NHS
The Tavistock and Portman
NHS Foundation Trust

# Board of Directors Part One

## Agenda and papers of a meeting to be held in public

**Tuesday 26th July 2022**

**Please refer to the agenda for timings.**

The Tavistock and Portman
NHS Foundation Trust

**BOARD OF DIRECTORS – PART ONE**
**MEETING HELD IN PUBLIC**
**TUESDAY, 26th July 2022 – 2.00pm-4.00pm**

| # | Agenda Item | Purpose | Lead | Format | Time |
|---|---|---|---|---|---|
| **OPENING ITEMS** | | | | | |
| 1. | Chair's welcome; apologies and confirmation of quorum | Inform | Chair | Verbal | 2.00 |
| 2. | Declarations of interest | Inform | Chair | Enclosure | |
| 3. | Minutes of last meeting | Approve | Chair | Enclosure 1, 1a | |
| 4. | Matters arising and action log | Review | Chair | Enclosure 1b | |
| 5. | Chairs Update | Inform | Chair | Verbal | 2.05 |
| 6. | Non-Executive Director Update | Inform | Non Executives | Verbal | 2.10 |
| 7. | Service Story- Gloucester House | Inform | Chief Executive Officer | Verbal | 2.15 |
| 8. | Chief Executive's Report | Inform | Chief Executive Officer | Enclosure 2 | 2.25 |
| **High Quality Clinical Services** | | | | | |
| 9. | Quality Committee Highlight Report | Assure | Chair of Committee | Enclosure 3 | 2.35 |
| 10. | Quality Report | Inform | Chief Nursing Officer | Enclosure 4 | 2.40 |
| **Improve the efficiency of what we do and deliver value for money** | | | | | |
| 11. | Performance, Finance and Resources Committee Highlight Report | Inform | Chair of Committee | Verbal | 2.45 |
| 12. | Finance Report | Inform | Chief Financial Officer | Enclosure 5, 5a | 2.50 |
| 13. | 2022-23 Budget - FINAL | Inform | Chief Financial Officer | Enclosure 6, 6a | 2.55 |
| 14. | Performance Report | Inform | Clinical Chief Operating Officer | Enclosure 7, 7a | 3.00 |
| **Meet our ambitions to become a diverse, inclusive and anti-racist organisation** | | | | | |
| 15. | People, Organisational Development, Equality, Inclusion and Diversity Committee Highlight report | Approve | Chair of Committee | Enclosure 8 | 3.10 |
| 16. | People Strategy and Plan | Approve | Chief People Officer | Enclosure 9, 9a | 3.25 |
| **Deliver High Quality Educational services** | | | | | |
| 17. | Education and Training Committee Highlight report | Inform | Chair of Education and Training Committee | Enclosure 10 | 3.35 |
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| CLOSING ITEMS | | | | | |
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| 18. | Any other business: | | | Verbal | 3.40 |
| 19. | Reflections and Feedback from the meeting | Discuss | Chair | Verbal | |
| 20. | Questions from the Public | Discuss | Chair | Verbal | |

**DATE AND TIME OF NEXT MEETING**

Tuesday 27th September, 2.00 – 4.00 pm

**EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC**

Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

The Tavistock and Portman
NHS Foundation Trust

# MEETING OF THE BOARD OF DIRECTORS

## PART ONE: MEETING HELD IN PUBLIC
## TUESDAY, 24TH MAY 2022
## Lecture Theatre
## Tavistock Centre and via Zoom

### PRESENT

Members

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| Deborah Colson | Non-Executive Director (Chair of the meeting) |
| Paul Burstow | Trust Chair |
| Helen Farrow | Non-Executive Director |
| Jenny Goodridge | Interim Chief Nursing Officer |
| Sally Hodges | Clinical Chief Operating Officer |
| David Holt | Non-Executive Director |
| Paul Jenkins | Chief Executive |
| David Levenson | Non-Executive Director |
| Aruna Mehta | Non-Executive Director |
| Terry Noys | Director of Finance |
| Brian Rock | Director of Education and Training and Dean of Postgraduate Studies |
| Shalini Sequeira | Non-Executive Director |

In attendance:

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| Natalia Barry | Governor |
| Hector Bayayi | Divisional Director Gender Services |
| Jenna Davies | Interim Director of Corporate Governance |
| Helen Farrington | Interim Director of Human Resources |
| Ffyona Dawber | Governor |
| Kathy Elliott | Lead Governor |
| Fiona Fernandes | Minute Taker |
| Badri Houshidar | Governor |
| Paru Jeram | Governor |
| John Lawlor | Trust Chair |
| Julian Lousada | Governor |
| Kenyah Nyameche | Governor |
| Caroline McKenna | Interim Chief Medical Officer |
| Nick Kirby | Interim Managing Director, UCL Health Alliance (item 10) |
| Michael Rustin | Governor |
| Sarah Stenlake | Freedom to Speak Up Guardian (item 7) |
| Laure Thomas | Director of Marketing and Communications |

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| | **Governance Matters** |
| 1 | **Chair's opening remarks and apologies for absence** |
| | Dr Colson thanked Prof Burstow for his leadership and contributions to the Board.<br><br>Dr Colson welcomed those attending and introductions were made by all as there were some new members attending.<br><br>Prof Burstow thanked everyone for the support that he had been given during his tenure as Trust Chair. He added that it was a privilege and was proud to be a part of the Tavistock journey. He wished everyone all the very best for the future.<br><br>It was confirmed that the meeting was quorate |
| 2 | **Declarations of Interest** |
| | There were none declared |
| 3 | **Minutes of the last meeting** |
| | Minutes of the meeting held on 29th March 2022 were approved pending minor amendments. |
| 4 | **Matters arising and action log** |
| | It was noted that there were several action points outstanding. These would be addressed through the new streamlining of Board Committees which Ms Davies is currently working on.<br><br>Ms Sequeira noted that she was expecting to sign off the Terms of Reference for the new People, Organisational Development, Equality, Diversity and Inclusion Committee to be signed off at this meeting as without this the committee is not established. There is a governance issue in that everything needs to be ratified before the committee can be established. There will be another meeting coming up and it would be useful if the Terms of Reference were ratified before the next board meeting on 26th July.<br><br>Dr Colson suggested that it would be beneficial to hold an additional meeting in July to get all the Terms of References ratified and consolidated.<br><br>Mr Jenkins noted that he would speak to Ms Davies and would inform the Board. |
| 4/22 | **Action:** Patient and Student Stories to be arranged for all future board meetings. |
| 5 | **Chief Executive's Report** |
| | <u>Executive Appointments</u><br><br>Mr Jenkins was pleased to inform the Board that Dr McKenna was appointed as the Interim Chief Medical Officer commencing on 6th June 2022.<br><br>Mr Levenson noted that it would be useful to have an indicative timeline for all the Executive appointments and when they would be recruited too. |
| | <u>Graduation</u> |

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| | Mr Jenkins noted that on 7th May 2022, the Trust held its first face-to-face graduation ceremony since 2019 which was well attended (150+). Jacqui Dyer, MBE was awarded an honorary doctorate, and a posthumous honorary doctorate was awarded to a much respected and admired colleague Mike Solomon. |
| | **Delivering Better Health Outcomes** |
| 6 | **Quality Priorities for 2022/23** |
| | The Report was taken as read and comments invited. |
| | Dr Hodges noted that the area around job planning would be implemented post the Strategic Review. Responding to Mr Levenson, Dr Hodges noted that there has been a job planning process setup moving from the appraisal process. Job planning would become part of management and would meet with staff more regularly to increase activity and efficiency.<br><br>Mr Rock noted that the focussing on clinical through the Strategic review/Consultation it is apparent that in DET. Faculty and managers are sighted on the activities and it will be part of the discussions on financial governance.<br><br>Responding to Mr Holt, Dr Hodges noted that the Priorities had been through the Operations Board, Patient Forum and the Quality Committee.<br><br>Mr Holt noted that when the Quality Priorities are presented to the Audit Committee, it would be useful to see the journey of where they have been reviewed in order that the board have the assurance.<br><br>Ms Mehta noted that as the Quality Priorities are linked to the Quality Committee, she would not be able to approve without having the assurance.<br><br>Mr Jenkins noted that the Integrated Governance Committee has had some oversight however due to a variety of factors have not been able to pull it altogether. |
| | The Board noted the report and on the proviso that the board has assurance of where the Quality Priorities have been reviewed, have approved delegated responsibility to the Audit Committee to sign off the final draft of the Quality Accounts 2021/22 |
| 7 | **Freedom to Speak Up Guardian Annual Report** |
| | The Report was taken as read and comments invited. |
| | A discussion followed regarding the report and recommendations.<br><br>Ms Mehta noted that point 7.2.1 mandatory training that this should start at board level – lead by example.<br><br>Ms Sequeira noted that in relation to management training, this has been raised several times and it would be very useful to get an update where this is currently at. |

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| | Ms Stenlake agreed that the 'You Said We Did' was a good idea and echoed the points raised by Ms Sequeira on management training. Ms Stenlake noted that there was a gap in skillset and something needed to happen to ensure that all staff are skilled.<br><br>Ms Farrington advised that they was a Freedom to Speak Up policy that had been drafted and would need to understand what resources would be required, and that she would look into the management training programme.<br><br>Mr Noys noted that he would dissent from approving the first point as he had not seen any figures.<br><br>In principal the Board agreed to support the recommendations and thanked Ms Stenlake for a very detailed and useful report. |
| | **Ensuring We Always Use Or Resources Wisely** |
| 8 | **Finance and Performance report** |
| | The Report was taken as read and Mr Noys noted that the results had not been audited and would be subject to change. The draft result for the year is a deficit before non-recurring costs of £6.6 million. For year-end there was a healthy cash balance which is ahead of budget and, CAPEX was not as high.<br><br>Non-Recurring costs relate to the write off of the fixed asset relating to Relocation and for other provisions including any potential redundancies as a result of the Strategic Review.<br><br>Ms Farrow noted that on Page 5 capital expenditure there was a huge amount spent on IT in March. Mr Noys responded that it was due to various projects for IT that were put on hold. |
| 9 | **Budget 2022/23** |
| | The Report was taken as read and Mr Noys noted that this was the indicative budget that was provided to the Board back in March and was based on the submission the Trust made to the ICS on 9th May 2022. The ICS had not yet finalised its budget with NHSEI, therefore these figures still remain draft.<br><br>The budget for 2022/23 was noted and approved. |
| | **Governance and Well Led** |
| 10 | **UCL Alliance Business Plan** |
| | Mr Jenkins introduced the report and noted that this was discussed the Alliance several times at the Board Meetings over the last year, and supported the creation of the Alliance and a number of the interim steps and priorities. The Board was also supporting the transitions to a more permanent and appropriate governance vehicle for the Alliance. The Alliance will be across the North Central London (NCL) to |

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| | provide and deliver common projects and developments. In a sector with so many providers, it was a very important mechanism for being able to deliver agreed priorities both by those steered by the ICB and the provider communities. Mr Kirby will be invited back to one of the Board Seminars to have more discussions. Organisations will be asked to contribute financially £29k per organisation. The purpose for the Board today is to:<br>• Approve the recommendation for the Trust to be a founding member of the UCL Health Alliance legal entity<br>• Approve the business plan for 2022/23<br>• Approve delegation of authority for board certification required by NHS England and Improvement (NHSEI) as part of their subsidiary approval process (this is only required by NHS Foundation Trusts)<br>• Take assurance from the details provided in the business plan and articles of association that this course of action represents the optimal model for system level collaboration between organisations in North Central London (NCL) |
| | Responding to Dr Colson, Mr Kirby noted that the costing in the business plan is for the full year that would be divided equally by the members is £45k however for 2022/23 it will be £29k per member. The business plan in annual and requires unanimous agreement from all the four members.<br>Mr Kirby informed the board that the ICB and Alliance intentions is to operate as a strategic concern and performance accountability. The provider Alliance is to be part of the delivery to improve recruitment and retention. ICB partnership is not engaged. |
| | The Board noted the report and unanimously agreed and approved the following recommendations:<br>• for the Trust to be a founding member of the UCL Health Alliance legal entity<br>• the business plan for 2022/23<br>• delegation of authority for board certification required by NHS England and Improvement (NHSEI)<br>• assurance from the details provided in the business plan |
| 11 | **Provider License Self-Assessment** |
| | The paper was taken as read and comments were invited.<br>Ms Davies advised that the Risk section needed to be updated and asked the board to approve the draft self-certification subject to changes.<br>Ms Davies noted that with relation to point 1.1 although the governance structure in in place the Trust did not have the committees constituted. Plans are in place to transition to a new governance structure.<br>Responding to Mr Levenson regarding point 1.5, Ms Davies noted that this was the outcome of internal audit and how we intend to investigate these going forward.<br>Mr Holt noted that this should be brought to the Audit Committee so that the amendments can be seen and that the Audit Committee should be given delegated authority. |

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| | The board noted the report and unanimously approved that delegated authority for this be given to the Audit Committee. |
| | **Reports for Noting** |
| 12 | **Education and Training Committee Highlight report** |
| | The report was taken as read and Mr Rock noted that there was a 3% drop in applications. Overall there was an increase in student numbers. We are actively tracking deferrals and 30+ deferrers have engaged in enrolment.<br>. |
| | Nursing Project:<br>There were discussions about the recommendations within the Nursing Project report, and it was agreed to progress these, given the demand for the Trust's provision, and its expertise in this area. The Committee noted the need for resource prioritisation within DET, to then develop a business case. There is a piece of work being done externally that was jointly done with Dr Caldwell and Mr Rock. Sessions were established for Claire Shaw to give a firmer footing for nursing training. |
| | The Board noted the report and agreed the progression of the Nursing Project. |
| 13 | **People, Organisational Development, Equality, Diversity and Inclusion Committee Highlight Report** |
| | The report was taken as read and Ms Sequeira highlighted the salient points:<br>• That the People Plan was triangulated with the Staff Survey and will focus on assurance.<br>• Received the first draft of the revised People Metrics dashboard<br>• Received a report against the Trust Race strategy and Race Action plan rom Dr Thanda Mhlanga the newly appointed Director of EDI.<br>• Gender Pay Gap - it was noted that the Trust has a pay gap that was smaller than the UK organisation average and that the intention was to capture actions to close it further in the wider EDI Strategy and plan<br><br>Responding to Ms Farrow, Ms Sequeira noted that this was brought to the committee by Natasha and that there was a fruitful discussion. Dr Mhlanga will be asked to consider this as part of the work that he is undertaking across all aspects. |
| 13/22 | **Action:** The Terms of Reference for the Committee to be brought to the Board meeting in July. |
| | The noted the report and ratified the plan. |
| | **CLOSING ITEMS** |
| 14 | **Any other Business** |
| | There was no other business raised. |
| 15 | **Reflections and Feedback from the meeting** |
| | Mr Noys noted that regarding resources that we need to think very carefully and |

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| | before any decisions are made, Mr Noys would need to be consulted in the first instance. |
| 16 | **Questions from the Public** |
| | There were no questions raised. |
| | **Date, time and venue of next meeting** |
| | Tuesday 26th July, 2.00 – 5.00 pm Lecture Theatre/Virtual |

The Tavistock and Portman
NHS Foundation Trust

# MEETING OF THE BOARD OF DIRECTORS

## PART ONE: MEETING HELD IN PUBLIC

**TUESDAY, 5TH July 2022**
**Lecture Theatre**
**Tavistock Clinic**
**And via Zoom**

### PRESENT

Members

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|---|---|
| John Lawlor | Chair |
| Jenny Goodridge | Chief Nursing Officer |
| Deborah Colson | Non-Executive Director |
| Helen Farrow | Non-Executive Director |
| Sally Hodges | Clinical Chief Operating Officer |
| David Holt | Non-Executive Director |
| Paul Jenkins | Chief Executive |
| David Levenson | Non-Executive Director |
| Aruna Mehta | Non-Executive Director |
| Brian Rock | Director of Education and Training and |
| | Dean of Postgraduate Studies |
| Shalini Sequeira | Non-Executive Director |
| Caroline McKenna | Interim Chief Medical Officer |
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| In attendance: | |
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| Badri Houshidar | Governor |
| Laure Thomas | Director of Marketing and Communications |
| Amanda Hawke | Minute taker |
| Alastair Hughes | Director of Strategy and Transformation |
| Alastair Dickins | Member of Staff |
| Helen Farrington | Interim Director of Human Resources |
| Rachel James | Divisional Director CYAF |
| Hector Bayayi | Divisional Director Gender Services |
| Tim Kent | Divisional Director AFS |
| Jenna Davies | Interim Director of Corporate Governance |

## Apologies for absence

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| Terry Noys | Deputy Chief Executive / Finance Director |

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| | **Governance Matters** |
| **1/22** | **Chair's opening remarks and apologies for absence** |
| | Mr Lawlor welcomed those attending and introductions were made by all as there were some new members attending.<br><br>Apologies were noted from Terry Noys. It was confirmed that the meeting was quorate |
| **2/22** | **Declarations of Interest** |
| | None |
| **3/22** | **Governance and Well Led** |
| | **Revised Board Terms of Reference** |
| | The Terms of Reference for all Board Committees have been reviewed following the Governance Review. |
| | **Performance, Finance and Resources Committee** |
| | Ms Mehta is the Chair of this Committee, Dr Hodges and Mr Noys are the joint Executive Leads.<br><br>Dr Hodges advised that she has met with Ms Davies to agree what information and data should be coming to this committee and also what needs to be fed back to the Board of Directors.<br><br>Ms Mehta commented that the timings of this committee this month will mean that we will not have a paper for the Board of Directors only a verbal report. There will be a standing item on this committee agenda for the strategic review.<br><br>Ms Mehta suggested that a diagram is produced to show how each of the committees relate to the others and to the Board of Directors and Council of Governors.<br><br>Comments were invited on the Terms of Reference:<br><br>• If papers from this committee cannot be reviewed by the Board due to timings these could come to Audit Committee<br><br>• Deep dive suggested to ensure that there is co-ordination across committees. Thought should be given to how PFR and Audit give assurance to the Board or the Quality Committee.<br><br>• Chairs of Committees should keep an open dialogue to ensure communication, an overlap of information is preferable across committees<br><br>The Terms of Reference were agreed. |
| | **Quality Committee** |
| | Mr Lawlor introduced the Terms of Reference. The Quality Committee will be discussing issues and scrutinising data. Executive leads are clear |

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| | that we should have a dialogue on what we are reporting and any risks attached. It will be a development process to get where we need to be on each committee.<br><br>Ms Colson advised that the first meeting of the Quality Committee was a base line as it differs greatly from the Integrated Governance Committee which it replaces. The questions that arise from this committee are - What are we looking at? What do we need to look at? How is the data relevant?<br><br>A dialogue between committees and chairs will be necessary to ensure the right data and information is scrutinised.<br><br>The Terms of Reference were agreed. |
| | **People, Organisational Development, Equalities, Diversity and Inclusion Committee** |
| | Ms Farrington advised that the purpose of this committee is to provide assurances across all people matters, making it clear that when we are looking at data it is in relation to our workforce. The People Strategy and implementation plans for this strategy will be monitored by this committee.<br><br>Ms Sequeira advised that we have already held two POD EDI Committees. The aim of this committee is to improve the quality for people and not just operational matters. The committee will be looking at the metrics, but do not yet have the data. The remit of the committee is wide, but the agenda will be managed carefully.<br><br>It was noted that the quorum for this committee is different to the others in that it only requires one NED, this needs to be standardised across all committees.<br><br>This committee can have Governors as ex-officio members, however we need to be mindful of how much is asked of Governors.<br><br>The Terms of Reference for this committee has already come to the Board for agreement.<br><br>Comments on the Terms of Reference were invited:-<br><br>• Discrepancy over whether the minutes or a Chairs Report from this committee will come to Board. Ms Davies confirmed that it will be a Chairs Report coming to the Board. This will be amended when all Terms of Reference are consistency checked.<br><br>• There was a question over adding members to committees. Ms Davies advised that if there is a change of delegation to a committee this needs Board approval. All members of a Committee need to be a member of the Board.<br><br>• Chairs can invite others to attend committee meetings<br><br>• It has been agreed to have a commissioner attend the Quality Committee. It was agreed that this is helpful. |

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| | **d. Audit Committee** |
| | Mr Lawlor advised that the Terms of Reference for this Committee have not altered significantly.<br><br>Mr Holt advised that there is an overlap between the Audit Committee and the Performance, Finance and Resources Committee. We will need to ensure that no issues fall between committees. It will be for the chairs of each committee to communicate on this.<br><br>Mr Lawlor advised that the Audit Committee takes an overview of all the Board Committees and seeks assurance that all committees are carrying out their duties.<br><br>Comments were invited:-<br><br>• It was noted that Sarah Stenlake our Freedom to Speak Up (FTSU) Guardian only works part-time and is being asked to provide reports multiple committees, this may be unrealistic given that she has to use her time to meet with staff.<br><br>• FTSU is required to report to the Audit Committee as part of the Committee remit on whistleblowing. The Interim Director of Corporate Governance will review the reporting requirements with the Interim Director of Human Resources |
| | The Education and Training Committee Terms of Reference have not been changed, however if the Trust becomes a degree awarding organisation they will need to be reviewed. Ms Davies confirmed that the Terms of Reference are currently fit for purpose. |
| **4/22** | **Non-Executive Champions and Committee Membership** |
| | Ms Davies introduced the paper and noted that the Trust was delayed in implementing the new NHS England guidance on Non-Executive Director Champions. Linked to NED champions we have also reviewed the membership of the Committees to ensure the champions align to the correct committee.<br><br>There was a discussion on which Board Committee Champions should be on and some changes were suggested. Each Champion will have a reporting line, but will not be required to provide a report to the Board.<br><br>It was noted that we will have five named NED Champions for particular areas. Mr Holt felt that we should look clearly at what NEDs are being asked to do so that it remains strategic and not operational.<br><br>Ms Colson asked about Gloucester House School and which Committee this report into. Ms Hodges advised that Gloucester House is unusual in that it reports directly to the Board of Directors. The Terms of Reference for Gloucester House can be set up differently in that the Chair of the Board of Directors is the proprietor of the school. |

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| | Reporting lines for Gloucester House need to be made clear. |
| **5/22** | **Board Governance SOP** |
| | The Terms of Reference for each Board Committee have been signed off. The Standard Operating Procedure for the Board Secretariat is to ensure that there is consistency and quality control across all Board Committees.<br><br>It was suggested that page numbering is added to Board and Committee papers.<br><br>It was suggested that Governors are invited to attend committee, this would be on an 'in attendance' basis and they would not be members of the committee. It would still be for the Committee Chairs to provide feedback to the Council of Governors meetings. |
| **CLOSING ITEMS** | |
| **4/22** | **Any other Business** |
| | None |
| | **Reflections and Feedback from the meeting** |
| | None |
| | **Date, time and venue of next meeting** |
| | Tuesday 26th July, 2.00 – 5.00 pm Virtual |

NHS
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## Board of Directors: Action Log

| Ref | Meeting Date | Agenda Item | Action Notes | Who | Due Date | Progress / Comments | Status |
|---|---|---|---|---|---|---|---|
| AP1 | 28.9.21 | 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 | Director of Finance | March 2022 | The item was discussed at the Performance, Finance and resource Committee | Closed |
| AP1 | 30.11.21 | 2.1.2 | Information briefing session to be arranged for the whole Board on the relationship with the ICS | CEO | None stated | To be scheduled in June. | Overdue |
| AP3 | 25.1.22 | 2.4.6 | Outcome measures to be discussed at the May Board | Medical Director | May 2022 | Outcome measure's and performance Management will be taken forward by the Performance, Finance and Resource Committee | Overdue |
| 3/22 | 29.3.22 | 6/22 | CEO to include items agreed in the meeting to the objectives. | CEO | April 2022 | Paper on Trust strategy and strategic objectives to be taken forward | Completed |
| 4/22 | 24.5.22 | 4 | Patient and Student stories to be arranged for all future board meetings | Corporate Governance Team | None stated | To be arranged for the meeting in September 2022 | |
| 13/22 | 24.5.22 | 13 | Terms of Reference for the People, Organisational Development, Equality, Diversity and Inclusion Committee to be ratified | Board | July 2022 | An additional meeting was held on 5th July to agree and approve all the Board committees Terms of Reference | Completed |

| Report to | Date |
|---|---|
| Board of Directors | 26th July 2022 |

| Chief Executive's Report |
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| **Executive Summary** |
| This report provides a summary of key issues affecting the Trust. |
| **Recommendation to the Board** |
| The Board of Directors are asked to note and 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 On 30th June we published the Outcomes to Consultation setting out our final proposals resulting from the Strategic Review, including new structures in the organisation. The documents also set out the basis on which the Board had agreed changes to our original proposals in response to feedback raised in the consultation. Current progress on implementation is detailed in a paper later in the agenda.

