock Centre, Seminar Room 1, 2 & 3

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Draft Minutes of the meeting held on 28 September 2021	Chair		1
1.4	Action log and matters arising	Chair		
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.15pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	3
2.4	Quality report and dashboard Q2	Medical Director/Director of Quality	2.40pm	4
3. Items for discussion				
3.1	Gender Identity Clinic (GIC) Transformation Programme	Divisional Director GIC	2.50pm	5
3.2	Gender Identity Development Service (GIDS) Transformation Programme	Divisional Director Gender Services	3.00pm	6
3.3	Strategic Review	Chief Executive	3.10pm	7 - late
3.4	Trust Priorities to March 2022	Chief Executive	3.20pm	8
4. Items for approval				
4.1	Race External Review Update	Interim Director of HR	3.30pm	9
5. Items for noting				
5.1	Board Assurance Framework (BAF)	Chief Executive	3.40pm	10
5.2	Guardian of Safer Working Hours Q2	Medical Director/Director of Quality	3.50pm	11
5.3	Serious Incidents Report Q2	Medical Director/Director of Quality	4.00pm	12

6. Board Committee Reports				
6.1	Audit Committee	Committee Chair	4.10pm	14
6.2	Education & Training Committee	Committee Chair	4.15pm	15
6.3	Integrated Governance Committee	Committee Chair	4.20pm	16 - late
7. Any other matters				
7.1	Any other business	All	4.25pm	
8. Date, time and venue of Next Meeting				
	29th January 2022, 2.00 – 5.00pm, online/venue to be confirmed			

Board of Directors Meeting Minutes (Part 1)
28th September 2021, 2.00pm-4.35pm, via Zoom

Present:			
Paul Burstow Chair	Dinesh Bhugra Non-Executive Director	Chris Caldwell Director of Nursing	Deborah Colson Non-Executive Director
Helen Farrow Non-Executive Director	Sally Hodges Clinical Chief Operating Officer	David Holt Senior Independent Director	Rachel James Divisional Director CYAF
Paul Jenkins Chief Executive	Terry Noys Deputy Chief Executive / Finance Director	Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Shalini Sequeira Associate Non-Executive Director
Dinesh Sinha Medical and Quality Director	Ailsa Swarbrick Director of Gender Services		
Attendees:			
Sarah Boulton Observer Office of Modern Governance	Kathy Elliott Governor - Stakeholder	Fiona Fernandes Business Manager Corporate Governance	Moosa Patel Observer Office of Modern Governance
Helen Robinson Interim Director of Corporate Governance	Juliet Singer Governor - Public	Gloria Taplin Business Manager Corporate Governance	Ian Tegerdine Interim Director of HR
Laure Thomas Director of Marketing and Communications			
Apologies:			
Tim Kent, Divisional Director AFS David Levenson, Non-Executive Director Freda McEwen, Governor Public			

Action Log

AP	Item	Action to be taken	Resp	By
27 July 2021				
1.	3.1.2	Amendments to the minutes of the meeting held 27 July 2021 (NHS E/I is a group not a panel)	FF	Immed
2.	5.1.2	There is a significant gap between the current risk rating and the target risk rating in the Board Assurance Framework Requested a debate at a subsequent Board meeting to look at this issue and the extent to which the Board was comfortable with this gap.(27 July 2021)	PJ / TN	TBC
28 September 2021				
1.	2.2.4	Education and Training Committee to report back to the Board with appropriate consideration and assurance around the impact that some of the constraints highlighted in 2.2.3 might have on our educational delivery	BR / DL	TBC
2.	2.3.2	Board Education and Training Committee: deep dive into the interaction between our training activity and our service delivery with regards to the child psychotherapy trainees cost deficit	BR / DL	TBC

3.	3.1.3.4	Share draft GIDS Workforce Strategy with the Board	AS	Immed
4.	3.1.3.4	Present to the Board a report on the wellbeing of staff in particular GIDS	AS	TBC
5.	4.1.8	Investigate and advise on options for delivering Unconscious Bias training for the Board	IJT	
6.	4.1.9	That the options are considered for providing additional support, coaching or otherwise to support Board members in leading the organisation to become anti-racist organisation in practice.	PJ	TBC
7.	6.1.1	EDI Committee Minutes from the September meeting to be circulated to the Board	IJT	asap
8.	6.1.2	Create a process flow chart to map out the internal complaints process	PJ / AH	Jan 22
9.	6.2.4	A detailed report on FOIs to better understand the pressure and resourcing implications and how we mitigate the risks to be brought to a board meeting	FF / DS	Jan 22

1. Administrative matters

1.1 Welcome and apologies

1.1.1 Prof. Burstow welcomed all of those present. Apologies were noted, as above.

1.1.2 It was noted that there would be a slight change in the order of the agenda related to 3.1 GIDS current developments.

1.2 Declarations of interest

1.2.1 No declarations of interest were declared.

1.3 Minutes of the previous meeting

1.3.1 The draft minutes of the 27 July 2021 were approved as an accurate record, subject to amendments **[AP1]**.

1.4 Matters arising and action points

1.4.1 Mr. Holt indicated that he had thought that there was an action associated with 5.1.2 related to his comment on the large number of risks where there was a significant gap between the current risk rating and the target risk rating. He requested a discussion at a subsequent Board meeting on this issue **[AP2]**.

1.4.2 Outstanding issue – the Operational Risk Register had not been discussed due to the need for this to be updated. Mr. Jenkins advised that the updated version would be circulating this to the Board later today.

1.4.3 All the actions were noted as completed.

2. Operational items

2.1 Chair and Non-Executives' reports

2.1.1 Prof. Burstow referred to the retirement from the Board of Prof.. Dinesh Bhugra on 31st October 2021 at the end of his term of office and advised that an external

recruitment process to appointment two new non-executive directors had now concluded. Approval was awaited from the Council of Governors related to the recommendations arising from this process. As a consequence of Prof Bhugra's departure, a new Vice Chair was required to take up matters in the Chair's absence. Prof. Burstow expressed his pleasure that Dr. Debbie Coulson had agreed to undertake this role and as the Vice Chair of the Board and formal proposed this appointment with effect from 1st November 2021.

RESOLVED:

That Dr. Colson be appointed as Vice Chair with effect from 1st November 2021.

2.2 Chief Executive's report

2.2.1 Mr. Jenkins presented the report and indicated that the majority of items mentioned in the report were being discussed as separate items on the agenda.

2.2.2 Mr. Holt queried whether, if the Board did meet face-to-face over the next few weeks if it would be possible to arrange for a nurse to provide the 'flu vaccination on such an occasion to encourage staff to be vaccinated.

2.2.3 Mr. Holt also raised the issue of face-to-face lectures and the direction we are taking and whether this was aligned or not with other higher education institutions? In response, Mr. Rock advised that he did not think we are out of step with the other institutions, but that there were quite a few significant differences, including the absence of a large campus that would allow us some flexibility and the existence of a different student group. We are planning and considering how we move from the current position to having more of our provision delivered in person. For the next term in the new academic year, work had been undertaken with course leads to identify those educational activities for which students could return on site. We are engaged in considering not just how we return back to pre-pandemic ways of working, operating, learning and teaching but how to build on the experience of variable delivery models. Opinions were being sought from both new and continuing students to enable greater flexibility in the provision.

2.2.4 The issue of the Board receiving assurances around the impact that some of these constraints might have on the Trust was questioned by Mr. Holt and in particular the role of the Education and Training Committee of the Board. He requested that the Committee be requested to report back to the Board with appropriate consideration of the matter and assurance **[AP1]**.

2.2.5 The plans for the Board and its Committees to return to face-to-face meetings was discussed. Mr. Jenkins advised that the view is that we need to start having our Board meetings in person from November but that this does not necessarily apply to Board committees for which it may be more advantageous to operate virtually. The main issue for in person meetings was the provision of an appropriate venue satisfying Covid constraints.

2.2.6 The Board of Directors noted the report.

2.3 Finance and performance report

2.3.1 Mr. Noys presented the report for the five months ended August 2021. This showed the Trust recording a net deficit for the period of £1.8m, against the NCL ICS Plan figure of £1.3m. The negative variance against Plan reflected Staffing costs being £401k higher than Plan and non-pay costs being £215k higher than Plan. The variance on staffing costs primarily reflected higher than Plan / Budget costs for Child Psychotherapy Trainees (£279k) and GIDS CQC Recovery Programme costs (£114k). The variance on non-pay costs reflected unbudgeted legal costs related to employment tribunals and the Judicial Review. Both legal costs and GIDS CQC Recovery Programme costs were anticipated to increase further over the coming months.

2.3.2 The deficit related to the child psychotherapy trainees was discussed and the non-reimbursement for the full cost of these trainees. The benefits from trainees undertaking clinical work which generates an income was recognised. The ongoing Strategic Review had considered this issue his but had not yet concluded if this was a positive or negative impact financially. It is also in relation to the value and benefit that goes beyond financial and also the gap between training fees we are funded for and the salary costs which also changes as the trainees progress in their training. Health Education are currently retendering for this provision and we are actively engaged in that process and utilising the insights that are coming from the strategic review to inform our response to the retendering. It would be helpful to have a deep dive into the interaction between our training activity and our service delivery which seems to be the main issue of this concern at the education and training committee **[AP2]**.

2.3.3 With regard to the NCL ICS Plan figure which included a higher level of vacancy factor than the Trust had included in its draft Budget, Mr. Noys explained that this was a presentational issue. The expectation from the NHSEI was for all FTs to achieve break even in 2022/23, and for 2021/22 to aspire to break even and to make efficiencies in the second half of the year.

2.3.4 The Board of Directors noted the report.

3. Items for discussion

3.1 GIDS Current Developments (Transformation Programme)

3.1.1 The outcome of the appeal judgement from the Judicial Review which upheld the Trust's appeal in full was welcomed. This was an important milestone and justified the Board decision to appeal. It had been helpful to have the most senior judges in the Court of Appeal clearly define the legal position.
At the heart of the Judges reasoning had been the legal arguments around Gillick and the lack of rationale for treating this area of care differently from a whole range of other complex interventions encountered by young people. It did not deny the complexity or contentiousness of this area of work or deny the issues of the need to strengthen and improve our transparency about our decision making or other aspects of our practice. The important recognition of the legitimacy of the clinical practice and the bodies that regulate and manage that clinical practice was highlighted. A small financial benefit was noted in

relation to the level of costs that had been awarded against us in the original JR and a small compensatory payment to us as a result of this appeal; however there were further legal costs as well as other costs associated with the ongoing work in GIDS.

3.1.2 Ms. Swarbrick commented that this judgement reminds us of the complexity, challenge and level of public and other interest in this area of work. She paid tribute to the hard work of staff in GIDS and to patients- for whom there was a great deal of ongoing uncertainty- and reiterated the GIDS commitment to high quality and safe care as the focus of the transformation programme.

3.1.3 The three broad areas of change were categorised as:-

3.1.3.1 Clinical practice and governance and safety following the CQC report and accommodating the findings from the first judicial review and following the appeal;

3.1.3.2 The waiting list and work to increase the capacity of the service and address demands. Validation of the waiting list, work with NHS England to support the best setup for a referral management service and a regional professional support service coming in the Autumn. Granular work within the team to look at the longest wait every week to see if we can move those patients to be seen and having first assessments. Capacity management-ensuring we are seeing patients appropriately and that they are being taken through the service in an effective way. Clear structured clinical pathways to plan this work carefully.

3.1.3.3 Workforce where real capacity challenges exist. Working in a service that is under enormous pressure is challenging on its own and then the rate of change and the new work being introduced adds to those pressures. Attention being given to retention and recruitment; wellbeing and skills development and learning. This is all underpinned by strengthening governance arrangements within the service.

In discussion the following points were raised:-

3.1.3.4 Mr. Jenkins commented that these changes would take a long time to have their full impact and noted the ongoing risks of workforce and the waiting list. It was acknowledged that there was a need to align with the travel of the strategic review. The changes in the timeframe for the strategic review would improve this alignment. A draft strategy document had been considered by the GIDS oversight committee which Ms. Swarbrick would circulate to the Board **[AP3]**.

Staff wellbeing was an ongoing challenge and reflection sessions for staff and access to individual counselling through the service the Trust uses having been put in place. Improving internal communications was ongoing. Wellbeing is one of the strategic objectives within the workforce strategy. Reward and recognition schemes for staff, and concrete pieces of work in our wait list action plan were relevant, particularly in relation to reducing the pressure through reviewing the case loads. It was requested that a report on the wellbeing of staff and how this is progressing be included in future reports to the Board. **[AP4]**.

Prof. Burstow highlighted the key risks to this programme of activity and indicated that it would be helpful for future reports to include escalation to the Board of those matters that are further exacerbating those risks.

Dr. Sinha welcomed the focus on wellbeing and emphasised the importance of avoiding having a cultural climate of blame or persecution both in the service and Trust- wide.

Prof. Bhugra queried how staff were mentored and how do we ensure that staff used their mentors? He suggested that a social attitude survey in conjunction with a charity might be commissioned to look at what people's views are on gender fluidity.

Mr. Jenkins highlighted one of the positive things to come out of this judicial review was an improved understanding of who owns this issue. Dr Hilary Cass, the appointed lead in an independent review into gender identity services for children and young people, was undertaking a lot of work around public engagement as part of this review. We have our own specific task on addressing challenges within our own services. While in the past, the Trust has played an active thought leadership role, he expressed the view that at this time the Trust needed to focus on our own services.

Prof. Burstow commented that this was a fair challenge and the expectation was that the commissioner would want to understand the essential attitudes that inform the environment that the service operates in-and that our commissioner should be invited to think about this in future discussions.

Ms. Colson requested additional information on the work around young people, supporting them and those that are on the waiting list and not yet receiving treatment? In response, Ms. Swarbrick advised that the Patient Engagement Group had been reinvigorated and was meeting monthly.

Ms. Caldwell commented that there was an opportunity for us to consider future needs as we restructure the organisation as part of the Strategic Review.

Prof. Burstow referenced the colleagues from OMG observing the meeting as part of the governance review which should aid us in ensuring that voices of any age, in particular young children, were heard at the Trust.

3.2 Safeguarding Review

3.2.1 Consideration of how to organise the responsibilities and arrangements for safeguarding as part of the strategic review recognising the importance of this issue across the organisation. A recent employment tribunal case relating to the handling of protected disclosures, and as a Board, we made a commitment for the organisation to learn lessons from this case including in relation to our assurance about the sufficiency and effectiveness of our current arrangements for safeguarding. This represented an opportunity to consider best practice and how we might aspire to improve.

3.2.2 Terms of Reference for an external review of safeguarding had been produced and potential reviewers who have the relevant skills and independence to carry out the review were being investigated, including seeking the advice of colleagues in NHS England. It was proposed that the review would encompass both adult and children and young people's safeguarding while ensuring sufficient granularity to address any specific issues in specific areas of practice and support the Board in reviewing the best future arrangements for safeguarding within the context of the Trust's Strategic Review and the changing structural landscape for health and social care in England.

3.2.3 In the terms of reference it was recommended that interviews be undertaken with key staff involved in safeguarding in the central team and clinical divisions and a wider survey of all staff was deemed appropriate. Ms. Caldwell would be leading the review and sourcing the provider.

RESOLVED: That the report be noted with the addition of a wider survey of all staff to be incorporated in the terms of reference.

4. Items for approval

4.1 Race External Review and Trust Response

4.1.1 At its last Board Seminar, the Board had received and explored the summary report and presentation from the 'Colour Brave Avengers', the organisation commissioned to undertake the independent review following a tender process. The report summarised the findings, recommendations, 'must do' actions and early actions and the draft Race Action Plan that had been produced by the review and suggests the next steps for action by the organisation.

4.1.2 The following eight recommendations of the Independent Review were highlighted:-

1. To ensure there is external accountability to complement the current governance framework and support for the implementation of the recommendations and action plan.
2. To revisit and update the vision for the Trust Race Equality Strategy and overall aim.
3. To set out between three and six clear race strategic objectives and explore how the Trust will engage all stakeholders in achieving them.
4. To make a clear statement from the board with a commitment to bold actions and sustainable change.
5. To undertake to adopt the ten 'Must' actions from the RACE Equality Assessment and report on their progress until achieved.
6. To ensure all race actions are included in the RACE Action Plan and then develop the accountability framework for its monitoring.
7. To publicly acknowledge to staff the findings of racial inclusion barriers, racist behaviours, and lack of diversity.
8. To provide support, training and guidance to the senior management and those responsible for following through on the day-to-day activities of the race action plan.

4.1.3 The Race Action Plan (RAP) brought all the key actions proposed by the review together and against the following seven action area themes:-

- Recruitment, Induction and Retention Actions
- Equality Diversity and Inclusion Actions
- Policy, Politics and Governance Actions
- Awareness, Education and Training Actions
- Information, Data Gathering and Publishing Actions
- Rewards, Recognition and Evaluation Actions
- Sponsoring, Support and Progression Actions

4.1.4 A number of early actions were to be progressed:-

- Quickly complete the root and branch review already underway of our 'employee dispute resolution' policies such as grievance, bully and harassment and freedom to speak up with a view to their race equality impact.
- Explore the development the informal dispute resolution processes and courageous conversations across all of our policy and procedures.
- Develop 'safe spaces' which are times and places where people can raise, discuss and report any issues relating to race and other protected characteristics in a confidential and supportive manner.
- Develop training and development for all staff on recognising and dealing with micro aggression related to race and other protected characteristics.
- Develop impactful training for HR staff and line managers to develop confidence in the appropriate management of employment issues relating to race and other protected characteristics.
- Undertake a review of recruitment processes using the 'debiasing' toolkit.

4.1.5 The need to revisit our Race Equality Strategy in order for the Race Action Plan to make sense was recognised.

4.1.6 The Race Action Plan would be discussed at every meeting of the Equality, Diversity and Inclusion (EDI) Board Committee and be formally reviewed by the Board every six months.

4.1.7 A post of Associate Director to lead on the EDI agenda and to consider, as part of the Strategic Review, the required resource investment.

4.1.8 Options to providing Unconscious Bias training for the board members should be considered. **[AP5]**.

4.1.9 Consider what additional support, coaching or otherwise we might need individually or collectively to support us in being allies in becoming an anti-racist organisation in practice **[AP6]**.

4.1.10 With regards to the reporting cycle, this needs to be visible at the Board at every meeting. We receive a report from the EDI Board sub-committee which needed to give a clear update on progress.

4.1.11 The Board of Directors noted the report and approved the recommendations.

5. Items for noting

5.1 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

5.1.1 The Workforce Race Equality Standard report presents the emerging data from the recent workforce race equality standard submission and sets out an analysis over a six year period. The report identifies that:-

- Little had changed in the organisation over the last six years in terms of the statistics and experience.
- The organisation was becoming more diverse, but only for the lowest banded roles.
- Access to continuing professional development for ethnic minorities' staff had decreased this year.
- Fairness in recruitment requires significant work if perceptions were to be improved.

5.1.2 Given the Trust's size, minor shifts in data can significantly change the position on diversity issues. Therefore, it was more important to review trends, rather than specific numbers.

5.1.3 Diversity had increased in the lower banded roles (bands 2-4). These roles are nonclinical roles, often in corporate services or clinical administrative positions. Band 8A was now the band with the highest disparity between white staff and ethnic minorities' staff.

5.1.4 It was more likely that white staff would enter a formal disciplinary process than ethnic minorities' staff who were less likely to access resources for training and development.

5.1.5 Those from ethnic minorities were significantly more likely to be appointed following shortlisting than white individuals. However, there was a perception of fairness amongst the minority staff even though the numbers indicated otherwise.

5.1.6 The Workforce Disability Equality Standard report presented the emerging data from the recent Workforce Disability Equality Standard data submission and sets out an analysis over a three year period.

The report identifies that:-

- Little has changed in the organisation over the last three years in terms of statistics and experience.
- Fairness in recruitment requires significant work if the perception were to be improved.
- Reasonable adjustments for disabled staff requires significant work to recover lost ground in relation to this metric.

5.1.7 Disabled applicants were more likely than non-disabled applicants to be appointed from shortlisting.

5.1.8 There was one metric which specifically related to disabled staff-*my organisation has made adequate adjustment to enable me to carry out work and has declined*

DRAFT

significantly in 2020. Through the Trust's disability and long-term health conditions staff network, there was evidence that, where disabled staff had to work from home, occasions of reluctance existed to provide the equipment required to allow disabled staff to work safely from home and this may have contributed to the poor response to this question.

5.1.9 The Trust had not used these reports as effectively as we could have over the years to inform our policy and development. Going forward the Trust will improve its use of this information to inform our equality, diversity and inclusion work.

5.1.10 The proposed target for the Board's approval as part of our race equality strategy refresh and plan would be representative of London ethnicity statistics.

6. Board committee reports

6.1 Equality, Diversity and Inclusion Committee

6.1.1 Prof. Bhugra advised that he was a member the Race and Health Observatories Academic Reference Group, established by the former NGS England CEO to collectively review information and research on race and health inequalities. The previous meeting had taken place on 8th September and Prof. Bhugra had requested that the summary of this meeting be presented to the Board at today's meeting, but due to a clerical issue, this had not been actioned. The information will be circulated to the Board. **[AP7]**.

6.1.2 There were three items highlighted:

- Mentoring was to be made more accessible and formal.
- Role of the Freedom to Speak Up Guardian to be strengthened including specifically complaints. The complaints process remained unclear to a lot of people, in particular to ethnic minority groups. The creation of a process flow chart was proposed to map out the internal complaints process **[AP8]**.
- The Freedom to Speak Up Guardian's work towards a national set of terms of reference and the focus on impact of service rather than on particular individuals.

6.1.3 The Board of Directors noted the report.

6.2 Integrated Governance Committee (IGC)

6.2.1 Dr. Sinha provided a verbal update highlighting the key topics:-

- CQC's activity, both in terms of our action plans and also on the expectation of being inspected as a well-led inspection. The IGC had discussed the implications and how to prepare the organisation.
- An update from the Operations Delivery Board concerning the work of aligning the Strategic Review with some of the changes already happening within GIDS and operationalising hybrid working more generally.

- GIDS Transformation Review – ta second Quality Summit that is due to take place next month and our relationship with NHSE/I in this context.
- Surrey Service which is a new service we are delivering with a collaborative and the recruitment has been challenging.
- Update from Data Security and Protection Sub-committee on problems around Freedom of Information Requests (FOIs) and in particular the number of Subject Access Requests (SARs). A number of these requests were gender based and we were struggling to turn these around as well as recent Information Commissioner's Office (ICO) reportable incidents and the implications of these on the Trust.
- Update from the Patient Safety and Clinical Risk Sub-Committee on learning events.
- The research update demonstrated how even in this unusual situation we had been able to complete recruitment for the Trust's Logic Project.
- Prof. Bhugra's commitment to governance had been acknowledged and thanks expressed for his contributions to the IGC.

6.2.2 Mr Noys reported recent communication from the ICO in respect of an information governance breach about 18 months ago. The ICO's investigation had not yet been completed but it was possible that that this would result in the Trust facing a fine.

6.2.3 The FOIs represented an operational challenge due to the defined response time. Grounds for refusal to respond to an FOI were very strict. The level of time and energy put in by services and staff in providing a response made it hard to manage the volume of FOIs received. The implications are reputational and operational exhaustion, as well as the possibility of complaints to the ICO if we do not respond in time which can result in penalties.

6.2.4 The Trust was seeking to fully comply with the Freedom of Information Legislation and therefore, a more detailed report would be submitted to the Board on compliance with FOI response times.**[AP9]**.

6.2.5 The Board of Directors noted the verbal report.

7. Any other matters

7.1.1 Prof. Burstow conveyed on behalf of the Trust appreciation and thanks for the service provided by Prof Bhugra to the Trust over the last seven years, including advocating and making a significant difference in mental health. He wished him well in his future endeavours.

7.1.2 The meeting closed at 4.35pm.

8. Date of next meeting

8.1 30th November 2021 at 2pm.

Report to	Date
Board of Directors	30th November 2021

Chief Executive's Report – Part 1

Executive Summary

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

Recommendation to the Board

Members of Board of directors are asked to discuss this paper.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Strategic Review

1.1 We are preparing for a key phase of work in relation to the Strategic Review including the completion of work on structures and financial forecasting ahead of the additional Part 2 Board meeting on 15th December.

2. Board Governance Review

2.1 The Office for Modern Governance has now completed its Board Governance Review. The Board is due to consider its findings at a Board Seminar on 7th December with the aim of agreeing final recommendations at its January 2022 meeting.

3. GIDS Transformation Programme

3.1 CQC held a second quality summit for GIDS on 18th October. This recognised the progress the Trust has made against its action plan and the steps we have taken to lay the foundations for delivering the improvements required by CQC. There was also a recognition of the measures which are beginning to be taken to develop the wider care pathway for this group of patients including the proposed launch of the Regional Professional Support Service.

3.2 It was agreed that a further Quality Summit will be held early in the New Year.

3.3 A more detailed report on progress against the Transformation Programme is tabled for alter in the agenda.

4. Covid19 Update

4.1 The Trust remains vigilant in managing its services and staff around the risk of Covid outbreaks as the incidence and prevalence of community infection has continued to rise. Colleagues will be aware of pressures on health systems from a combination of ongoing pandemic and elective activity, which has impacted both adult and children's pathways.

4.2 We continue to follow NCL wide IPC guidance including that relating to the wearing of masks, ongoing need for social distancing etc and there has been no change in processes since the last update.

4.3 For now, the Trust, its clinical services and all our staff and trainees have continued with a proportionate return to Trust premises. Our aim is to continue to deliver a higher proportion of face-to-face services for improved communication, working within teams, team building, offering patient choice, staff wellbeing, confirming future patterns of working in all our pathways etc. We are not seeking at this point to return to pre-pandemic patterns of work/ delivery.

4.4 DeT has continued with its hybrid model for educational services operating to a specific guidance, in line with the overall Trust IPC measures.

4.5 We continue to use some of our larger spaces for groups with the caveat of continuing IPC measures including in the use of common areas.

4.6 There remains a challenge in the divergence in the removal of virtually all community social restrictions, as versus the need for health care organisations to continue to adhere to IPC.

4.7 There continue to be concerted efforts to promote the highest possible rates of vaccination for Trust staff. The Trust has done additional communications to staff, including through a recent all staff meeting to ensure accurate knowledge of vaccination status, including take up of booster vaccination through the national programme.

4.8 This is particularly important as the Department of Health and Social Care has formally announced that individuals undertaking CQC regulated activities in England (all of our clinical work) must be fully vaccinated against Covid-19 no later than Friday 1 April 2022. This

measure aims to ensure patients and staff are protected against infection.

4.9 Health and social care workers, including volunteers who have face-to-face contact with service users, will need to provide evidence they have been fully vaccinated against COVID19 in order to be deployed. The regulations will apply to health and social care workers who have direct, face-to-face contact with people while providing care – such as doctors, nurses, dentists and domiciliary care workers, unless they are exempt. They will also apply to ancillary staff such as porters or receptionists who may have social contact with patients but are not directly involved in their care. There will be further updates to the organisation based on detailed implementation guidance, as received.

4.10 This means that staff must have their first dose by 3 February 2022, so that they can have their second dose before the April deadline.

4.11 We have implemented the winter flu vaccination programme and are working to ensure high take up of this vaccination due to the dual risks of flu and Covid19 this winter.

4.12 The Trust EPRR Gold group continues to meet fortnightly to take stock of the changing situation and modify communications to the Trust using a variety of methods including all staff briefings, communication messages etc.

5. Equalities

5.1 Work is underway to produce a refreshed Race Equality Strategy and Race Equality Action to address the recommendations made by the Colour Brave Avengers. The aim will be to complete this work by the end of the year to allow the Board to consider and agree the Strategy and Action Plan at its January meeting. A fuller report on progress is set out later in the agenda.

Paul Jenkins
Chief Executive
23rd November 2021

Report to	Date
Board of Directors	30 November 2021

Report on Finances

Executive Summary

This paper provides details of the Trust financial performance in the first half of the year and provides a forecast for the second half / full year.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Director
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REPORT ON FINANCES

1. INTRODUCTION

1.1. This paper provides details of the Trust financial performance in the first half of the year and provides a forecast for the second half / full year.

2. SUMMARY

£m	H1 Act	H2 F'Cast	Full Year F'Cast	Change
Income	30.3	29.5	59.8	-
Pay costs	(24.0)	(26.0)	(50.0)	(8)%
Non-pay costs	(7.4)	(8.9)	(16.2)	(20)%
Operating deficit	(1.1)	(5.4)	(6.5)	-
Other costs	(1.1)	(1.2)	(2.3)	-
Net deficit	(2.2)	(6.6)	(8.8)	-

2.1. For the first half of the year the Trust recorded a net deficit of £2.2m. This is slightly higher than the forecast deficit (of £1.8m) previously indicated to the Board.

2.2. For the second half the Trust is currently forecasting a deficit of £6.6m making for a full year forecast deficit of £8.8m. This compares with the 'Budget' figure – reported to the Board in March - of a deficit of £8.3m.

2.3. It is important to note that, at the time that this report was produced, the second half forecast had not been approved by the NCL ICS.

2.4. Based on the forecast, Trust cash reduces to £4.6m by the end of March 2022.

2.5. It should be noted that the current financial regime is a fluid one and that the forecast is subject to amendments (potentially significant ones) based on ICS direction.

3. INCOME

3.1. Clinical income – of £42m for the year - is based on the Trust's current understanding of its block grant from NHS Specialised Commissioning (£16m for the full year) and ICS-directed block grant income (£14m for the full year).

3.2. Together this block income (of £30m) accounts for 71% of total annual clinical income. The balance comes from a range of services such as FDAC, Gloucester House, City and Hackney etc.

3.3. Education and Training income – of £17.8m for the year - reflects HEE monies of around £9m (including NWSDU and child psychotherapist income), £1.5m for short courses and £6.4m for long courses (including OfS grant and Bursary funding).

3.4. The forecast assumes a reduction on second half income of £0.8m, being the claw back of COVID monies.

4. PAY COSTS

4.1. These are forecast at £50m for the full year, with second half spend increasing by £2m (8%) to £26m, compared with £24m in the first half.

5. NON-PAY COSTS (Excluding Depreciation, PDC and Interest)

5.1. These are forecast at £16.2m for the full year, with second half spend increasing by £1.5m (20%) to £8.8m, compared with £7.3m in the first half.

5.2. The increase is due, principally, to the reclassification of Relocation-related costs from capital to revenue expenditure, which reflects the fact that many of the costs incurred in the current year relate to work on the disposal of the Belsize Lane site and are not, therefore, deemed capable of being capitalised.

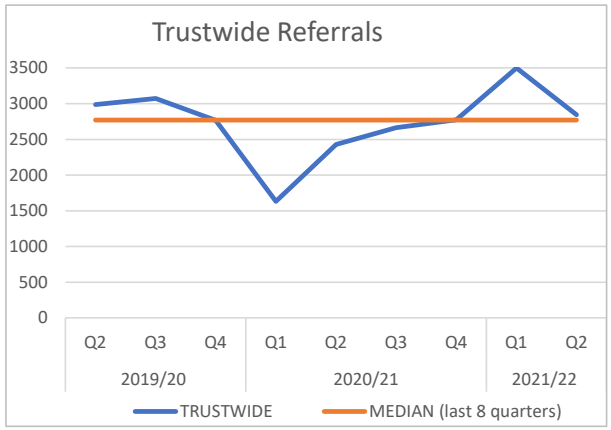
6. CASH FLOW

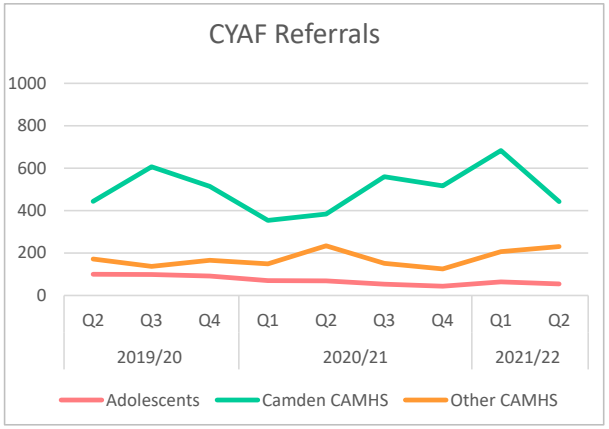
6.1. Based on the assumptions used within the Forecast, cash is forecast to reduce from the September position of £13.5m to £4.6m by the end of the financial year.

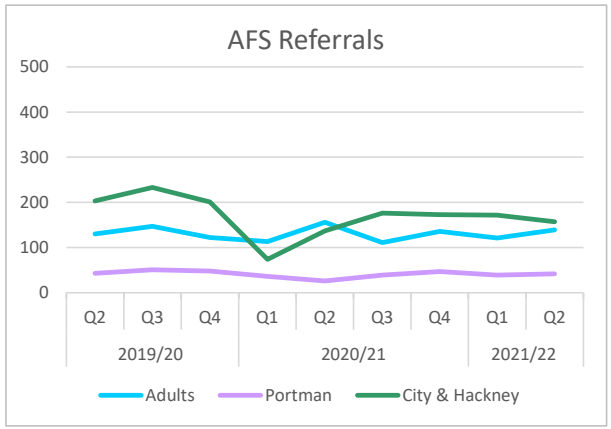
6.2. The actual position is likely to be better than that currently forecast but that does depend upon a number of factors, notably:

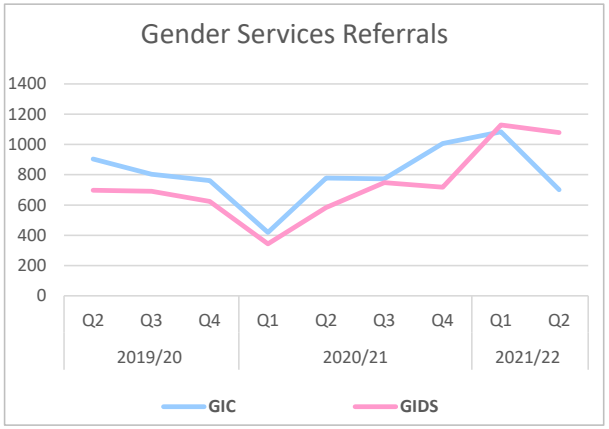
- Level of vacancies
- Redistribution of ICS funds
- Additional / unforecast spend on Strategic Review / GIDS Transformation / Legal costs
- Additional fourth quarter funding from Health Education England, NHS England and other bodies utilising year to date "underspend".

Q2 2021/22: Trust Reach – Access









Data source: Q2 data as recorded on 07/10/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous financial year data run on 14/06/2021. Q1 data run on 21/09/21. Other historical data as reported in relevant earlier reports.
Q2 data has been run without meeting the threshold on number of unoutcomed appointments.

Number of Referrals Received:

In the data below we include all referrals received over the last two years including accepted, rejected and pending. This data is Trust-wide and covers all contracts and all service lines.

Trust-wide, In Q2 the trust received 2845 referral, a decrease of 654 from Q1. So, a 19% decrease from Q1 but 20% above the quarterly average number of referrals received during last financial year, 2375.

Adolescents: in Q2 received 54 referrals, 10 fewer than in Q1. This quarter the service was 8% above the quarterly average number of referrals received during last financial year, 59.

Camden CAMHS: in Q2 received 443, 241 fewer than in Q1. This quarter the service was 2% under the quarterly average number of referrals received during last financial year, 454.

Other CAMHS: in Q2 received 230 referrals, 23 more than in Q1. This quarter the service was 39% above the quarterly average number of referrals received during last financial year, 165. Teams like FS and FDAC have a delay in recording referrals due to their nature, this affects Q1 figures after re-running data.

Adults Complex Needs: in Q2 received 139, 18 more than in Q1. This quarter the service was 8% above the quarterly average number of referrals received during last financial year, 129.

Portman: in Q2 received 42, 3 more than in Q1. This quarter the service was 14% above the quarterly average number of referrals received during last financial year, 37.

C&H PCPCS: in Q2 received 157, 15 fewer than in Q1. This quarter the service was 12% above the quarterly average number of referrals received during last financial year, 140.

GIDS: in Q2 received 1079, 49 fewer than in Q1. This quarter the service was 80% above the quarterly average number of referrals received during last financial year, 598.

GIC: in Q2 received 701, 383 fewer than in Q1. This quarter the service was 6% under the quarterly average number of referrals received during last financial year, 744. The service is experiencing a backlog of referrals and this affects the figures reported. There is a process in place to rectify this issue.

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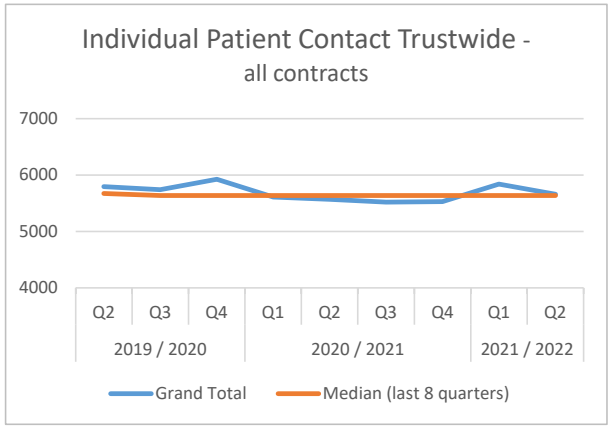
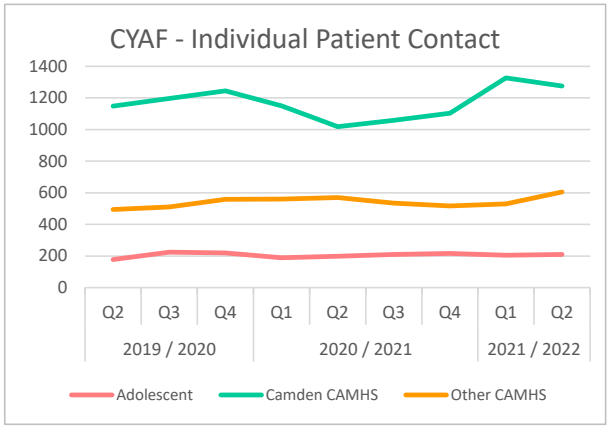
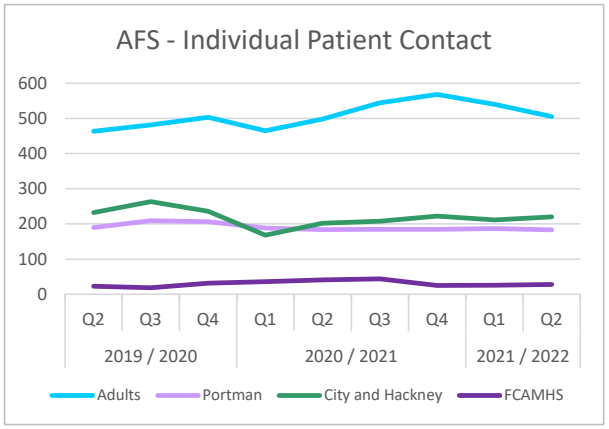
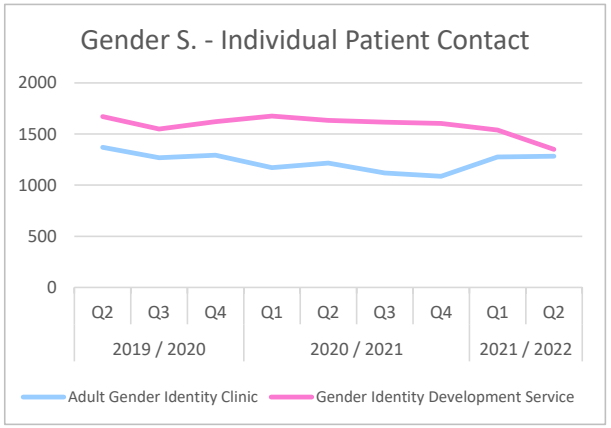
Q2 2021/22: Trust Reach – Access









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Individual patients in contact with our services

In the data below we include all individual patients, in all contracts, who have had contact with our service, excluding EIS and Mosaic. They are reported only once per quarter. Data includes face to face, telephone and zoom contacts.

Trust-wide, In Q2 the trust saw 5560 individual patients, a decrease of 179 patients from Q1. So, a 3% decrease from Q1 but 2% above the quarterly average individual patients seen last financial year, 5556.

Adolescents: in Q2 saw 210 individual patients, 5 more than in Q1. This quarter the service was 3% above the quarterly average number of patient contacts during last financial year, 204.

Camden CAMHS: in Q2 saw 1275 patients, 51 fewer than Q1. This quarter the service was 18% above the quarterly average number of patient contacts during last financial year, 1083.

Other CAMHS: in Q2 had contact with 606 patients, 76 more than in Q1. This quarter the service was 11% above the quarterly average number of patient contacts during last financial year, 546.

Adults Complex Needs: in Q2 saw 505 patients, 35 fewer than in Q1. This quarter the service was 3% under the quarterly average number of patient contacts during last financial year, 519.

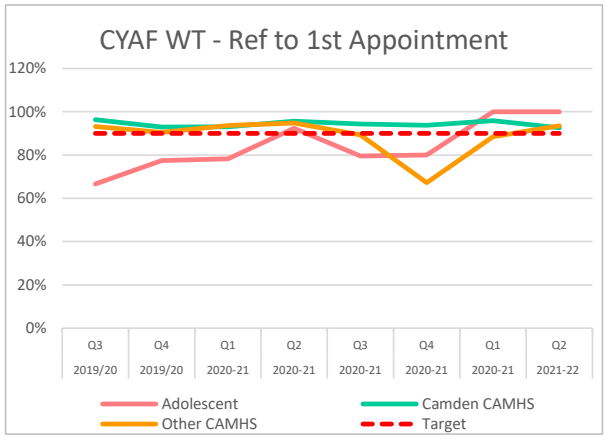
Portman: in Q2 had contacts with 183 patients, 4 fewer than in Q1. This quarter the service was 1% under the quarterly average number of patient contacts during last financial year, 186.

C&H PCPCS: in Q2 made contact with 220 patients, 9 more than in Q1. This quarter the service was 10% above the quarterly average number of patient contacts during last financial year, 200.

GIDS: in Q2 contacted 1351 patients, 188 fewer than in Q1. This quarter the service was 17% under the quarterly average number of patient contacts during last financial year, 1632.

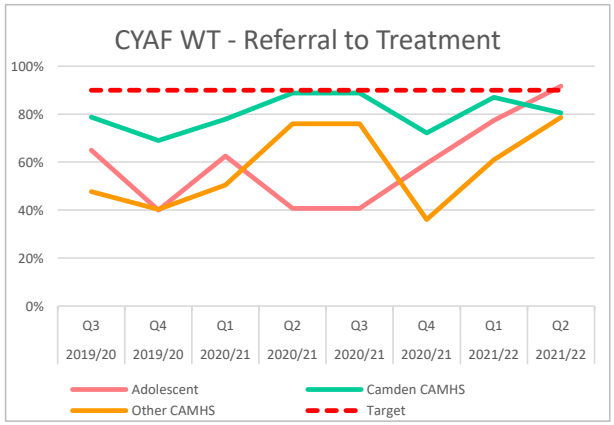
GIC: in Q2 contacted 1282 patients, 7 more that in Q1. This quarter the service was 12% above the quarterly average number of patient contacts during last financial year, 1148.

Q2 2021/22: Quality Responsive – Access



Service Lines	Seen on Time	Breached	total 1st appt	% compliance
Adolescents under 18	3	0	3	**100%**
Adolescents over 18	29	0	29	**100%**
Camden CAMHS	338	27	365	**93%**
Other CAMHS	158	11	169	**93%**

Camden CAMHS target within 8 weeks
Other CAMHS with in 8 weeks
Adolescents under 18 within 8 weeks
Adolescents over 18 within 11 weeks



Service Lines	Seen on Time	Breached	total 2nd appt	% compliance
Adolescents under 18	2	1	3	**67%**
Adolescents over 18	20	1	21	**95%**
Camden CAMHS	223	54	277	**81%**
Other CAMHS	118	32	150	**79%**

Camden CAMHS target within 8 weeks
Other CAMHS within 8 weeks
Adolescents under 18 within 8 weeks
Adolescents over 18 within 18 weeks

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Previous financial year data run on 14/06/2021. Q1 data run on 09/09/21. Other historical data as reported in relevant earlier reports.

CYAF Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations, Zoom sessions and face to face activity.

Referral to 1st Appointment: In Q2 CYAF saw 93% of patients within the contractual waiting times. This is a lower rate compared to 95% in Q1.
Referral to Treatment: In Q2 CYAF saw 80% of patients within the contractual waiting times. This is a lower rate compared to 82% in Q1.

Adolescent services
Referral to 1st Appointment – in Q2 the whole service line saw 100% of patients within contractual waiting times, same performance as in Q1.
- Adolescents under 18 - 100%
- Adolescents over 18 - 100%

Referral to Treatment– – in Q2 the whole service line saw 92% of patients within contractual hours, a compliance improvement compared to 77% in Q1.
- Adolescents under 18 - 67%
- Adolescents over 18 - 95%

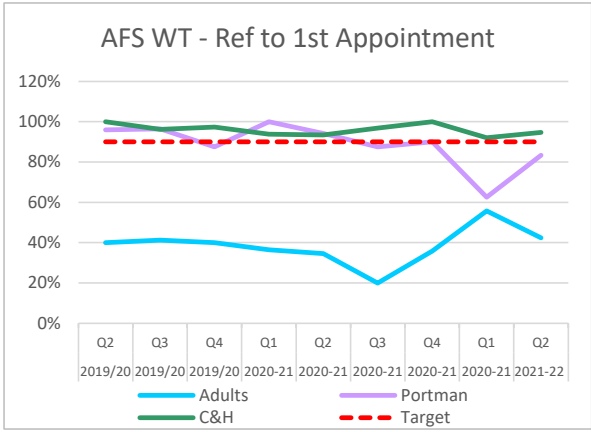
Camden CAMHS
Referral to 1st Appointment – has consistently met the target since 2017/18. The compliance rate in Q2 was 93%, a decrease compared to 96% in Q1.
Referral to Treatment– in Q2 81% of the patients had an appointment within 8 weeks, a decrease in compliance compared to 87% in Q1.

Other CAMHS
Referral to 1st Appointment – in Q2 they achieved 93%, an increase in compliance compared 88% to Q1.
Referral to Treatment– in Q2 79% of the patients had an appointment within the contractual waiting times, a significant improvement compared to 61% in Q1.

The following services are not measured in WT metrics above as they follow a different delivery model: *First Step, FDAC, Gloucester House and Returning Families*. Please find further information for these teams in data at appendix Page 23

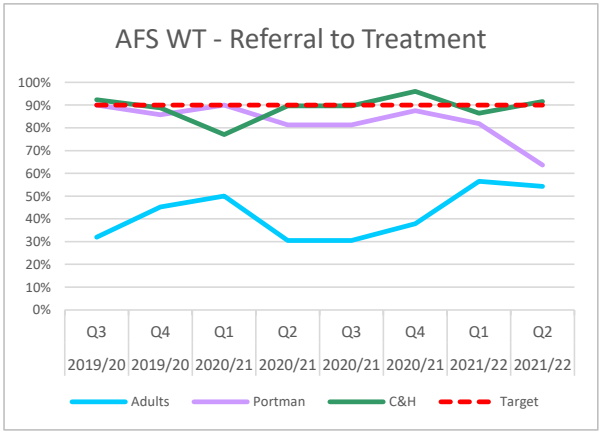
For further comments from service leads please see the commentary part of the report Page 20

Q2 2021/22: Quality Responsive – Access



Service Lines	Seen on Time	Breached	total 1st appt	% compliance
Adult Complex Needs	14	19	33	**42%**
Portman	10	2	12	**83%**
City & Hackney PCPCS	90	5	95	**95%**

Adults Complex Needs within 11 weeks
Portman within 11 weeks
PCPCS within 18 weeks



Service Lines	Seen on Time	Breached	total 2nd appt	% compliance
Adult Complex Needs	19	16	35	**54%**
Portman	7	4	11	**64%**
City & Hackney PCPCS	65	6	71	**92%**

Adults Complex Needs within 18 weeks
Portman within 18 weeks
PCPCS within 18 weeks

AFS Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations.

Referral to 1st Appointment: In Q2 AFS saw 81% of patients within the contractual waiting times. In Q1 this compliance was 74%.
Referral to Treatment : In Q2 AFS saw 78% of patients within the contractual waiting times. In Q1 this compliance was 72%.

Adult Complex Needs
Referral to 1st Appointment –in Q2 they had 42% compliance, a decrease on Q1, when 56% compliance was achieved.
Referral to Treatment– in Q2 they had 54% compliance, a slight decrease on Q1, when they had 56% compliance.

Portman
Referral to 1st Appointment – in Q2 they achieved 83% compliance, an increase on Q1 when they had 63% compliance.
Referral to Treatment– in Q2 64% of patients were seen within contractual times, a decrease on Q1, when they had 82% compliance.

C&H PCPCS
Referral to 1st Appointment – in Q2 they achieved 95% compliance, an increase on Q1, when they had 92% compliance.
Referral to Treatment– in Q2 they had 92% compliance, an increase on Q1, when they had 86% compliance.

For further comments from service leads please see the commentary part of the report Page 20

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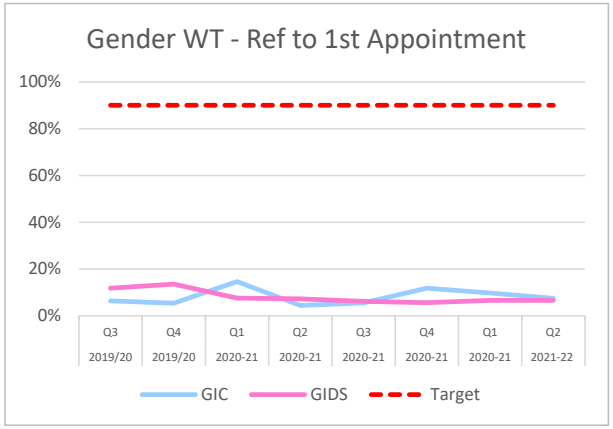
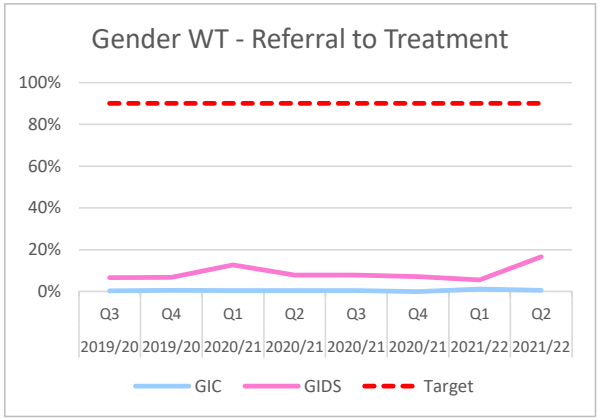
Q2 2021/22: Quality Responsive – Access



Service Lines	Seen on Time	Breached	total 1st appt	% compliance
GIDS	17	242	259	**7%**
GIC	9	112	121	**7%**

GIDS target within 18 weeks
GIC target within 18 weeks



Service Lines	Seen on Time	Breached	total 2nd appt	% compliance
GIDS	7	35	42	**17%**
GIC	1	157	158	**1%**

GIDS target within 18 weeks
GIC target within 18 weeks

Gender Services Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations.

Gender Services Directorate have had an unusually high number of referrals over the past few years and challenging demand nationwide. Work is continuing to address Waiting Times issues.

Referral to 1st Appointment: Gender Services Directorate saw in Q2 7% of patients within the contractual waiting times. Same performance as in Q1.
Referral to Treatment : Gender Services Directorate saw in Q2 4% of patients within the contractual waiting times. This compares to 2% in Q1.