## 2. Integrated Care Board

2.1 On July 1st the North Central London Integrated Care Board formally came into existence as statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.

## 3. Board Governance Review

3.1 Work has been progressing with the implementation of the Board Governance Review. In particular we have been working to establish the new structure of committees recommended in the Review.

3.2 The Board held an extraordinary meeting on 5th July at which it agreed terms of reference for:

- People Organisational Design, Equalities, Diversity and Inclusion (PODEDI) Committee
- Quality Committee
- Performance, Finance and Resources (PFR) Committee
- Audit Committee

3.3 The terms of reference for the Education and Training Committee are being reviewed over a longer period so they can reflect the requirements of the Trust's desire to move, in the future, to securing Taught degree awarding powers.

3.4 By the time of the July Board, meetings will have been held of all the new committees.

3.5 In addition, the Board has agreed a Standard Operating Procedure for Board business.

## 4. People Strategy

4.1 A key priority for the Trust has been the development of a People Strategy. A draft strategy has been discussed by PODEDI and is on the agenda for consideration later in the meeting.

4.2 The People Strategy will provide an overarching framework, based on national priorities, for our work to improve the working experience of staff in the organisation, address challenges in respect to equalities and respond to areas of concern identified in the staff survey.

## 5. Executive appointments

5.1 I am very pleased that we have been able to make some key appointments to the senior team in the Trust. This includes:

- Elisa Reyes-Simpson who has been appointed as Interim Chief Education and Training Officer.

- Alastair Hughes who has been appointed as Interim Director of Strategy and Transformation.

5.2 Jenna Davies will be leaving the Trust on 1st August to take up a substantive new role. I am very grateful for the significant contribution which Jenna has made to strengthening governance at the Trust. He role will be picked up on an interim basis by Julie Dawes ahead of making a substantive appointment to the role of Director of Corporate Governance as part of the implementation of the Strategic Review.

## 6. SOF 3

6.1 We have been working with the ICB to agree the exit criteria for SOF 3.

Paul Jenkins
Chief Executive
19th July 2022

| Report to | Date |
|---|---|
| The Board of Directors | 26 July 2022 |

Quality Committee Highlight report

## Executive Summary

The Quality Committee met for the first time on 5 July 2022. Dr Colson welcomed members to the Committee and highlighted that the Committee Terms of Reference were due to be approved by the Board on the 5th July 2022.

The Committee reviewed the approved Quality Account, the discussion focused on the Quality priorities for 22/23 and the baseline metrics. The Committee discussed how it would receive ongoing assurance against the delivery of the priorities throughout the year.

The Committee placed considerable focus on the Gender Identity Development Service and the improvements being made within the Trust. The Committee reviewed assurance reports related to the CQC improvement plan and the waiting list action plan. The Committee also noted the external support being offered by the system and the regulators. The Committee will continue to seek assurance on both improvements to the service and the waiting list. The Committee also requested that the harm review group reports directly to the Committee.

The Committee received a report from the Patient safety and risk group. Dr McKenna highlighted to the Committee that the new patient safety strategy is being implemented within the NHS and asked that the committee commit time to understanding the strategy and how the Trust was implementing it internally.

The Committee also reviewed the quality report, the Committee supported the improvements and approach to improve the quality report put forward by the Chief Nurse.

## Recommendation to Board

| The Board is asked to note the report | |
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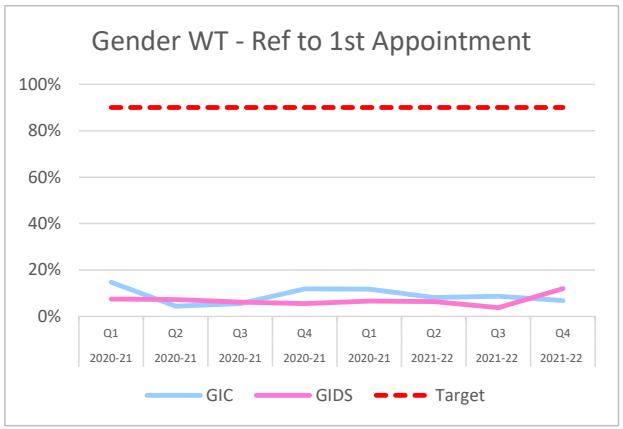
| **Trust strategic objectives supported by this paper** | |
| Quality of Care | |
| **Author** | **Responsible Director** |
| Jenna Davies- Director of Governance | Chair of Quality Committee |

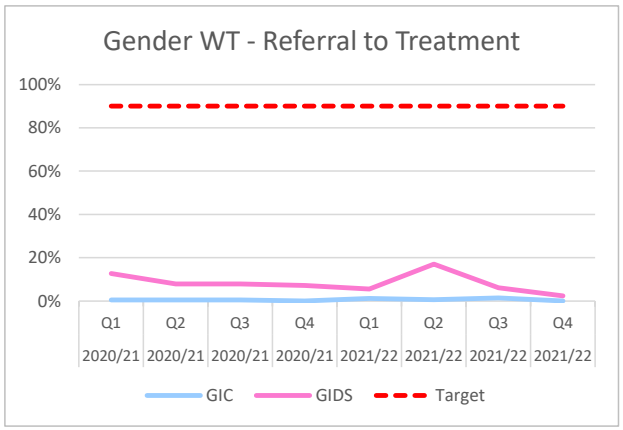
# Quality Report

## Q4 2021/22: Quality Responsive – Access




| Service Lines | %Compliance | <= 18 wks | 18 ≤ 30 wks | 30≤ 42wks | 42 ≤48 wks | 48≤54 wks | 54 wks + |
|---|---|---|---|---|---|---|---|
| GIDS | **12%** | 11 | 3 | 1 | 2 | 2 | 73 |
| GIC | **7%** | 7 | 2 | 3 | 1 | 1 | 89 |

GIDS target within 18 weeks
GIC target within 18 weeks




| Service Lines | % compliance | <= 18 wks | 18 ≤ 30 wks | 30≤ 42wks | 42 ≤48 wks | 48≤54 wks | 54 wks + |
|---|---|---|---|---|---|---|---|
| GIDS | **2%** | 2 | 1 | 3 | 0 | 1 | 75 |
| GIC | **0%** | 0 | 0 | 0 | 0 | 1 | 184 |

GIDS target within 18 weeks
GIC target within 18 weeks

Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q4 data has been run without meeting the threshold on a number of unoutcomed appointments. Q4 report will include a rerun of all 21/22 quarters.
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021.

## Gender Services Waiting Times:

When calculating the waiting times all contracts and all activity are included including significant telephone conversations. The 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 time issues.

**Referral to 1st Appointment**: Gender Services Directorate saw 9% of patients within the contractual waiting times in Q4. This is a higher rate compared to 6% in Q3.

**Referral to Treatment** : Gender Services Directorate saw 1% of patients within the contractual waiting times in Q4. This is a lower rate compared to 3% in Q3.

**GIDS**: the current waiting time is advised on the Tavi's website to young people and referrers to promote awareness about the WT issue in GIDS. GIDS is currently seeing young people for their first appointment who were referred in 2018 and there were 5143 patients waiting at the end of Q4.

**Referral to 1st Appointment** – Q4 had 12% compliance, an increase on 4% in Q3.

**Referral to Treatment** – Q4 had 2% compliance, a decrease on 6% in Q3.

**GIC**: The Gender Identity Clinic in London continues to have an extremely high number of referrals which is challenging within the current clinic parameters. GIC is currently seeing patients for their first appointment who were referred in 2017. At the end of Q4 there were 10924 patients waiting for a first assessment.

**Referral to 1st Appointment** – Q4 had 7% compliance, a decrease on 9% in Q3.

**Referral to Treatment** – Q4 had 0% compliance, an decrease on 1% in Q3.

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For further comments from service leads please see the commentary part of the report. Page 23

## Q4 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 December 2021, with 97.4% 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.

In order to improve on DQMI and MHSDS completion rates, the subject is 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. We are pleased to see that the completion rates for Ethnicity, Employment and Accommodation continues with an upwards trend.

| | Target | 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 | Month 7 October 2021/22 | Month 10 January 2021/22 |
|---|---|---|---|---|---|---|---|---|---|
| **Valid NHS number** | 95% | 98.97% | 98.99% | 99.16% | 99.60% | 99.50% | 99.26% | 99.30% | 99.24% |
| **Valid Postcode** | 95% | 99.79% | 99.70% | 99.72% | 99.53% | 99.64% | 99.65% | 99.67% | 99.64% |
| **Valid Date of Birth** | 95% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Valid Organisation code of Commissioner** | 95% | 99.14% | 99.13% | 99.14% | 99.13% | 99.04% | 99.13% | 98.88% | 98.94% |
| **Valid Organisation code GP Practice** | 95% | 98.55% | 98.28% | 98.33% | 99.12% | 99.09% | 99.03% | 99.01% | 99.12% |
| **Valid Gender** | 95% | 99.38% | 98.80% | 98.50% | 99.98% | 99.95% | 99.96% | 99.98% | 100% |
| **Ethnicity** | 95% | 75.94% | 75.82% | 73.88% | 88.77% | 88.88% | 90.94% | 91.07% | 91.19% |
| **Employment Status (for adults)** | 95% | 56.68% | 55.94% | 54.92% | 66.98% | 63.64% | 66.44% | 67.57% | 68.44% |
| **Accommodation status (for adults)** | 95% | 55.48% | 54.69% | 53.63% | 66.59% | 63.31% | 65.70% | 67.01% | 67.66% |
| **Primary Reason For Referral** | n/a | 99% | 99% | 100% | 100% | 100% | 100% | 100% | 100% |
| **Ex-British Armed Forces Indicator** | n/a | 48% | 56% | 62% | 64% | 73% | 77% | 80% | 81% |
| **DQMI -Data Quality Maturity Index** The DQMI Indicator is not submitted in the same intervals. | 95% | 95.60% | 95.70% | 95.7% | 96.6% | 96.4% | 97% | 97.3% (Nov '21) | 97.4% (Dec '21) |

Data source: Data warehouse, informatics team 07/04/2022

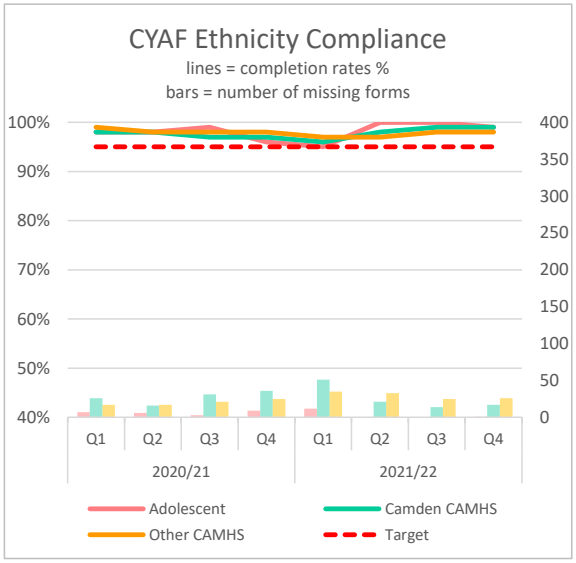
## Q4 2021/22: Single Oversight Framework – Access

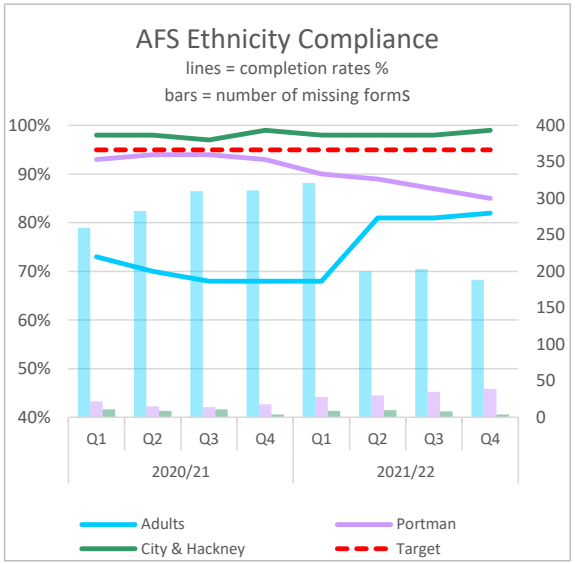
### Ethnicity Rates Internal Reports

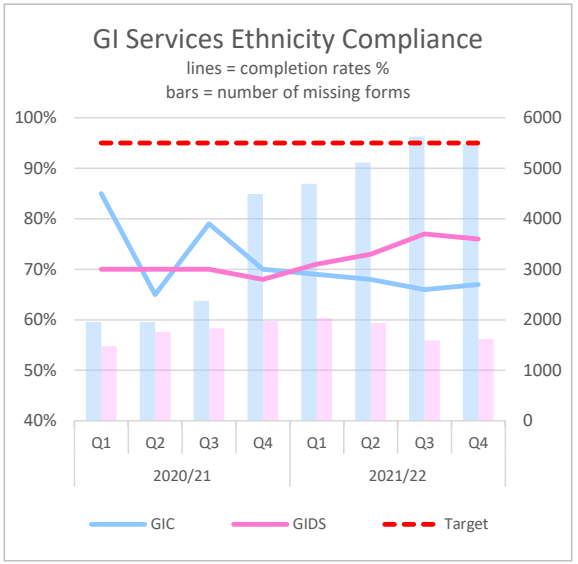
Ethnicity completion rates have been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. 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 has implemented the use of an acceptance letter which is sent before any appointment is offered. This includes a 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. GIC and GIDS started a similar project to ACN sending the 'patients detail forms' with their acceptance letters. This is starting to show improvement on collection rates.

Unfortunately Portman has a decreasing trend on completion rates. The process in place is being discussed with an expectation on improving the trend in the new financial year.

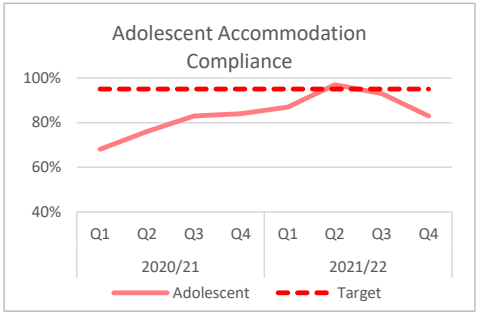


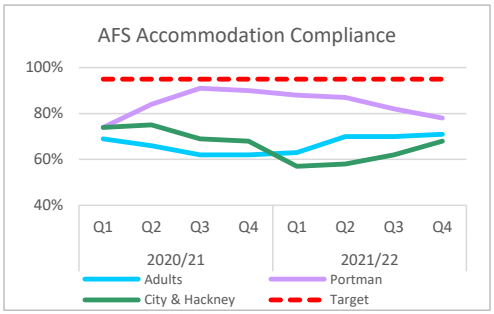



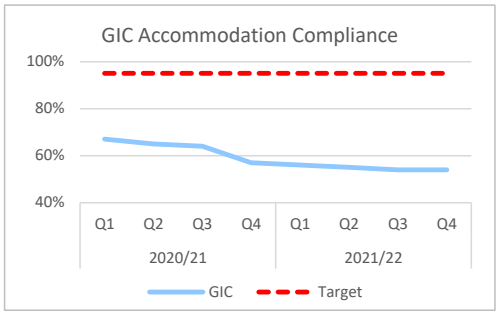



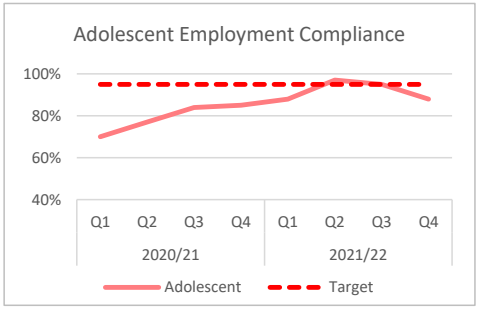

Data source: Q4 data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

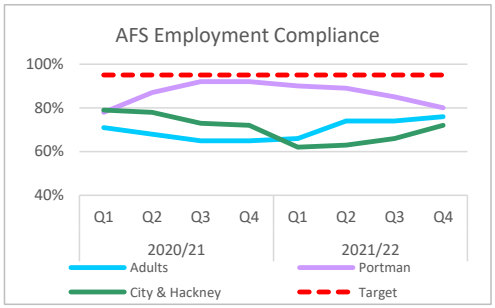
## Q4 2021/22: Single Oversight Framework – Access

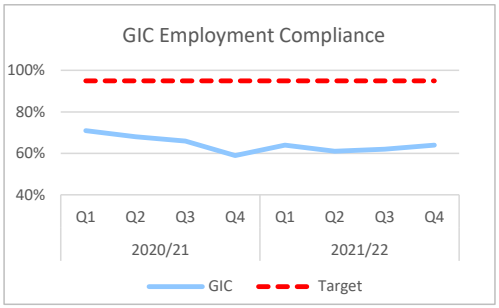


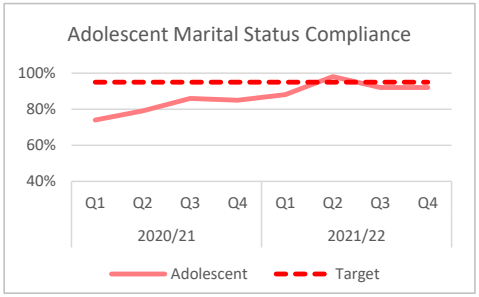



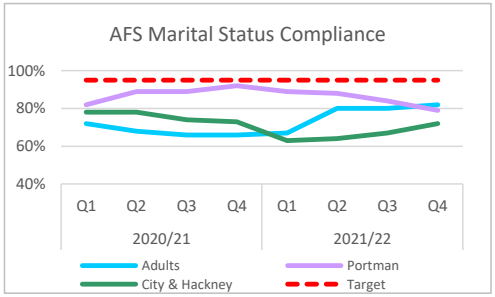



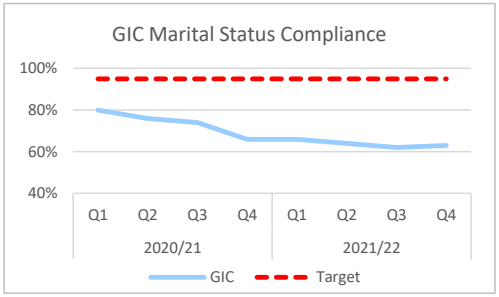




Data source: Q4 data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

### 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.

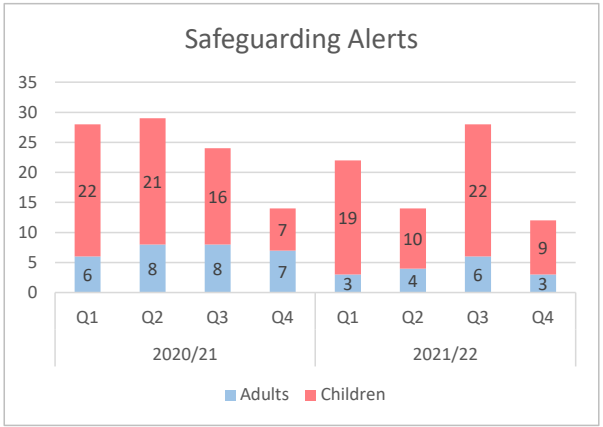
We are expecting that the 'patients detail forms' sent along with acceptance letters would start showing data improvement over the next few quarters.

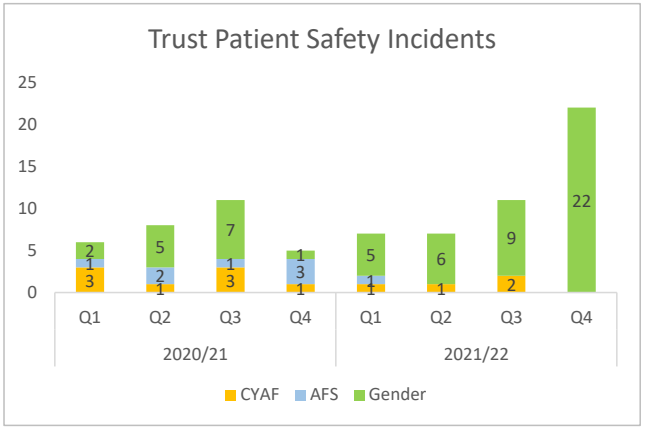
We are working on a solution to correct a minor glitch in the CareNotes report with regards to the information held on the Social Inclusion From. We have found a few cases where information has been provided but not included on the last social inclusion form, and the report is not counting this data.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

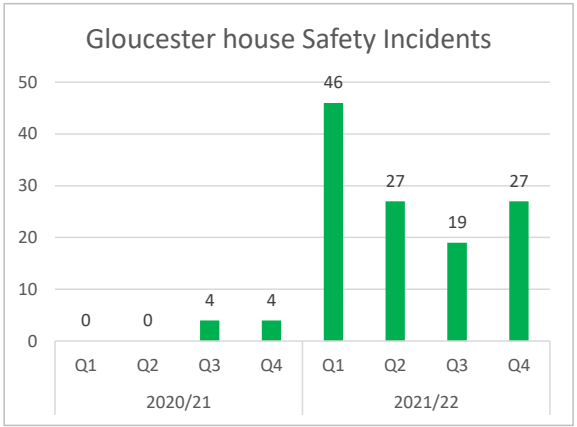
## Q4 2021/22: Quality Safety – Care

| | Incidents Reported by Risk Level – Trust wide | 2020/21 Q1 | 2020/21 Q2 | 2020/21 Q3 | 2020/21 Q4 | 2021/22 Q1 | 2021/22 Q2 | 2021/22 Q3 | 2021/22 Q4 |
|---|---|---|---|---|---|---|---|---|---|
| Numbers of incidents logged in our QP system (all types) | 1-4 | 37 | 33 | 32 | 62 | 64 | 40 | 30 | 36 |
| | 5-8 | 11 | 19 | 30 | 29 | 42 | 69 | 29 | 24 |
| | 9-12 | 3 | 3 | 12 | 20 | 11 | 5 | 16 | 4 |
| | 15+ | 1 | 2 | 1 | 3 | 1 | 1 | 1 | 2 |
| | Total | 52 | 57 | 75 | 114 | 118 | 115 | 76 | 66 |

**Ongoing IT connection issues at Lief House*



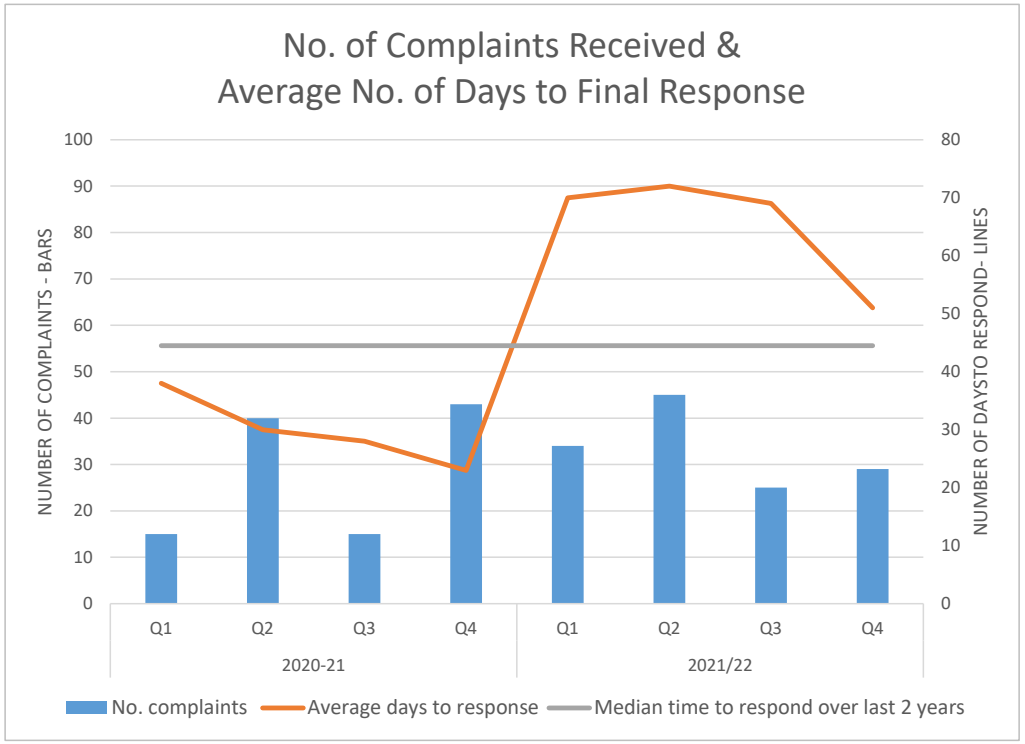

The 9 safeguarding children referrals are in reference to risks of physical abuse; neglect; emotional abuse; isolation; low mood; vulnerability; self-harm; aggressive behaviour and emotional abuse.
The 3 safeguarding adults concerns are in reference to concerns about financial abuse, emotional abuse, sexual abuse and risk of radicalisation, of which 2 were logged as historical concerns and 1 as current concern.

In Q4 informatics discovered a large number of SIs as part of a large data sweep, many of these deaths occurred prior to Q4. Of the 22 patient safety incidents in the Gender services 1 x related to attempted suicide and the rest to patient deaths. Of the patient deaths, for the majority of them we do not have the cause of death as we are still awaiting coroner's reports or responses from the GPs. Due to staff shortages within the department Q4 patient incidents are yet to be added on NRLS as patient safety incidents.

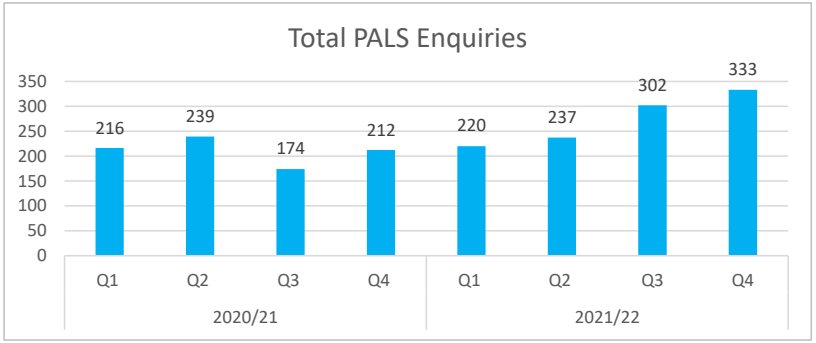
Ongoing Incidents of violence towards staff and damage to property.

Data & commentary source: Q1 , Q2, Q3 & Q4 data run by Health & Safety and Safeguarding Departments 11/04/2022
Other historical data as reported in relevant earlier reports.

## Q4 2021/22: Quality Responsive – Care




| Complaints by Directorate | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 | Q1 21/22 | Q2 21/22 | Q3 21/22 | Q4 21/22 |
|---|---|---|---|---|---|---|---|---|
| Children Young Adults and Families | 0 | 1 | 0 | 3 | 1 | 5 | 4 | 0 |
| Adult and Forensic | 3 | 11 | 3 | 7 | 4 | 9 | 5 | 2 |
| Gender | 12 | 25 | 11 | 27 | 27 | 31 | 16 | 27 |
| Corporate | 0 | 3 | 1 | 7 | 2 | 0 | 0 | 0 |
| **Total complaints** | **15** | **40** | **15** | **43** | **34** | **45** | **25** | **29** |




This is a slight increase in the number of complaints received during this quarter, 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. We are working to address the backlog of complaints and extra resources are being allocated to complaints work. All complainants are advised that there is likely to be a delay in the response to their complaint due to the backlog caused by the COVID-19 pandemic. Average response times are currently around 1.5 months. The complaints that has been responded was partially upheld. Following upheld or partially upheld complaints, where appropriate, action plans are written to ensure that changes are made to improve our services.

Main themes:
Access to Treatment/Drugs (how to access services and what is available)
Appointments (availability/waiting times)
Communication issues (letters, notifications, getting through to teams)

Data & commentary source: Q1 , Q2, Q3 & Q4 data run by Health & Safety and Safeguarding Departments 07/04/2022
Other historical data as reported in relevant earlier reports.

## Q4 2021/22: Quality Responsive – Care

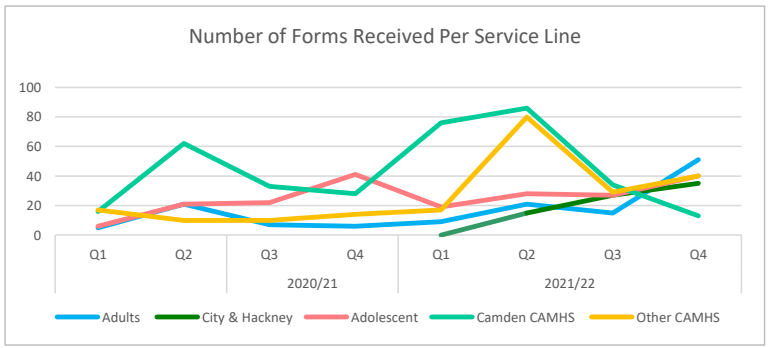
| Quality Key Performance Indicators | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KPI – London Contracts | Monitoring | Target % | 2021/22 | | | | | | | | | | | | RAG Progress | | | |
| | | | Q1 | | | Q2 | | | Q3 | | | Q4 | | | | | | |
| | | | Numerator | Denominator | % | Numerator | Denominator | % | Numerator | Denominator | % | Numerator | Denominator | % | Q1 | Q2 | Q3 | Q4 |
| Question 1 from ESQ "What was your experience of your care/treatment?" | Quarterly | 92% | 100 | 103 | 97% | 203 | 211 | 96% | 96 | 98 | 98% | 167 | 175 | 95% | | | | |
| 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% | 89 | 91 | 98% | 152 | 161 | 94% | | | | |
| Q3 ESQ "How seriously were your views and worries taken?" | Quarterly | n/a | 100 | 102 | 99% | 202 | 204 | 99% | 89 | 91 | 98% | 156 | 164 | 95% | | | | |
| 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% | 81 | 82 | 99% | 136 | 144 | 94% | | | | |
| Q5 from ESQ "How helpful was the information received about the trust before you first attended?" | Quarterly | 75% | 47 | 53 | 89% | 104 | 117 | 89% | 42 | 48 | 88% | 71 | 84 | 85% | | | | |
| Q6 from ESQ "Would you recommend this service to friends and family?" | Quarterly | 80% | 91 | 96 | 95% | 181 | 193 | 94% | 88 | 91 | 97% | 155 | 165 | 94% | | | | |

The ESQs completion rates are part of our KPIs and as such they include London Contracts only.

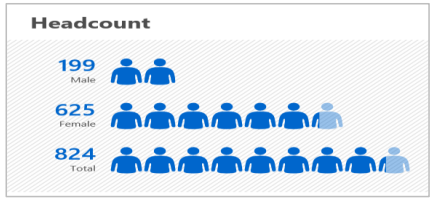
Traditionally the responses and feedback from our patients has been very positive and the comments and scores received are commendable. However, there is a consensus that the number of forms returned could be higher. A new shorter form which aims to improve the collection rates was implemented during April 21. Please note that 21/22 data refers only to new forms, and prior data refers to the old forms.

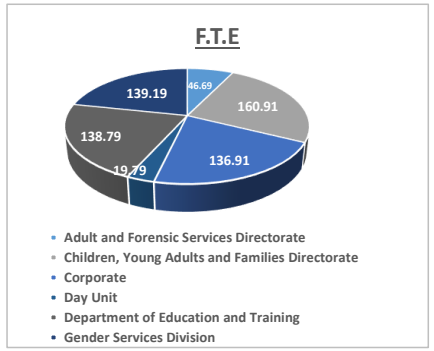
We are pleased to see an increase on number of forms in Adults complex Needs, Other CAMHS and C&H PCPCS. An online collection method (Qualtrics) was tested in Q4; this methodology should increase the number of forms sent to patients and our return rate.

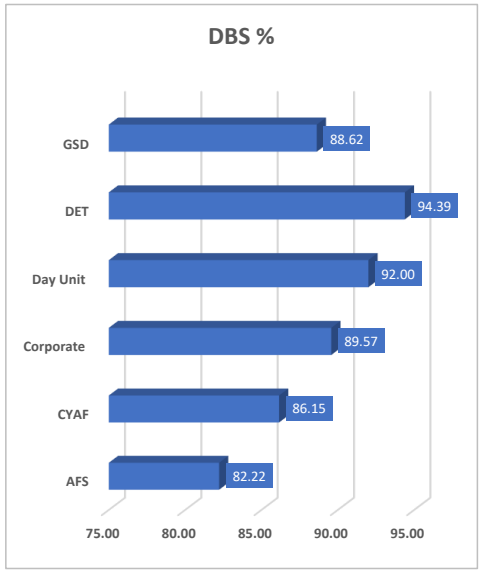
Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q4 data run on 07/04/22. Previous data run as reported in earlier reports.
*ESQ % = (Certainly true + Partly True)/(Certainly True + Partly True + Not True)

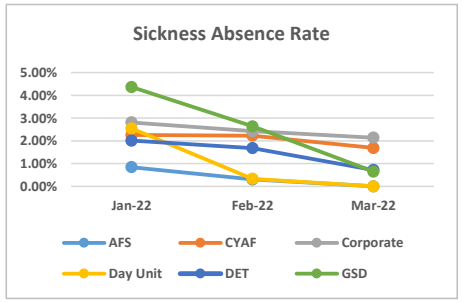


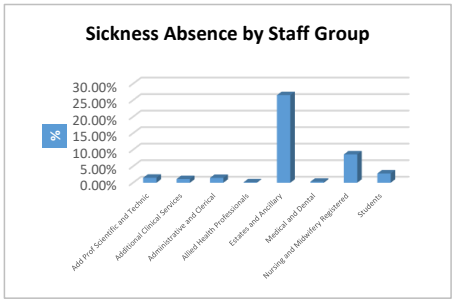
## Q4 2021/22: Quality Well-Led

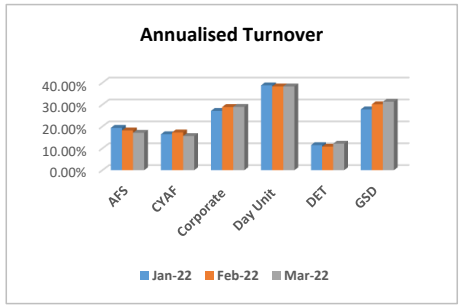


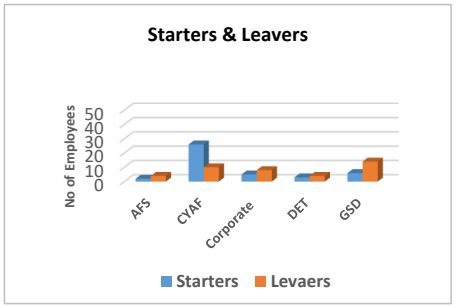



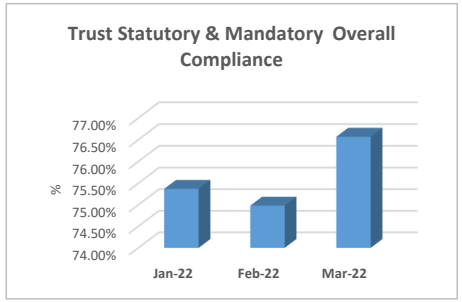



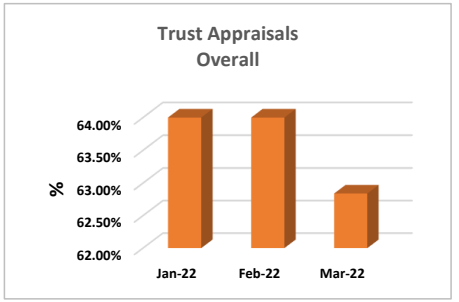




**At the end of Q4, the Trust employee headcount is 824 (642.48 full time equivalent). A high rate of female employees representing 76% and male employees at 24%. The CYAF division holds the highest headcount, the smallest being Day unit.**

**Turnover currently at 21.53% (12m). The data is based on headcount and shows people leaving or returning to active service, this would include those going on or returning from maternity leave or career break. A break down in section three indicates turnover in each directorate for Q4.**

**Sickness absence has improved over the past three months, decreasing by 1.52% (Trust Overall). A breakdown in section four indicates sickness absence in each directorate. The GSD division in January held the highest sickness level at 4.37%, compared to the other directorates ranging from 0.85% to 2.81%. Each directorate at the end of Q4 remain under the 3% average from 0% to 2.14%.**

**Compliance has remained within 70% and above. We did see a slight decrease in Feb-22 by 0.39%, however this has started to increase at the end of Q4 by 1.59%.**

**Appraisals have also improved from the last quarter by 10%.This now stands at 63% at the end of Q4.**

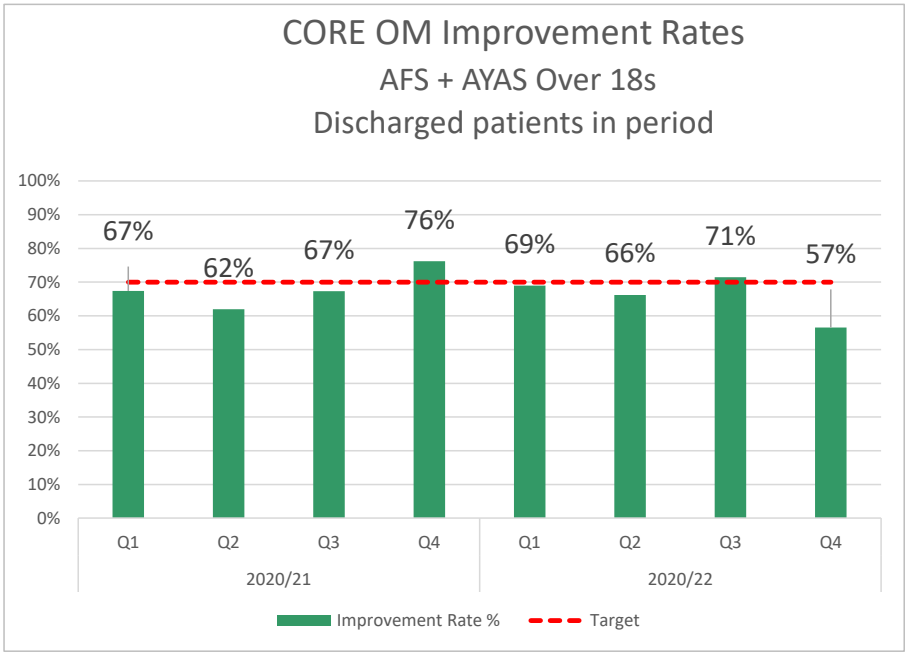
**DBS checks within our Trust are maintained to a high standard at 89.01%, not all positions will need a DBS. The need and level of check required depends on the activities and type of patient access an employee will have.**

Data Source: Human Resources Department: 11/04/22

## Q4 2021/22: Quality Effective – Outcome Measures

### A F S and Adolescents over 18

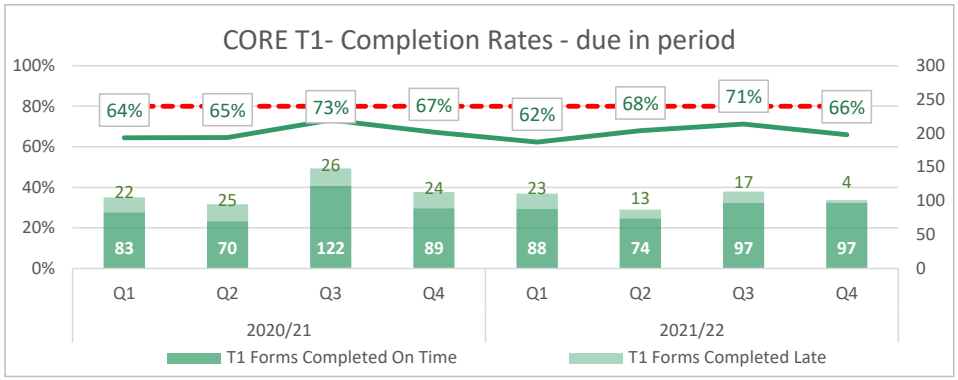
CORE OM data is run including all contracts

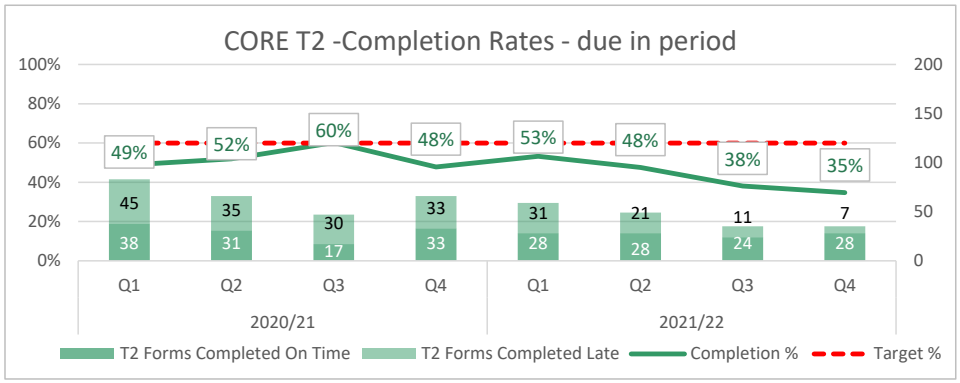



The CORE OM improvement rates include all patients discharged in the period with a minimum of two completed CORE OM forms. It compares scores from the first form completed to the last one.