GIDS: as a measure of awareness the GIDS website shares information about the WT issue; the current waiting time is advised on the website to young people and referrers. GIDS is currently seeing young people for their first appointment who were referred in 2018.

Referral to 1st Appointment – in Q2 had 7% compliance, same as in Q1.
Referral to Treatment – in Q2 had 17% compliance, an increase on 6% in Q1.

GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.

Referral to 1st Appointment – in Q2 had 7% compliance, a decrease on 10% in Q1.
Referral to Treatment – in Q2 had 1% compliance, same as in Q1.

For further comments from service leads please see the commentary part of the report Page 22

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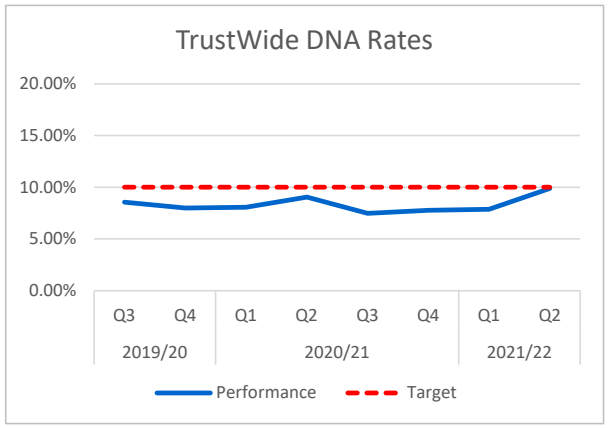
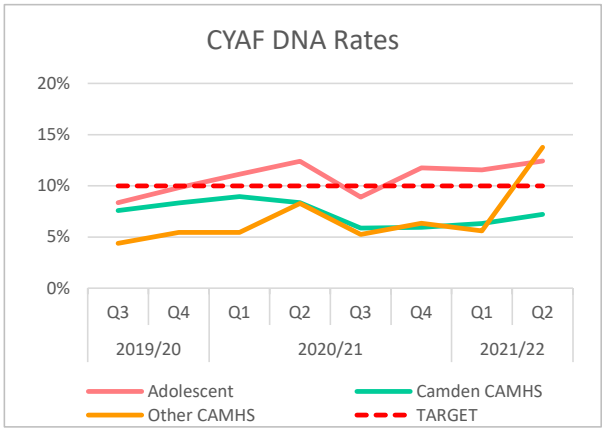
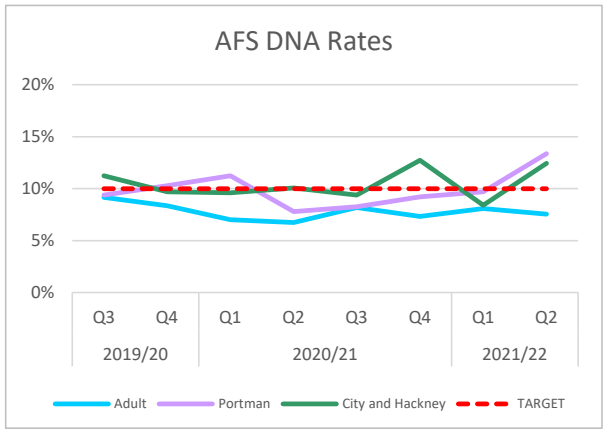
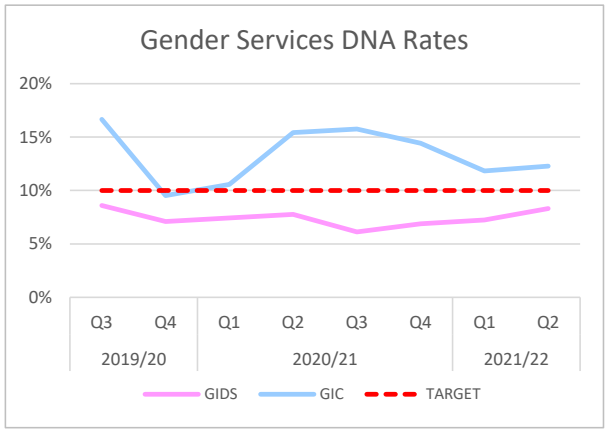
Q2 2021/22: Quality Effective – Access









Did Not Attend (DNA)

This data is Trust-wide and covers all contracts and all service lines. DNA rates are expected to be no higher than 10%.

Trust-wide, we continue to meet the DNA target. In Q2 our compliance rate was 9.88%. Last financial year average rate was 8.09%. The trust has met this target over the last 3 years.

Adolescents: in Q2 had an 12.4% -149 DNAs and 1051 attended appointments. The DNA quarterly average during last financial year was 11%.

Camden CAMHS: in Q2 had a DNA rate of 7.2% - 467 DNAs with 5997 attended appointments. Target has been met for the last 2 years. The DNA average during last financial year was 7.3%.

Other CAMHS: in Q2 had a DNA rate of 13.8% -413 DNAs and 2586 attended appointments. The average during last financial year was 6.3%.

Adults Complex Needs: in Q2 had a DNA rate of 9.3% - 320 DNAs and 3128 attended appointments. Target has been met for the last 2 years. The average during last financial year was 7.6%.

Portman: in Q2 had a DNA rate of 11.7% -186 DNAs and 1171 attended appointments. The average during last financial year was 8.7%.

C&H PCPCS: in Q2 had DNA rate of 10.1% -88 DNAs and 783 attended appointments. The average during last financial year was 10.1%.

GIDS: in Q2 had a 8.3% DNA rate -262 DNAs out of 2894 attended appointments. The average during last financial year was 7%.

GIC: in Q2 had a 12.3% DNA rate - 242 DNAs and 1728 attended appointments. The average during last financial year was 14%.

For further comments from service leads please see the commentary part of the report
Page 23, 24 & 25

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Q2 2021/22: Single Oversight Framework – Access

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers, with the indicators acting as a trigger to detect possible governance issues and identify potential support needs. The framework looks at five themes. MHSDS data is viewed alongside other quality of care information e.g. formal complaints, staff FFT, patient safety incidents (reported externally), and operational performance. The other four include Finance and use of resources (covered separately), Operational performance, Strategic change and Leadership and improvement capability (well-led)

Mental Health Service Data Set (MHSDS) and Data Quality Maturity Index (DQMI) Dataset Score

The DQMI was introduced into reporting in April 2018, with new data sets added in April 2019 and is in line with the Single Oversight Framework.

-Single Oversight Framework: 1 (the best of the four possible ratings, no identified support needs)

-The DQMI is published with a three-month delay – The most recent published DQMI is for June 2021 96.4% against a target of 95%.

- From February 2021, our gender services are not included in MHSDS data submissions, although we continue to monitor internal compliance rates.

The Quality Assurance Team use the Data Warehouse Information, which is used for internal reporting, to identify gaps in reporting. In order to improve on DQMI and MHSDS completion rate, the reports are discussed at the Quality Assurance Group (QAG) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved.

	Target	Month 7 October 2019/20	Month 10 January 2019/20	Month 1 April 2020/21	Month 4 July 2020/21	Month 7 October 2020/21	Month 10 January 2020/21	Month 1 April 2021/22	Month 4 July 2021/22
Valid NHS number	95%	98.95%	99.01%	98.97%	98.99%	99.16%	99.60%	99.50%	99.26%
Valid Postcode	95%	99.72%	99.71%	99.79%	99.70%	99.72%	99.53%	99.64%	99.65%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.15%	99.21%	99.14%	99.13%	99.14%	99.13%	99.04%	99.13%
Valid Organisation code GP Practice	95%	98.78%	98.46%	98.55%	98.28%	98.33%	99.12%	99.09%	99.03%
Valid Gender	95%	99.47%	99.41%	99.38%	98.80%	98.50%	99.98%	99.95%	99.96%
Ethnicity	95%	78.76%	77.79%	75.94%	75.82%	73.88%	88.77%	88.88%	90.94%
Employment Status (for adults)	95%	57.94%	56.67%	56.68%	55.94%	54.92%	66.98%	63.64%	66.44%
Accommodation status (for adults)	95%	56.90%	55.64%	55.48%	54.69%	53.63%	66.59%	63.31%	65.70%
Primary Reason For Referral	-	98%	99%	99%	99%	-	100%	100%	100%
Ex-British Armed Forces Indicator	-	41%	46%	48%	56%	-	64%	73%	77%
DQMI -Data Quality Maturity Index The DQMI Indicator is not submitted in the same intervals.	95%	94.10%	-	95.60%	95.70%	-	96.6%	96.4%	-

Data source: Data warehouse, informatics team 11/10/2021

Q2 2021/22: Single Oversight Framework – Access

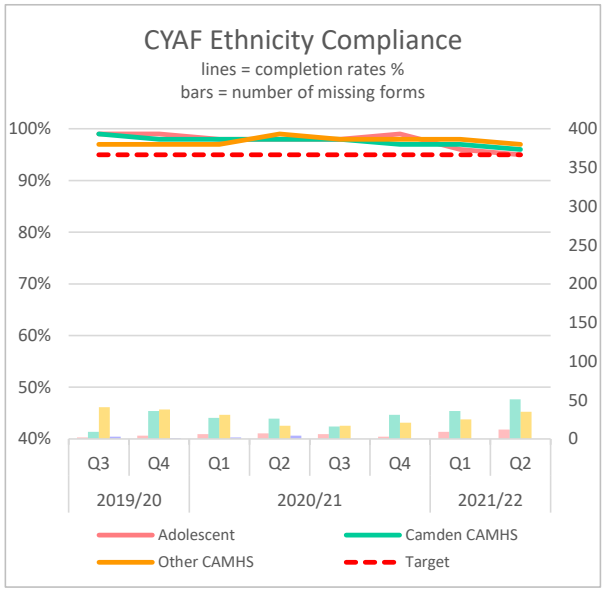
Ethnicity Rates Internal Reports

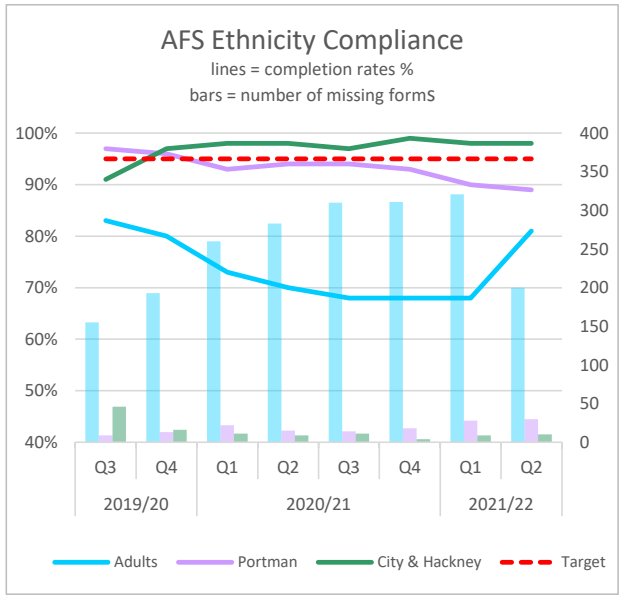
Ethnicity completion rates have been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. A significant factor in not reaching the target is the large number of patients open to these teams who have not been seen. The Quality Assurance Team (QAT) continue to work with teams in the Quality Assurance Group (QAG), raising awareness of the situation in order to improve this data further.

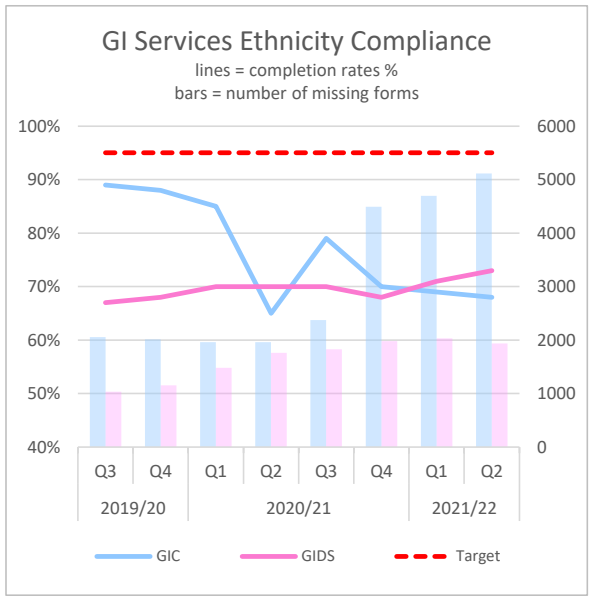
Adults Complex Needs have improved their performance significantly. We are pleased to see that the number of patients with missing ethnicity codes has decreased sharply. We believe this is due to the introduction of a new acceptance letter. This is sent before any appointment is offered, in order to improve communication and expectations and it includes NHS monitoring form, where demographic data is requested. The service is continuing to explore new ways to improve the rate of missing demographic data: communicating directly with the clinicians and reviewing the referrals data inputting process.

GIDS has improved the situation gradually and we hope to see further improvement over the next quarter. GID started a similar project to A CN sending the 'patients detail forms' with their acceptance letters, this is starting to show improvement.

GIC has an increasing number of patients with missing ethnicity information, we believe this could be related to a big influx of referrals (internal and external). GIC has started to implement a similar approach to A CN and GIDS. We are expecting to see results over the next few months.

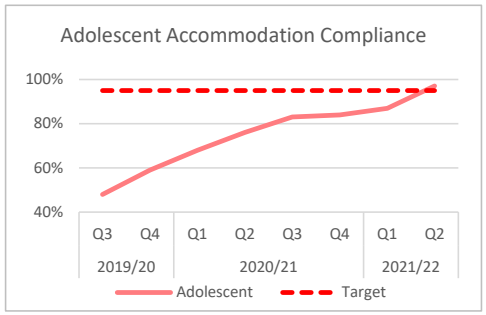


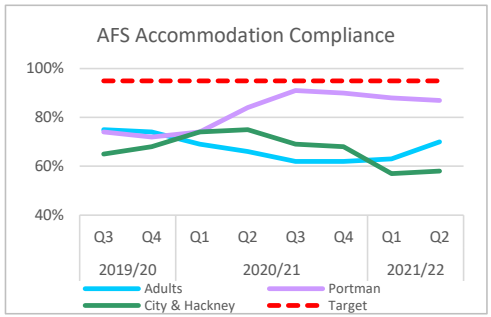


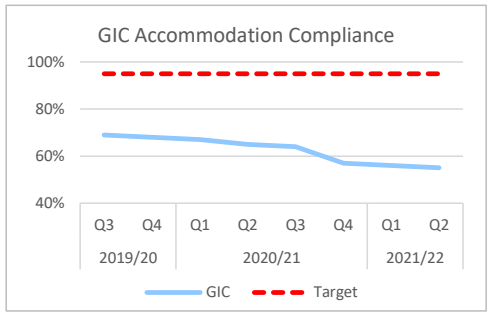


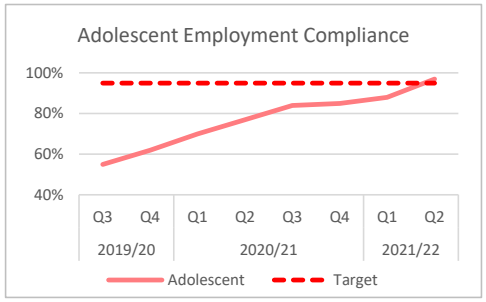
Data source: Q2 data as recorded on 07/10/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q2 data has been run without meeting the threshold on number of unoutcomed appointments.

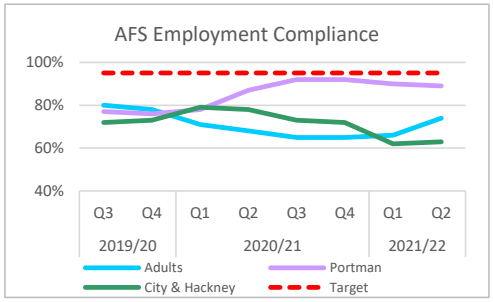
Q2 2021/22: Single Oversight Framework – Access

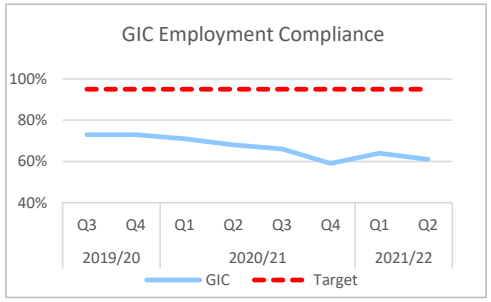


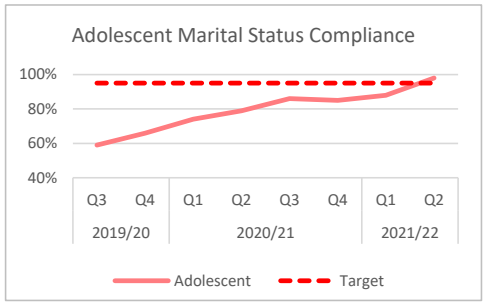


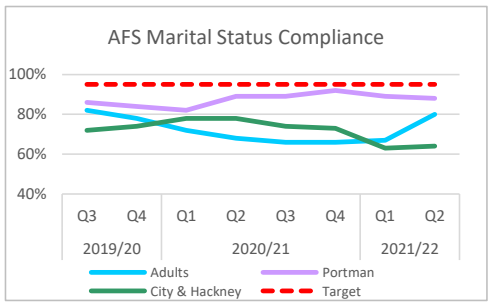


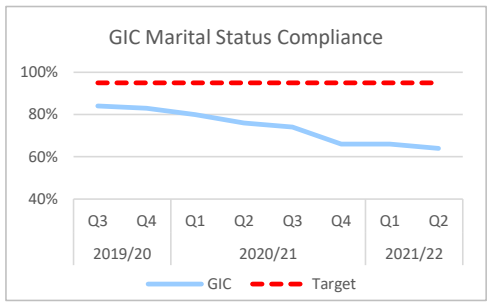












Data source: Q2 data as recorded on 07/10/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Q1 data has been run without meeting the threshold on number of unoutcomed appointments.

Accommodation, Employment and Marital Status Rates Internal reports

These parameters are only required for patients over 18 years of age.

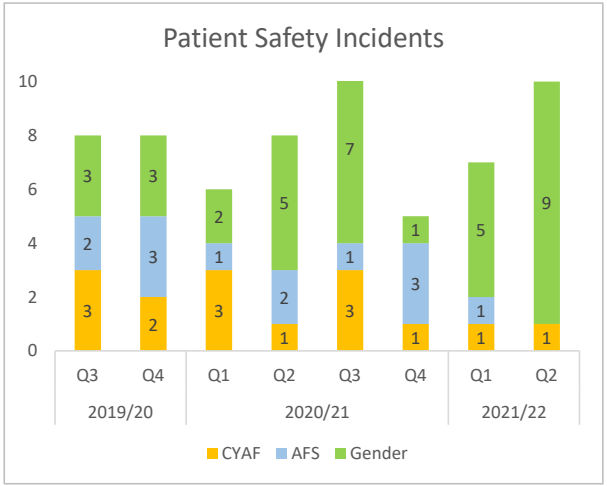
Please note the strong and sustained improvement of Adolescents over 18's Services data collection.

We are expecting that the 'patients detail forms' sent along with acceptance letters would start showing data improvement over the next few quarters.

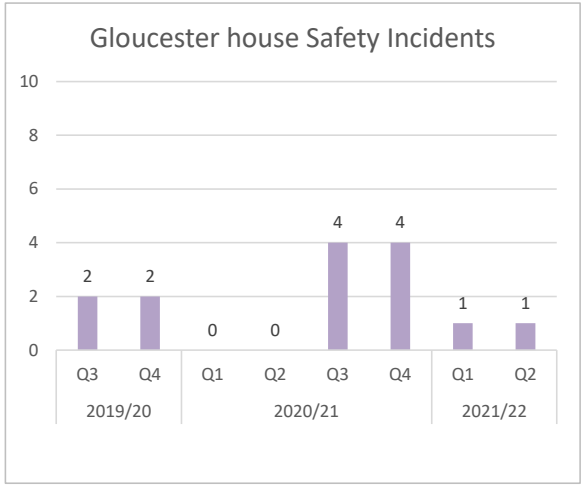
We are working on a solution to correct a minor glitch in the CareNotes report with regards to the information held on the Social Inclusion From. We have found a few cases where information has been provided but not included on the last social inclusion form, and the report is not counting this data. When a solution is implemented we are hoping see a slight improvement on our performance.

Q2 2021/22: Quality Safety – Care

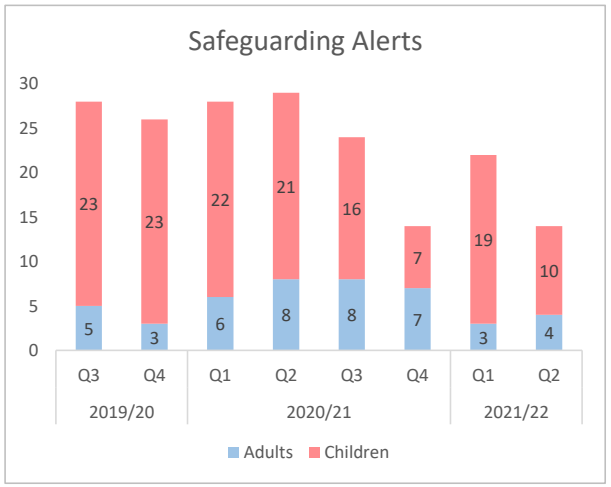
Numbers of incidents logged in our QP system (all types)	Incidents Reported by Risk Level – Trust wide	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2
	1-4	65	60	37	33	32	62	59	37
	5-8	28	30	11	19	30	29	31	33
	9-12	12	18	3	3	12	20	16	5
	15+	0	1	1	2	1	3	11	1
	Total	106	109	52	57	75	114	117	76



Family MH team - patient died due to overdose.
GIC have recently run a Demographic Batch Service and have found that several patients had died, either not seen or not closed cases. Deaths of natural causes.
GIDS, One patient, not seen, had died by suicide.
GIDS, One patient had disclosed sexual abuse but not shared with family. But had been disclosed by GIDS service when requesting further information.



Two pupils running and pushing each other on the stairs, one child fell on member of staff and the staff elbow it their face. Under eye was slightly swollen. Ice pack given and pupils spoken to about running on the stairs.



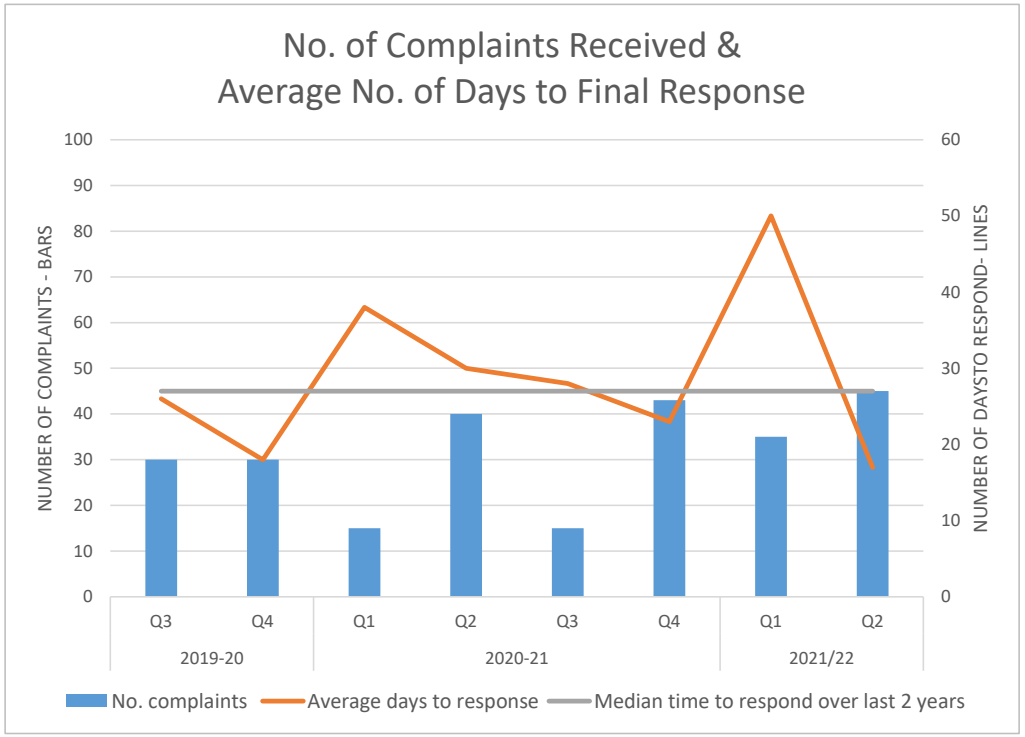
The safeguarding children alerts refer to concerns of sexual abuse; domestic violence and abuse; aggressive behaviour; neglect; exposure to inappropriate online material and concerns regarding parents 'mental health and their capacity to look after the children.

The safeguarding adults concerns refer to concerns about: 1 x financial, emotional and self-neglect ; 1 x domestic violence; 1 x physical abuse and self-neglect; 1 x concerns related to online activity and risks. There was one referral to the local authority.

Data & commentary source: Q1 and Q2 data run by Health & Safety and Safeguarding Departments 14/10/2021
Previous financial year data run on 14/06/2021. SG as reported in earlier reports.