We have a 57% improvement rates in Q4 which is a marked decrease from previous. This rate could be related to the usage of Qualtrics and the initial work with automated distribution lists. 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 report that the percentage of patients discharged with a minimum of 2 CORE OMs forms is gradually increasing over the last 3 quarters.

Data source: Data as recorded on 12/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team



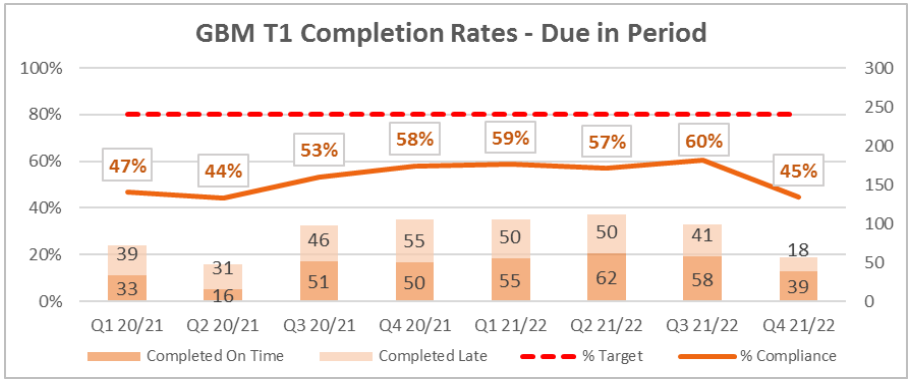

Completion rates include forms completed on time and late. As we are reporting 'due in period' the most recent quarter's compliance will be naturally lower as late forms are not created yet

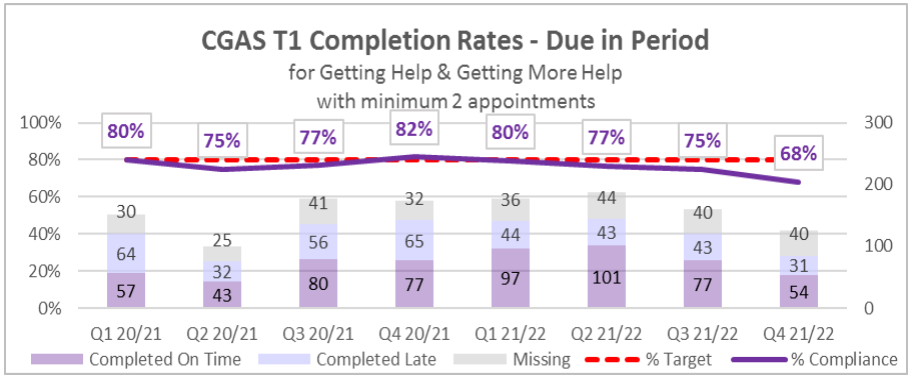
-**CORE T1 rates**: expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 the compliance rate was 66%. and the last 3 months average is 67%.

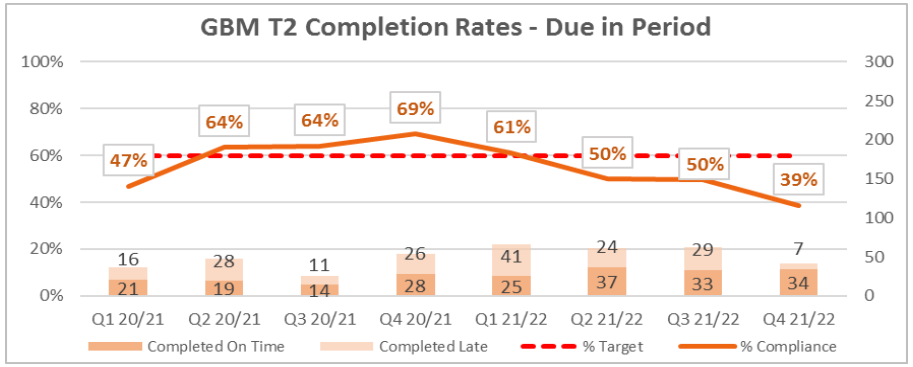
-**CORE T2 rates**: expected 6 months after T1, deemed as on time if within 7 months of T1. In Q4 we achieved 35%. and the last 3 months average is 46%. T2 forms are particularly challenging for teams that have a long waiting list.

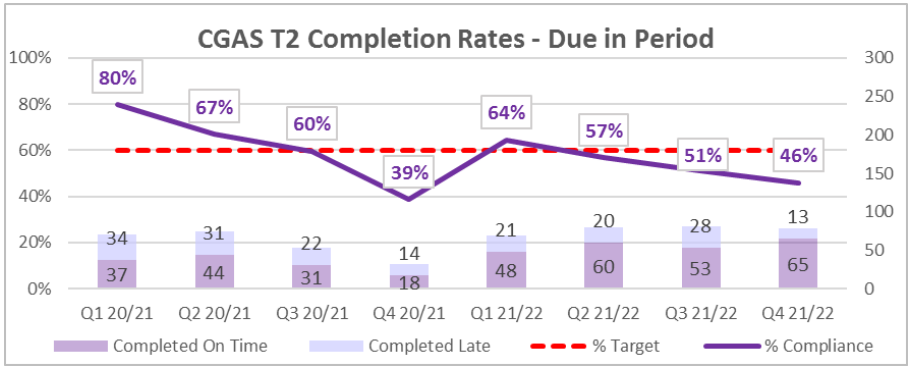
## Q4 2021/22: Quality Effective – Outcome Measures C Y A F - Under 18

GBM & CGAS completion rates are part of our KPIs and as such they include London Contracts only.
Cohort excludes following teams: Retuning Families, First Step and First Step Rehab, Gloucester House and Healios .




We have developed a new report that has improved our data accuracy and our internal reminder system. It also allows us to assess which forms were recorded on time or late. We now can retrospectively update previously reported quarterly data; this has an impacted in particular the last year's financial year's data. As we are reporting 'due in period' the most recent quarter compliance will be naturally lower as late forms are not created yet.

**-GBM T1** - expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 completion rates for due forms is 36% and the last 3 months average is 47%.

**-GBM T2** - expected 3 months after T1, deemed as on time if within 4 months of T1. We exclude discharged patients who were not seen after T1 -- In Q4 we achieved 39% compliance and last 3 months average is 46%.

Data source: Data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team

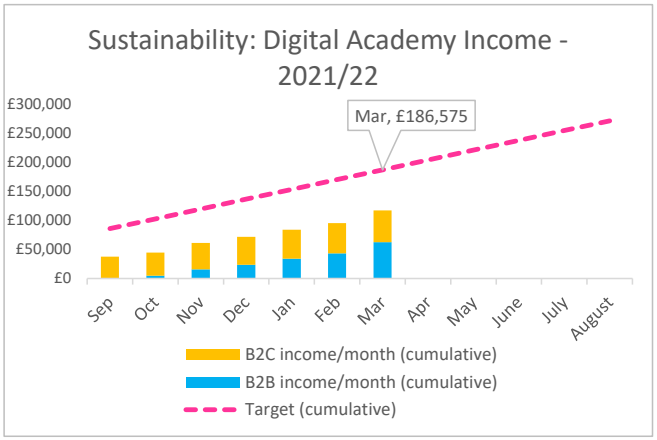
We have developed a new report that has improved our data accuracy and our internal reminder system. It also allows us to assess which forms were recorded on time or late. We now can retrospectively update previously reported quarterly data; this has impacted in particular the last financial year's data. As we are reporting 'due in period' the most recent quarter's compliance will be naturally lower as late forms are not created yet

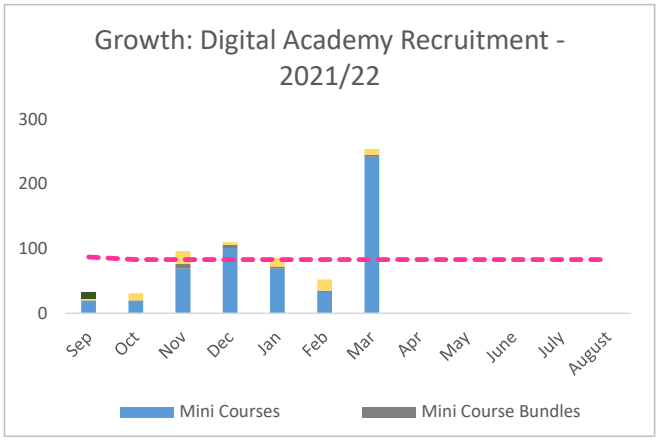
**-CGAS T1 rates**: expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 the compliance rate was 68%. and the last 3 months average is 73%.

**-CGAS T2 rates**: expected 6 months after T1, deemed as on time if within 7 months of T1. We exclude discharged patients who were not seen after T1. In Q4 we achieved 46%. and the last 3 months average is 51%.

See Slide 37 for further GBM and CGAS information

## Q4 2021/22: Directorate of Education and Training (DET)

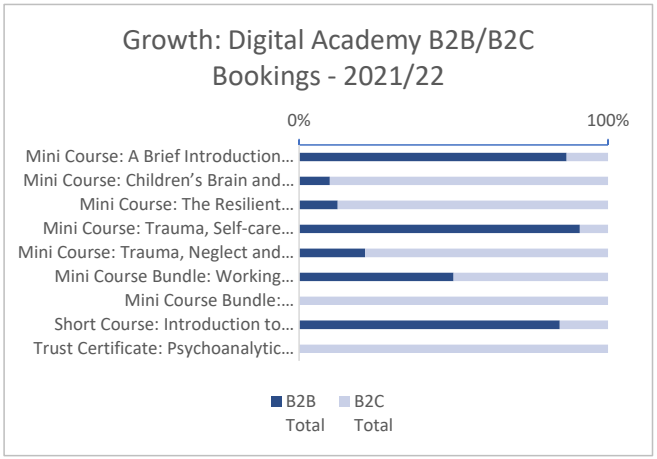


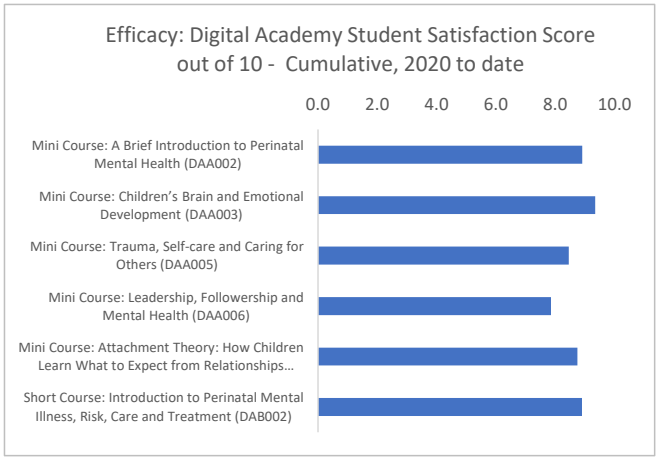




The 'Sustainability' graph shows cumulative individual booking income via the MyTAP system for all Digital Academy products in the 21/22 academic year from 1 Sep 2021 until 31 March 2022 (£116,989) against target (£186,575).

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 unrecognised and invoice-pending B2B income for Sep 21 - Mar 22 stands at £52,460, which takes the total forecast Digital Academy income to £169,449 (9% under target). Discussions regarding a solution to reporting bookings/enrolment and invoice income in a more unified fashion are ongoing.

March 2022 was an exceptional month for the Digital Academy, hitting 306% of the bookings target and 130% of the income target for the month – the best month on record for the Digital Academy. March's results continue to be driven by large numbers of enrolments for the lower-price mini courses from B2B group bookings, combined with a financial year end pressure to use up budgets. (53% of total income for this academic year to date is from B2B group bookings; the remaining income comes from B2C or individual consumers.)




'The 'Growth' chart reflects the importance of B2B group bookings to the DA. 53% of income over the Sep 21 - Mar 22 period was from B2B bookings. This is driven by a high volume of B2B bookings being for the lower-cost mini courses. B2C activity for his period made up 39% of the total bookings and 67% of total income.

81% of all bookings in March 2022 were for the perinatal mini course, funded by NHS Improvement/NHS Midlands, Cambridgeshire and Peterborough NHS Trust and by Herts Valleys CCG; however, this contributed 64% of the month's total income.

The 'Efficacy' chart shows positive student satisfaction rates across all products, with the majority of respondents scoring their experience highly (8+). The Attachment Theory Mini Course, which was launched in November 2021, has received a positive 8.3/10 score so far. Improvements to communications are underway to improve the quantity of surveys completed by students, with student feedback being reviewed and actioned on a monthly basis.

Data & commentary source: DET Department 11/04/2022

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

| **Waiting Times** - feedback and action plan from Service Leads – CYAF Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adolescent /AYAS** | This quarter AYAS continue to meet the KPI requirements. The breaches were due to COVID related leave. | The referral rate is slowly returning to normal after a prolonged depression due to covid. The focus of the service is to continue to provide 1st and 2nd appointments in a timely manner. |
| **Camden CAMHS** | Camden CAMHS have continued to exceed the target for seeing patients for initial assessments within the required time period. It is noted that there is a slight reduction for this quarter. There were a higher number of cases where the 1st appointment target has been breached. Some work has been done by the Camden intake team to look at these cases that had been: it was identified that most of these cases were delayed due to waiting for responses from other services (see next section for plan).<br><br>The target for WT to treatment was achieved this quarter.<br>There continue to be significant staffing and recruitment challenges this quarter and it is commendable in this context that the service has continued to be able to respond to need in a timely way. | Learning continues to be implemented to learn from cases that were not seen in a timely way, including use of QI projects to reduce waiting times and optimise allocation processes to clinicians in teams. Team managers and admin leads continue to use a 'weekly waiter' report to monitor cases that are waiting for a 1st or 2nd appointment.<br><br>This work has identified some system issues around liaison with other services and a new process has been put in place to work with referrers and other teams to respond in a more timely way to reduce waiting times. |
| **Other CAMHS** | We are exploring the data in relation to the current waiting times compared to Q3 the compliance- the breaches have been a combination of internal and external breaches. For example - patients cancelling a number of 1st appointments which resulted in delays in offering the 2nd appointments. A number of appointments were not updated in Carenotes therefore the breaches are now cancelled and Carenotes updated e.g. staff attempting to contact the families. However the families are getting in touch before the breach dates. Measures will be put in place to remind Clinicians to update Carenotes with Patient contact activities. Therefore, the number of breaches<br>CWP – breaches cause by the CWP service not in operation for this financial year these cases were transferred to FMH Service hence the breaches.<br>ASF funding has been agreed and recruitment of clinician and operations manager this service is now operational and should see an improvement in the waiting times for the next quarter. | Continue to manage the compliance rates and follow up with team managers to increase compliance of waiting times in a timely manner. |

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

| Waiting Times - feedback and action plan from Service Leads – AFS Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adult Complex Needs** | We continue to struggle to meet the targets for 1st and 2nd appointment, particularly in our Trauma unit where we have a considerable waiting list. | Our plans for the next quarter are to;<br>- Continue to review our treatment pathways to ensure our capacity and demand are more aligned and to release capacity for those waiting to be seen.<br>- Review our staffing model as part of the strategic review and redirect resources where appropriate to help with the longer waits as well as review opportunities to source additional funding to further expand capacity, in addition to the 2 new trauma posts that started at the end of Q4. |
| **Portman** | We have minimal waiting times to see patients and the majority of patients are seen within 8 weeks. After a referral is received, a process starts which usually includes writing to referrers and waiting for them to provide more/the correct information necessary to progress the referral or waiting for patients to respond to our request to write in to us, both of which are an established and essential part of the intake process. A new referral form was implemented in the last six months to help referrers provide the required information early on in the process, however as our patient population present with such complex pathology we often have to seek information missing from initial referrals (eg. consent for and disclosure of probation reports) and then wait for this.<br><br>The majority of patients are seen for the second appointment within one month of their first appointment. Clinicians have been instructed to offer a second assessment appointment between 2-3 weeks after the first appointment, and so most second appointments will fall in the 2<4 week category in line with our clinic policies. | We will continue to ensure that patients receive their first appointment as soon as is possible, after all the initial enquires have been made on receipt of the original referral. All clinicians have been reminded of the target of seeing patients for their first appointment within 11 weeks.<br><br>We have reminded clinicians to offer second appointments between 2-3 weeks after the first appointment, and that the second appointment must occur within 18 weeks from the original receipt of referral. |
| **City and Hackney PCPCS** | We are pleased with PCPCS's waiting time figures for a first appointment in Q4. 98% of our patients were seen within the target time frame, which reflects the services commitment to respond to local demand in a timely manner. Although the majority of our patients also received their second appointment within the target time frame, we are disappointed that our compliance has dropped slightly since Q3. We recently introduced a new admin staff- led booking system, designed to reduce delays in patients starting their treatment. Unfortunately this new system has been adversely affected by extended sickness absence within the admin team, which has impacted on the teams' ability to establish the new system during Q4. | Due to the reduced administrative capacity at PCPCS in Q4, our clinicians have temporarily resumed their previous role of booking treatment patients' first appointments themselves. We are also in the process of recruiting temporary admin staff to help cover the current staff shortage and we hope this will enable us to re-introduce the new admin-led system during the next quarter. We are also prioritising the recruitment of new clinical and administrative staff, due to some team members moving on to new roles, either within the Trust or externally. |

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

| Waiting Times - feedback and action plan from Service Leads – Gender Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **GIDS** | The drop in activity in Q4 is in part because the service where young people had a telephone assessment at 17 years and 6 months has stopped. The telephone assessments counted as activity for that patient. This service has transitioned to supporting the transfer of patients to an adult provider of their choice. Although activity is low, the bulk of the YP seen are the longest waiters.<br><br>The overall number of young people seen at 2nd appointments continues to fluctuate whilst performance against the target remains very low. | The low levels of assessment activity is being addressed through the implementation of the newly formed recovery plan for GIDS.<br><br>Introduce a revised clinical pathway to refocus activity on securing YP 1st and 2nd appointments in quick succession This is as part of the overall GIDS recovery plan. |
| **GIC** | We continue to receive a large number of referrals to the service and this is not in the long term sustainable as it has a direct impact on waits for the 1st appointments and wait between appointments.<br><br>We have commissioned some consultants to do some demand and capacity modelling to ensure that we have a clear trajectory of delivery for improving the those on the waiting list and between appointments<br><br>We also submitted a business case to NHSE (Feb 22) for the CX Clinic proposal which aims to increase the activity for 1st appointments but are yet to hear from NHSE on the outcome<br><br>We have revised our DNA policy to ensure that those not making use of the appointments they are offered are discharged if appropriate this freeing up clinicians time to focus on seeing more 1st appointments and shortening the gap between appointments | Commissioned modelling will start with view to establishing a trajectory and staff required as well as any system changes required to develop this work. |

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

| DNAs - Feedback and action plan from Service Leads – CYAF Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adolescent /AYAS** | The outcome of multiple strategies within AYAS has finally come to fruition with the DNA rate coming back below 10% following a long period of it being over this. | To maintain vigilance in relation to DNA's and ensure that the data is flowing from admin to clinical management to monitor this. |
| **Camden CAMHS** | DNA for Camden CAMHS continue to be consistently below the 10% | Team continue to implement strategies to reduce DNAs, including SMS reminder, agreeing appointment =s with YP/ families in advance.. |
| **Other CAMHS** | DNA rates have dipped slightly in since the last quarter. Current monitoring will be implemented to explore whether the DNA appointment are true DNA reasons. | Will explore the DNA rates with team managers and service manager to monitor the reasons behind the DNA's – Monitor whether the staff entering DNA using correct DNA reasons. Will email communications to staff advising that appointments marked as DNA should be marked when the time has elapsed during the appointment and no contact from the patient advising of the cancellation. |

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

| DNAs - feedback and action plan from Service Leads – AFS Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adult Complex Needs** | We're pleased that we continue to meet the target for DNA, and intend to maintain the performance going forward. | We intend to continue to meet out target by;<br>- Offering patients the choice of being seen remotely by zoom or telephone if they are unable to come to the building.<br>- Providing adequate admin cover for telephone lines and adult patient inboxes to take messages of cancellation or rescheduling of appointments<br>- Ensuring DNA policy is followed |
| **Portman** | Our DNA rate has risen from 10% in the last quarter to 12.7% in this quarter. Our target is 10% and below. | We have noted that as pandemic restrictions continue to be lifted, patients have been missing appointments to attend to other medical and personal issues, as well as for leisure and travel. Sometimes this has been without discussion with the clinician. We continue to address this issue with patients as it occurs, and all DNA appointments are addressed in the context of the psychotherapeutic treatment.<br><br>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 always have an impact on our DNA rates. |
| **City and Hackney PCPS** | There has been a slight rise in our DNA rate during Q4, which may be related to our introduction of a new booking system for first appointments. Previously, new patients were required to respond to an opt-in letter, before an initial appointment was offered. We noted that a number of patients were not opting in, although they did want to be seen. Therefore we have been trialling a new system whereby the 'opt in' step has been removed and the new patient is telephoned directly by an administrator with an appointment offer. | We will carefully monitor our DNA rate under the new booking system during the next quarter. We are aware that actively 'opting in' can increase motivation and compliance, and possibly those patients who do not opt in may be less invested in attending their appointments. |