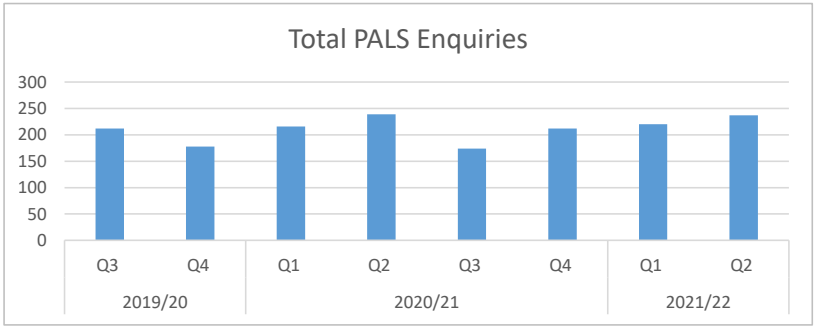
Q2 2021/22: Quality Responsive – Care

See Slide 33 for further KPI complaints information



This is an increase in the number of complaints received during the previous quarter. Of the 45 complaints received in Q2 5 had been responded to, leaving 40 open. The backlog of complaints is still being addressed following the 'pause' in the complaints process in place from the end of March 2020 due to the coronavirus crisis. Unfortunately due to staff shortages it has not been possible to reduce the number of outstanding complaints. All complainants are advised to expect a delay in the response to their complaint and that it is not possible to say when we will be able to respond to a complaint. The complaints that have been responded to were not upheld.

Complaints by Directorate	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
Children Young Adults and Families	4	4	0	1	0	3	1	5
Adult and Forensic	2	4	3	11	3	7	4	8
Gender	24	21	12	25	11	27	28	32
Corporate	0	1	0	3	1	7	2	0
Total complaints	**30**	**30**	**15**	**40**	**15**	**43**	**35**	**45**



Accessing treatment and support issues, followed by communication and appointment issues are the top two categories, fairly equal across Gender/Adult/C&F and young people's services.

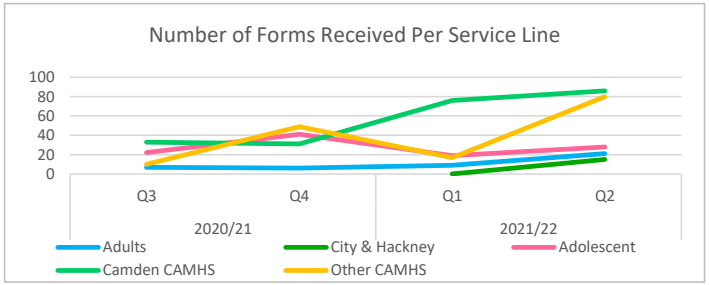
Data & commentary source: Complaints Department & PALS department 04/10/2021
Previous quarters' data as reported in relevant earlier reports.

Q2 2021/22: Quality Responsive – Care

Quality Key Performance Indicators																			
KPI – London Contracts	Monitoring	Target %	2021/22												RAG Progress			
			Q1			Q2			Q3			Q4			Q1	Q2	Q3	Q4
			N	D	%	N	D	%	N	D	%	N	D	%				
Question 1 from ESQ "What was your experience of your care/treatment?"	Quarterly	92%	100	103	97%	203	211	96%										
Q2 from ESQ "How involved did you feel in the decisions made about your care/treatment?"	Quarterly	n/a	101	104	97%	200	210	95%										
Q3 ESQ "How seriously were your views and worries taken?"	Quarterly	n/a	100	102	99%	202	204	99%										
Q4 from ESQ "How well are people you've seen here working together to help you?"	Quarterly	n/a	91	92	99%	180	183	98%										
Q5 from ESQ "How helpful was the information received about the trust before you first attended?"	Quarterly	75%	47	53	89%	104	117	89%										
Q6 from ESQ "Would you recommend this service to friends and family?"	Quarterly	80%	91	96	95%	181	193	94%										

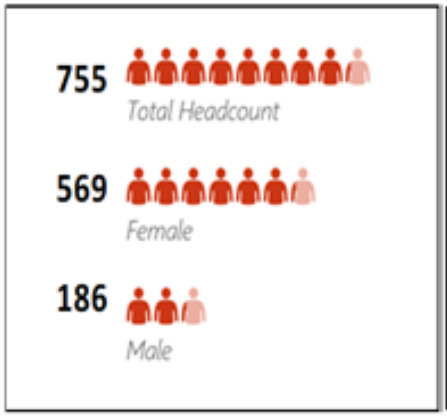
ESQ Rates, the ESQs completion rates are part of our KPIs and as such they include London Contracts only.

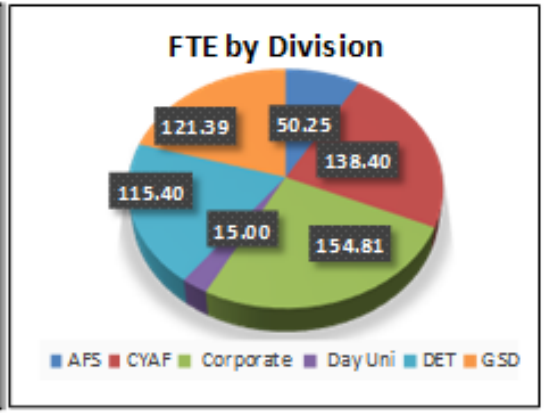
Traditionally, the responses and feedback from our patients have been very positive and we were very pleased with the comments and scores received. However, we felt that the number of forms returned could be higher. A new shorter form which aims to improve the collection rates was implemented during Q1. Please note Q1 and Q2 data refers only to new forms (first form dated 16/04/2021), and prior quarter's data refers to the old forms. We are pleased to see improvement in collection rates in Q2. As the usage of this new form is established we hope to see growth in all service lines. Please note the City and Hackney has started to collect ESQs forms in July 2021. The usage of Qualtrics is planned for Q3, this methodology should increase the number of forms sent and our return rate.



Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 and Q2 data run on 11/10/21
*ESQ % = (Certainly true + Partly true)/(Certainly True + Partly True + Not True)

Q2 2021/22: Quality Well-Led



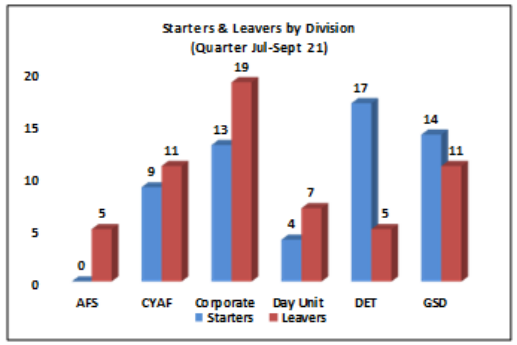


	% Annualised Turnover Rate
May-21	18.61%
Jun-21	20.46%

	% Appraisal Rate
May-21	25.58%
Jun-21	30.92%

	% Sickness Absence Rate
May-21	1.49%
Jun-21	1.62%

	% Mandatory Training Compliance
May-21	74.42%
Jun-21	72.61%

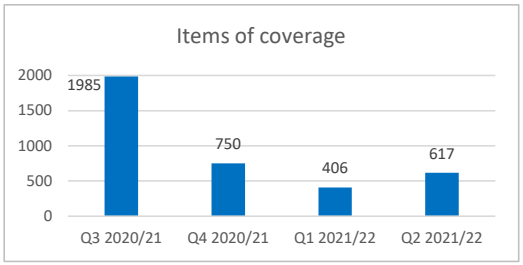


The Trust's staff survey was launched on 23/09/2021. 737 employees were eligible to take part. The current rate of 33.5% on the 06/10/2021 of employees have taken part. A positive response so far. In addition to this, best performing Mental Health Trust. The trust is above average for the mental health and learning disability trust which stands at 49%.The Trust has reached its overall compliance target. Just over 95 %. An increase in Appraisals overall and DBS checks at a balanced level.

Data Source: Human Resources Department: 11/10/21

Q2 2021/22: Media & Digital – Care

Media overview



In Q2 2021-22 we attracted 617 pieces of media coverage (up from 406 in Q1): 41 in July, 29 in August and 547 in September.

The media coverage for September focused on the outcome of an employment tribunal and the GIDS judicial review.

The employment tribunal outcome, which found in favour of the claimant, was covered by the Daily Mail, BBC Online, Newsnight, the Today programme, the Observer, the Times, Community Care, Personnel Today, the HR Director, and the Ham & High. The Trust provided a brief media statement to enquiries, encouraging our staff to come forward with any safeguarding concerns they may have, and describing that we have strengthened our mechanisms for raising concerns in recent years.

The Bell v Tavistock judicial review appeal was successful for the Trust, reinstating the authority of healthcare professionals (together with the young person and their parents) to make decisions about care for trans young people without court intervention or approval. Our statement is published here. The appeal attracted widespread media coverage, including around 20 pieces of national media coverage from key outlets such as BBC Online, Sky News and the Metro. Paul Jenkins gave an interview to Channel 4 News, Sky News and the BBC Today Programme.

Digital overview

Traffic to our main site continues to remain notably higher compared to the same quarter last year. Social followers continue to grow.

- Website users **up 36%**: 126,552 vs 93,260
- Pageviews **up 74%**: 576,095 vs 330,905 (51% of pageviews, 291,294, were to the training section)
- Sessions **up 27%**: 178,369 vs 140,929

Most-visited news stories:

1. The Vaccine Bus is coming! Walk-in jabs available at the Trust, 926 views
2. Referrals to the Gender Identity Development Service (GIDS) level off in 2018-19, 670 views
3. New bursaries to increase racial diversity on our courses, 584 views

Most-visited course pages:

1. Working with children, young people & families: a psychoanalytic observational approach (M7), 8,368 views
2. Child and adolescent psychoanalytic psychotherapy (M80), 6,093 views
3. Systemic psychotherapy (M6), 5,629 views

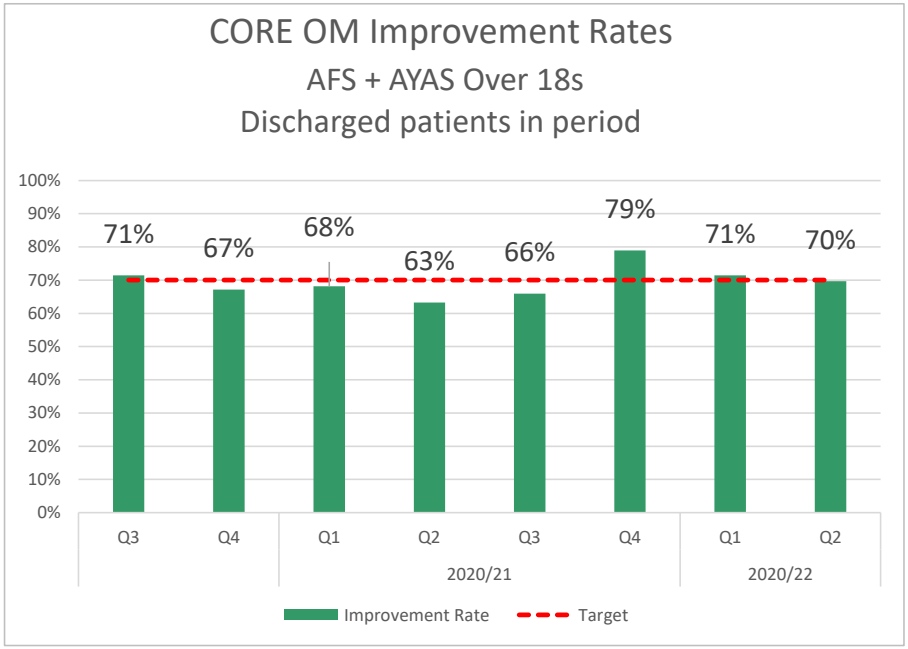
Social channels – followers compared to last quarter

- Twitter: **@taviandport:** 8,399, up from 8,166, **@tavitraining:** 5,516, up from 5,448
- LinkedIn: 13,716, up from 13,321
- Facebook: 7,308, up from 6,693
- Instagram: 1,159, up from 939

Data & commentary source: Communications Department 12/10/21

Q2 2021/22: Quality Effective – Outcome Measures

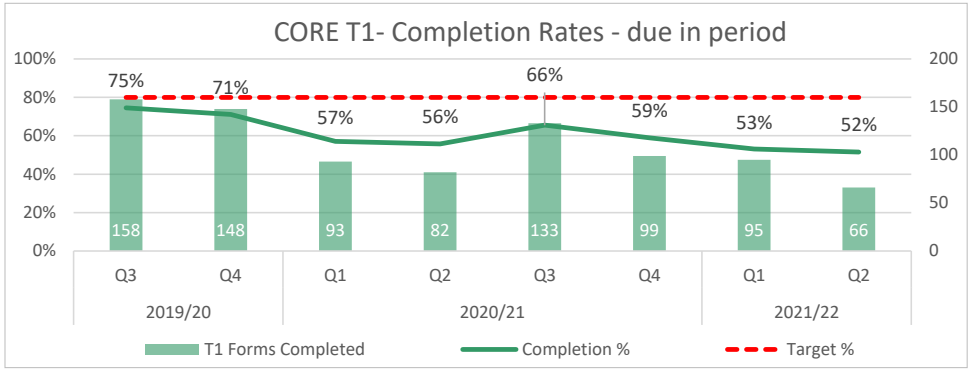
A F S and Adolescents over 18

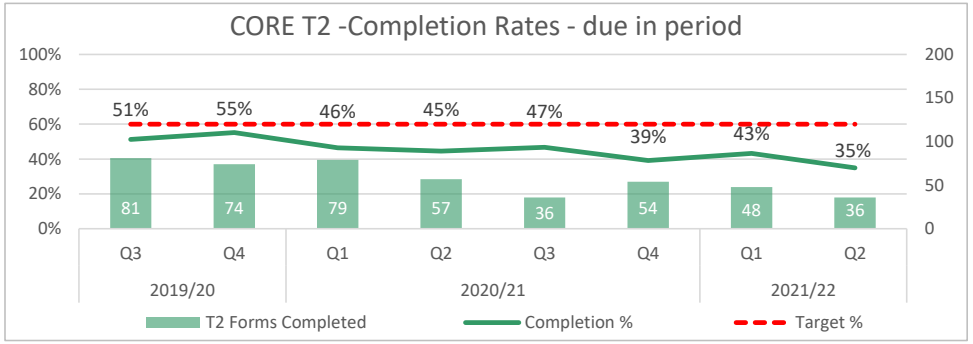


The CORE OM improvement rates include all patients discharged in period with a minimum of two completed CORE OM forms. It compares scores from the first form completed to the last one.

We are pleased to see the improvement rates in Q2 met the 70% target.

The services are working on improving the reminder system and collection processes in order to ensure the forms are collected regularly throughout the pathway of the patient, including end of treatment forms.





We are pleased to be able to report on T1 and T2 completion rates including the number of completed forms out of the forms due. The CORE OM completion rates include forms due in period for all contracts.

-CORE T1 rates: in Q2 the services achieved a 52% compliance out of the forms due in period. Please note that T1 is seen as due contractually after second appointment, and we allow a month for the postage and administrative process.

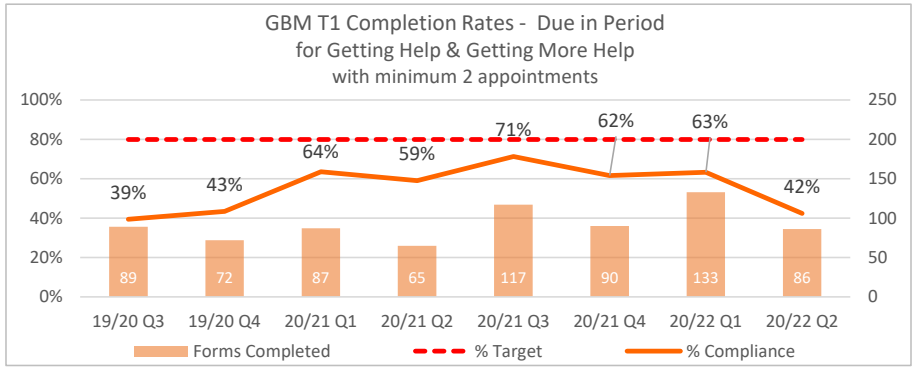
-CORE T2 rates: in Q2 35% of the forms due for completion were completed. Please note that T2 is due contractually 6 months after T1 completion date, we also add a month grace period for admin and postage process. T2 are particularly challenging for teams that have a long waiting list.

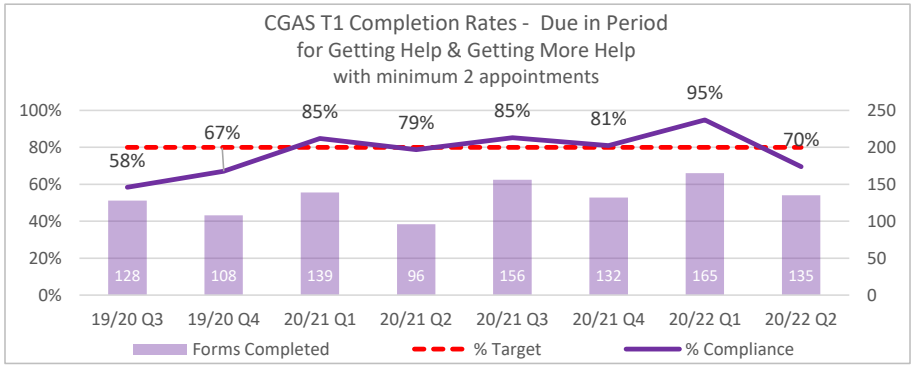
Note the previous quarters that were re-run include forms completed late. Last quarter compliance would be naturally lower, as not able to include late forms.

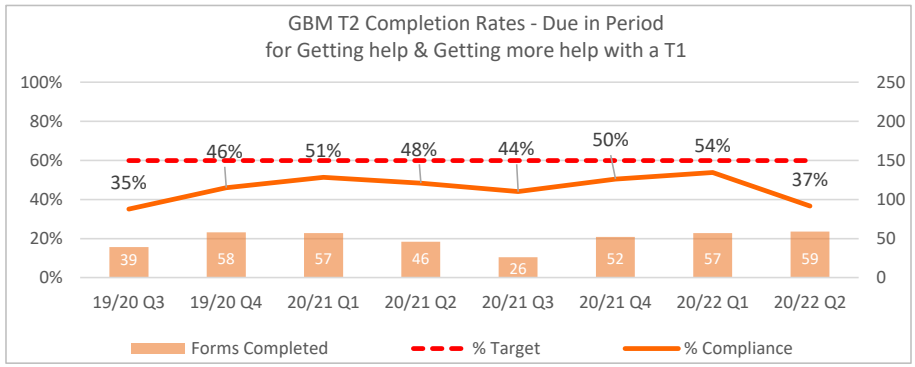
Data source: Q1 and Q2 data as recorded on 08/10/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous financial year data run on 15/06/2021. Other historical data as reported in relevant earlier reports.

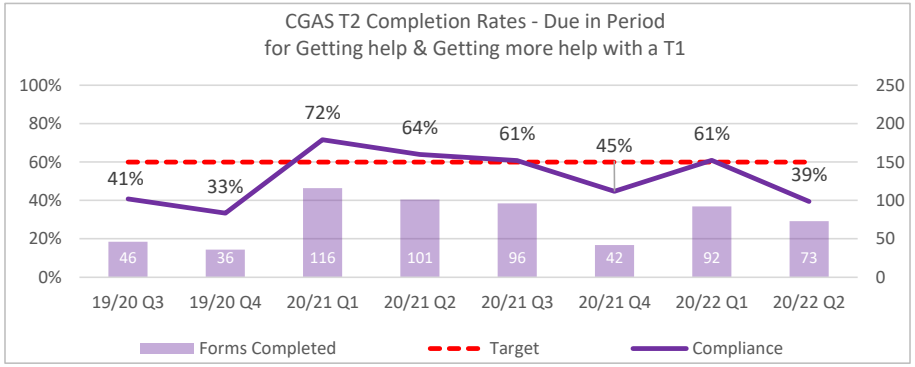
Q2 2021/22: Quality Effective – Outcome Measures

C Y A F - GBM & CGAS completion rates are part of our KPIs and as such they include London Contracts only.









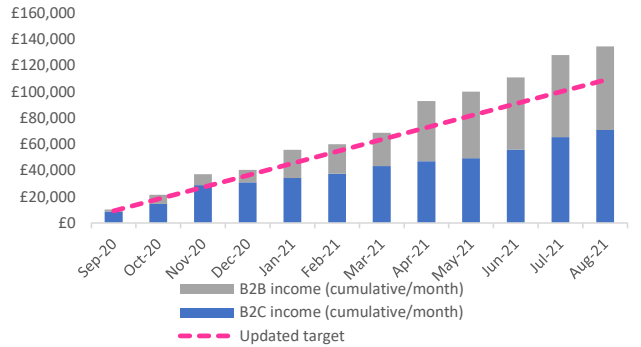
GBM reminder system provides more flexibility to complete forms, and it should help increase our performance. The GBM T1s are expected after second appointment and GBM T2s 3 months after T1.
-**GBM T1 rates**: in Q2 completion rates have reached 42%.
-**GBM T2 rates**: in Q2 completion rates have reached 37%.
Note the previous quarters that were re-run include forms completed late. Last quarter compliance would be naturally lower, as not able to include late forms.

The CGAS completion rates are part of our KPIs and as such they include London Contracts only.
The CGAS completion T1 are expected after second appointment and T2 6 months after T1.
-**CGAS T1 rates**: in Q2 the compliance rate met 70%, just 10 under the target.
-**CGAS T2 rates:** in Q2 the compliance rate reached 39%.
Note the previous quarters that were re-run include forms completed late. Last quarter compliance would be naturally lower, as not able to include late forms.

Data source: Q2 data as recorded on 06/07/2021 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 data run on 08/10/21. Previous financial year data run on 01/07/2021. Other historical data as reported in relevant earlier reports.

See Slide 37 for further GBM and CGAS information

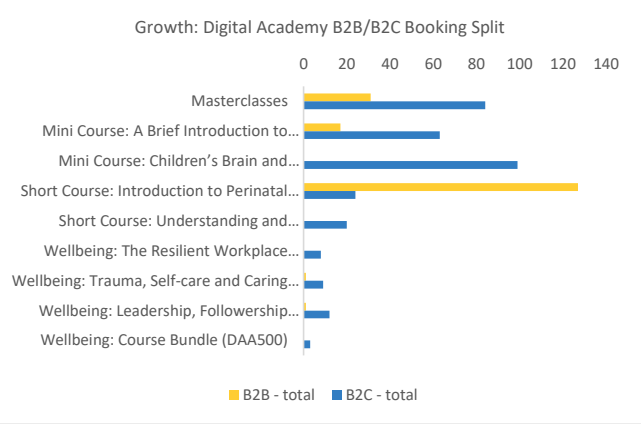
Q2 2021/22: Directorate of Education and Training (DET)

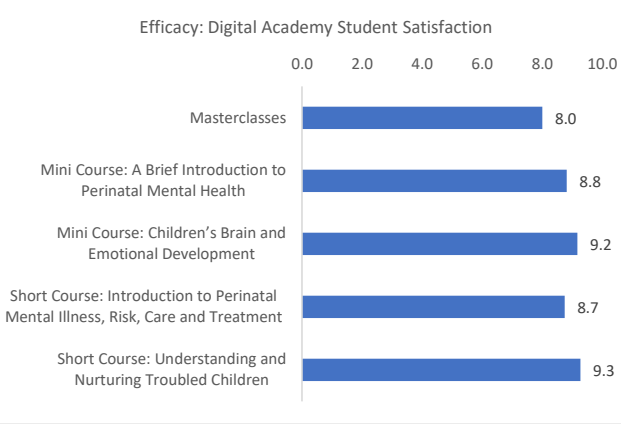


The 'Sustainability' graph shows cumulative individual booking income via the MyTAP system for all Digital Academy products since launch to the end of August 2021 (£134,627), against revised business case target for the first year of operation (£109,000).

This graph does not show all organisational group booking (B2B) income, which is invoiced outside of the MyTAP system, and only shows incrementally as students enrol on MyTAP. The total invoiced B2B income to date stands at £89,040, with an estimated £64,812 not yet reflected in the graph, which takes the total forecast Digital Academy income to £199,439 since launch.

The 'Growth' chart shows that bookings were above target in April but below target in May and June. The April peak was related to financial year-end and an influx of B2B bookings as organisations sought to use up training budgets. Other peaks in November, January and July relate to marketing campaign activity and the bookings generated by those campaigns. Full deployment of a B2B engagement plan, new referral relationships with partner organisations and a digital lead generation campaign should develop recruitment in this area.





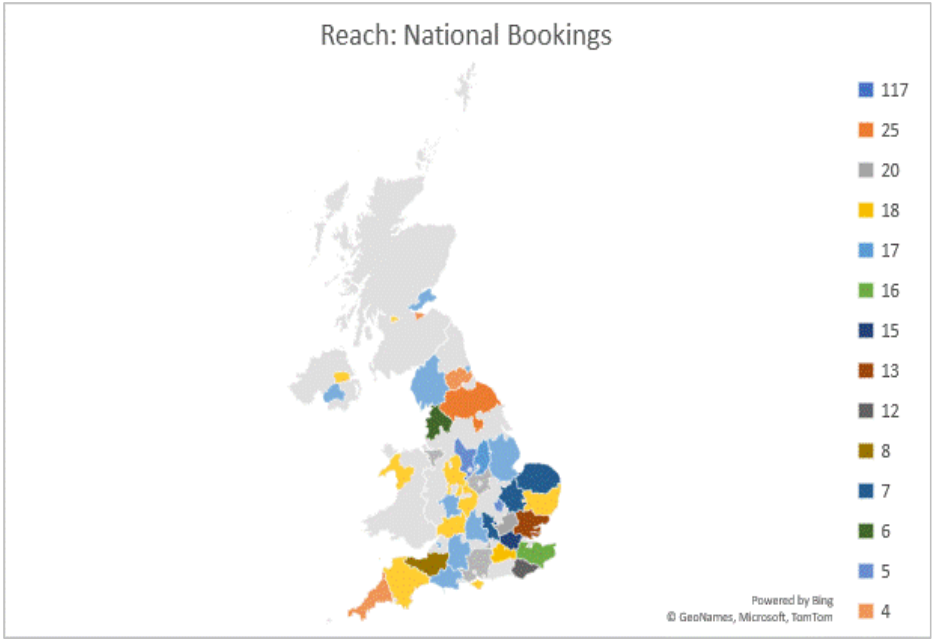
'The 'Growth' chart shows that individual business-to-consumer (B2C) bookings form the majority of DA growth, with 65% of all students coming from that area and Masterclasses/Children's Brain and Emotional Development Mini Course being the strongest performers.