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

| DNAs - Feedback and action plan from Service Leads – Gender Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **GIDS** | DNA rates continue to be low, supporting the improvements made in the management of patient bookings. | Introduction of a revised booking process aims to reduce DNA further. |
| **GIC** | DNA's for quarter 3 were on a downward trend primarily due to more assiduous follow up of patients that DNA. Clinicians have been reviewing the patients for any risk, contacting them directly to understand reason for DNA and also discharging them if the service is no longer required and or the patient is pre-contemplative and has DNA'd several appointments but present no/very little clinical risk. | We are mobilising our DNA policy pilot, aligned to the work that we started in the last quarter. This effectively means that all clinicians will have additional number of appointments per month, pro rata that they can review and discharge if appropriate.<br><br>All staff will apply the same principles to patients who DNA and where there is nominal risk these patients will be discharged – see DNA policy and approach on website. Letters have also gone out to all patients who have appointments from the first week of April outlining the DNA policy<br><br>Where an appointment is still required the patient will be booked in after they have contacted the service but this must be within 6 months of DNA letter being sent |

# 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*** | Separate guides for the job planning process were established for each division and were used for the first round of job planning.<br><br>To ensure the same approach to job planning was used across the organisation going forward, a set of trust wide job planning principles were then agreed in Q4 and included in the strategic review documentation.<br><br>These principles specify the amount of time needing to be focused on clinical work and guidance on how this should be adjusted based on management responsibilities. The principles are being incorporated into a new trust wide policy and job plan template to support the implementation. | |
| ***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…* | The focus in Q4 was to update the principles and templates, and so there wasn't a significant increase in the number of staff with completed job plans.<br><br>A relaunch of job planning will be undertaken in Q1 2022/23 with staff being asked to update their job plans using the new template and in accordance with the new principles. | |
| ***Agree principles across the Trust on the identified areas to ensure staff have sufficient capacity for clinical work as expected for their banding and role*** | As above, the new principles have been agreed and shared across the organisation. | |
| ***Implement the agreed principles and review job plans accordingly*** | Job planning will be re-launched in Q1 with the aim of all staff having completed a plan and had it signed off by the end of Q2. . | |
| ***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 procedure.<br><br>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. The timing will need to be confirmed but may align with the annual appraisal cycle. | |

# 3. Quality Priorities

**3.2 Quality Priority 2**

| 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)*** | A monthly report is in place. Performance has improved in 3/4 divisions but does still vary significantly both within and across divisions:<br>CYAF ~ 98% in March 2022 up from 96% in April 2021<br>AFS ~ 89% in March 2022 (Portman 85%, Complex Needs 82%, PCPCS 100%) up from 86% in April<br>GIDS 79% in March 2022 up from 68% in April<br>GIC 67% in March 2022 down from 70% in April | |
| ***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 was developed that reflects the new questions as well as adding in a breakdown of completion and experience by ethnicity.<br>The quality team conducted a baseline review of experience by ethnicity and the results didn't reveal a clear indication that experience differed by ethnicity. However, the volume of returns the trust received means this couldn't be seen as conclusive. The exercise will be repeated when the volume of returns has increased.<br>Qualtrics was trailed to distribute the ESQ 12+ in 3 services (Adult Complex Needs, AYAS and PCPCS) in Q4, which significantly increased returns. The use of Qualtrics for ESQ will be expanded over the next quarter. | |
| ***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.<br>Further work is required over the next quarter to identify the cause of the reduced performance in the services still falling short of the target. | |
| ***Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review*** | Once the remaining gaps in processes are identified and resolved, updated guidance will be issued. | |
| ***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 final guidance being drafted. Monitoring has been ongoing via the report each month and any specific QI projects will measure their direct impact separately. | |

3.3 **Quality Priority 3**

| 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)*** | In March 2022 the Divisional Directors and General managers agreed to reset the Quality Priorities, the outcome of which was to reinstate the previous quality priority relating to the waiting list. We agreed to develop a consistent framework across the trust aligned to the reporting and the focus will be as follows;<br><br>Priority 3 – Waiting Times<br><br>• Develop a waiting list management framework to ensure that reports and actions are consistently delivered and monitored<br>• Review waiting list initiatives currently being implemented across different service lines to ensure that best-practice is adhered to and embedded across the Trust<br>• Develop and implement a trust-wide access policy to formalise waiting list management including patient tracker lists (PTL), DNAs, cancellations and non-responders<br>• Building on the clinical harm SOP, develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions<br>• Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support | |
| ***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)*** | | |
| ***Implement, monitor & review these plans, based on agreed measures for waitlist reduction (Q3 and Q4)*** | | |

3.4 **Quality Priority 4**

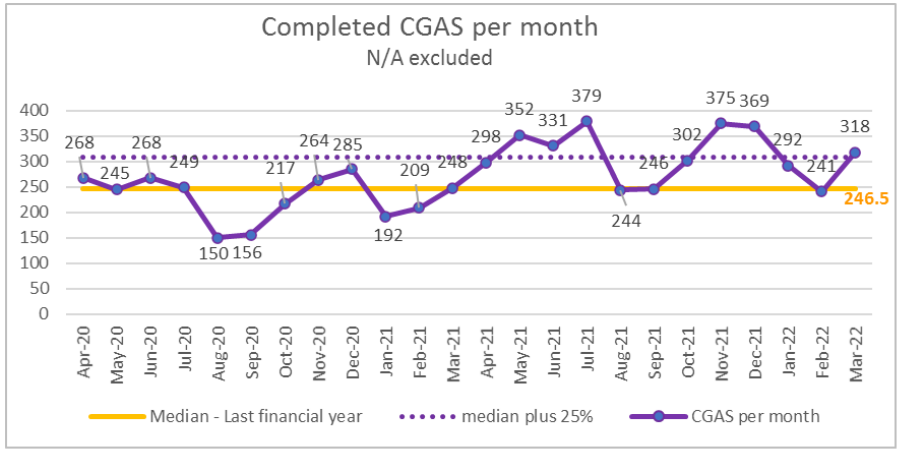
<table>
<tr><th>Quality Priority</th><th>4. Embed meaningful use of outcome measures across the Trust</th><th>Quality Priority</th></tr>
<tr><th>Key Workstreams</th><th>Quarterly Narrative Updates</th><th>RAG Rating</th></tr>
<tr><td>To complete a pilot of an appropriate software solution for OM data e-mail out and return that is compatible with Carenotes data. To reduce administrative time in manual data input</td><td>Qualtrics was trailed in Adult Complex Needs, PCPCS and AYAS to distribute and collect CORE and ESQ Outcome Measures (OMs) over Q3 & 4. The process saves considerable admin and clinical time and has improved OM returns. However, it still requires manual input of data onto Carenotes.<br><br>A Carenotes upgrade scheduled in early Q1 2022/23 will facilitate automated data entry and we anticipate the software will be in place by the end of Q2.</td><td></td></tr>
<tr><td>To increase OM returns across all services by 25% above baseline by year end</td><td>Overall return rates for OMs have increased by 22% compared to the last financial year (see table below). Whilst this is just shy of the 25% target, it still represents significant improvement which can be built on over the next<br><table><tr><th>Outcome Measure</th><th>20/21 median</th><th>2021/22 median</th><th>% Increase</th></tr><tr><td>CGAS</td><td>246.5</td><td>310</td><td>26%</td></tr><tr><td>GBM</td><td>113.5</td><td>122</td><td>7%</td></tr><tr><td>CORE</td><td>78.5</td><td>93.5</td><td>19%</td></tr><tr><td>ESQ</td><td>41.5</td><td>59</td><td>42%</td></tr><tr><td>Total</td><td>480</td><td>584.5</td><td>22%</td></tr></table><br>The continued expansion of Qualtrics across more services and measures should facilitate this for CORE, ESQ and RCADS. Improved Carenotes logic, as well as increased access to data and reminders for clinicians should also help continue to improve CGAS and CORE OM completion.</td><td></td></tr>
<tr><td>To pilot brief and STP wide OM feedback (e.g. dialogue) OR for specific clinical services (e.g. Trauma) nationally benchmarked OM</td><td>Following engagement with other trauma providers The Adult Trauma Unit started trialling 3 new outcome measures more relevant to their patient group in Q3/4. Going forward this should provide more accurate data on trauma treatment impact as well as providing data that can be benchmarked against other relevant services.</td><td></td></tr>
</table>

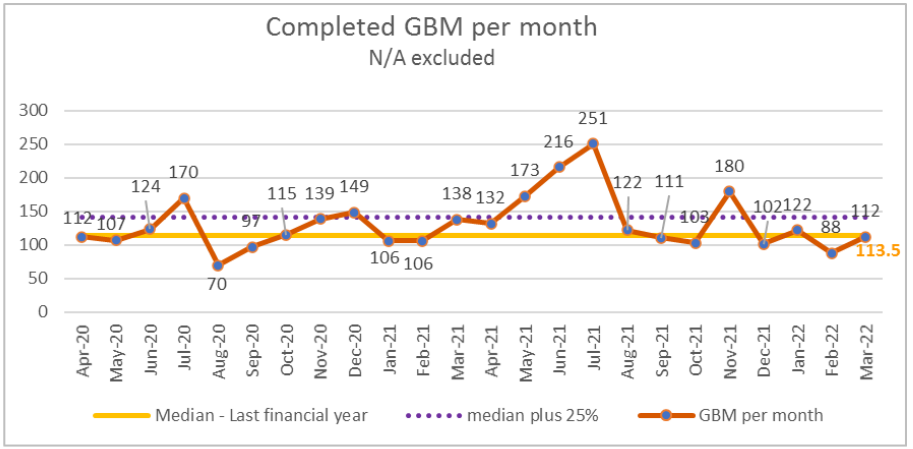
**QP4 Supporting information**:

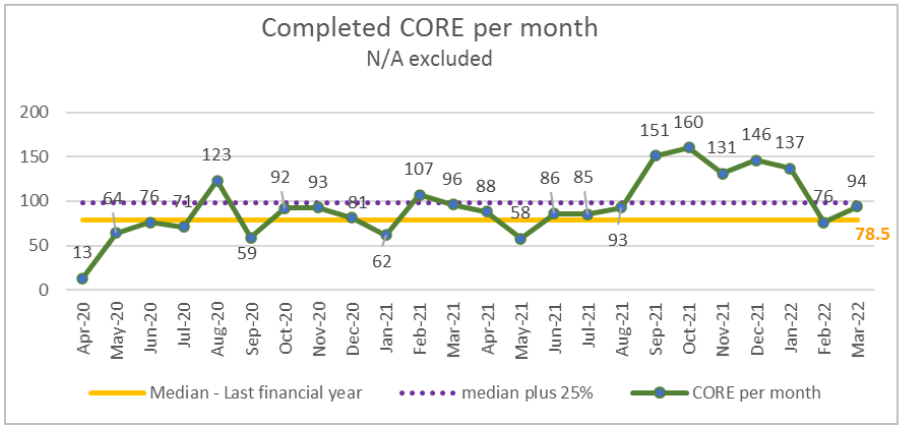
3.3 **Quality Priority 4**

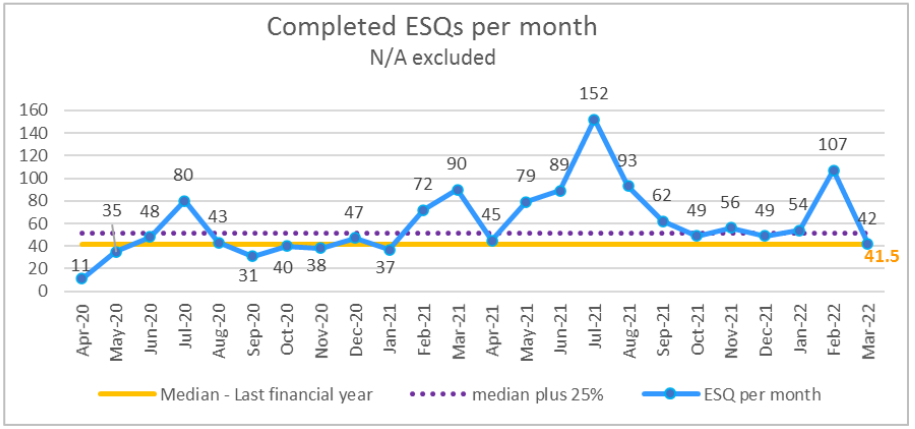
This a trust-wide data report that includes the total number of forms completed in period, for all contracts, excluding forms marked as N/A. It measures the usage of OM forms in period.

- 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.




Data source: 05/04/2022 SRRS (Internal Reporting System) Reported by the Quality Team

# 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**<br>A - 90% of complaints acknowledged within 3 working days. | Quarterly | >90% | 94% | 89% | 90% | 90% | | | | |
| B - 80% of complaints responded to within 25 working days.<br>We are including closed rather than open, recent open complaint might not have been open for 25 working days. | Quarterly | >80% | 9% | 2% | 4% | 0% | | | | |
| D - 100% of upheld complaints identify learning and improvements as a result. | Quarterly | 100% | 100% | 100% | 100% | 100% | | | | |
| E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis. | Bi-annually | n/a | n/a | n/a | n/a | n/a | | | | |
| F - Evidence of relevant complaint action plan implementation | Quarterly | n/a | Discussion at team meetings on areas of improvement | Discussion at team meetings on areas of improvement | Discussion at team meetings on areas of improvement | Discussion at team meetings on areas of improvement | | | | |
| **Complaints: A - Provide quarterly complaints and claims update to include:**<br>i) no. of complaints where response is outstanding at 3 months and reasons why | Quarterly | n/a | 3<br>Delays to investigation owing to pressure of work on staff and staff absences | 9<br>Delays to investigation owing to pressure of work on staff and staff absences | 14<br>Delays to investigation owing to pressure of work on staff and staff absences | n/a | | | | |
| ii) Number of complaints reported to CQC | Quarterly | n/a | 0 | 0 | 0 | 0 | | | | |
| iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman | Quarterly | n/a | 0 | 0 | 0 | 0 | | | | |
| iv) Number of re-opened complaints. | Quarterly | n/a | 0 | 0 | 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**<br>Target: <5% green (5-9% amber, >10% red) | Quarterly | <5% | 2.99% | 2.22% | 3.59 | 3.74 | | | | |
| **Audit of Trust Consent Policy standards**<br>To perform an audit on 20 patient notes. | Q4 | n/a | | | | Consent To Treatment Audit Completed | | | | |
| **Clinical Audit**<br>A - Provide CCGs with copy of Trust wide audit programme in Q2. | Q2 | n/a | | Clinical Audit Annual Programme 2021/22 Infographic | | | | | | |
| B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement | Q2 & Q4 | | | Clinical Audit and NICE Guidelines | | Bi-annual findings and recommendations of audits Completed | | | | |
| C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes | Q4 | | | | | Bi-annual findings and recommendations of audits Completed | | | | |
| **Reporting on Guidelines**<br>Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date. | Q2 & Q4 | n/a | | Clinical Audit and NICE Guidelines | | Report on compliance with new relevant NICE Clinical Guidelines | | | | |

Reports available on request.

# Section Five: Trust Targets – KPI

| 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**<br>Quality and Development of staff: Target 90% of staff to have a PDP. | Quarterly | 90% | 24% | 24% | 49% | 63% | | | | |
| **Sickness and Absence**<br>Sickness and absence rates. Target: <2% green (2-6% amber, >6% red) | 6 monthly | <2% | 1% | 1% | 3% | 1% | | | | |
| **Staff Training**<br>% 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**<br>% of eligible staff are currently compliant on all of their mandatory training | Quarterly | >95% | 75% | 74% | 70% | 77% | | | | |
| **DBS checks - Standard and enhanced**<br>% of staff that require an Enhanced DBS check and have one within the 3 year renewal period | Quarterly | 100% | 98% | 92% | 93% | 89% | | | | |
| **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<br><br>Run for London Contracts only | 80% initial completed care plans | Q1-Q4 | 80% | **Q4 compliance 53% -- out of 90 assessment summaries completed, 48 initial care plans were created**<br><br>We still struggle to meet our targets for care plan completion and review. In this quarter we had planned to amend the process for creating care plans from assessment summaries to reduce the steps in the process and make this simpler. The required changes in Carenotes have been requested and we hope to begin to see an impact on this within Q1. | | | | |
| | 80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019 | Q1-Q4 | 80% | **Q4 compliance 23% -- 236 Assessment Summaries completed, of those, 54 Review Care Plans were created/shared . The percentage of those care plans completed within 6 months of the initial Assessment Summary was 3%+**<br><br>See above. | | | | |
| | 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% | **Q4 compliance 99% -- we received 84 responses from CYAF patients to the ESQ question 'How well are people you've seen here working together to help you?'. 66 patients answered 'A lot' and 10 answered 'A little'**<br><br>We are pleased that service users and their families continue to have a positive experience of our service. We have now turned our attention to increasing the number of ESQs we receive be agreeing a consistent logic for the sending of the forms across CYAF and making this an automated process using Qualtrics. | | | | |

Data source: 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Team

# Section Five: Trust Targets – KPI – London Contracts

| Target | Detail of indicator | End of Year Target % | % Progress 21/22 | RAG Progress Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|---|
| CYAF Outcome Monitoring<br><br>GBM - Goal Based Measure<br>CGAS - Children's Global Assessment Scale<br><br>Run for London Contracts only | **GBM** Time 1<br>% of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice | 80% | **Q4 compliance 45% -- 57 GBM T1's out of 128 due in period were completed**<br><br>GBM compliance has declined in Q4. We had planned to improve our system for sending reminders this quarter, while reports are available there has been a lack of clarity around roles which we will attend to in Q1. We note that often in the subsequent quarter we see an improvement in the previous. This links to staff completing the measures "late" and we hope this will become less pronounced as we move to better reminder systems | | | | |
| | **GBM** Time 2<br>% patients who had an second appointment 4 months prior or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired GBM Time 1 | 60% | **Q4 compliance 39% -- 41 GBM T2's out of 106 due in period were completed**<br><br>As above. We also note that the logic for time 2 changed this year and therefore more were due than last year when our compliance was higher. | | | | |
| | **CGAS** Time 1<br>% of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice | 80% | **Q4 compliance 68% -- 85 CGAS T1's out of 125 due in period were completed**<br><br>As above. | | | | |
| | **CGAS** Time 2<br>% patients who had an second appointment 4 months prior or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired CGAS Time 1 | 60% | **Q4 compliance 46% -- 78 CGAS T2's out of 170 due in period were completed**<br><br>As above. | | | | |

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Data source: 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Team

| Report to | Date |
|---|---|
| Board of Directors | 26 July 2022 |

Month 3 Finance Report

## Executive Summary

Attached is the Month 3 (period to June 22) Finance Report.
This shows that the Trust has incurred a deficit of £886k. This is, however, ahead of the Plan / Budget position of a deficit of £1.1m. The improvement is driven by lower than Plan / Budget costs.

The narrative accompanying the schedules is rather sparse (compared with usual reporting) and will be enhanced in future reports.

## 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, Chief Financial Officer | Terry Noys, Chief Financial Officer |

The Tavistock and Portman NHS
NHS Foundation Trust

# MONTHLY FINANCE REPORT

**Period 3** **3** **Jun-22**

**Section**

**FINANCE REPORT** **Page 2**
**Period 3**
**Jun-22** **I & E Summary**

| £000 | Plan | Actual | Variance | Var % |
|---|---|---|---|---|
| INCOME | 16,269 | 15,574 | (696) | (4%) |
| PAY | (12,328) | (12,007) | 321 | (3%) |
| NON-PAY | (4,434) | (3,920) | 514 | (12%) |
| **EBITA** | **(493)** | **(354)** | **139** | **(28%)** |
| Interest receivable | 3 | 17 | 14 | |
| Interest payable | (7) | (4) | 2 | |
| Depreciation | (576) | (491) | 85 | |
| Dividend | (54) | (54) | 0 | |
| **Net Surplus /(Deficit)** | **(1,126)** | **(886)** | **240** | **(21%)** |

**Commentary**

Income is negative to Plan by £696k reflecting:
- Lower long and short course income in DET
-Lower income in Complex Needs and Portman Clinic in AFS
- Lower income across a range of services across CYAF

Pay costs are lower than Plan by £321k, reflecting a range of vacancies across the Trust
It should be noted that thre Trust is running a high level of agency costs - more than £900k in the first quarter of the finacial year

Non-pay costs are £514k lower than plan. This reflects lower non pay costs across most areas, but most notably £229k lower costs in DET reflecting lower long and short course income

## Finance Report - Period 3: June 2022
## Balance Sheet



| Statement of financial position | Expected Sign | 05AUDITPY Audited PY March £'000 | 05PLANYTD Plan June YTD £'000 | 05ACTYTD Actual June YTD £'000 |
|---|---|---|---|---|
| **Non-current assets** | | | | |
| Intangible assets | + | 92 | 83 | 13 |
| On-SoFP IFRIC 12 assets | + | 0 | 24,331 | 23,809 |
| Interests in **off-SoFP** PFI/LIFT assets | + | 0 | 0 | |
| Other property, plant and equipment (excludes leases) | + | 24,094 | 0 | |
| Other assets | + | 0 | 0 | |
| **Total non-current assets** | + | **24,186** | **24,414** | **23,822** |
| **Current assets** | | | | |
| Inventories | + | 0 | 0 | |
| Receivables: due from NHS and DHSC group bodies | + | 2,284 | 2,284 | 2,187 |
| Receivables: due from non-NHS/DHSC group bodies | + | 5,370 | 5,370 | 3,408 |
| Other financial assets | + | 0 | 0 | |
| Other current assets | + | 0 | 1 | |
| Assets held for sale and assets in disposal groups | + | 0 | 0 | |
| Cash and cash equivalents: GBS/NLF | + | 9,043 | 13,393 | 7,181 |
| Cash and cash equivalents: commercial / in hand / other | + | 5,773 | 0 | 5,986 |
| **Total current assets** | + | **22,470** | **21,048** | **18,762** |
| **Current liabilities** | | | | |
| Trade and other payables: capital | - | 0 | 0 | |
| Trade and other payables: non-capital | - | (12,883) | (20,660) | (4,888) |
| Borrowings | - | (445) | (445) | (445) |
| Other financial liabilities | - | 0 | 0 | (14,948) |
| Provisions | - | (4,322) | (4,322) | (2,275) |
| Other liabilities: deferred income including contract liabilities | - | (7,743) | 0 | |
| Other liabilities: other | - | 0 | 0 | |
| **Total current liabilities** | - | **(25,393)** | **(25,427)** | **(22,556)** |
| **Total assets less current liabilities** | +/- | **21,263** | **20,035** | **20,028** |
| **Non-current liabilities** | | | | |
| Trade and other payables: capital | - | 0 | 0 | |
| Trade and other payables: non-capital | - | 0 | 0 | |
| Borrowings | - | (2,220) | (2,221) | (2,221) |
| Other financial liabilities | - | 0 | 0 | |
| Provisions | - | (32) | (32) | 0 |
| Other liabilities: deferred income including contract liabilities | - | 0 | 0 | |
| Other liabilities: other | - | 0 | 0 | |
| **Total non-current liabilities** | - | **(2,252)** | **(2,253)** | **(2,221)** |
| **Total net assets employed** | +/- | **19,011** | **17,782** | **17,807** |
| **Financed by** | | | | |
| Public dividend capital | + | 5,543 | 5,543 | 5,543 |
| Revaluation reserve | + | 13,938 | 13,872 | 13,938 |
| Financial assets at FV through OCI reserve | +/- | 0 | 0 | |
| Other reserves | +/- | 0 | 0 | |
| Merger reserve | +/- | 0 | 0 | |
| Income and expenditure reserve | +/- | (470) | (1,633) | (1,674) |
| Non-controlling interest | +/- | 0 | 0 | |
| **Total taxpayers' and others' equity** | +/- | **19,011** | **17,782** | **17,807** |
| ***Check: does the balance sheet balance?*** | | | | OK |

**FINANCE REPORT** **Page 4**
**Period 3**
**Jun-22**

| **FUNDS FLOW** | **YTD Act £'000** | **YTD Plan £'000** | **YTD Var £'000** |
|---|---|---|---|
| **Net Surplus/(Deficit)** | **(886)** | **(1,126)** | **240** |
| Depreciation / amortisation | **491** | **576** | **(85)** |
| PDC dividend paid | **54** | **54** | **0** |
| Interest paid | **4** | **7** | **(2)** |
| Change in working capital | **(986)** | **(66)** | **(920)** |
| **Net operating cash flow** | **(1,323)** | **(556)** | **(767)** |
| Interest received | **17** | **3** | **14** |
| **Cash flow available for investment** | **(1,306)** | **(553)** | **(753)** |
| Purchase of property, plant & equipment | **(343)** | **(870)** | **527** |
| **Net cash flow before financing** | **(1,649)** | **(1,423)** | **(226)** |
| Repayment of debt facilities | **0** | **0** | **0** |
| **Net increase / (decrease) in cash** | **(1,649)** | **(1,423)** | **(226)** |
| Opening Cash | 14,816 | 14,816 | 0 |
| **Closing cash** | **13,167** | **13,393** | **(226)** |

| Report to | Date |
|---|---|
| Board of Directors | 26 July 2022 |

2022/23 Budget - FINAL

## Executive Summary

At the meeting of the Board of Directors on 24 May 2022, an initial Budget / Plan was approved, with a deficit of £6m. The paper to the Board noted that the initial Budget / Plan was still susceptible to change as it required ICS approval. Due to pressures on the ICS to achieve an overall break-even position, the Trust (like all other trusts within the ICS) was asked to provide an improved figure. This the Trust did, agreeing a final position with the ICS of a net deficit of £3.76m.
This paper provides an update on the changes made.
Detailed monthly I&E, balance sheet and cash flows are appended to this paper.

## Recommendation to the Committee

The Committee is asked to note the report and recommend approval of the Plan to the Board

## Trust strategic objectives supported by this paper

Finance and Governance

| Author | Responsible Director |
|---|---|
| Terry Noys, Deputy CEO and Director of Finance | Terry Noys, Deputy CEO and Director of Finance |

# 2022/23 TRUST BUDGET / PLAN

## 1. INTRODUCTION

1.1. This paper provides summary details on the final 2022/23 Budget / Plan for the Trust. This is an update on the previous 'initial' Budget provided to the Board in May and is based on the submission the Trust made to the ICS on 26 May 2022 – which has been approved by the ICS.

## 2. OVERVIEW

| £m | 2021/22 Out-Turn | 2022/23 Indicative Plan | 2022/23 Final Plan | Change in Plan |
|---|---|---|---|---|
| Income | 64.0 | 64.9 | 65.1 | 0.2 |
| Pay costs | (49.3) | (50.5) | (50.0) | 0.5 |
| Non-pay costs | (18.9) | (17.9) | (16.3) | 1.6 |
| | ---- | ---- | ---- | |
| Operating deficit | (4.2) | (3.5) | (1.2) | 2.3 |
| Other costs | (2.4) | (2.5) | (2.5) | - |
| | ---- | ---- | ---- | |
| Deficit before 'exceptional' items | (6.6) | (6.0) | (3.7) | 2.3 |
| 'Exceptional' items | (5.7) | Nil | Nil | - |
| | ---- | ---- | ---- | |
| Net deficit | (12.3) | (6.0) | 3.7 | 2.3 |

2.1. The final Plan shows the Trust making a deficit of £3.7m on income of £65.1m.

2.2. The changes between the final Plan and the initial Plan (presented in May) are primarily:

- Additional income proposed by NHSEI to reflect inflationary pressures
- Increase in vacancy factor
- Revised assumptions around non-pay costs.

## 3. INCOME (As previously reported)

3.1. Clinical income is based on figures provided by NHSEI and assumes an inflationary increase of 1.7% plus uplifts for 'volume' and to take account of the Mental Health Standard, resulting in a £3.1m increase in income. (The figures include £17m for Specialised Commissioning services – GIDS, GIC, Portman and FCAMHS).

3.2. Against this increase, clinical income also reflects the loss of contracts worth £2.1m (being Lighthouse and Youth Endowment fund, non-recurrent HEE contracts and other sundry consultancy contracts)

3.3. DET income is based on 2021/22 figures with an assumption of 'flat' student numbers.

3.4. £1.8m of new (as yet unidentified) income is also included as the Trust's CIP (Continuous Improvement Programme) contribution.

3.5. The figures for 2020/21 include £2.2m of covid / top-up funding which does not repeat in 2022/23.

## 4. REVENUE EXPENDITURE (Slightly amended from previous version)

4.1. Pay costs assume a 2% annual inflationary increase plus 1% for increments. Together with the full year effect (of posts recruited part way through 2021/22) and posts assumed to be recruited to in 2022/23, this adds £3.8m to staff costs.

4.2. Set against this increase is a vacancy factor of £3.5m (6.5% of gross staffing costs).

4.3. The figure for staffing costs is potentially less secure than normal, given the uncertainties surrounding the implementation of workforce structures post Strategic Review.

4.4. Non-Pay costs reduce (compared with 2021/22) as it is assumed that legal costs (notably those related to the judicial review) and CQC Transformation costs are at a lower level.

4.5. Energy costs are budgeted at £0.2m, so are not significant in terms of the Trust's cost base.

4.6. 'Other' costs increase slightly as the result of a higher depreciation charge.

## 5. BALANCE SHEET, CASH FLOW AND CAPITAL EXPENDITURE (Amended)

5.1. Cash is expected to reduce in the period from £14.8m to £6.2m reflecting:

- Deficit for the year of £3.7m
- Proposed capital expenditure of £3.5m
- Utilisation of provisions (notably redundancy provision).

5.2. The budget for Capital Expenditure of £3.5m is the level permitted by the ICS.

## 6. RISKS AND OPPORTUNITIES (As previously reported)

### Income

6.1. A key risk is an in-year reduction in income for the GIDS service.

6.2. The Budget assumes £1.8m of – as yet – unidentified new income.

## Expenditure

6.3. There is still some uncertainty regarding post-SR implementation staffing structures (and the timing of implementation). These could have a positive or negative impact on the final result.

6.4. In order to meet one of its SOF 3 exit criteria obligations, the trust will need to incur expenditure to deliver an Estates Strategy. Similarly, the Trust will incur significant expenditure in recruiting new executive directors These costs are not included in the Budget.

| Statement of comprehensive income | 04PLANM01 | 04PLANM02 | 04PLANM03 | 04PLANM04 | 04PLANM05 | 04PLANM06 | 04PLANM07 | 04PLANM08 | 04PLANM09 | 04PLANM10 | 04PLANM11 | 04PLANM12 | 04PLANCY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan 30/04/2022 Month 1 £'000 | Plan 31/05/2022 Month 2 £'000 | Plan 30/06/2022 Month 3 £'000 | Plan 31/07/2022 Month 4 £'000 | Plan 31/08/2022 Month 5 £'000 | Plan 30/09/2022 Month 6 £'000 | Plan 31/10/2022 Month 7 £'000 | Plan 30/11/2022 Month 8 £'000 | Plan 31/12/2022 Month 9 £'000 | Plan 31/01/2023 Month 10 £'000 | Plan 28/02/2023 Month 11 £'000 | Plan 31/03/2023 Month 12 £'000 | Plan 31/03/2023 Year Ending £'000 |
| Operating income from patient care activities | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,448 | 3,673 | **41,601** |
| Other operating income | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | 1,956 | **23,472** |
| Employee expenses | (4,128) | (4,102) | (4,102) | (4,263) | (4,263) | (4,263) | (4,232) | (4,232) | (4,240) | (4,240) | (4,240) | (3,740) | **(50,045)** |
| Operating expenses excluding employee expenses | (1,642) | (1,634) | (1,634) | (1,634) | (1,604) | (1,604) | (1,586) | (1,586) | (1,486) | (1,486) | (1,486) | (1,160) | **(18,542)** |
| **OPERATING SURPLUS/(DEFICIT)** | **(366)** | **(332)** | **(332)** | **(493)** | **(463)** | **(463)** | **(414)** | **(414)** | **(322)** | **(322)** | **(322)** | **729** | **(3,514)** |
| **FINANCE COSTS** | | | | | | | | | | | | | |
| Finance income | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | **12** |
| Finance expense | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | (2) | **(24)** |
| PDC dividends payable/refundable | (15) | (17) | (17) | (17) | (17) | (17) | (17) | (17) | (17) | (17) | (17) | (52) | **(237)** |
| **NET FINANCE COSTS** | **(16)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(18)** | **(53)** | **(249)** |
| Other gains/(losses) including disposal of assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Corporation tax expense | | | | | | | | | | | | | **0** |
| **SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR** | **(382)** | **(350)** | **(350)** | **(511)** | **(481)** | **(481)** | **(432)** | **(432)** | **(340)** | **(340)** | **(340)** | **676** | **(3,763)** |

| Earnings before interest, taxation, depreciation and amortisation (EBITDA) | 04PLANM01 | 04PLANM02 | 04PLANM03 | 04PLANM04 | 04PLANM05 | 04PLANM06 | 04PLANM07 | 04PLANM08 | 04PLANM09 | 04PLANM10 | 04PLANM11 | 04PLANM12 | 04PLANCY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan 30/04/2022 Month 1 £'000 | Plan 31/05/2022 Month 2 £'000 | Plan 30/06/2022 Month 3 £'000 | Plan 31/07/2022 Month 4 £'000 | Plan 31/08/2022 Month 5 £'000 | Plan 30/09/2022 Month 6 £'000 | Plan 31/10/2022 Month 7 £'000 | Plan 30/11/2022 Month 8 £'000 | Plan 31/12/2022 Month 9 £'000 | Plan 31/01/2023 Month 10 £'000 | Plan 28/02/2023 Month 11 £'000 | Plan 31/03/2023 Month 12 £'000 | Plan 31/03/2023 Year Ending £'000 |
| **Operating surplus/(deficit)** | (366) | (332) | (332) | (493) | (463) | (463) | (414) | (414) | (322) | (322) | (322) | 729 | **(3,514)** |
| Add back depreciation and amortisation | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | **2,292** |
| | | | | | | | | | | | | | |
| **EBITDA** | **(175)** | **(141)** | **(141)** | **(302)** | **(272)** | **(272)** | **(223)** | **(223)** | **(131)** | **(131)** | **(131)** | **920** | **(1,222)** |
| **Income relating to EBITDA** | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,404 | 5,629 | 65,073 |
| **EBITDA percentage** | **(3.2%)** | **(2.6%)** | **(2.6%)** | **(5.6%)** | **(5.0%)** | **(5.0%)** | **(4.1%)** | **(4.1%)** | **(2.4%)** | **(2.4%)** | **(2.4%)** | **16.3%** | **(1.9%)** |

| Statement of financial position | 05PLANM01 | 05PLANM02 | 05PLANM03 | 05PLANM04 | 05PLANM05 | 05PLANM06 | 05PLANM07 | 05PLANM08 | 05PLANM09 | 05PLANM10 | 05PLANM11 | 05PLANM12 | 05PLANCY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan 30/04/2022 Month 1 £'000 | Plan 31/05/2022 Month 2 £'000 | Plan 30/06/2022 Month 3 £'000 | Plan 31/07/2022 Month 4 £'000 | Plan 31/08/2022 Month 5 £'000 | Plan 30/09/2022 Month 6 £'000 | Plan 31/10/2022 Month 7 £'000 | Plan 30/11/2022 Month 8 £'000 | Plan 31/12/2022 Month 9 £'000 | Plan 31/01/2023 Month 10 £'000 | Plan 28/02/2023 Month 11 £'000 | Plan 31/03/2023 Month 12 £'000 | Plan 31/03/2023 Year Ending £'000 |
| **Non-current assets** | | | | | | | | | | | | | |
| Intangible assets | 89 | 86 | 83 | 80 | 77 | 74 | 71 | 68 | 65 | 62 | 59 | 56 | **56** |
| O**n-SoFP** IFRIC 12 assets | 24,129 | 24,230 | 24,331 | 24,432 | 24,533 | 24,634 | 24,735 | 24,836 | 24,937 | 25,038 | 25,139 | 25,242 | **25,242** |
| Other assets | | | | | | | | | | | | | **0** |
| **Total non-current assets** | **24,218** | **24,316** | **24,414** | **24,512** | **24,610** | **24,708** | **24,806** | **24,904** | **25,002** | **25,100** | **25,198** | **25,298** | **25,298** |
| **Current assets** | | | | | | | | | | | | | |
| Inventories | | | | | | | | | | | | | **0** |
| Receivables: due from NHS and DHSC group bodies | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | 2,284 | **2,284** |
| Receivables: due from non-NHS/DHSC Group bodies | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | 5,370 | **5,370** |
| Other current assets | 1 | 1 | 1 | 1 | | | | | | | | | **0** |
| Cash and cash equivalents: GBS/NLF | 14,319 | 13,856 | 13,393 | 12,769 | 11,953 | 9,079 | 8,933 | 8,387 | 7,833 | 7,279 | 6,503 | 6,202 | **6,202** |
| Cash and cash equivalents: commercial/in hand/other | | | | | | | | | | | | | **0** |
| **Total current assets** | **21,974** | **21,511** | **21,048** | **20,424** | **19,607** | **16,733** | **16,587** | **16,041** | **15,487** | **14,933** | **14,157** | **13,856** | **13,856** |
| **Current liabilities** | | | | | | | | | | | | | |
| Trade and other payables: capital | | | | | | | | | | | | | **0** |
| Trade and other payables: non-capital | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (20,660) | (19,725) | **(19,725)** |
| Borrowings | (445) | (445) | (445) | (445) | (445) | (445) | (445) | (445) | (445) | (445) | (445) | (445) | **(445)** |
| Other financial liabilities | | | | | | | | | | | | | **0** |
| Provisions | (4,322) | (4,322) | (4,322) | (4,322) | (4,322) | (2,042) | (2,042) | (2,042) | (2,042) | (2,042) | (2,042) | (2,042) | **(2,042)** |
| Other liabilities: other | | | | | | | | | | | | | **0** |
| **Total current liabilities** | **(25,427)** | **(25,427)** | **(25,427)** | **(25,427)** | **(25,427)** | **(23,147)** | **(23,147)** | **(23,147)** | **(23,147)** | **(23,147)** | **(23,147)** | **(22,212)** | **(22,212)** |
| **Total assets less current liabilities** | **20,765** | **20,400** | **20,035** | **19,509** | **18,790** | **18,294** | **18,246** | **17,798** | **17,342** | **16,886** | **16,208** | **16,942** | **16,942** |
| **Non-current liabilities** | | | | | | | | | | | | | |
| Borrowings | (2,221) | (2,221) | (2,221) | (2,221) | (1,998) | (1,998) | (1,998) | (1,998) | (1,998) | (1,998) | (1,776) | (1,776) | **(1,776)** |
| Provisions | (32) | (32) | (32) | (32) | (32) | (32) | (32) | (32) | (32) | (32) | (32) | (32) | **(32)** |
| Other liabilities: other | | | | | | | | | | | | | **0** |
| **Total non-current liabilities** | **(2,253)** | **(2,253)** | **(2,253)** | **(2,253)** | **(2,030)** | **(2,030)** | **(2,030)** | **(2,030)** | **(2,030)** | **(2,030)** | **(1,808)** | **(1,808)** | **(1,808)** |
| **Total net assets employed** | **18,512** | **18,147** | **17,782** | **17,256** | **16,760** | **16,264** | **16,216** | **15,768** | **15,312** | **14,856** | **14,400** | **15,134** | **15,134** |
| **Financed by** | | | | | | | | | | | | | |
| Public dividend capital | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | 5,543 | **5,543** |
| Revaluation reserve | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | 13,872 | **13,872** |
| Income and expenditure reserve | (903) | (1,268) | (1,633) | (2,159) | (2,655) | (3,151) | (3,199) | (3,647) | (4,103) | (4,559) | (5,015) | (4,281) | **(4,281)** |
| Non-controlling Interest | | | | | | | | | | | | | **0** |
| **Total taxpayers' and others' equity** | **18,512** | **18,147** | **17,782** | **17,256** | **16,760** | **16,264** | **16,216** | **15,768** | **15,312** | **14,856** | **14,400** | **15,134** | **15,134** |
| ***Check: does the balance sheet balance?*** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** | **OK** |

| Borrowings | 05PLANM01 | 05PLANM02 | 05PLANM03 | 05PLANM04 | 05PLANM05 | 05PLANM06 | 05PLANM07 | 05PLANM08 | 05PLANM09 | 05PLANM10 | 05PLANM11 | 05PLANM12 | 05PLANCY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan 30/04/2022 Month 1 £'000 | Plan 31/05/2022 Month 2 £'000 | Plan 30/06/2022 Month 3 £'000 | Plan 31/07/2022 Month 4 £'000 | Plan 31/08/2022 Month 5 £'000 | Plan 30/09/2022 Month 6 £'000 | Plan 31/10/2022 Month 7 £'000 | Plan 30/11/2022 Month 8 £'000 | Plan 31/12/2022 Month 9 £'000 | Plan 31/01/2023 Month 10 £'000 | Plan 28/02/2023 Month 11 £'000 | Plan 31/03/2023 Month 12 £'000 | Plan 31/03/2023 Year Ending £'000 |
| **Current** | | | | | | | | | | | | | |
| Borrowings: overdraft | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Borrowings: DHSC capital loans (principal only) | 445 | 445 | 445 | 445 | 445 | 445 | 445 | 445 | 445 | 445 | 445 | 445 | **445** |
| Accrued interest on DHSC loans | | | | | | | | | | | | | **0** |
| Borrowings: other (non-DHSC) | | | | | | | | | | | | | **0** |
| Accrued interest on other (non-DHSC) loans | | | | | | | | | | | | | **0** |
| **Total current borrowings** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** | **445** |
| **Non-current** | | | | | | | | | | | | | |
| Borrowings: DHSC capital loans | 2,221 | 2,221 | 2,221 | 2,221 | 1,998 | 1,998 | 1,998 | 1,998 | 1,998 | 1,998 | 1,776 | 1,776 | **1,776** |
| Borrowings: DHSC working capital/revenue support loans | | | | | | | | | | | | | **0** |
| Borrowings: other (non-DHSC) | | | | | | | | | | | | | **0** |
| **Total non-current borrowings** | **2,221** | **2,221** | **2,221** | **2,221** | **1,998** | **1,998** | **1,998** | **1,998** | **1,998** | **1,998** | **1,776** | **1,776** | **1,776** |