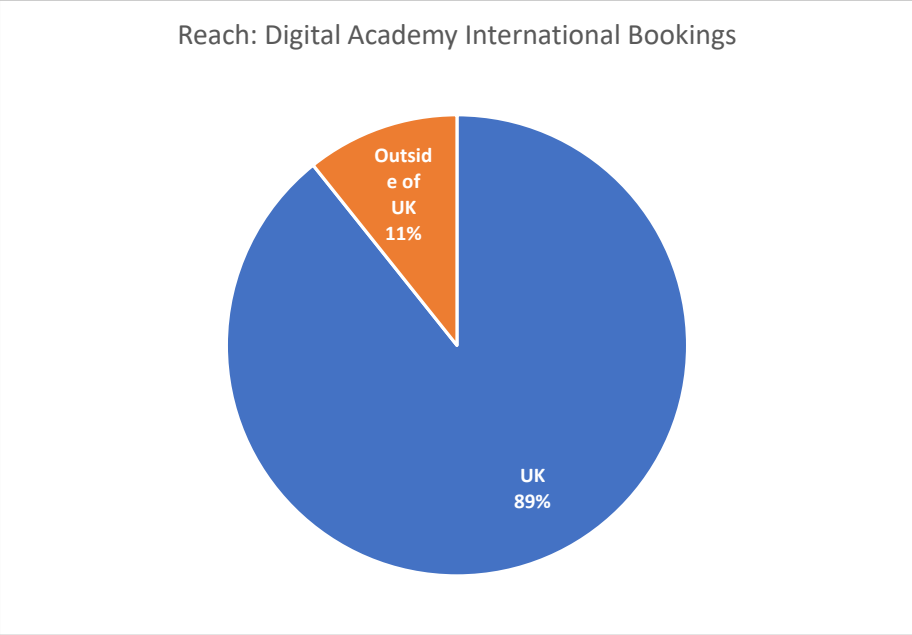
Although B2B bookings make up only 35% of all DA students, income received from that area actually accounts for 49% of total DA income. The Introduction to Perinatal Mental Health Short Course is the strongest performer, contributing 96% of all B2B income and 47% of all DA income to date. A live perinatal webinar and further B2B activity planned for autumn 2021 should continue to drive success here.

The 'Efficacy' chart shows positive student satisfaction rates across all products, with the majority of respondents scoring their experience highly (8+). Masterclass formats have been reviewed and are being rolled out in July 2021. Results of a Pearson efficacy research project were published in August 2021 which showed high levels of student satisfaction and experience scores. The main area of improvement for the Digital Academy is in increasing interactivity of learning, the number of videos, and developing collaborative tools.

Data & commentary source: DET Department 06/10/2021

Q2 2021/22: Directorate of Education and Training (DET)





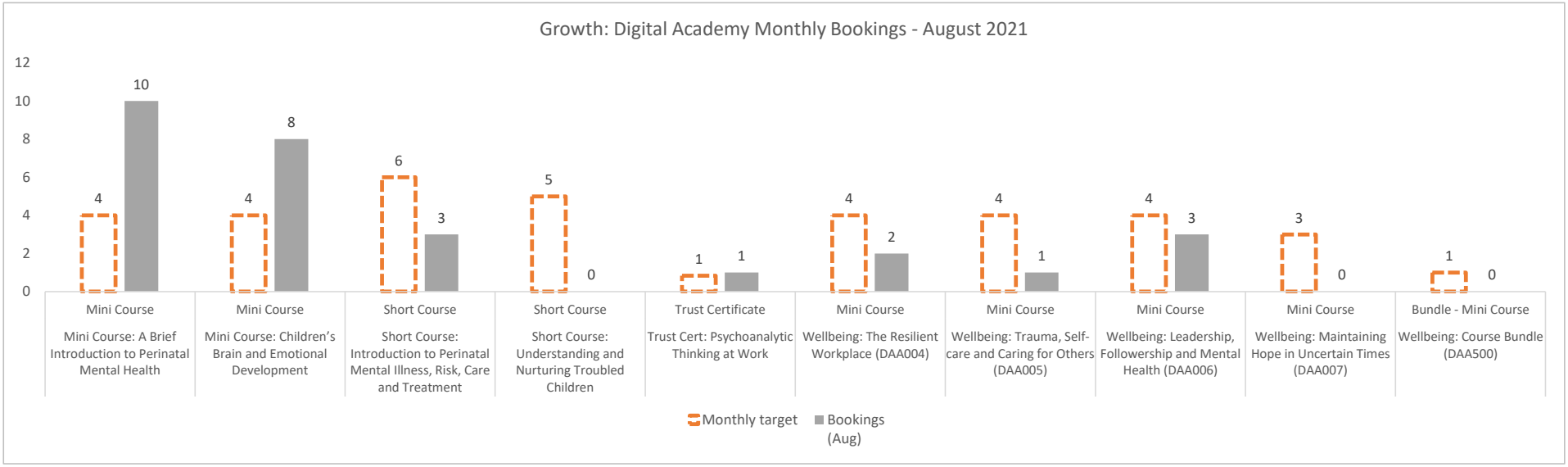
The 'Reach' chart displaying the map shows the national spread of DA bookings, which continues to grow each month. 86% of total DA bookings originated from England, with the next biggest source country being Ireland with 2.5% of bookings.

Nationally, there is healthy spread of bookings, with engagement strongest in the south east of England. 33% of bookings have come from the London/Greater London area, with strong results from the Home Counties. The next biggest source of bookings is Yorkshire with 7% and Nottinghamshire with 6% to date.

Internationally, the DA continues to perform well, with web engagement from 25 countries. As the 'Reach' pie chart shows, the majority of bookings originate from the UK, with 11% from international sources. Marketing activity is planned to expand the DA's international reach in the coming months.

Data & commentary source: DET Department 06/10/2021

Q2 2021/22: Directorate of Education and Training (DET)



This 'Growth' chart indicates bookings per course for the entire month of August 2021. The Perinatal and Children's Development Mini courses both performed above target.

It should be noted that bookings for the DA Trust Certificate are only recognised when students are fully enrolled. As of the close of applications, 10 students had enrolled on the course.

Also of note are the bookings for the new-format Masterclass, our most recent of which was on the Trust's Perinatal Mental Health training through the DA. Strong engagement from service contacts led to over 1,150 sign-ups to the free webinar and nearly 600 people turned up on the day. We are monitoring conversions onto our related courses.

Data & commentary source: DET Department 06/10/2021

Quarterly Quality Report Commentary Q1 2020/21

Introduction

As requested by the Board of Directors the following paper provides additional commentary and narrative from the Q2 Quarterly Quality Dashboard, specifically commentaries form Service Leads on Waiting Times and DNAs which covers the reporting period and plans for the following quarter.

Quality Priorities and KPIs are also covered, this year CQUINS are not part of the report due to Covid -19 crisis.

Please note the data in this report is mainly for Trustwide, with the exception of KPIs that apply to London Contracting or NHSE contracts only.

The following metrics are summarised below:

1.2 **Waiting Times – Commentary and planned actions - CYAF**

Waiting Times - feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adolescent /AYAS	AYAS continue to perform well in terms of seeing patients within the required time period and initiating an appropriate initial care plan. As you can see the relatively small number of under 18's seen in this quarter mean that when one breaches the % compliance reduced significantly. The patients who breached are both complex cases referred on to AYAS from Camden CAMHS and there has been significant attempts to help them access the service and to keep them as patients within AYAS rather than discharge them due to poor engagement.	To continue to offer patients an initial and second appointment within the assigned KPI. The number of referrals is increasing and so we will have to work consistently for this to be achieved.
Camden CAMHS	Camden CAMHS have continued to exceed the target for seeing patients for initial assessments within the required time period. In the small number of cases where the 1st or 2nd appointment target has been breached, processes have been looked into and learning implemented e.g. delays in intake processes in passing cases to the relevant clinical team.	Learning continues to be implemented to learn from delayed cases, including use of QI projects to reduce waiting times and optimise allocation processes to clinicians in teams. Team managers and admin leads also use a 'weekly waiter' report to monitor cases that are waiting for a 1st or 2nd appointment. A process has also been implemented to ensure cases that are likely to need WFT intervention to be passed straight to that team, so as not to be delayed within the intake processes.
Other CAMHS	We are pleased to see that we have continued to achieve target for referral to First Appointment and that there has been a steady improvement towards target for referral to treatment in the last two quarters. There have been difficulties with several referrals received having incomplete or inadequate information and several with no allocated social worker or family being unsure about whether they wanted the service, which have all caused delays to first appointment.	Continue to monitor key issues regarding compliance to ensure timely action if required.

1.1 **Waiting Times – Commentary and planned actions - AFS**

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adult Complex Needs	Adult Complex Service has been facing difficulties to see new patients referred to us due to the combination of the increase number of referrals to Trauma Unit and the decrease of staff resources both by many staff members that have left the service and also the Strategic Review and our financial issues due to the massive reduction of National Training contract. The latter of them have made the service to be put in a difficult position to recruit new permanent staff members. They have resulted in further breach on both categories.	Adult Complex Needs Service have been working with Strategic Review Team. We are going to recruit two Band 5 full time clinicians for one year in Trauma Unit and have just done so for Band 8a 4 sessions in Fitzjohns Unit. We will be working with the team to think about recruiting further members of staff who can see those patients who are waiting for the first and second appointment especially in Trauma Unit.
Portman	The majority of patients are see within 8 weeks. The delays in waiting times after initial referral have been looked into closely by the Intake team, and they have conveyed that these are mainly down to waiting for patients to write in or for referrers to provide more information and not closing these soon enough when a response is not forthcoming.	We will continue to ensure that patients receive their first appointment as soon as is possible.
City and Hackney PCPCS	PCPCS is mostly pleased with our waiting time figures for this quarter. The majority of our patients received their 1st and 2nd appointments within the appropriate timeframe, and the service provided them the help and support they need in a timely manner. Our clinicians have worked exceptionally hard under very challenging circumstances, including the impact of remote working, significant changes to the senior staff team and some staff shortages, including long term sickness.	We are working to return the team to full capacity and we have this month recruited to 2 vacant posts, plus the clinician on long term sickness is now making a gradual return to work. We are also bringing in 2 new clinical trainees this month, who will contribute to our treatment capacity and help us improve on current waiting times. We are working to increase our treatment capacity by implementing a number of measures including job planning and providing more therapy groups.

1.3 **Waiting Times – Commentary and planned actions – Gender Services**

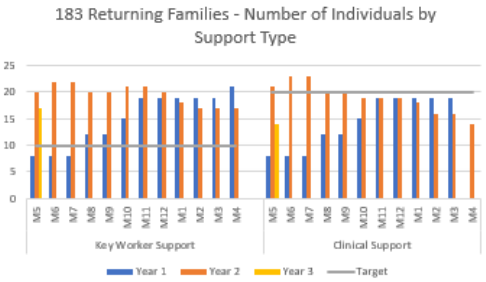
Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q1	Objective / plan for next Quarter
GIDS	Waiting times from referral to first appointment continue to be below the standard set but there was an improvement in the second quarter for the waiting time from referral to second appointment. We continue to review the longest waiting patients each week and this has helped waiting times to plateau in some regions. Plans are being developed to increase capacity to support the long term aims of reducing waiting times. We are also working through the validation responses from patients and families and are starting to see improvements from our intake programme.	- Confirm plans for increasing and releasing capacity to support the reduction of waiting lists and times for patients. - Continue with processing the validation responses from patients and families. - Continue and advance work reviewing the longest waiting patients each week. - Continue to work with NHSE on the redirecting of referrals to their Gender Development Referral Support Service and the development of their Regional Professional Support Services.
GIC	The service has had an extremely high number of referrals received during 2021/22 Q1, which was a 70% increase from 2017/18 Q1 coupled with a significant decrease in clinical capacity. We remain concerned about the gap between first and second appointments and are working through a programme of work to develop a robust response to this. As above this is unlikely to meet the current demand so we will continue working with NHSE to address the capacity issues as well as develop internal systems that enable us to decrease the gap between appointments.	We are working with HR and Finance to develop a recruitment strategy and to harmonise the posts that we have so there is scope for development and critical mass within the service to deal with the appointments. We are considering scope from other clinical disciplines with an interest in gender to join our services supported by a recruitment drive and strategy This however, will not be sufficient to meet current need for first appointments therefore we have submitted 2 business proposals with NHSE currently which will address the waiting times and patient support.

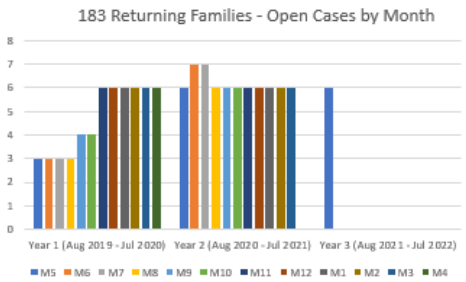
1.3 **Waiting Times – Appendix**

Service metrics for teams that are not measured based on waiting times:
The following teams are not measured in WT metrics as they follow a different delivery model.
First Step, FDAC, Gloucester House, and Returning Families.
Please see below metrics used monitor for First Step, FDAC and Returning Families below. With regard to Gloucester House we are developing appropriate ways to measure and map their activity, we are hoping to be able to share this in Q2.

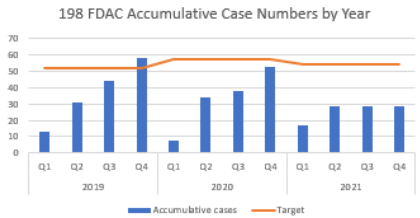
See Slide 3 for main CYAF WT data

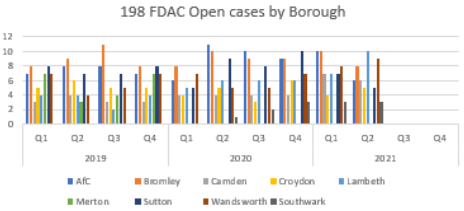
183 - Returning Families Unit



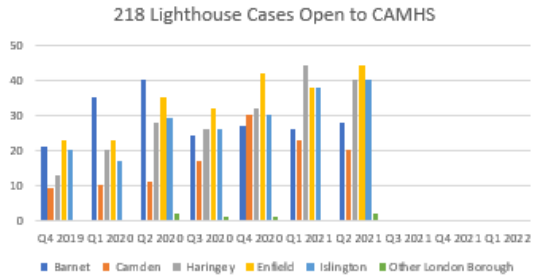


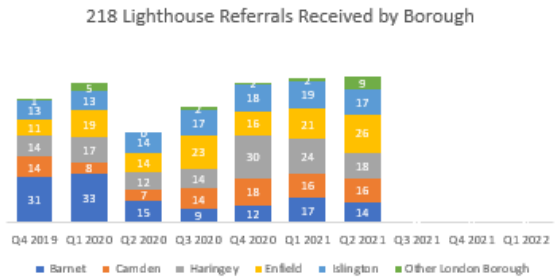
198 - Family Drugs and Alcohol Court (FDAC)



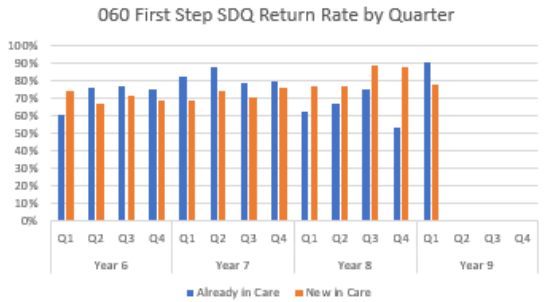


218 - The Lighthouse





060 - First Step



2.2 **DNA – Commentary and planned actions - CYAF**

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adolescent /AYAS	AYAS has been experiencing a higher number of DNA's since the start of 2021. It is not totally clear as to why this is as previous protocols such as bringing patients back to face to face appointments and having individualised plans as we initiated in Q3 for 2020/2021 worked well to reduce this.	We have asked for more details in relation to the modality that people are not attending – whether this is a remote appointment or an in-person appointment. We initially asked for this data earlier in the year when the DNA rate started to increase and it has now been agreed. Once we have this data we will start to develop specific interventions to address difference "types" of DNA's
Camden CAMHS	DNAs for Camden CAMHS have been consistently below the 10% target.	Teams continue to implement strategies to reduce DNAs, including SMS reminders, agreeing appointments with YP/families in advance.
Other CAMHS	Data in contracts suggests that the rise in DNAs in Q2 may be linked to the rise in people being contacted by track and trace. That data shows a drop in DNAs by mid September.	Continue to monitor the reasons for DNAs and which modalities may be affected more.

2.1 **DNA – Commentary and planned actions - AFS**

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adult Complex Needs	Adult Complex Needs Service remains below the target of DNA rate. We are seeing the increasing number of patients in person and the DNA rate remains the same.	The DNA rate remains under 10% regardless of whether patients are seen either remotely or in person in our service. We continue to sustain the good practice to them.
Portman	Our DNA rate has risen in the last two quarters.	We have noted that as pandemic restrictions have lifted, patients have been noted to be missing appointments to attend to other medical and personal issues, as well as for leisure. As the rate has risen above 10% for two quarters, we will address this in our team meetings and continue to monitor this. It is important to note that the population of the patients we treat, especially those with antisocial personality disorder, are known to be 'hard to reach' and often are difficult to engage and miss appointments, and this is likely to have an impact on our DNA rates.
City and Hackney PCPS	We are disappointed that PCPCS's DNA rate has risen above the Trust's target of 10%. As it is PCPCS's remit is to see hard-to-engage patients, some level of non-attendance is to be expected. However we have noted a rise in DNA's for those patients attending remotely via telephone and we are working to better understand this so we can take steps to stem this trend. We continue to use telephone contact, letters, email, and SMS reminders to inform patients of their appointment details and encourage engagement with their treatment.	As surgeries are gradually re-opening their doors, our clinicians are gaining access to more of the spaces from which we worked prior to the pandemic. This in turn enables us to offer more face to face assessment and treatment appointments, which we hope will facilitate engagement for some patients and reduce the number of DNAs. We will use supervision to closely monitor DNA patterns and identify constructive ways to address this with our patients, supporting them to make full use of the appointments available to them.

2.3 **DNA – Commentary and planned actions – Gender Services**

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q1	Objective / plan for next Quarter
GIDS	The number of patients who DNA appointments continues to show positive results by remaining below 10%. Work was undertaken to revise the internal processes and policy for managing patients who DNA. Additional and supporting actions to reduce DNA rates have taken place through the distribution of validation letters to patients and families and the weekly review of the longest waiting patients on a case by case basis.	- Audits to be conducted on the impact of the policy and process change for the management of patients who DNA. - Review and revise the use of text messages to remind patients of appointments.
GIC	The DNA rate is fairly similar to last quarter. It is back to a level that we have become accustomed to, however we hope that with releasing more information on our website, we will be able to bring this down.	We have published the DNA rate on the website in hopes that it inspires more attendance. The updated DNA policy of 2 DNA's and review to discharge has been going well. We are also through the managing waiting times workstream developing a plan to further address the DNA rates. Greater detail will be provided when the plans have been fleshed out.

3. Quality Priorities

3.1 Quality Priority 1

Quality Priority	1. Embed a revised job planning process within clinical services	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
Clarify parameters for job planning across the directorates (AFS, CYAF and Gender) and the processes for updating job plans when situations change	Guides for the job planning process have been established for CYAF, AFS & GIDs. GIC are in the process of establishing their process. The general managers are also working with HR to produce a trust wide job planning policy (currently at draft phase) and work is also underway to identify a suitable job planning software to support the trust process going forward.	On going
Ensure all clinical staff across the Trust have an initial job plan and review these at a divisional level to identify areas that reduce clinical capacity *e.g. supervision, team meetings etc…*	Currently there are draft plans on file for ~80% of CYAF & AFS and 90+% for GIDs. Some teams such as AYAS, Autism & LD and PCPCS have completed all job plans are in the process of reviewing areas that reduce clinical capacity with the GM & ADs. Reviews are being booked for the remaining teams.	On going
Implement the agreed principles and review job plans accordingly	Some of this work is already agreed in the guidance documentation and any remaining gaps are being discussed in the divisional directors meeting in Q3, which the general managers also attend.	On going
Agree standard timescales and mechanism for reviewing job plans and monitoring capacity on an ongoing basis	The suggested timescales and mechanisms for review and monitoring are mentioned in the divisional guides and will be confirmed in the trust job planning policy currently being worked on in collaboration with HR. Its likely job planning will be an annual process with individual and team performance against job plans being reviewed at regular interviews during the year.	On going

3. Quality Priorities

3.1 Quality Priority 1

Quality Priority	2. Improve the collection of race and equality data	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
Complete report of ethnicity data completion rates within each of the clinical divisions (AFS, CYAF and Gender)	Monthly report is in place. Performance has improved in 3/4 divisions but does still vary significantly: CYAF ~ 98% (AYAS 100%, Camden 98%, Other CAMHS 97%) up from 96% in April AFS ~ 90% (Portman 90%, Complex Needs 82%, PCPCS 98%) up from 86% in April GIDS – 74% up from 68% in April GIC – 68% down from 70% in April	**Achieved**
Provide a baseline of Experience of Service Questionnaire (ESQ) completion by ethnicity (Q1) and provide comparative data analysis during 2021/22	The new shortened ESQ was launched in April/May and a new Carenotes report has been developed that reflects the new questions as well as adding in a breakdown of completion and experience by ethnicity. Work is still needed to create a process to analyse and share this information by ethnicity. This is expected to start in Q3.	**On going**
Clarify the current initial data collection methods and processes for updating based on changed situation	All services have shared their current practices and a summary document was circulated in July so learning could be shared. Some new practices based on the learning as well as a QI project were implemented in Q2 resulting in improved collection rates in most services. A working group will also be established to explore collection processes further in Q3.	**Achieved**
Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review	Guidance on collection processes will be drafted in Q3 following the working group meetings.	**On going**
Implement guidance and report again across the directorates to monitor adherence and make adjustments where needed	As mentioned above, some initial learning has been implemented in advance of the guidance being drafted. Monitoring has been ongoing via the report each month and any specific QI projects will measure their direct impact separately.	**On going**

3.4 **Quality Priority 4**

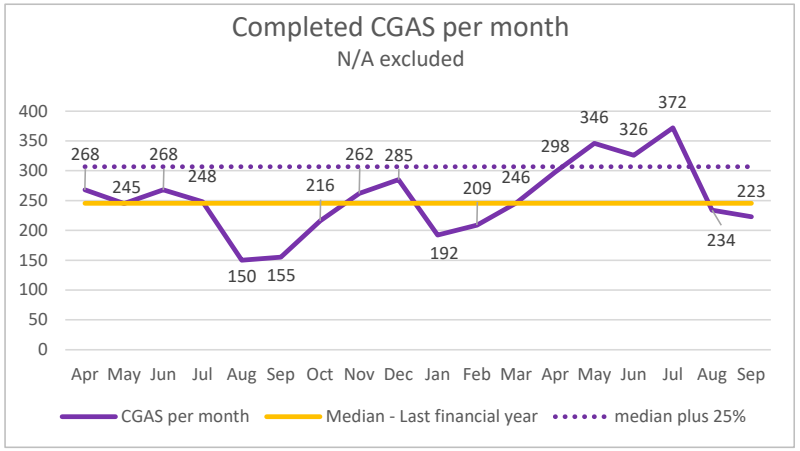
Quality Priority	3. Improve Waiting Times Across the Trust	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
Review waiting times across Trust services and identify range, variation and areas of good practice in waitlist management, based on Trust data (Q1)	It has not been possible to do this across the Trust due to other pressures. Work has been ongoing on addressing the GIDS waiting list, in line with the CQC Waiting List Action Plan.	On going
Agree key areas of focus and hold workshops to develop plans and QI projects to address wait times, ensuring that work aligns with strategic review changes (Q2)	It has not been possible to do this due to other pressures. Work has been ongoing on addressing the GIDS waiting list, in line with the CQC Waiting List Action Plan.	On going
Implement, monitor & review these plans, based on agreed measures for waitlist reduction (Q3 and Q4)	N/A	On going