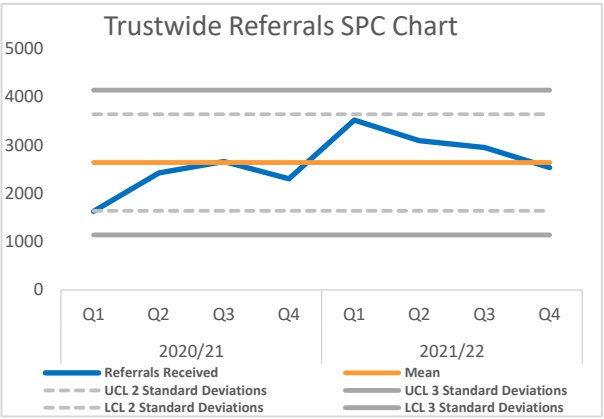
| Statement of cash flows | 06PLANM01 | 06PLANM02 | 06PLANM03 | 06PLANM04 | 06PLANM05 | 06PLANM06 | 06PLANM07 | 06PLANM08 | 06PLANM09 | 06PLANM10 | 06PLANM11 | 06PLANM12 | 06PLANCY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan 30/04/2022 Month 1 £'000 | Plan 31/05/2022 Month 2 £'000 | Plan 30/06/2022 Month 3 £'000 | Plan 31/07/2022 Month 4 £'000 | Plan 31/08/2022 Month 5 £'000 | Plan 30/09/2022 Month 6 £'000 | Plan 31/10/2022 Month 7 £'000 | Plan 30/11/2022 Month 8 £'000 | Plan 31/12/2022 Month 9 £'000 | Plan 31/01/2023 Month 10 £'000 | Plan 28/02/2023 Month 11 £'000 | Plan 31/03/2023 Month 12 £'000 | Plan 31/03/2023 Year Ending £'000 |
| **Cash flows from operating activities** | | | | | | | | | | | | | |
| **Operating surplus/(deficit)** | (366) | (332) | (332) | (493) | (463) | (463) | (414) | (414) | (322) | (322) | (322) | 729 | **(3,514)** |
| Non-cash income and expense: | | | | | | | | | | | | | |
| Depreciation and amortisation | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | 191 | **2,292** |
| Impairments and reversals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Income recognised in respect of capital donations (cash and non-cash) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Increase/(decrease) in other liabilities | 2,660 | (1,330) | (1,330) | 2,660 | (1,330) | (1,330) | 2,660 | (1,330) | (1,330) | 2,660 | (1,344) | (1,345) | **(29)** |
| Increase/(decrease) in provisions | | | | | | | (2,270) | | | | | | **(2,270)** |
| All other movements in operating cash flows | (2,693) | 1,297 | 1,297 | (2,693) | 1,309 | (875) | (24) | 1,297 | 1,195 | (2,794) | 1,222 | 507 | **(955)** |
| **Net cash generated from/(used in) operations** | **(208)** | **(174)** | **(174)** | **(335)** | **(293)** | **(2,477)** | **143** | **(256)** | **(266)** | **(265)** | **(253)** | **82** | **(4,476)** |
| **Cash flows from investing activities** | | | | | | | | | | | | | |
| Interest received | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | **12** |
| Purchase of property, plant and equipment and investment property | (290) | (290) | (290) | (290) | (290) | (290) | (290) | (290) | (290) | (290) | (290) | (290) | **(3,480)** |
| | | | | | | | | | | | | | **0** |
| **Net cash generated from/(used in) investing activities** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(289)** | **(3,468)** |
| **Cash flows from financing activities** | | | | | | | | | | | | | |
| Interest paid | | | | | (12) | | | | | | (12) | | **(24)** |
| PDC dividend (paid)/refunded | | | | | | (108) | | | | | | (94) | **(202)** |
| Cash flows from (used in) other financing activities | | | | | | | | | | | | | **0** |
| **Net cash generated from/(used in) financing activities** | **0** | **0** | **0** | **0** | **(12)** | **(108)** | **0** | **0** | **0** | **0** | **(12)** | **(94)** | **(226)** |
| **Increase/(decrease) in cash and cash equivalents** | **(497)** | **(463)** | **(463)** | **(624)** | **(594)** | **(2,874)** | **(146)** | **(545)** | **(555)** | **(554)** | **(554)** | **(301)** | **(8,170)** |
| **Cash and cash equivalents at start of period** | 14,816 | **14,319** | **13,856** | **13,393** | **12,769** | **12,175** | **9,301** | **9,155** | **8,610** | **8,055** | **7,501** | **6,947** | **14,816** |
| Opening balance adjustment | | | | | | | | | | | | | |
| Restated cash and cash equivalents at start of period | **14,816** | **14,319** | **13,856** | **13,393** | **12,769** | **12,175** | **9,301** | **9,155** | **8,610** | **8,055** | **7,501** | **6,947** | **14,816** |
| Unrealised gains/(losses) on foreign exchange | | | | | | | | | | | | | **0** |
| **Cash and cash equivalents at end of period** | **14,319** | **13,856** | **13,393** | **12,769** | **12,175** | **9,301** | **9,155** | **8,610** | **8,055** | **7,501** | **6,947** | **6,646** | **6,646** |
| ***Cash balance per SOFP*** | **14,319** | **13,856** | **13,393** | **12,769** | **11,953** | **9,079** | **8,933** | **8,387** | **7,833** | **7,279** | **6,503** | **6,202** | **6,202** |

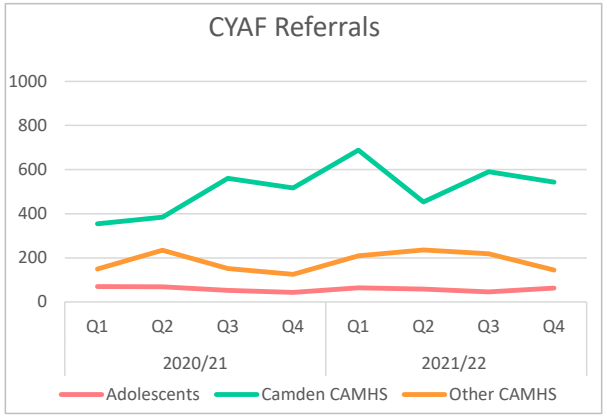
| MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS<br>Board of Directors, 26th July 2022 | | | |
|---|---|---|---|
| Performance report | | | **AGENDA ITEM:**<br>**12** |
| **Report Author and Job Title:** | Quality Team | **Responsible Director:** | Sally Hodges |
| **Action Required** | Approve ☐ Discuss ☒ Inform ☐ | | |
| **Situation** | Report outlines wait times, appointments offered, outcome measures and DNA data | | |
| **Background** | This is the first report on performance for this committee so needs to be viewed as a baseline, alongside financial performance information | | |
| **Assessment** | A number of key issues identified<br>1. Number of patients seen remains steady but numbers of appointments offered has reduced, what does this mean for the pathways<br>2. Number of appointments in GIDs has reduced by 34%, is there a corresponding drop in staff numbers ><br>3. Other CAMHS has demonstrated a significant drop in first appointments, is this due to reduced staff numbers<br>4. All adult services have seen a drop in 1st appointments<br>There will always be some variation from Q to Q do we have a view on acceptable tolerance limits<br>5. DNA rates have been met<br>6. Gender and adult services not meeting ethnicity targets<br>7. Outcome measures continue to be an issue with maintaining a consistent approach | | |
| **Recommendation** | The paper is for information. Members of the Board of Directors are asked to note the report | | |
| **Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline** | This report relates to the BAF risk on waiting times | | |

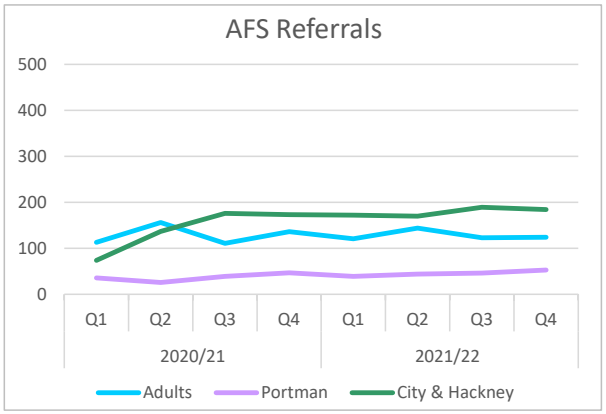
| | | |
|---|---|---|
| **Legal and Equality and Diversity implications** | The implications relate to access and patients on waiting lists | |
| **Strategic Objectives** (highlight which Trust Strategic objective this report aims to support) | Excellence in patient outcomes and experience ☒ | Excellence in employee experience ☐ |
| | Drive operational performance ☒ | Long term financial sustainability ☒ |
| | Develop clinical and commercial strategies ☐ | |

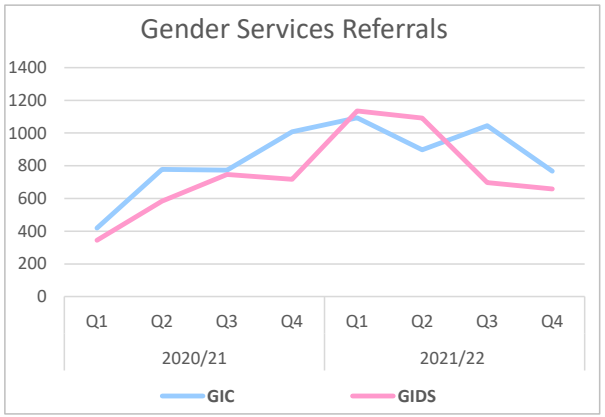
# Performance Report

## Q4 2021/22: Trust Reach – Access




Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021.

## Number of Referrals Received:

The graphs to the left and data below summarises all referrals received over the last two years including those accepted, rejected and pending. This data is Trust-wide and covers all contracts and all service lines.

In Q4 2538 referrals were received Trust-wide, 416 fewer than in Q3; a decrease of 14%. However, the Trust was 7% above the quarterly average number of referrals received during the last financial year.

**Adolescents**: in Q4 63 referrals were received, 17 more than in Q3. This quarter the service was 7% above the quarterly average number of referrals received during last financial year (59).

**Camden CAMHS**: in Q4 543 referrals were received, 47 fewer than in Q3. This quarter the service was 20% above the quarterly average number of referrals received during last financial year (454).

**Other CAMHS**: in Q4 145 referrals were received, 73 fewer than in Q3. This quarter the service was 12% under 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 will affect previous quarters' figures after data has been re-run.

**Adults Complex Needs**: in Q4 124 referrals were received, 1 more than in Q3. This quarter the service was 4% under the quarterly average number of referrals received during last financial year (129).

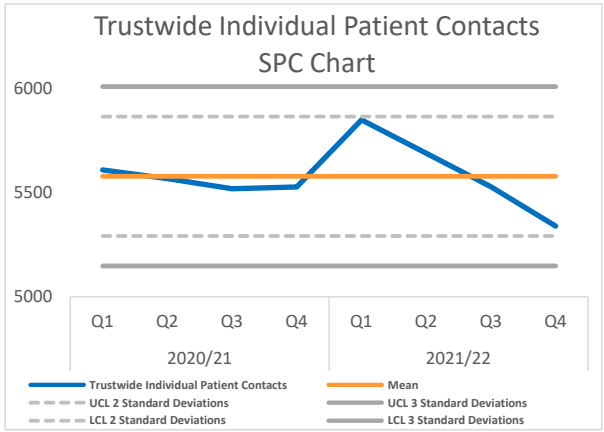
**Portman**: in Q4 53 referrals were received, 7 more than in Q3. This quarter the service was 43% above the quarterly average number of referrals received during last financial year (37).

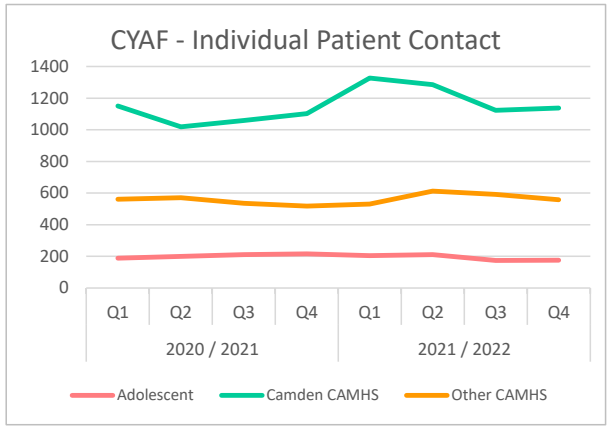
**C&H PCPCS**: in Q4 184 referrals were received, 5 fewer than in Q3. This quarter the service was 31% above the quarterly average number of referrals received during last financial year (140).

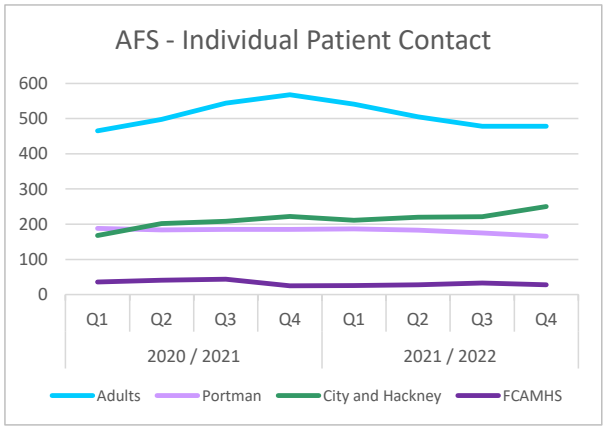
**GIDS**: in Q4 659 referrals were received, 38 fewer than in Q3. This quarter the service was 10% above the quarterly average number of referrals received during last financial year (598).

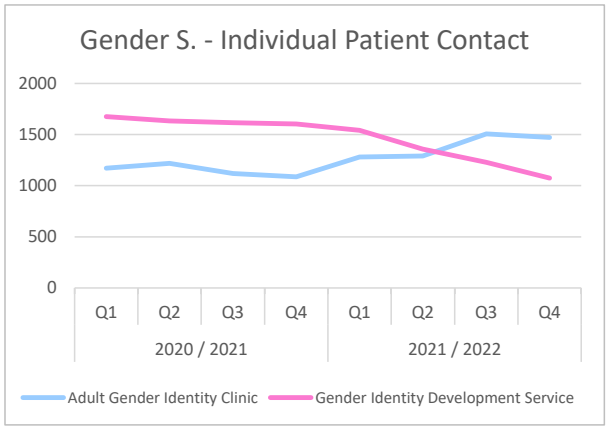
**GIC**: in Q4 767 referrals were received, 278 more than in Q3. This quarter the service was 3% above the quarterly average number of referrals during last financial year (744). GIC is still experiencing a backlog inputting referrals; this is currently running at a 4-week delay .

**Q4 2021/22: Trust Reach – Access**




Data source: Q4 data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 and Q2 21/22 data run on 07/04/21. Previous financial year data run on 14/06/2021.

## Individual patients in contact with our services

These graphs outline the data for all individual patients, in all contracts, who have had contact with our services, excluding EIS and Mosaic. They are reported only once per quarter. Data includes face to face, telephone and zoom contacts.

Trust-wide, 5340 individual patients were seen in Q4, 161 fewer than in Q3 (3% decrease from Q3). The Trust was 0.5% under the quarterly average number of individual patients seen during the last financial year.

**Adolescents**: in Q4 176 individual patients were seen, 36 fewer than in Q3. This quarter the service was 14% below the quarterly average number of patient contacts during the last financial year (204).

**Camden CAMHS**: in Q4 1138 individual patients were seen, 15 more than Q3. This quarter the service was 5% above the quarterly average number of patient contacts during the last financial year (1083).

**Other CAMHS**: in Q4 558 individual patients were seen, 33 fewer than in Q3. This quarter the service was 2% above the quarterly average number of patient contacts during the last financial year (546).

**Adults Complex Needs**: in Q4 478 individual patients were seen, the same as in Q3. This quarter the service was 8% under the quarterly average number of patient contacts during the last financial year (519).

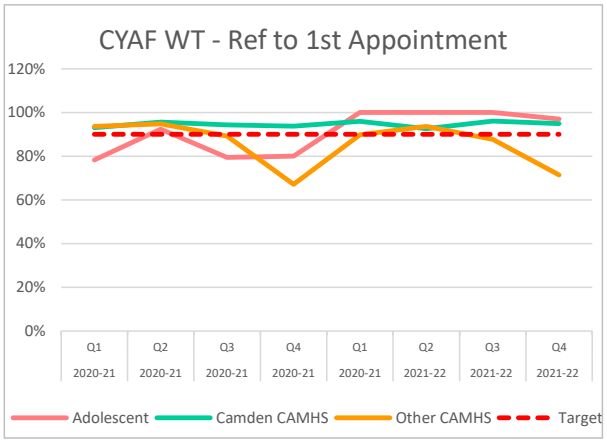
**Portman**: in Q4 166 individual patients were seen, 9 fewer than in Q3. This quarter the service was 11% under the quarterly average number of patient contacts during the last financial year (186).

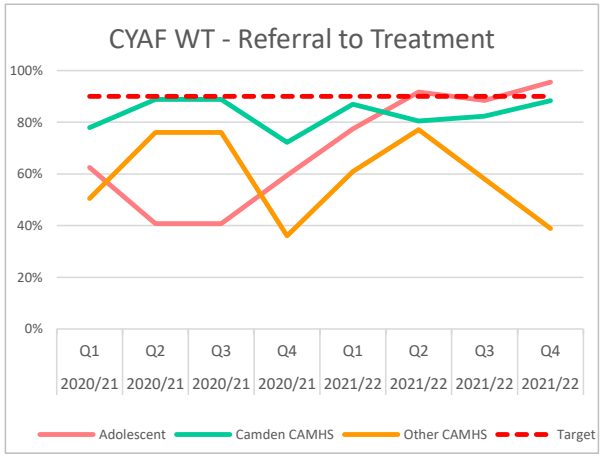
**C&H PCPCS**: in Q4 250 individual patients were seen, 29 more than in Q3. This quarter the service was 25% above the quarterly average number of patient contacts during the last financial year (200).

**GIDS**: in Q4 1075 individual patients were seen, 154 fewer than in Q3. This quarter the service was 34% under the quarterly average number of patient contacts during the last financial year (1632).

**GIC**: in Q4 1471 individual patients were seen, 34 fewer than in Q3. This quarter the service was 28% above the quarterly average number of patient contacts during the last financial year (1148).

## Q4 2021/22: Quality Responsive – Access




| Service Lines | %Compliance | 0 ≤ 2 wks | 2 ≤ 4 wks | 4 ≤ 8 wks | 8 ≤ 11 wks | 11 ≤ 18 wks | 18 wks + |
|---|---|---|---|---|---|---|---|
| Adolescents under 18 | **100%** | 3 | 0 | 4 | 0 | 0 | 0 |
| Adolescents over 18 | **96%** | 16 | 1 | 5 | 3 | 1 | 0 |
| Camden CAMHS | **95%** | 188 | 93 | 89 | 11 | 8 | 1 |
| Other CAMHS | **71%** | 12 | 9 | 39 | 7 | 15 | 2 |

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 | %Compliance | <= 2 wks | 2 ≤ 4 wks | 4≤ 8 wks | 8 ≤11 wks | 11≤18 wks | 18 wks + |
|---|---|---|---|---|---|---|---|
| Adolescents under 18 | **100%** | 0 | 0 | 5 | 0 | 0 | 0 |
| Adolescents over 18 | **94%** | 3 | 1 | 6 | 4 | 2 | 1 |
| Camden CAMHS | **88%** | 66 | 74 | 133 | 15 | 15 | 6 |
| Other CAMHS | **39%** | 2 | 7 | 26 | 17 | 19 | 19 |

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

Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021.

## 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 Q4 CYAF saw 91% of patients within the contractual waiting times. This is a lower rate compared to 95% in Q3.

**Referral to Treatment**: In Q4 CYAF saw 78% of patients within the contractual waiting times. This is a higher rate compared to 77% in Q3.

**Adolescent services**

**Referral to 1st Appointment** – in Q4 the whole service line saw 97% of patients within contractual waiting times; a slight decrease compared to 100% in Q3.

- Adolescents under 18 - 100%
- Adolescents over 18 - 96%

**Referral to Treatment**– in Q4 the whole service line saw 95% of patients within contractual hours, a compliance increase compared to 88% in Q3.

- Adolescents under 18 - 100%
- Adolescents over 18 - 94%

**Camden CAMHS**

**Referral to 1st Appointment** – has consistently met the target since 2017/18. The compliance rate in Q4 was 95%, a slight decrease compared to 96% in Q3.

**Referral to Treatment** – in Q4 88% of the patients had an appointment within 8 weeks, an increase in compliance compared to 82% in Q3.

**Other CAMHS**

**Referral to 1st Appointment** – in Q4 they achieved 71%, a decrease in compliance compared to 88% to Q3.

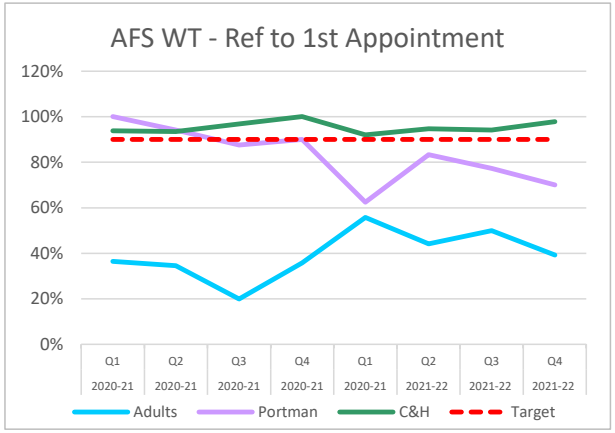
**Referral to Treatment**– in Q4 39% of the patients had an appointment within the contractual waiting times, a significant decrease compared to 58% in Q3.