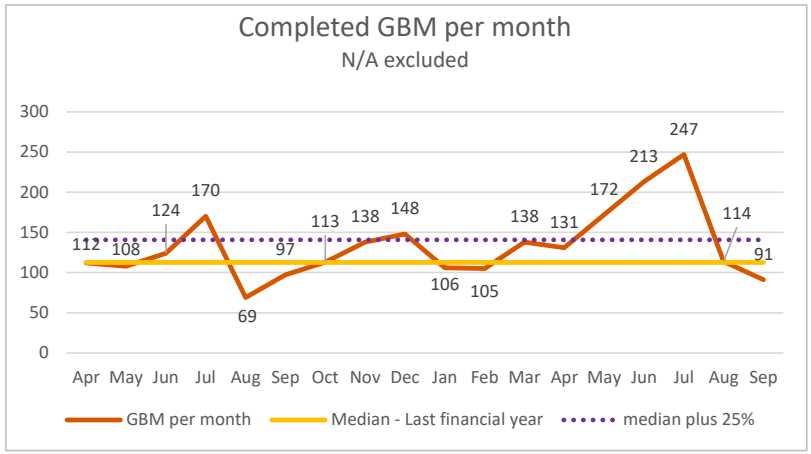
3.4 **Quality Priority 4**

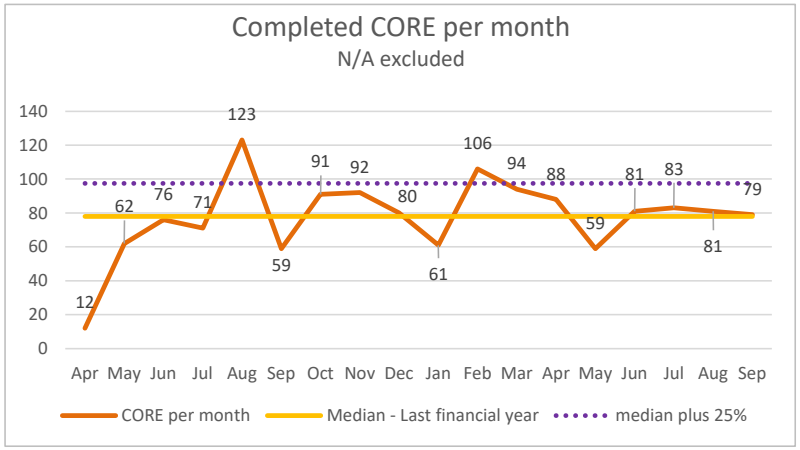
Quality Priority	4. Embed meaningful use of outcome measures across the Trust	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
To complete a pilot of an appropriate software solution for OM data e-mail out and return that is compatible with Carenotes data. To reduce administrative time in manual data input	*Informatics and technical progress Q2* • *More staff are becoming aware of Qualtrics and its function for data collection with an increase in requests to take part in the project.* • *Ongoing training available for Qualtrics applications.* • *REMINDER The new user form is also uploaded on the Intranet on the Qualtrics page* *Project Update – AFS Pilot project.* • *CORE OMs distribution is now a task being entirely managed by clinical administrators, who now have a clearer understanding of their role in this and of the Carenotes Assist Panel. An SOP has been written, with a step-by-step guide on how to facilitate a mail out via Qualtrics.* • *The aim is for CORE OM and ESQ to become business as usual for adult complex needs administrators by the end of October 2021* • *ESQs have been added to Qualtrics, planning to send ESQs as an email link for patients to complete* • *Adults' patients contact details (email addresses) are available in Qualtrics.* • *Adults' admin user accounts set-up on Qualtrics,* • *After the pilot with AFS, the plan is then to roll out Qualtrics with CYAF service.* *Hackney PCPCS* • *The CORE OM form is currently emailed to patients who are receiving treatment remotely and done in-person with patients seen face to face.* • *We have not noticed any difference in returns via these two methods, although some patients have reported they prefer doing the CORE OM outside of the clinical session. Therefore, we believe a move to an online system would be beneficial to both patients and the Trust, as it would grant patients their own space to complete the form.* • *Aim to move to using CORE 10, it is briefer, more suited to short-term work and informatics support is easier to report.*	On going
To increase OM returns across all services by 25% above baseline by year end	We note improvements in the CYAF measures above 25%. The difference between this and the collection of CORE is that GBMs are completed in sessions with patients and CGAS are completed by the clinician only, making both easier to complete for a larger pool of patients than CORE.	On going
To pilot brief and STP wide OM feedback (e.g. dialogue) OR for specific clinical services (e.g. Trauma) nationally benchmarked OM	This is a longer-term ambition which we will continue to discuss with system wide colleagues. The trauma service is researching national measures and we will then compare this with contract expectation and develop a CCG narrative about the value of a more clinically meaningful measures (to patients as well as clinically). The wider issue of system wide impact is yet to be resolved and may be some time off due the wholescale review of all NCL mental Health services.	On going

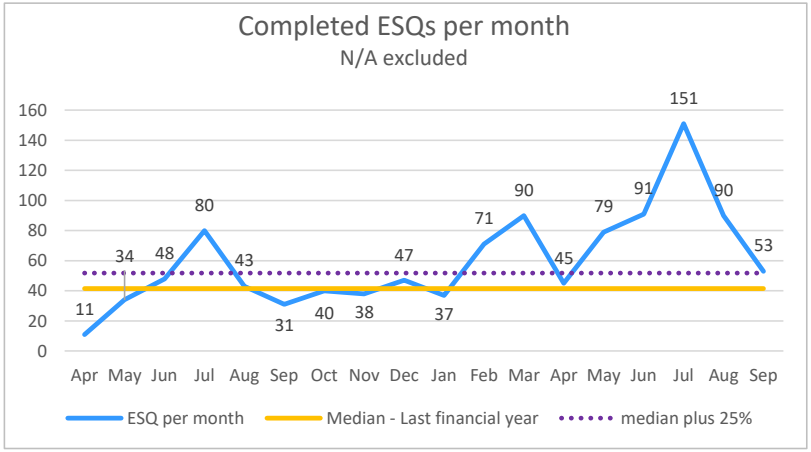
3.3 **Quality Priority 4**

QP4 Supporting information: This a trust-wide data report that includes the total number of forms completed in period, for all contracts, excluding forms marked as N/A. It measures the usage of OM forms in period.
- The yellow lines shows last financial year median, when the number of completed forms is above the median this means an improvement on the previous year's performance.
- The dotted line represents the 25% improvement on last year's performance, when the number of forms is above the dotted line it shows we have met the QP target.
Please note a minor glitch in the report has been fixed and the figures are marginally different. It still shows the same trend previously reported, as the change was minimal.









Section Five: Trust Targets – KPI

See Slide 11 for complaints graphical representation

Quality Key Performance Indicators										
Target	Monitoring	Target %	% Progress 21/22				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Complaints* - % Response to Complaints A - 90% of complaints acknowledged within 3 working days.	Quarterly	>90%	34/35 97%	41/45 91%						
B - 80% of complaints responded to within 25 working days. We are including closed rather than open, recent open complaint might not have been open for 25 working days.	Quarterly	>80%	3/24 12.5%	1/2 50%						
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	100%	100%	100%						
E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis.	Bi-annually	n/a	yes	yes						
F - Evidence of relevant complaint action plan implementation	Quarterly	n/a	yes	yes						
Complaints: A - Provide quarterly complaints and claims update to include: i) no. of complaints where response is outstanding at 3 months and reasons why	Quarterly	n/a	19 Pressure of work on staff	19 Pressure of work on staff						
ii) Number of complaints reported to CQC	Quarterly	n/a	0	0						
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	0	0						
iv) Number of re-opened complaints.	Quarterly	n/a	0	0						

Section Five: Trust Targets – KPI

Quality Key Performance Indicators										
Target	Monitoring	Target %	% Progress 21/22				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Trust Service cancellation rates Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	2.99%	2.22%						
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q4	n/a								
Clinical Audit A - Provide CCGs with copy of Trust wide audit programme in Q2.	Q2	n/a		See attached clinical audit paper Microsoft Word Document						
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	Q2 & Q4			See attached clinical audit paper Microsoft Word Document						
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Q4									
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	Q2 & Q4	n/a		See attached clinical audit paper Microsoft Word Document						

Section Five: Trust Targets – KPI

See Slide 13 on HR for graphical representation

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target	Monitoring	Target%	% Progress 21/22				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Appraisal/ Personal Development Plan Quality and Development of staff: Target 90% of staff to have a PDP.	Quarterly	90%	24%	24%						
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%	1%	1%						
Staff Training % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red	Annually	>95%								
Mandatory Training % of eligible staff are currently compliant on all of their mandatory training	Quarterly	>95%	75%	74%						
DBS checks - Standard and enhanced % of staff that require an Enhanced DBS check and have one within the 3 year renewal period	Quarterly	100%	98%	92%						
Enhanced DBS Checks: The DBS is not 100% because the report will account for staff who are on career break, long-term sickness absence, career breaks and maternity leave. In addition the report will not be reflective of staff who have expired and currently going through the re-check process. The process still remains where the team will produce monthly DBS reports and contact staff who are due for renewal and chase those that require renewals.										

Section Five: Trust Targets – KPI – London Contracts

Target	Detail of indicator	Reported	Target %	% Progress 21/22	RAG Progress Q1	Q2	Q3	Q4
CAMHS Transformation Targets Run for London Contracts only	80% initial completed care plans	Q1-Q4	80%	**Q2 compliance 56% -- out of 108 assessment summaries completed, 61 initial care plans were created** There seems to be a slight increase this quarter. The likely increase could be due to our admin teams using the simplified version of the report, which is prompting the mobilisation for clinicians to completing the patient care plan. In order to increase completion of care plans for the next quarter the service manager will run reports and send directly to the clinicians on a monthly basis, this process should create an increase of Care plans generated for Q3.				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	**Q2 compliance 26% -- 446 Assessment Summaries completed, of those, 114 Review Care Plans were created/shared . The percentage of those care plans completed within 6 months of the initial Assessment Summary was 8%** A 4% decrease in the compliance. However, the number of review care plans complete last quarter was 58, this quarter has seen a significant rise in the compliance rate of the number of completed review care plans to 114. It seems that the new simplified version of report is playing an important factor in our compliance rate.				
	85% CYP in relevant services (CAMHS in CSF integrated service) reporting 'certainly true' or 'partly true' to CHI-ESQ question 7 ('I feel that the people who have seen me are working together to help me')	Q1-Q4	85%	**Q2 compliance 98% -- we received 182 responses from CYAF patients to the ESQ question '*How well are people you've seen here working together to help you?*'. 143 patients answered 'A lot' and 17 answered 'A little' - numbers based on new ESQ responses.** A further increase and we are happy to see that, we are again, above our targets for our ESQ's and we will continue to work together to deliver the high standard of clinical care to our patients throughout our clinical services.				

Data source: 11/10/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Section Five: Trust Targets – KPI – London Contracts

See Slide 16 for OM graphical representation

Target	Detail of indicator	End of Year Target %	% Progress 21/22	RAG Progress Q1	Q2	Q3	Q4
CYAF Outcome Monitoring GBM - Goal Based Measure CGAS - Children's Global Assessment Scale Run for London Contracts only	GBM Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q2 compliance 42% -- 86 GBM T1's out of 203 due in period were completed** There has been a reduction in Q2, likely impacted by the amount of leave taken over the summer period and fewer reminders being circulated. Many forms, including GMB, are completed late and so we expect compliance to significantly increase when the numbers are refreshed at the end of Q3 (it increased from 45 to 63% in Q1). Reminders will be stepped up in Q3 and we are also exploring how new technology can help encourage greater completion.				
	GBM Time 2 % patients who had an second appointment 4 months prior Q2 or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired GBM Time 1	60%	**Q2 compliance 37% -- 59 GBM T2's out of 161 due in period were completed** There has been an increase compared to Q1 but we are still falling well short of our target. The reasons and plan to improve are the same as above.				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q2 compliance 70% -- 135 CGAS T1's out of 194 due in period were completed** There has been a similar performance to Q1 but still short of the 80% target. As with GBM this will have been impacted by summer leave and less reminders being circulated. As with GMB, forms are often completed late and so would expect compliance to significantly increase when the numbers are refreshed at the end of Q3 (it increased from 68 to 95% in Q1). Reminders will be stepped up in Q3.				
	CGAS Time 2 % patients who had an second appointment 4 months prior Q2 or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired CGAS Time 1	60%	**Q2 compliance 39% -- 73 CGAS T2's out of 185 due in period were completed** As above.				

Data source: 06/07/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Report to	Date
Tavistock and Portman NHS Foundation Trust Board	Tuesday 30th November 2021

Gender Identity Clinic (GIC) Strategic Review Transformation Programme

Executive Summary

This paper seeks to give the Trust Board an outline of how the Adult Gender Identity Clinic (GIC) will be respond to the Trust Strategic Review delivered through a Transformation Programme of work. The paper also seeks sign off and approval of the proposed approach and asks that the Trust Board note the risk associated with this proposal. It is informed by the Trust Strategic Review, The National Service Specification for Gender Dysphoria Services and the Royal College of Psychiatrists, "Good practice guidelines for the assessment and treatment of adults with gender dysphoria". It is also informed by a service line diagnostic process which is ongoing and has looked at management and clinical structures measured against the contractual and commissioning intentions, lessons learnt from the current 70% increase in activity as well as a forensic review of the budgets, recruitment and retention, workforce modelling and current pathways and practice.

GIC Core Proposition

- Reduction of waiting list and waiting times between appointments in the context of a 70% increase in referrals over a 2 year period, with no substantive increase in staffing and or how the service lines are organised.
- Review of the workforce to ensure that they are working and focusing on the right things aligned to the strategic review, with particular focus on the ratio between clinical and admin staff, job planning and improvement of accountability and managerial grip.
- Managing staff sickness and management framework in the context of very specific challenges to delivering some of the work that we have agreed with stakeholders.
- Development of robust governance structures relating to Clinical Governance, Reporting, Risk Management, Operational and Strategic management to support accountability and a cogent narrative to the Trust and stakeholders.
- Focus on key deliverables aligned to service specifications and clinical pathways rather than a current focus the non-commissioned activity and change management of clinic's culture of exceptionalism.
- Stakeholder engagement and development of intuitive comms framework in the context of unprecedented legal and public scrutiny of the service.

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Strategic Review Transformation Programme

The GIC Transformation programme will be structured around four main workstreams and three enabling workstreams. These workstreams will become a consistent framework for planning and monitoring the implementation of the programme, and be used across the programme governance to ensure the objectives of the programme are met. These workstreams will have significant interfaces and these will need to be managed by workstreams leads. We anticipate that each work stream will generate further work packages whose deliverables will be supported through targeted Task and Finish groups made up of relevant staff and stakeholders. The GIC staff have all been socialised to this approach and have coalesced into workstreams based on their subject matter expertise and areas of interest.

Main Workstreams

- Managing Waiting List
- Mapping the Pathway
- CQC and Quality Improvement
- Equality Diversity and Inclusion

Enabling Workstreams

- Workforce
- Communications
- Digital

Governance

Governance and oversight will be through a GIC Transformation Steering Group who will report up the board via the Gender Oversight Committee (GOC) on which a NED and three execs sit.

End

Recommendation to the [Board / Council]
• Members of the Trust Board are asked to note, discuss and approve the GIC Strategic Review Transformation Programme approach and core propositions. • Members of the Trust Board are asked to note the risks that such a large scale programme of work will involve.
Trust strategic objectives supported by this paper
Trust Strategic Review

Author	Responsible Executive Director
Divisional Director GIC	Divisional Director, Gender Services

Gender Identity Clinic (GIC) Strategic Review Transformation Programme

1. Introduction

1.1. This paper seeks to give the Trust Board an outline of how the Adult Gender Identity Clinic (GIC) will be responding to the Trust Strategic Review delivered through a Transformation Programme of work.

1.2. The paper also seeks sign off and approval of the proposed approach and asks that the Trust Board are sighted to the risks.

1.3. It is informed by the Trust Strategic Review, The National Service Specification for Gender Dysphoria Services and the Royal College of Psychiatrist's "Good practice guidelines for the assessment and treatment of adults with Gender Dysphoria"

1.4. It is also informed by a service line diagnostic process which is ongoing and has looked at, management and clinical structures measured against the contractual and commissioning intentions, lessons learnt from the current 70% increase in activity as well as a forensic review of the budgets, recruitment and retention, workforce modelling and current pathways and practice.

1.5. It is important to note that some of the proposals presented in this document will not directly map to the Strategic Review structures as the GIC is a national tertiary, highly specialist service and as such, have to balance meeting the Trust's Strategic Review challenge whilst maintaining the fidelity of the highly prescriptive national commissioning, clinical and contractual obligations as well as best practice for Gender.

1.6. This landscape is continually shifting currently, in the context of unprecedented focus on gender nationally and internationally, therefore the proposals maybe subject to change over the next few months in response to changes in contractual and clinical guidance as well as the new care models for gender being implemented by NHS England and the Gender Clinical Reference Group.

1.7. This approach is informed by a service line diagnostic process which is ongoing and has looked at, management and clinical structures measured against the contractual and commissioning intentions, lessons learnt from the current increase in activity as well as a forensic review of the budgets, recruitment and retention, workforce modelling and current pathways and practice.

1.8. Some of the outputs from this work is still emerging therefore the GIC will need a few more weeks to refine the proposal to ensure it is aligned to all key findings of the foundational work being carried out within the context of key areas of focus for the strategic review.

2. Core Proposition

2.1. The GIC proposal focusses on service and quality improvement, developing robust clinical governance frameworks, development of responsive patient centred pathways and efficient use of existing resources by reducing variation in process and pathways.

2.2. The GIC function in a fundamentally different way to the rest of the trust as several elements of delivery relate to specialist gender and physical health with a limited focus on mental health.

2.3. There is however a need to develop the current clinical and operational functions, as well as workforce to be better aligned to efficient delivery of the service specification. Fundamentally the GIC are responding to the Strategic Review and NHSE Specialised Commissioning challenge based on the following core propositions:

2.3.1. Reduction of waiting list and waiting times between appointments in the context of a 70% increase in referrals over a 2 year period, with no substantive increase in staffing and or how the service lines are organised.

2.3.2. Review of the workforce to ensure that they are working and focusing on the right things aligned to the strategic review, with particular focus on the ratio between clinical and admin staff, job planning and improvement of accountability and managerial grip.

2.3.3. Managing staff sickness and management framework in the context of very specific challenges to delivering some of the work that we have agreed with stakeholders.

2.3.4. Development of robust governance structures relating to Clinical Governance, Reporting, Risk Management, Operational and Strategic management to support accountability and a cogent narrative to the Trust and stakeholders.

2.3.5. Focus on key deliverables aligned to service specifications and clinical pathways rather than a current focus the non-commissioned activity and change management of clinic's culture of exceptionalism.

2.3.6. Stakeholder engagement and development of intuitive comms framework in the context of unprecedented legal and public scrutiny of the service.

2.3.7. Development of a mature link between GIC and Corporate functions of the Trust

2.3.8. Meaningful responses to the Freedom to Speak Up and Race Equality Independent Review and Staff Survey.

2.3.9. Improving our relationship with primary care and ICS Chief Pharmacists to ensure that they fully sign up to our shared care protocol.

2.3.10. Formulating a robust response to the CQC action plan and Quality Priorities as well as managing relationship between our delivery and advocacy role have a mandate to responding to the Strategic review to address the following challenges.

2.3.11. The GIC Transformation programme will be structured around four core workstreams and three enabling workstreams. These workstreams will become a consistent framework for planning and monitoring the implementation of the programme, and be used across the programme governance to ensure the objectives of the programme are met.

3. Strategic Review Transformation Programme

3.1. The GIC Transformation programme will be structured around four main workstreams and three enabling workstreams. These workstreams will become a consistent framework for planning and monitoring the implementation of the programme, and be used across the programme governance to ensure the objectives of the programme are met.

3.2. These workstreams will have significant interfaces and these will need to be managed by workstreams leads. We anticipate that each work stream will generate further work packages whose deliverables will be supported through targeted Task and Finish groups made up of relevant staff and stakeholders.

3.3. The staff have all been socialised to this approach and have coalesced into workstreams based on their subject matter expertise and areas of interest.

3.4. Main Workstreams

- Managing Waiting List
- Mapping the Pathway
- CQC and Quality Improvement
- Equality Diversity and Inclusion

3.5. Enabling Workstreams

- Workforce
- Communications
- Digital

3.6. This approach has been informed by forensic review of the current clinical pathways, process mapping how clinics are booked, the DNA and cancellation rates and modelling of the workforce aligned to supporting baseline data that will be used to inform how service pathways and clinical functions will be organised in future to respond to our key challenges and main propositions.

3.7. This work is running in tandem with the development of the management and clinical structure but is of sufficient maturity for us to have made the working assumptions that we have.

3.8. The clinical and operational outputs of the transformation programme will be supported by appropriate Project Management and Quality Improvement frameworks.

4. Governance

4.1. Governance and oversight will be through a GIC Transformation Steering Group who will report up the board via the Gender Oversight Committee (GOC) on which a NED and three execs sit.

4.2. The Task and Finish Groups and Workstream Leads will report to the GIC Executive Team and Gender Divisional Director on a monthly basis as a minimum

5. Risks

5.1. **Dovetail with a reciprocal corporate response** – These proposals have been developed without line of sight of the Trust Corporate Review proposals. Our assumptions are predicated on a robust and mature corporate support function being presented. A failure of the corporate proposals to dovetail to respond to this challenge will result in the service having to plug the gaps again to respond to contractual and governance obligations, thus compromising the fidelity of the proposed outcomes

5.2. **Additional funding and resource from NHSE** – we have presented 3 bids for additional funding from NHS England commissioners with view to increasing clinical capacity within the pathway and are currently working with NHSE and Business Development to ensure that we get the business cases over the line. There is a risk that we may not be able to meet some of the key deliverables should we not be awarded any funding through the bid process.

5.3. **Recruitment** – Recruitment into clinical post may take long but this will be mitigated by a full recruitment and retention strategy.

5.4. If we do not have adequate HR support, we will not be able to manage people effectively

5.5. **Model assumptions by the trust** – A model of resignation and natural attrition is unlikely to deliver timely outcomes and may result in significant delay in transition to the new structure and model.

Management and clinical activity data dashboards – If we do not have good real-time reliable data, managers will not be able to manage activity effectively

5.6. **Cultural Change** – In order to achieve changes, there will need to be significant cultural change. Staff are used to working autonomously and not being overly managed, they will find a more tightly managed system very challenging and this will require significant and rigorous oversite over a sustained period of time.

6. Conclusions and Recommendations

6.1. Members of the Board are asked to note, discuss and approve the GIC Strategic Review Transformation Programme approach and core propositions.

6.2. The Board are asked to note the risks that such a large scale programme of work will involve.

6.3. The GIC Divisional Director will bring to board or appropriate forum an update in the next quarter when GIC have a mature plan and updates.

Appendix A

	WORKSTREAM	WORK PACKAGES
Core	1. Managing the Waiting List	Reduction in the current numbers on people on our waiting list focusing on: • Pathway – Mapping the pathway to ensure that it is aligned to the service specification and to mitigate inefficiency in the pathway. • Staffing– Reviewing staffing to ensure that they are deployed to functions that are most likely to address any bottle necks within the pathway. • Training – What training, support and development is required to support efficient transition to the proposed model of addressing the waiting list. • Models of care – Review the models of care for each of the clinical functions to ensure that they are operating in the most efficient way aligned to the key priorities and service specification. **Support and Management** • Workshops – Resurrecting the waiting list workshops that were held by clinicians prior to Covid-19 restrictions as well as considering clinical groups that Clinicians can run for less complex cases as a way of meeting demand. • Partnerships – with 3rd sector and or other NHS Gender Services to develop a network of access for the patients and clinicians regarding how we collectively address the waiting list. Cross pollination of best practice.
Core	2. Pathway Mapping	Map the pathway to ensure that practice is aligned to the operating framework, service specification and current best practice. The outcome will inform mitigation and or changes to ensure that the service addresses. • Bottle necks in the pathway • Internal waits • Appointment Scheduling (links with job planning)

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		• Clarity around discharge and messaging (Comms. WS) • Appointment booking, confirming, cancelling, DNAs
Core	3. CQC and Quality Priorities	Review the CQC action plan and respond to all the outstanding actions as well as any emerging themes focusing on: • Service quality assurance processes (quality concerns) • Review current governance frameworks and use of meetings Clinical Governance/GIC Exec and Clinical MDT meeting • Capital works and signs within building • Waitlist • Outcome Measures
Core	4. Equality, Diversity and Inclusion	Set up a representative group of people that will help us to deliver the EDI priorities following the publication of the Independent Race Equality Review Report and feedback from the past 2 years relating to gender, freedom to speak up and staff experience surveys. • Develop GIC mission statement re: EDI • Set up the group that is to work to this workstreams • Agree what to prioritise and a suite of actions • Ensure that a representative of this group are included in exec meetings
Enabling	5. Workforce	Review of workforce and training and aligned to the Pathways work stream and the Trust Strategic Review. Clinicians • Job Planning, Banding and Succession planning • Clinical Structure – clear line management and supervision structures Administration • Tasks • Capacity • Single points of failure

		• Central functions • Links with Corporate services
Enabling	6. Communications	Overarching support across work steams including: • Waiting List messages and communications • Pathways messaging including discharging and DNAs • Recruiting new members of the PPI users group and wider engagement with less heard from groups • Website messaging including ensuring easy read is an option for all external communications (info leaflets, patient material, web site, etc.) • Staff communications including EDI involvement • Communication and engagement with GP's
Enabling	5. Digital	The service needs to consider the use of technology and digital as follows ESR: • Referral pathways using the digital platform and how this is managed • How this is linked to current pathways • Development of a Single Point of Access so that the pathway is not silted up and cause significant delays to the pathway • CareNotes forms for GIC review **SPA** • Development of a GIC dashboard so service managers and clinicians can get data in real time to inform management and clinical decisions **ACCRX** Bolt on platform to help clinicians gain contemporaneous diagnostic and clinical data such as bloods as well as enable more intuitive communication with patients in anticipation of appointment. Will result in reduction of admin and missed appointments. Compatible with CareNotes.

Report to	Date
Board of Directors	30 November 2021

GIDS Transformation Programme: Update

Executive Summary

This report summarises GIDS Transformation Programme progress, forthcoming activity and key risks and issues.

Recommendation to the Board

Members of Board of Directors are asked to note and discuss this paper.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Divisional Director, Gender Services	Chief Executive

GIDS Transformation Programme: Update

1. Introduction

1.1 This paper provides an update on the Gender Identity Development Service (GIDS) Transformation Programme, to November 2021.

2. Background

2.1 The GIDS Transformation Programme started in January 2021. As previously reported, it encompasses projects to develop a new endocrine pathway following various legal rulings (including the judicial review appeal judgement of 17 September 2021); waiting list management; clinical governance, safety and practice; organisational design and development, including staff engagement; and data. The programme is informed by a refreshed Patient and Public Involvement (PPI) Stakeholder Group.

2.2 Monitoring is via the GIDS Oversight Committee, which meets fortnightly and is chaired by the Trust Chief Executive; and the weekly GIDS Interim Management Board (IMB). All the Project Boards within the Transformation Programme meet regularly as they develop and implement their plans.

3 Progress

3.1 Staff in GIDS continue to work extremely hard in very challenging circumstances to care for patients, as well as contributing to the changes being developed and implemented through the transformation programme. I continue to be very grateful to them.

3.2 Work continues to progress against the actions agreed in the CQC Action Plan and the CQC Waitlist Action Plan. We report monthly to CQC against these. Some specific areas of progress, since the last Board Report (September 2021), include:

- The CQC Quality Summit held in October 2021, with system partners, discussed progress since the last Summit (May 21), and forthcoming priorities.
- Piloting a new, structured initial consultation for all GIDS patients which will produce an initial consultation summary report (which will include an initial care plan); and will also address a number of CQC actions
- Currently revising safeguarding and consent SOPs.
- Introducing record keeping Quality Improvement (QI) collaboratives within regional teams.

- Ongoing roll out of revised clinical review and decision making processes for endocrine treatment, to reflect legal and service specification changes.
- Finalising work to bring together separate regional waitlists, to ensure more consistent processes and practice, and to reduce the potential for inequities in access.
- Working with NHSE/I to support the smooth implementation of the new Regional Professional Support Service and the National Referral Management Service.
- Introduction of new internal governance and accountability arrangements.
- Conducting a focused recruitment and retention drive, to build capacity in the service.
- Continuing use and refinement of the GIDS management information dashboard; including embedding its use within governance meetings.
- Development of internal communications, engagement and PPI strategies, focused on ensuring we communicate and engage well with GIDS staff and also with young people and families.
- Management of Transformation Programme; in order to realise intended programme benefits.

3.3 Forthcoming activity includes:

- Continued development and implementation of actions in the CQC Action Plan and the Wait List Action Plan, and monthly reporting against these.
- Scoping incorporation of QI methodology and capacity building within the service, as part of implementation planning.
- Ongoing roll out of new endocrine treatment decision making arrangements.
- Continuing pilot of structured initial consultation for all GIDS patients, due to complete by the end of 2021.
- Ongoing weekly patient tracking list (PTL) meetings in each GIDS team, to address and move forward the longest waiting patients.
- Ongoing recruitment and retention activity.
- Roll out of rewards and recognition initiatives, as part of implementation of the Workforce strategy.
- Progression of job planning project including agreeing targets.
- Continuing to implement new GIDS governance arrangements via a new fortnightly Service Management Group (SMG), responsible for monitoring and overseeing service resourcing and performance
- Designing and testing new, structured care and treatment pathways.
- Continued monthly PPI Stakeholder Group with young people and parents.

4 Key risks

4.1 Key risks continue to relate to the waiting list, and workforce capacity to ensure good clinical care and to address demand. These are reflected in the Trust's Operational Risk Register.

5 Conclusion

5.1 The Board are asked to consider and note this update.

Ailsa Swarbrick
Divisional Director of Gender Services (GIDS)
19 November 2021

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	30th November 2021

Setting Priorities and milestones to March 2022

Executive Summary

Following discussion at the October Board seminar this paper seeks the agreement of the Board of Director around core priorities and milestones for the Trust for the period up to March 31, 2022.

Recommendation to the [Board / Council]

The Board of Directors are asked to approve the recommendations in this paper.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director

Setting priorities to March 2022

1. Introduction

1.1. As the Board is aware the Trust is managing a uniquely challenging set of priorities, at present, reflecting both internal and external objectives and demands.

1.2. As the Board discussed at its October seminar it will be helpful to have agreed frame which support decisions on where effort prioritised in the next 6 months.

1.3. This paper sets out a set of key priorities and milestones which the Board is asked to agree.

2. Background

2.1 Current pressures on the organisation are being driven by a number of factors:

- Alongside many other parts of the NHS, a challenging service environment with high levels of demand (number and acuity) for many of our clinical services and a busy agenda for training and education.

- The scale of our internal change programme as manifested by the Strategic Review, the Governance Review and our response to the External Review on Race.

- A significant number of external pressures including preparation for expected regulatory visits.

- Ongoing issues in relation to gender services including the delivery of the GIDS Transformation Programme.

- Gaps in a number of corporate structures, and other teams, exacerbated by the need to minimise substantive recruitment in some areas ahead of consultation.

3. Setting a framework for priorities

3.1 Key priorities and milestones are set out at Annex A in three categories:

- Essential priorities – largely reflecting our internally focused key objectives

- Other non-negotiables – including externally set priorities which will need to be addressed.

- Watching brief – important issues which it is important we keep in view but where it is unlikely, we can do much proactive work in the next 6 months.

4. Conclusions and Recommendations

4.1. The Board of Directors are asked to agree the priorities and milestones to March 31 set out at **Annex A**.

Paul Jenkins
Novemver 2022

Annex A

Core Priorities	
Priority	**Milestone**
Strategic Review	Launch consultation – end Jan 2022 Consultation – February 2022 Board sign off of proposals – end March 2022 External engagement with ICS and key partners. Three-year financial trajectory Board statement on longer term strategy
GIDS Transformation	Prepare for 3rd Quality Summit (end January 2022) and potential reinspection
Race Equality	Board sign off refreshed Race Equality Strategy and Action Plan – end January 2022 Further programme of staff engagement

Governance	Board sign off of Governance Review recommendations – end January 2022. Implementation of urgent must do actions. BAF and Risk Management 2022 Business Plan
Relocation	Progress OBC External engagement including LB Camden/ICS
Business as usual (Clinical and Education and Training)	Support ongoing operations Focus on supporting staff wellbeing Response to Covid/winter pressures
Other Non-Negotiables	
CQC Inspection	Prepare for possible well led inspection
Ofsted Inspection	Prepare for possible inspection of Gloucester House
ICS Commissioning Review	Engage with process and anticipated recommendations on priorities and resource allocation
Business Development	Completion of core bids eg M80 reprocurement
Finance	ICS reporting and management of H2 position 2022/3 draft budget

Watching Brief

Degree Awarding Powers

Longer term business development strategy

Longer term recommendations of the Governance Review

Longer term partnership opportunities

Report to	Date
Board of Directors	30th November 2021

EDI Activity – November Update

Executive Summary

This report lists out the EDI activity completed to date and planned for the remainder of Q3 and Q4 of 2021-22. The following update includes the Trust's current response to the findings and initial action plan on Race Equality from the 'Colour Brave Avengers' report and the CQC requirements and provides a projected timescale for completion for each area of work.

Staff across the Trust are naturally concerned to know what we are doing in response to these recent reports and recommendations, and it is proposed that we use this EDI activity plan to keep staff updated via our internal comms updates and enable them to ask questions around each area and become involved in bringing about the required changes this work is designed to achieve.

As noted in the external review it is also proposed that a further external review in in 18 months to 2 years is required to check on our progress in all areas, at which time we would hope that the desired changes will have impacted positively on staff across all directorates and services in the organisation and will take the Trust closer to the Trust objective of becoming an anti-racist organisation.

As we move to the developed RES and RAP and overall EDI strategy and plan, as part of the People Plan, we will be able to better demonstrate and report our actions against key EDI strategic objectives and themes.

In the meantime the report lists key actions as follows

- NED Recruitment outcome & NED Workforce Race Equality Standards (WRES) Training Opportunity
- Developing the Trust Race Equality Strategy 2021 onwards
- Colour Brave Avengers Report
- White Allies Programme
- CYAF Quality Improvement Pilot using 'Inclusive Employers' Toolkit

- Work with Staff Networks –Action Plan
- Trust wide Diversity Champion appointments
- Staff Training – Training proposal to support Race Equality Action Plan (RAP)
- New Reporting System for Incidents of discrimination
- Review of Exiting staff – managing exit Interviews
- Workforce Race Equality Standards (WRES)
- EDI Communications for all staff

Ongoing and planned immediate work in other areas of the EDI agenda includes the below:

- Development of the Trust People Plan
- New Line Manager's Forum & Handbook
- Recruitment – New Recruitment & Selection Training
- Mediation & Dispute Resolution Plans
- Mentoring & Coaching Plans
- Safe Psychological Spaces for Staff
- Plans to increase disability awareness across the Trust
- Workforce Disability Equality Standards (WDES)
- Review of policy and procedure management

Please see Activity detail in Appendix A

Recommendation to the Board
Members of Board of directors are asked to note this paper.
Trust strategic objectives supported by this paper
All Trust Strategic Objectives

Author	Responsible Executive Director
Associate Director of Equality, Diversity & Inclusion	Interim Director of Human Resources

APPENDIX A

EDI ACTIVITY 2021-22

1. NED Recruitment outcome & NED WRES Training Opportunity
2. Developing the Trust Race Equality Strategy 2021 onwards
3. Colour Brave Avengers Report
4. White Allies Programme
5. CYAF Quality Improvement Pilot using 'Inclusive Employers' Toolkit
6. Work with Staff Networks – Action Plan
7. Trust wide Diversity Champion appointments
8. Staff Training – Training proposal to support Race Equality Action Plan (RAP)
9. New Reporting System for Incidents of discrimination
10. Review of Exiting staff (staff leavers) – managing exit Interviews
11. Workforce Race Equality Standards (WRES)
12. EDI Communications for all staff

1. NED Recruitment

Following a recruitment process and strategy to actively outreach to a more diverse candidate pool we are delighted that the appointments of the two NEDs to the Board will help to meet our ambition of becoming an ethnically more representative organisation as both appointees identify as from ethnically diverse backgrounds.

2. EDI Development opportunity for NEDS

We look forward to the next opportunity to nominate a Non- Executive Director, (NED) to attend a 3-day Workforce Race Equality Standard, (WRES) Advisors programme, one of many interventions which culminate into an ambition to shift race inequality across the NHS in London as set out in the vision in the London Workforce Race Strategy.

3. Trust Race Equality Strategy 2021 onwards

With the support from the National Workforce Skills Development Unit we have now successfully commissioned the consultant firm MRL Consultants,

who will be joining the Trust on a short term basis to assist in creating the Trusts' next Race Equality Strategy due to be delivered to the Board at the end of January 2022.

This work has now begun re next Race Equality Strategy and regular weekly meetings are in place with the Associate Director of EDI. These meetings focus on the previously completed work of Colour Brave Avengers report including reviewing the thematic responses from individuals who took part in the interviews over the summer. They are also looking at the identified race action plan (RAP) and CQC recommendations. We plan to have a draft strategy ready for by 10th December for Board input/approval.

To date MRL have conducted 30 minute interviews arranged with a variety of relevant stakeholders as listed below with a few remaining this week. Some initial feedback from both interviewees and the interviewers have reported that they found it useful and insightful and were able to provide input which they feel will be invaluable within the new strategy.

Shalini Sequeira	Emily Lee	Brian Rock	Katie Argent	Laverne Antrobus
Steve Bambrough	Nsimire Bisimwa	Sarah Stenlake	Hannah Poupart	Geraldine Creehan
Laure Thomas	Mike Smith	Judy Blackwood	Pauline Williams	Paul Dugmore
Tosin Bowen-Wright	Sally Hodges	Dinesh Sinha	Paul Jenkins	

4. White Allies Programme

The Trust was invited to apply for places on this NHS London programme for white allies. After sharing with staff via comms, we received 11 applications in total for this training and were able to identify the 6 staff below to complete this training from the Trust.

We hope this training will provide this level of leadership with the required skills and awareness to help the Trust navigate the journey to becoming an

anti-racist, more inclusive organisation in relation to staff, patients and students.
The participants will be asked to provide feedback for any Trust wide learning from the course via relevant forums.

Participating Staff	2021 Dates	2022 Dates
Sally Hodges Terry Noys Paul Dugmore Nell Nicholson Tim Kent Lydia Hartland-Rowe	6th October 2021 10th November 2021 8th ~December 2021	12th January 2022 9th February 2022 9th March 2022

5. CYAF Q1 Pilot using Inclusive Employers Toolkit

Staff across the organisation have an appetite for change and not only want to know what we are doing as an organisation, they want to be more involved, which of course is essential. An EDI rep from within the CYAF admin teams, Anna Sava, raised the request for us to consider implementing an NHS Inclusive Employers toolkit enabling staff to implement best practice and suggestions for how to work towards reducing racism perceived or otherwise within NHS organisations. This suggestion has been approved by Rachel James and HR has agreed to fund the toolkit, which we are in the process of ordering

A small working group is being identified to take this work forward across CYAF with a view to getting it approved at directorate level for roll out early in 2022. Depending on the outcome from this work, it could then be cascaded to other directorates.

6. Work with Staff Networks Action Plan

The following table outlines the work currently underway in relation to strengthening our staff networks. These networks are an excellent offering for staff to be able to get together with their peers, voice concerns and

suggest ways forward. There is still much work to do in relation to some of the younger networks but we have committed staff teams, who give up their spare time to enable and push the network forward. This work has been greatly enhanced by the introduction of the Diversity Champion roles.

Each network has a Terms of Reference (TOR)	By DEC
Each network has a Board Sponsor to increase their profile and keep the Board apprised of their work. This could also be enhanced by the work of the senior staff on the White Allies programme.	By DEC
Each network has a champion and their role description is updated with training and support options **CQC REQUIREMENT** 2.5N_TWSHOULD Clarify and review the role of equality champions within each directorate.	By DEC
Work with comms so each network has an intranet page	By DEC
Each network has a budget, suggest minimum of £500pa	By DEC
Each network has a management team – align across networks	By DEC
Organise bi-monthly network chair & champion & AD of EDI for planning purposes	By DEC
Ensure up to date EDI page on intranet and website	By DEC
Invite champion and network chairs to present to EDI committee	By DEC
Build calendar of important dates – already started work with NCL re sharing calendars	By DEC
Introduce Managers Forum – this will provide managers with an opportunity to share best practice, issues that are at play across many teams, and to find the support they require in their work, which is often very difficult. **HR have sourced mandatory training which we hope will also aid their work.**	By JAN

Work with networks, champions and staff across the Trust, to increase diversity reps on interview panels **CQC REQUIREMENT** 2.5k_TWSHOULD Undertake an audit of recruitment processes to assess compliance and adherence to the set out processes. This will include reviewing outcomes and monitoring compliance with diversity reps on panels.	By FEB
Create Managers Handbook – to support their work and increase consistency of approach across directors	By FEB
Link networks externally via NCL to share the work we are doing, but also to learn from others across the ICS	By FEB

7. Trust wide Staff Diversity Champions

The Trust now has 3 of the 4 roles recruited to for our Trust wide diversity champions. The final role for the Race Diversity Champion will be going out to all staff for expressions of interest this week and we hope they will be in post very shortly.

- Disability/LT Conditions – Rupert Armitstead
- LGBTQI+ – Natasha Nelson
- Trans – Taylor Serban
- REN – recruitment pending

These roles will not only support the work of the relevant networks but will also provide an essential conduit to the revised EDI reporting structures. For those that did not see the piece from the two newly appointed Gender champions in the In Mind magazine, I strongly recommend you looking at that, and you will get a flavour of the commitment and passion they have in taking these roles forward.

8. Staff Training – Training proposal to support Race Equality Action Plan (RAP)

In the past the Trust has provided Safer Recruitment training and this remains a mandatory element on ESR and includes a basic overview of EDI and the protected characteristics,

We have reinstated this training and booked 3 initial sessions for 23rd November, 16th December and 22nd January. The HR team will be evaluating the feedback from these sessions before decided on further wider roll out.

The HR team are working with the charity 'BRAP', which is a charity who have developed a recognised and widely used training programme to support real change in the area of EDI in relation to recruitment and selection training. We are using the intelligence gathered in the external race review held over the summer to inform the areas we most need to concentrate our training efforts on.

We understand the need to go further from the basics with our future trainings and BRAP will enable that, and is being used by other organisations within our ICS.

9. New Reporting System for Incidents of discrimination

At present, we have limited data regarding how racism or perceived racism and other elements of discrimination are happening across the Trust. To increase our data around this area to help inform work going forward, we are proposing to introduce a new anonymous reporting tool for all staff so they can begin to report on a centralised system and enable us to firstly address their concerns, but also to be able to identify where we are going wrong and work to address that. This form will not only address race but will apply to all elements of discrimination.

Please find below a link to an example form around incident related to protected characteristics.

https://forms.office.com/Pages/ResponsePage.aspx?id=m9DFCU-Xwk2gSdX49sUox7zmFqzhr7NKv_yGlZVT5eBUMU1HRFhIOVo3QkI5RjlEWUEzNDBTQzc3SS4u

Information submitted would be stored in the Microsoft Office platform of the Associate Director of EDI. It is proposed to embed the form on a page on the intranet, as well as having a button on the homepage and the staff network landing pages.

On the same page as the form is embedded, we can include links to the freedom to speak up/raising concerns pages. Once the new safe spaces and mediation systems are up and running, we can include those too.

Each incident form would be reviewed by the AD of EDI and a meeting arranged with the reporter, if requested, and onward appropriate action taken in relation to the incident.

Monthly thematic stats would be made available to divisional directors for information and action within their areas of responsibility.

10. Review of staff leavers – managing exit interviews

The below break down of leavers by job role and ethnicity and consider leavers in the last year (up to 31/10/21)

- Our staff ethnicity mix at 1/11/21 is 69% identifying as from white backgrounds and 31% identifying as from Black and Minority Ethnic backgrounds.

- Our leaver profile during the last year to 31/10/21 is that 69% of leavers were white and 31% from Black and Minority Ethnic backgrounds.

This data suggests that people are leaving the Trust in proportion to the ethnic profile of the Trust which is what we would hope would be the case and is reassuring that there does not appear to be any race bias to the leaver profile.

This of course does not discount the clear evidence we have from multiple other sources that our black and Minority Ethnic staff report worse experiences of work at the Trust when compared with their White colleagues which form the key drivers of our RES and RAP.

So it is key we gather all the data we need to ensure we are able to provide an overall assessment of how staff are experiencing working at the Trust.

Exit Interviews

HR are developing plans to measure staff experience at multiple points in the employee lifecycle as part of this there will be an overhaul of the exit interview procedure and the potential use of ESR to log and manage exit interviews.

11. Workforce Race Equality Standards (WRES) including the RAP

There are many plans in place to support the Race Equality Action Plan (RAP) and the CQC "should do" recommendations including the following:

- Introducing a managers' handbook to increase consistency and eliminate inequality when dealing with basic staff management issues
- As previously mentioned, providing a forum for managers to meet and network regularly to increase the level of consistency in management experienced by staff across the organisation.
- Looking at our policies and procedures in relation to EDI and ensuring they are adequate, this is also being done in line with sharing policies and good practice across our NCL patch.
- Work with HR colleagues & staff side re Job banding/monitoring etc
- Reviewing our use of ESR re skills audit linked to talent management and staff advancement and retention
- There is lots of work planned around the basic recruitment processes followed including ensuring our role descriptions & job adverts are updated and fit for purpose, which is happening now to ensure they are ready for use within the Strategic Review process.
- Re-introducing and supporting diversity on our interview panels, providing staff with the appropriate training and also ensuring mandatory relevant training for all hiring managers and panel chairs.

- Increasing the pool of patient reps on panels is also on the agenda and there is work planned with clinicians to see how we can identify and reach more patients who may be able to assist with this work.
- As previously mentioned looking at exit interviews – we are investigating what outsourcing this process would look like and will review the benefits against in-house provision and how the information is gathered and used.

We are also looking at the research recently produced in the "No More Tick Boxes" by Roger Klein among others, which includes considering positive action during the recruitment and selection process and clear strategies around staff advancement and retention.

12. EDI Communications for all staff

This is a vital element of all our planning, because if staff are not kept regularly updated with our current and future plans, they naturally feel little is going to change as little is being done, which is far from the reality.

The communications team are instrumental in enabling us to get this information to staff on a regular basis and their work in this areas is much appreciated. However, we need to ensure we are giving them full and regular updates on the activity around all elements of our EDI work so they can find areas in which they can contribute, as we cannot do this work without taking the entire workforce with us.

Report to	Date
Board of Directors	30 November 2021

Board Assurance Framework (BAF)

Executive Summary

The Trust BAF is a working document has been reviewed and is presented to the Board for discussion. Updates are highlighted as usual in red.

Recommendation to Board

The Board are asked to:

- discuss the board assurance framework

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
Chief Executive	Chief Executive

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

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

1.2 The following Framework and approach are in line with the Risk Management Policy and Strategy, and Risk Management Procedure. The approach is outlined in Appendix 1.

1.3 The BAF Heatmap on page 6 presents all current Strategic risks on a single page as an overview of the current position.

2 RISK SUMMARY [risk descriptions are shortened]

2.1 Ten risks are identified within the BAF with four carried forward from 2020/21:

2.2 There are one risk rated 16 and one rated 15 as follows:

- **Risk 190**: If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will not be in a position to benefit from growth and will be at risk of becoming unsustainable
- **Risk 185**: If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work

2.3 There are five risks rated 12 are as follows:

- **Risk 186:** If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.
- **Risk 90**: If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy.
- **Risk 103**: The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services.
- **Risk 105**: The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.

- **Risk 187** The risk that insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.

RISK APPETITE

3.1 The **Trust's Risk Appetite Statement and assessment** was agreed at the July meeting of the Board of Directors.

3.2 Risk Appetite Statement:

'*The Trust recognises that its long term sustainability depends on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that could materially impact on patient or staff safety. It will also not accept any risks that could jeopardise its regulatory compliance or have a significant impact upon its reputation. However, the Trust has a greater appetite to accept risks in relation to its pursuance of innovation and the challenging of current working practices in order to realise positive benefits.*'
Agreed Board, July 2019

Overarching risk appetite descriptions

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

Risk Appetite assessment against Strategic Aims

Strategic Aims/ Risk Category	Safety	Financial	Reputation	Compliance/ Regulation	Delivery
People	L	M	M	L	H
Services: Clinical	L	M	H	L	M
Services: Education	L	M	M	L	M
External System Engagement	L	M	M	L	M
Finance and Governance	M	M	M	M	H

Growth and Development	M	S	H	L	H

4.CONCLUSION

4.1 The Board is invited to discuss the board assurance framework and comment on whether, with the action plans as set out, the risks are tolerated.

Board Assurance Framework 2021/22 – Summary –

Strategic Aims 2021: Finance and Governance, Services: Clinical; Services: Education; External system engagement; People; Growth and Development.

Risk ID	Risk	Risk Lead	Strategic Aim	Corporate Objective	May 2020	July 2020	Nov 2020	May 2021	July 2021	Nov 2021	Target Risk L=likelihood C=consequence Risk = L x C
185 (1)	If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	**CEO**	Finance & Governance	1				15 (3x5)	15 (3x5)	15 (3x5)	Amber (2x5)
186 (2)	If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.	**DoHR**	Finance & Governance	1				16 (4x4)	12 (4x3)	12 (3x4)	Amber (3x4)
90 (3)	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy (updated 2020/21 risk)	**DoF**	Finance & Governance	2	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Amber (2x5)
187 (4)	Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.	**MD/COO/ DoE&T**	Finance & Governance	4				9 (3x3)	9 (3x3)	12 (4x3)	Green (2x2)

Risk ID	Risk	Risk Lead	Strategic Aim	Corporate Objective	May 2020	July 2020	Nov 2020	May 2021	July 2021	Nov 2021	Target Risk L=likelihood C=consequence Risk = L x C
188 (5)	If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts	**DoF&E**	Finance & Governance	5				9 (3x3)	9 (3x3)	9 (3x3)	Green (2x2)
108 (6)	The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings. (updated 2020/21 risk)	**MD/COO/ DoE&T**	Services clinical	4	6 (3x2)	6 (3x2)	6 (3x2)	9 (3x3(	9 (3x3)	9 (3x3)	Green (2x2)
189 (7)	If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	**DoE&T**	Services education	6				9 (3x3)	9 (3x3)	9 (3x3)	Yellow (2x3)
190 (8)	If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will be at risk of becoming unsustainable and not be in a position to benefit from growth	**CEO**	Growth & Development	8				16 (4x4)	16 (4x4)	16 (4x4)	Yellow (2x3)
103 (9)	The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services. (updated commentary 2020/21 risk)	**CEO/DoHR**	People	9	8 (2x4)	12 (3x4)	12 (3x4)	12 (4x3)	12 (4x3)	12 (4x3)	Green (2x3)
105 (10)	The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. (updated commentary 2020/21 risk)	**DoHR**	People	10	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Yellow (2x3)

Strategic Aim: Finance and Governance

RISK ID 185 (1): If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	
Risk Owner: Chief Executive	Date reviewed: November 2021
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The Trust faces a number of challenges to ensure it is financially sustainable and that its work is relevant and aligned to the needs of the ICS. A Strategic Review has been launched to address this.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 3 x Consequence 5 = 15	TARGET risk rating 2 x 5 = 10
Rationale for current score: The Trust has an underlying deficit of £5.3m. This and other challenges will require a significant programme of change. No change in current score or rationale for November 2021	
Controls/Influences *(what are we currently doing about this risk?)*: Well-structured programme with focus on agreeing clear "compass points" for the direction of travel. Strong programme of staff engagement. Development of a phased plan, balancing operational and financial risk, to deliver a balanced position in the medium term.	Assurances received *(independent reports on processes; when; conclusions)*: Programme Board chaired by CEO (+) Board reports and monthly Board seminar (+) Input of critical friend (+)
Gaps in controls/influences: NCL MH Commissioning review Changes in wider NHS financial regime post H2	Action plans in response to gaps identified: Strong engagement with NCL Review (ongoing)

RISK ID 186 (2): If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.	
Risk Owner: Director of HR	Date reviewed: November 2021
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The implementation of the Strategic Review will have far reaching impact on the way we employ and communicate to staff. The process of the Strategic Review and subsequent staff consultation for change will require broad and deep communication and engagement with staff.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 3 x Consequence 4= 12	TARGET risk rating 3 x 4=12
Rationale for current score: We are just completing the early discovery stage of the Strategic Review and at this stage it is difficult to judge whether our communication and engagement plans will prove to be adequate in prioritising attention to the staff impacted by the Strategic Review. Update July 21: Communications and engagement strategy is now developed and in place. Update Nov 21 Communications and engagement activity remain in place as we move towards formal consultation launch.	
Controls/Influences *(what are we currently doing about this risk?)*: Strategic Review Programme Board Board oversight Clear programme structure with clearly defined work strands in the key areas Appointed external 'critical friend' to scrutinise the process Close engagement with staff side unions	Assurances received *(independent reports on processes; when; conclusions)*: Strategic Review Programme Board reports and minutes (+) Board reports on the Strategic Review (+) Regular meetings with unions and clear engagement in strands of work (+)
Gaps in controls/influences: Understand impact of work on staff	Action plans in response to gaps identified: Review communication plan (ongoing)

RISK ID 90 (3): If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy.	
Risk Owner: Director of Finance	Date reviewed: November 2021
Corporate objective 2: In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Centre site	
Background / Context The Tavistock Centre ("TC") is an old building with serious issues around its mechanical and electrical systems. The way the building is laid out is also old fashioned and does not meet current requirements for patients and students. Repairs to the TC would be disruptive to patient / student experience. Accordingly, the Trust is looking to relocate its main activities from TC to a new site – Jamestown Road ("JR") – to which end a contract for sale and purchase of the site has been exchanged with the owners of JTR.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x 5=10
Rationale for current score: The Trust has now got active engagement with NHSE/I and the NCL ICS. The Relocation project is also treated as a priority project within the NCL estates stream. However, NCL has not yet determined which projects will be formally supported and the bridging financing required for Relocation has not been identified. The Relocation project also assumes that a Registered Provider (yet to be identified) will provide some of the funding required. With regard to the TC itself, recent surveys have confirmed the potential fragility to the electrical systems in the building. Contract with Camden requires completion by end March 2022. Trust has sought extension to June 2022, however, this is still not long enough to enable completion. Despite support from senior Camden officials / Councillors, still not clear whether Camden would agree to extend further, in which case Relocation would 'fall'. Camden waiting to hear about ICS view on Relocation.	
Controls/Influences *(what are we currently doing about this risk?)*: Established Programme Board with NED and Governor representation Estates & Facilities Compliance and Risk sub-committee of the IGC Regular contact with NHSE/I, NCL ICS and Camden Council	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of the Programme Board (+/-) Minutes of the sub-committee (+/-) Stock condition survey on TC
Gaps in controls/influences: Post COVID working arrangements in TC Formal NHSE/I approval of Relocation project Bridging finance unidentified Need for Camden to agree contract extension	Action plans in response to gaps identified: Outline Business Case being prepared (February 22) Negotiate extension with Camden (February 22)

RISK ID 187 (4): Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.

Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: Nov 2021

Corporate objective 4: To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance

Background / Context

There are a number of contextual factors that are impacting on capacity including the pandemic and the strategic review. Analysis of clinical leadership provision through the strategic review process has highlighted a large variation in performance and capacity in leaders. This will need to be addressed through the strategic review process if we are to be fit for purpose going forward.

Strategic review workshops continue to highlight the variation across the trust, which is being addressed where ever possible

The delay in the strategic review continues to cause issues in the leadership of clinical services as there is anxiety about future roles and structures

In this continuing context, there are strains on delivery of business as usual that need active mitigation and this could affect regulatory inspection outcomes

INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 TARGET risk rating 2 x 2 = 4

CURRENT risk rating: Likelihood 4 x Consequence3 = 12 increased

Rationale for current score:

The variation in sessions and training/capacity in clinical leaders varies significantly and they are not able to meet current leadership requirements consistently. There is both variation in management capacity and skills evident across our teams. The uncertainty of the strategic review has led to the loss of some staff as they have sought more secure employment elsewhere.

CQC inspection and JR transformation have heightened capacity challenges in the gender division

Increasing likelihood of reinspection of GIDS and a well led inspection adding to the challenge

Loss of morale and confidence in addressing challenges arising from ongoing contextual changes

Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*:
This will be reviewed through the SR process	High level principles documents shared and agreed to guide restructure of teams and functions (+)

Interim capacity challenges are being mitigated through operational and other forums A GIDS governance flow has been set up to follow through and support ongoing transformation linking it with Trust level structures Strategic Review Programme Board & consultation process Gender Oversight Committee – chaired by CEO – to monitor GIDs service transformation CQC Preparatory Group which is meeting 2 weekly	Good feedback from recent Quality Summit from CQC and other stakeholders (+) Strategic Review Programme Board minutes / reports (+) GIDS CQC inspection report (+/-) Gender Oversight Committee minutes (+)
Gaps in controls/influences: There are continuing issues with staff engagement with SR There are continuing issues with staff attrition and engagement in GIDS transformation GIDS inadequate CQC rating Challenges in delivering mitigations on known gaps in assurance	Action plans in response to gaps identified: SR process improvements allow for a good engagement plan in the upcoming period for required changes Continuing engagement and involvement of GIDS team including recruitment of various external seniors to support delivery CQC action plan at Trust level and GIDS

RISK ID 188 (5): If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts

Risk Owner: Director of Estates, Facilities and Capital Projects	Date reviewed: November 2021
Corporate objective 5: To develop a Green Plan for the Trust, with a clear action plan and measurable objectives	

Background / Context

This follows on from the launch of the campaign *For a Greener NHS* January 2020 and from the requirement for all organisations to have a Green Plan by 2021. The NHS recognises that the climate emergency is also a health emergency. As the largest employer in Britain the NHS is responsible for around 4% of the nation's carbon. For the emissions we control directly (the NHS carbon footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. For the emissions we can influence (the NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. This activity is a requirement for the relocation OBC.

INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9	TARGET risk rating 2 x 2=4
CURRENT risk rating: Likelihood 3x Consequence 3 = 9	

Rationale for current score: The Trust does not have a Green Plan as yet and is due to complete a green plan by the end of July 2021. Green Plan was signed off at July Board and will form part of the Relocation Outline Business Case. Current score unchanged.	
Controls/Influences *(what are we currently doing about this risk?)*: Established regular meetings of Environment Group Attendance of the Greener NCL Board	Assurances received *(independent reports on processes; when; conclusions)*: Relocation programme board oversight of Green Plan outcome (+) Environment Group stakeholder engagement group in place (+) Member of the Greener NCL Board
Gaps in controls/influences: Green Plan has been set with actions over next 2-3 years.	Action plans in response to gaps identified: The Green Plan has been signed off by the Board and has been shared with staff and externally with NCL. Agreed set of actions developed for the coming 12 months including procurement of utilities by April 22

Strategic Aim: Services Clinical

RISK ID 108 (6): The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings (updated 2020/21 risk)	
Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: November 2021
Corporate objective 4: To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance	

Background / Context The strategic review discovery work and staff feedback suggest that we have inadequate systems, structures and processes for managing data. We are aware that there continue to be issues at all points in the system; data entry, data tools and system outputs.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 2 = 6 CURRENT risk rating: Likelihood 3 x Consequence 3 = 9	TARGET risk rating 2x2=4
Rationale for current score: We are making significant strategic decisions on data that we do not feel confident in unless we have completed a manual review. Data entry is a significant issue for us, and without being able to properly represent the work we do, we risk reputational and financial consequences. We have also found gaps in automated processes with some of our reporting that could affect decisions affecting patient care (spine reports) No change in current score or rationale for NOV 2021	
Controls/Influences *(what are we currently doing about this risk?)*: The strategic review has provided a much clearer analysis of the issues and we will be using the change process to ensure that we are able improve confidence in data through improvements at all points in the data journey Quality Assurance Board oversight for data issues The automation processes are being actively addressed including in seeking input from suppliers	Assurances received *(independent reports on processes; when; conclusions)*: Notwithstanding identified issues there have been significant improvement in understanding of gaps in the input, use and understanding of data Data led discussions now inform various forums including Quality Assurance Board, Trust Board etc. Dashboards have been developed for CYAF and AFS clinical divisions. There is work across divisions to ensure that the CYAF, AFS and GIDS dashboards are all producing consistent data. Quality Assurance Board reports & minutes (+)
Gaps in controls/influences: Cultural challenge such as evident challenges in timely data input onto Trust platforms which remains a challenge ex. care notes Technical capability in collecting and using data in certain domains Fragmented ownership of data leading to confusion and lack of confidence	Action plans in response to gaps identified: We will continue to improve structures and processes for easing input, use and understanding of data across our services The Strategic review is aiming for better working of services involved in the processing and analysis of data to reduce duplication and clearer ownership We will continue our efforts to engage and empower staff in using data to achieve better outcomes in their interventions Staff training in running mitigating manualised reports

Strategic Aim: Services: Education

RISK IS 189 (7): If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	
Risk Owner: Director Education & Training	Date reviewed: November 2021
Corporate objective 6: To develop and deliver high quality, outcome focused and financially sustainable educational services which are data informed and responsive to changing requirements.	
Background / Context We have increased our year 1 student enrolment figures consistently over time and have also adapted our provision to meet the challenges of the pandemic and have also established and completed development in the Digital Academy and delivery of online learning through the pandemic. As difficult as the pandemic has been, it has also enabled and accelerated different ways of learning and teaching. However, it has been difficult to adapt our existing provision in more fundamental ways to significantly increase reach. There remain cultural barriers to further development and delivery online exacerbated by fatigue of online learning. This should be mitigated when we return to include more face to face delivery in a more blended format.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood x Consequence = 3x3=9	TARGET risk rating 2 x 3=6
Rationale for current score: Although there is evidence of successfully developing and delivering new provision it is often not well co-ordinated and sufficiently responsive to market need or opportunity, especially in the domain of long course development. Related factors include timely and relevant market assessment and external engagement, capability and capacity of teaching staff, PSRB requirements, resourcing and culture that can limit pedagogical range.	
Controls/Influences *(what are we currently doing about this risk?)*:	Assurances received *(independent reports on processes; when; conclusions)*: Adaptation and pivot through COVID-19 with online delivery (+)

Established Development Forum in DET with governance links to BDG Strategic review; Positive exemplars Education and Training Committee oversight	Pulse student surveys with high levels of satisfaction (+) Successful Digital Academy launch (+) Education and Training Committee reports and minutes (+) More focused development in the areas identified by BDG incl. SMHL training, perinatal and leadership and management
Gaps in controls/influences: Scoping of broader strategic opportunities and resourcing for the nursing workforce	Action plans in response to gaps identified: External consultancy project commissioned to explore development opportunities for the nursing workforce (Dec 2021)

Strategic Aim: Growth & Development

RISK ID 190 (8): If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will not be in a position to benefit from growth and will be at risk of becoming unsustainable	
Risk Owner: Chief Executive	Date reviewed: November 2021
Corporate objective 8: To maximise the potential of our historical relevance to current and emerging business pre-occupations for the purpose of business growth and organisation profile	
Background / Context The Trust has historically relied on new business development to support its financial sustainability. The move to new integrated care structures and the immediate impact of the pandemic has led to a reduction in opportunities. To address this a number of priority areas have been identified including new opportunities outside traditional markets.	

INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 TARGET risk rating 2 x 3 =6 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	
Rationale for current score: The move to integrated care and the pandemic has had a significant impact on new opportunities. SR impacting on resources available to support longer term and more strategic business development.	
Controls/Influences *(what are we currently doing about this risk?)*: Targeting of resources on core opportunities for business development including retenders. Workstream plans for new priorities. Exploration of partnership opportunities with GOSH	Assurances received *(independent reports on processes; when; conclusions)*: Tracking of core business development opportunities.
Gaps in controls/influences: Availability of external opportunities Diversion of resources due to the Strategic Review	Action plans in response to gaps identified: Targeting of resources on core opportunities Identification of business development needs in design of new structures.

RISK ID 103 (9): The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services	
Risk Owner: Chief Executive/Director of HR	Date reviewed: November 2021
Corporate objective 9 To set a clear direction for the Trust as an anti-racist organisation with key supporting actions	
Background / Context: The Trust faces a significant challenge on diversity. Unless addressed this will have a negative consequence on staff engagement and the quality of services.	
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4= 8 TARGET risk rating 2 x3 =6 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	

Rationale for current score: Staff and student surveys and a narrative of negative staff experience highlight that the Trust has a long way to go to ensure equality of opportunity and experience for all staff. Unless addressed this will impact negatively on the attractiveness of the Trust as an employer and the quality and effectiveness of its services for patients and students.	
Controls/Influences *(what are we currently doing about this risk?)*: Declared ambition of becoming an anti-racist organisation. Race Equality Strategy Steering Group Consultants commissioned to lead external review of Trust culture Race Equality Staff Network; Race Equality Staff Allies Group Equality Diversity Inclusion Committee Workforce Race Equality Strategy (WRES) and action plan	Assurances received *(independent reports on processes; when; conclusions)*: External Race Equality Review Race Equality Strategy Steering Group minutes (+) Equality Diversity Inclusion Committee minutes (+) Staff survey
Gaps in controls/influences: Engagement of all staff	Action plans in response to gaps identified: Work to produce a refreshed Race Equality strategy (January 2022)

RISK ID 105 (10): The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. . (updated 2020/21 risk)	
Risk Owner: Director of HR	Date reviewed: November 2021
Corporate objective 10 Develop a People Strategy for the Trust with a focus on future workforce needs and addressing staff engagement, welfare and morale.	
Background / Context With the well-researched link between staff engagement and service quality and delivery, the Trust has lower engagement indicators than it would aspire to as seen in the staff survey.	

INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 TARGET risk rating 2 x3 =6 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	
Rationale for current score: The lack of an in date comprehensive People and Organisational Development strategy and plan 'People Plan'. Update 7/21 Trust position against national people plan pledges established, Trust people plan being developed in line with Strategic review timetable Update 11/21 – First Draft people plan developed, links made to Race Equality strategy work, on plan to deliver on timeline	
Controls/Influences *(what are we currently doing about this risk?)*: Links to WRES actions Planned development of the Trust People Plan over Q 1 to 3 Integrated Governance Committee (IGC)	Assurances received *(independent reports on processes; when; conclusions)*: Reports to IGC (+) Board scrutiny of staff survey (+)
Gaps in controls/influences: Lack of OD and People subcommittee to scrutinise progress on people agenda Lack of in date people and OD strategy and plan	Action plans in response to gaps identified: To develop OD and People subcommittee (Sept 2021) To develop People plan (Dec 2021)

Appendix 1

APPROACH TO RISK SCORING

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

4.3 Each significant risk is then given a score for the:

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

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

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

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

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

4.5 The risks each have a Risk ID reference from the electronic register, and are also numbered 1–10 on this report. The Risk ID does not imply a higher or lower level of inherent or residual risk.

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

4.7 Directors review and update the BAF and confirm the **initial/ current risk** scores for each risk

4.8 The BAF is reviewed by the Executive Management Team in advance of being taken to Board.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	30/11/2021

Guardian of Safer Working Hours Q2 2021

Executive Summary

This is the report for Q2 period.
The report details the number of trainees on the rota at present. The issues reported by the trainees have been problems with logging on reports on the DRS system and delayed fine payments.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

All Trust objectives

Author	Responsible Executive Director
Guardian of Safer Working Hours	Medical & Quality Director

Guardian of Safe working hours Q2 2021 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q2 (July- September 2021)

1.2. This will be my 2nd year in this post.

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
July	6	2	4	-
August	2	1	1	-
September	1	0	1	-

2.2 Work schedule reviews

- There have been no formal requests for a work schedule review.

2.3 Vacancies

The Child and Adolescent training scheme has 3 vacancies. 3 new trainees to start in February 2022. Total number of trainees 9, 5 part time, 4 full time

2.4 Locum

The NROC is currently being staffed by Trainees and occasionally an external locum.

The trainees do 1 locum shift/month in addition to their normal working schedules and on call rota

2.5 Fines

	Extra hours worked		Total fine	Amount paid to trainees	Fine Remaining
	Normal	Enhanced			
	hrs	hrs	£	£	£
July	1.5	7.95	1097.742	411.64	686.102
August	0	2.5	303.40	113.775	189.625
September	0	8	970.88	364.08	606.80
Total	1.5	18.45	2372.022	888.16	1482.527

3. Junior Doctors Forum (JDF)

Delay in fine payments for 2 trainees, DRS logging on errors reported to HR

New Trainee representatives in post.

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sheva Habel for LNC on 8th November 2021.

Conclusions and Recommendations

4.1. Members of the Board are asked to note the report
4.2. We continue monitoring the impact of the post COVID crisis on the exception reports.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	

Serious Incidents – Quarterly Report – Q2 2021-22

Executive Summary

This quarterly serious incident summary report for the Board covers Q2 2021-22.

Clinical Incidents

During Q2 there were 24 clinical incidents logged:

- AFS - 2
- CYAF - 7
- Gender - 13
- DET - 1
- Trust wide -1

(For comparison - 35 clinical incidents reported in Q1 2021/22).

Of the 24 clinical incidents, 19 incidents reached the threshold for discussion at the incident panel, which is held monthly and chaired by the Medical Director. 8 incidents were related to patient deaths and in all cases, reviews of the appropriate level have been completed or planned, awaiting information from other sources:

1. MH team open case. Not clear if death was by suicide. Trust notified in Aug 2021. Concise Report completed and discussed at Incident Panel September 2021. The incident has been logged externally on STEIS and the Trust has appointed internal investigators. Trust is leading serious investigation, which will report in Q3.
2. Death of patient on GIDS waiting list. Likely suicide. Trust was notified of the incident July 2021. Concise Report completed and discussed at IP September 2021.
3. Death of patient on GIDS waiting list. After running spine report it was identified that patient died, suspected suicide. Trust was notified July 2021. Concise Report completed and discussed at IP in October 2021.
4. Death of patient on GIC waiting list. Cause of death unknown. Trust notified July 2021. Concise Review completed and discussed at IP August 2021.
5. GIC notified by GP letter (received August 2021) of death of patient in February 2021. Cause of death Covid-19. Mortality review completed and discussed at IP in September 2021.
6. GIC. Patient died of natural causes at home December 2020. The Trust was notified in Aug 2021. Mortality review completed and discussed at IP in September 2021.
7. GIC - This patient's death was reported as part of a larger data collection. The Trust was notified in Sep 2021. Incident discussed at IP in September 2021. Awaiting more information from GP in order to establish the type of investigation the Trust should do.

8. GIC - Death was discovered as part of a larger data collection. A letter has been sent to GP requesting further details. The Trust was notified in Sep 2021. Incident discussed at IP in September 2021. Awaiting more information from GP in order to establish the type of investigation the Trust should do.
9. 2 other SI investigations, as reported in previous report are awaiting completion and timelines have needed to be extended due to issues with capacity, training in RCA etc.

Learning from incidents

The last event took place on Thursday 23rd of September 2021 on the National Confidential Inquiry into Suicide and Safety in Mental Health and was very well received.

Additionally, over the year there has been numerous events, to encourage and share learning and good practice, with the new approach of online learning enabling greater remote attendance. There will be more events planned for rest of 2021/22 and onwards (dates to be circulated).

Topics for learning over the year have included:

- **Learning from youth services - during Q1**

- **The role of the Coroner, giving evidence at Coroner's Court and supporting those in such circumstances – delivered 4th February 2020**

National reports have in recent years repeatedly called for additional support for staff involved in serious incidents, which may include involvement with inquests and attending Coroner's Court. This learning lessons event included a presentation on the role of the coroner, giving evidence at Coroner's Court and supporting those in such circumstances. Learning was linked to a serious incident investigation.

- **Gang-related violence, knife crime and county lines – delivered 18th June 2020**

There have been a number of serious incidents over the last year linked to gang related violence, knife crime and county lines. These issues are of serious concern in the local area at present, as well as nationally, and affect many young people seen in the Trust. This event was an opportunity to hear about some of these cases, to share the learning and to think together about how we can best support young people in these situations. This was an opportunity to discuss challenges in clinical practice and participants benefitted from being in a multi-disciplinary forum to maximise learning.

- **Infection Prevention and Control (IPC) – delivered on 15th October 2020**

Infection Prevention and Control (IPC) occupies a unique position in the field of patient safety and quality since it is relevant to healthcare staff and patients at every single health care encounter. The current Covid-19 pandemic underscores this reality, as we recognise that strict infection prevention and control practice in our workplaces is essential in order to stop the development or further spread of infection. This learning lessons event was an opportunity to learn from other organisations who had recent outbreaks, hear from Trust staff members about the impact of IPC on clinical practice and who have been engaged in IPC work. It will be a forum to consider the ways we are likely to work in the foreseeable future and learn lessons.

- **Adult Safeguarding – delivered on 3rd November 2020**

This was an opportunity to discuss key issues in adult safeguarding practice linked to case presentations.

- **Suicide Prevention – delivered on 2nd December 2020**

This event discussed recent evidence and guidance on suicide prevention including around Covid-19. The presentation drew particularly on the resources available from University of Manchester, National Confidential Inquiry into Suicide and Safety in Mental Health.

Events in 2021

All relevant services continue to feed into the work around the action plans identified in the 2018 CQC inspection, and these action plans are regularly monitored by the Executive Management Team.

Identified learning via the Incident Panel

The following are learning lessons from incidents discussed at the incident panel in Q4 2020-21:

Incident Panel	Examples of Lessons Learned
Aug 2021 Incident Panel	Discussion of process and liaison for SIs reporting and investigation, including with other organisations Discussion and agreement to use complex clinical scenario detailed in review for future learning lessons event Discussion of need for oversight and improvement of intake processes to prevent delays or inadvertent breakdown in patient experience
Sep 2021 Incident Panel	Discussion on need for automation of spine reporting on care notes as awareness of a number of deaths had only been raised on a service running manualised reports. Need to follow through on duty of candour in all cases as appropriate

Recommendation to the Board
The Board of Directors is asked to note this paper
Trust strategic objectives supported by this paper
Clinical Services

Author	Responsible Executive Director
Medical Director	Medical Director

Report to	Date
Board of Directors	30 November 2021

Report on Audit Committee Meeting – 14 October 2021

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 14 October 2021.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

Author	Responsible Director
Terry Noys, Deputy CEO and Director of Finance	David Holt, Chair of Audit Committee

HIGHLIGHTS OF A MEETING OF THE AUDIT COMMITTEE HELD ON 14 OCTOBER 2021

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 14 October 2021.

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

2. TRUST PRIORITIES / RESOURCES

2.1 Throughout the various agenda items discussed by the Committee a near common theme was the degree of stress that the organisation was facing. Amongst other matters, the Committee noted:

- The extensive work being undertaken as part of the GIDS transformation project
- The work relating to the GIDS CQC action plan (and the need to prepare for a probable CQC inspection)
- Issues around recruitment, notably for Gender but also for the recently mobilised Surrey contract
- Potentially negative internal audits, notably one on payroll
- The pressures resulting from complex and, sometimes malicious, Freedom of Information requests
- The efforts going into the Strategic Review.

2.2 In light of this, the Committee asked the executive team to brief the Board and to highlight how resources were being prioritised and what issues (if any) were being negatively impacted.

3. AUDITORS ANNUAL REPORT

3.1 This had already been reviewed in June but the Committee revisited the report in order to reflect on the section on value for money ("vfm"). The Committee noted that, under the new vfm regime, the external auditors would now formally write to the Committee during the year – and not simply wait until the year end - if they considered there to be any risks to a positive year end vfm opinion.

3.2 Given this new regime, the Committee noted the importance of the external auditors exercising a degree of common sense in their application of this requirement, both in order to take into account the broader context of any particular issue but also to avoid discouraging open debate and robust challenge in Committee meetings.

4. AUDIT COMMITTEE TERMS OF REFERENCE ("ToR") / EFFECTIVENESS

4.1 Given the external Governance review commissioned by the Board, the Committee agreed to defer its review of its ToR until that review had reported.

4.2 With help from RSM (the Trust's internal auditors), the Committee had carried out a review of its effectiveness.

4.3 Although the outcome of this review was highly positive, the Committee felt that, in the light if the on-going Governance review and matters referred to in section 2, it made sense for the non-executive directors who make up the Committee, to meet and reassess whether or not they had prioritised their efforts, for the remainder of the financial year, appropriately.

4.4 The Committee also confirmed its earlier decision to undertake a 'deep dive' (in January 2022) into the Trust's efforts around Equality, Diversity and Inclusion.

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Report to	Board of Directors
Report from	Education & Training Committee – 07 October 2021

Key items to note

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

Enrolment & Welcome Week
The Committee received an update on the delivery of a successful Welcome Week online, and an overview of enrolment and re-enrolment, with around 620 new long course students (which is on par with last year). The Committee will receive a full recruitment and enrolment report at its next meeting.

Return to the Building
The Committee received assurance around continuing online delivery, and an update on plans to return to the building. The Committee noted the differences between the Trust and traditional higher education institutions in terms of being able to return to face-to-face delivery.

M80 Overspend in relation to Child Psychotherapy Trainees
The Committee received assurance that the overspend in relation to M80 Child Psychotherapy trainees is a budgeting issue, rather than a substantive broader issue. In reality, the actual income and costs are more aligned. The Board will receive a further update through the Finance Director. The Committee noted that the retendering of M80 will allow the Trust a chance to revisit the insights from the discovery phase of the strategic review and put in place a developmental model.

Annual Student Survey
The Committee noted the Annual Student Survey Summary report, which detailed a lower completion rate, and an overall satisfaction rate of 82%. The Committee noted that further analysis is required to understand the data, and a full report will be received in due course.

Student Complaints
The Committee received assurance and an update on improvement measures through the annual student complaints report.

Degree Awarding Powers
The Committee received an update on the feasibility review of the likelihood of success of an application for degree award powers, and to understand the gaps, route to application, and timings. The Committee agreed to proceed with an application for full taught degree award powers (tDAP), subject specific, and up to level 7. The Committee will receive an action plan and timetable at its next meeting.

CEDU Annual Review
The Committee noted the CEDU annual review report, which covers financial year 2020/21. The Committee noted that income has held up at a time during which all delivery was online, and contribution has increased significantly with the reduction in delivery costs. The Committee noted improvements in widening access to online delivery, and an increase in geographic spread. The

Committee noted that further work is needed to raise awareness of our offer. The principle of Digital First delivery going forward was supported.

Digital Academy Review and Strategic Planning
The Committee received an overview of the workshops with Pearson, and noted the huge amount of learning and experience in developing the Digital Academy to where it is now. The Committee was updated on some of the development and thinking as we move to further define our digital education strategy.

Actions required of the Board of Directors
The Board of Directors is asked to note this paper.

Report from	Debbie Colson
Report author	Brian Rock, Director of Education & Training/ Dean of Postgraduate Studies
Date of next meeting	02 December 2021