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



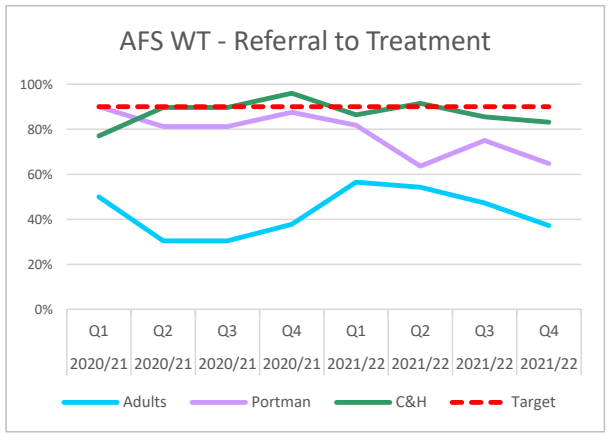
For further comments from service leads please see the commentary part of the report Page 21

## Q4 2021/22: Quality Responsive – Access




| Service Lines | %Compliance | 0 ≤ 2 wks | 2 ≤ 4 wks | 4 ≤ 8 wks | 8 ≤ 11 wks | 11 ≤ 18 wks | 18 wks + |
|---|---|---|---|---|---|---|---|
| Adult Complex Needs | **39%** | 12 | 3 | 2 | 3 | 5 | 26 |
| Portman | **70%** | 6 | 1 | 5 | 2 | 1 | 5 |
| City & Hackney PCPCS | **98%** | 11 | 14 | 44 | 9 | 11 | 2 |

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




| Service Lines | %compliance | <= 2 wks | 2 ≤ 4 wks | 4≤ 8 wks | 8 ≤11 wks | 11≤18 wks | 18 wks + |
|---|---|---|---|---|---|---|---|
| Adult Complex Needs | **37%** | 1 | 7 | 3 | 1 | 4 | 27 |
| Portman | **65%** | 0 | 1 | 3 | 5 | 2 | 6 |
| City & Hackney PCPCS | **83%** | 3 | 4 | 31 | 21 | 15 | 15 |

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 Q4 AFS saw 76% of patients within the contractual waiting times. In Q3 this compliance was 79%.

**Referral to Treatment** : In Q4 AFS saw 68% of patients within the contractual waiting times. In Q3 this compliance was 73%.

**Adult Complex Needs**

**Referral to 1st Appointment** –in Q4 39% compliance was achieved, a decrease on Q3 (50% compliance).

**Referral to Treatment**– in Q4 37% compliance was achieved, a decrease on Q3 (47% compliance).

**Portman**

**Referral to 1st Appointment** – in Q4 70% compliance was achieved, a decrease on Q3 (77% compliance).

**Referral to Treatment**– in Q4 65% of patients were seen within contractual times, a decrease on Q3 (75% compliance).

**C&H PCPCS**

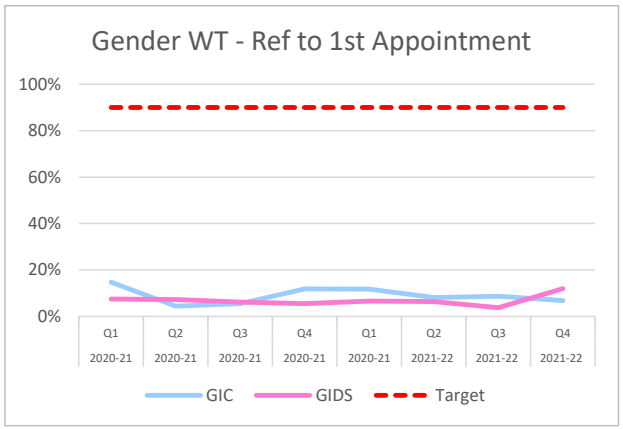
**Referral to 1st Appointment** – in Q4 98% compliance was achieved, an increase on Q3 (94% compliance).

**Referral to Treatment**– in Q4 83% compliance was achieved, a decrease on Q3 (86% compliance).

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

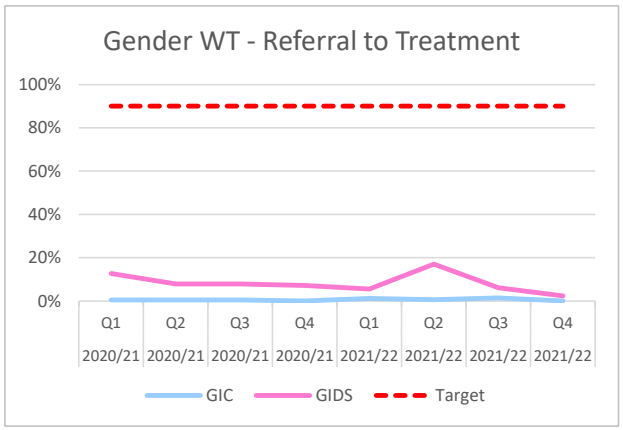
Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q4 data has been run without meeting the threshold on a number of unoutcomed appointments. Q4 report will include a rerun of all 21/22 quarters.
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021.

## Q4 2021/22: Quality Responsive – Access




| Service Lines | %Compliance | <= 18 wks | 18 ≤ 30 wks | 30≤ 42wks | 42 ≤48 wks | 48≤54 wks | 54 wks + |
|---|---|---|---|---|---|---|---|
| GIDS | **12%** | 11 | 3 | 1 | 2 | 2 | 73 |
| GIC | **7%** | 7 | 2 | 3 | 1 | 1 | 89 |

GIDS target within 18 weeks
GIC target within 18 weeks




| Service Lines | % compliance | <= 18 wks | 18 ≤ 30 wks | 30≤ 42wks | 42 ≤48 wks | 48≤54 wks | 54 wks + |
|---|---|---|---|---|---|---|---|
| GIDS | **2%** | 2 | 1 | 3 | 0 | 1 | 75 |
| GIC | **0%** | 0 | 0 | 0 | 0 | 1 | 184 |

GIDS target within 18 weeks
GIC target within 18 weeks

Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q4 data has been run without meeting the threshold on a number of unoutcomed appointments. Q4 report will include a rerun of all 21/22 quarters.
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021.

## Gender Services Waiting Times:

When calculating the waiting times all contracts and all activity are included including significant telephone conversations. The 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 time issues.

**Referral to 1st Appointment**: Gender Services Directorate saw 9% of patients within the contractual waiting times in Q4. This is a higher rate compared to 6% in Q3.

**Referral to Treatment** : Gender Services Directorate saw 1% of patients within the contractual waiting times in Q4. This is a lower rate compared to 3% in Q3.

**GIDS**: the current waiting time is advised on the Tavi's website to young people and referrers to promote awareness about the WT issue in GIDS. GIDS is currently seeing young people for their first appointment who were referred in 2018 and there were 5143 patients waiting at the end of Q4.

**Referral to 1st Appointment** – Q4 had 12% compliance, an increase on 4% in Q3.

**Referral to Treatment** – Q4 had 2% compliance, a decrease on 6% in Q3.

**GIC**: The Gender Identity Clinic in London continues to have an extremely high number of referrals which is challenging within the current clinic parameters. GIC is currently seeing patients for their first appointment who were referred in 2017. At the end of Q4 there were 10924 patients waiting for a first assessment.

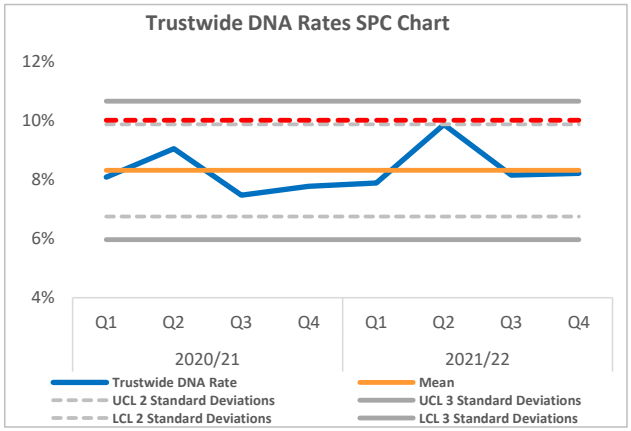
**Referral to 1st Appointment** – Q4 had 7% compliance, a decrease on 9% in Q3.

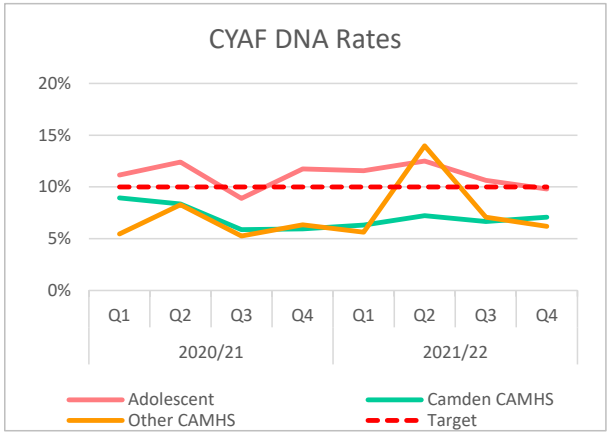
**Referral to Treatment** – Q4 had 0% compliance, an decrease on 1% in Q3.

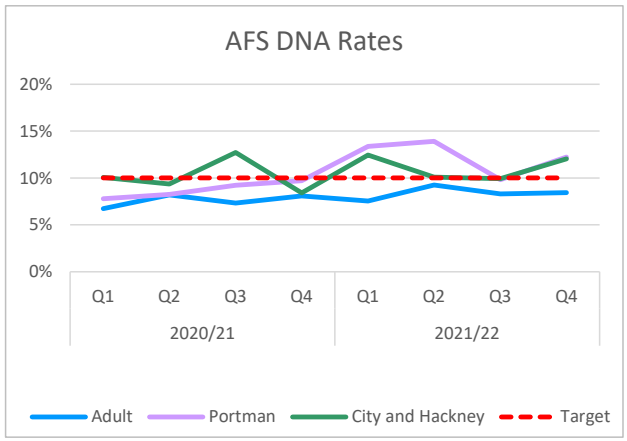


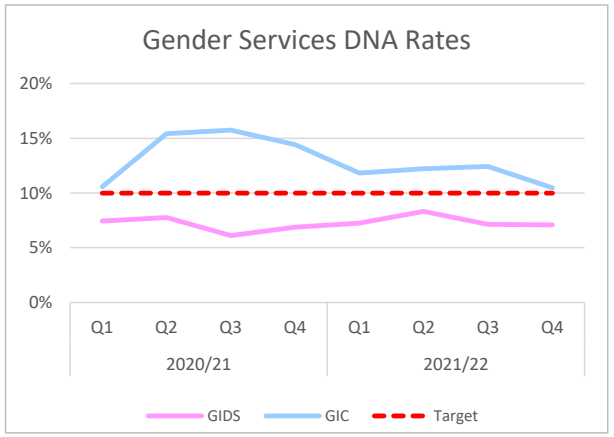
For further comments from service leads please see the commentary part of the report. Page 23

## Q4 2021/22: Quality Effective – Access




Data source: Q4 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1, Q2 and Q3 21/22 data run on 28/03/22. Previous financial year data run on 14/06/2021.

## 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%.

We continue to meet the DNA target Trust-wide (8.21% compliance rate for Q4), although there is variation above and below the target on a divisional level. The last financial year average rate was 8.09% and the Trust has met this target over the last 3 years.

**Adolescents**: Q4 had a DNA rate of 9.8% - 128 DNAs and 1179 attended appointments. The quarterly average during the last financial year was 11%.

**Camden CAMHS**: Q4 had a DNA rate of 7.1% - 537 DNAs with 7063 attended appointments. The DNA average during last financial year was 7.3%. The target has been met for the last 2 years.

**Other CAMHS**: Q4 had a DNA rate of 6.2% - 204 DNAs and 3093 attended appointments. The average during the last financial year was 6.3%.

**Adults Complex Needs**: Q4 had a DNA rate of 8.5% - 322 DNAs and 3489 attended appointments. The average during the last financial year was 7.6%. The target has been met for the last 2 years.

**Portman**: Q4 had a DNA rate of 12.2% - 183 DNAs and 1313 attended appointments. The average during the last financial year was 8.7%.

**C&H PCPCS**: Q4 had a DNA rate of 12.1% - 145 DNAs and 1058 attended appointments. The average during the last financial year was 10.1%.

**GIDS**: Q4 had a DNA rate of 7.1% -205 DNAs out of 2686 attended appointments. The average during the last financial year was 7%.

**GIC**: Q4 had a DNA rate of 10.5% - 245 DNAs and 2094 attended appointments. The average during the last financial year was 14%.

For further comments from service leads please see the commentary part of the report Page 25 26 & 27

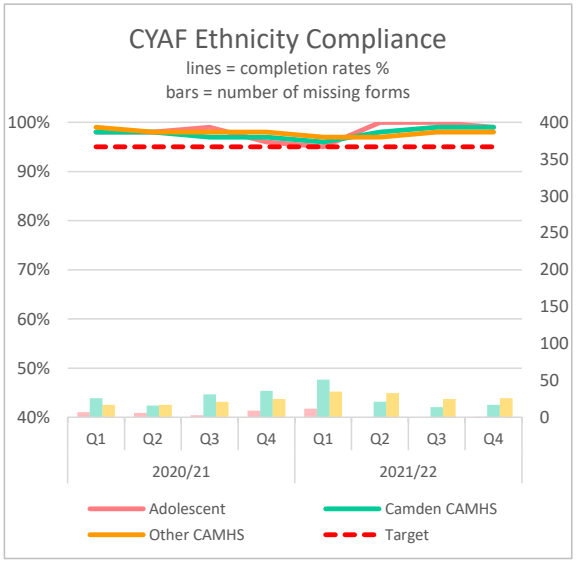
## Q4 2021/22: Single Oversight Framework – Access

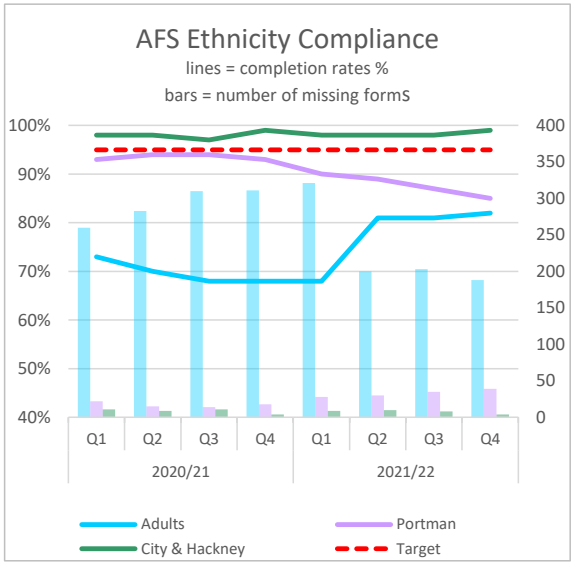
### Ethnicity Rates Internal Reports

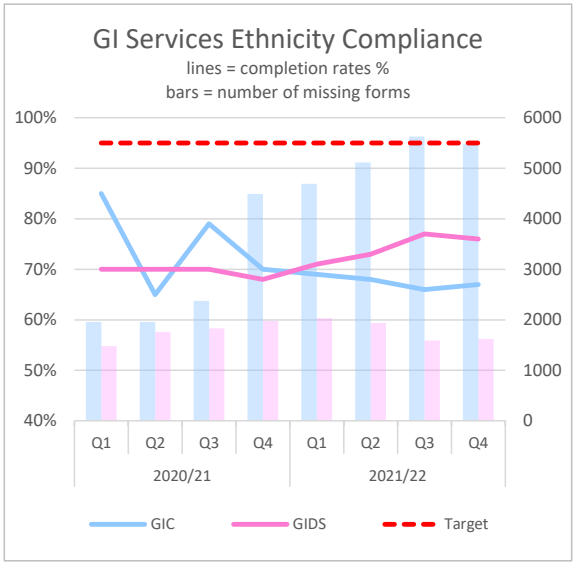
Ethnicity completion rates have been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. 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 has implemented the use of an acceptance letter which is sent before any appointment is offered. This includes a 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. GIC and GIDS started a similar project to ACN sending the 'patients detail forms' with their acceptance letters. This is starting to show improvement on collection rates.

Unfortunately Portman has a decreasing trend on completion rates. The process in place is being discussed with an expectation on improving the trend in the new financial year.

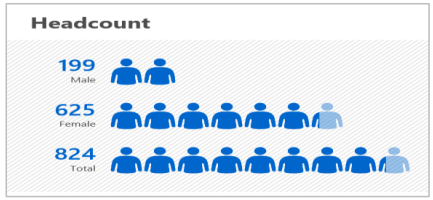


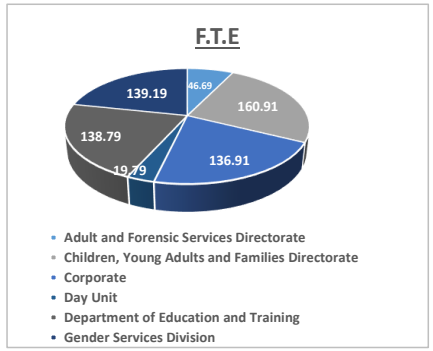



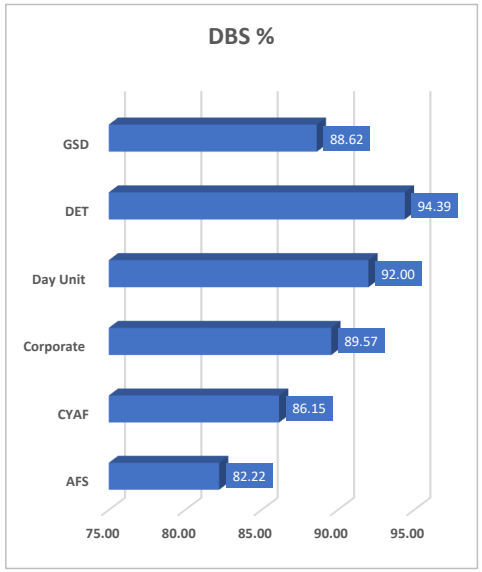



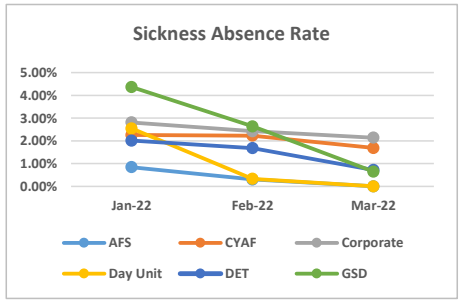

Data source: Q4 data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

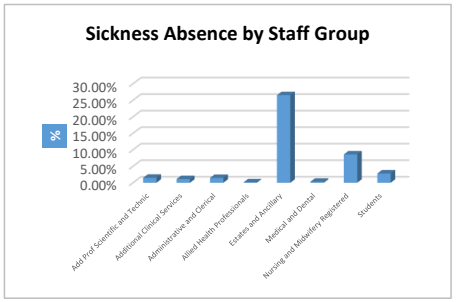
## Q4 2021/22: Quality Well-Led

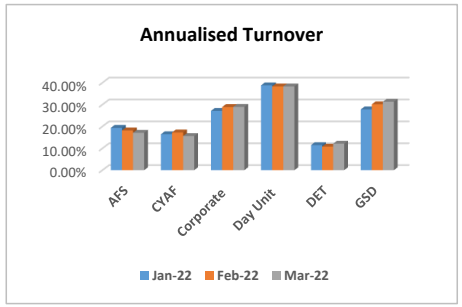


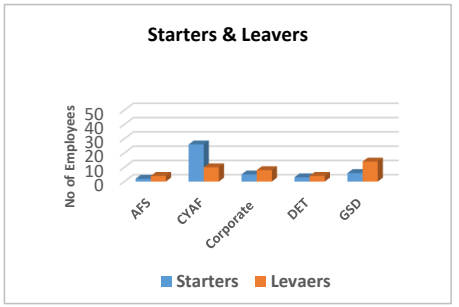



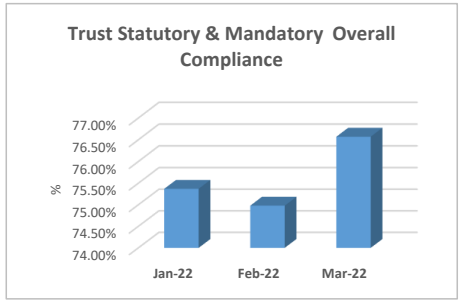



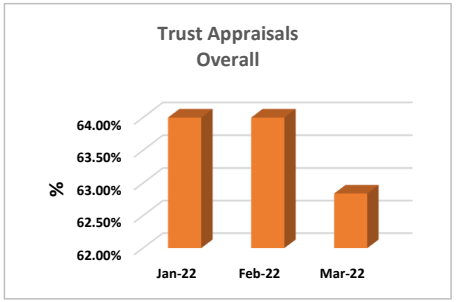




**At the end of Q4, the Trust employee headcount is 824 (642.48 full time equivalent). A high rate of female employees representing 76% and male employees at 24%. The CYAF division holds the highest headcount, the smallest being Day unit.**

**Turnover currently at 21.53% (12m). The data is based on headcount and shows people leaving or returning to active service, this would include those going on or returning from maternity leave or career break. A break down in section three indicates turnover in each directorate for Q4.**

**Sickness absence has improved over the past three months, decreasing by 1.52% (Trust Overall). A breakdown in section four indicates sickness absence in each directorate. The GSD division in January held the highest sickness level at 4.37%, compared to the other directorates ranging from 0.85% to 2.81%. Each directorate at the end of Q4 remain under the 3% average from 0% to 2.14%.**

**Compliance has remained within 70% and above. We did see a slight decrease in Feb-22 by 0.39%, however this has started to increase at the end of Q4 by 1.59%.**

**Appraisals have also improved from the last quarter by 10%.This now stands at 63% at the end of Q4.**

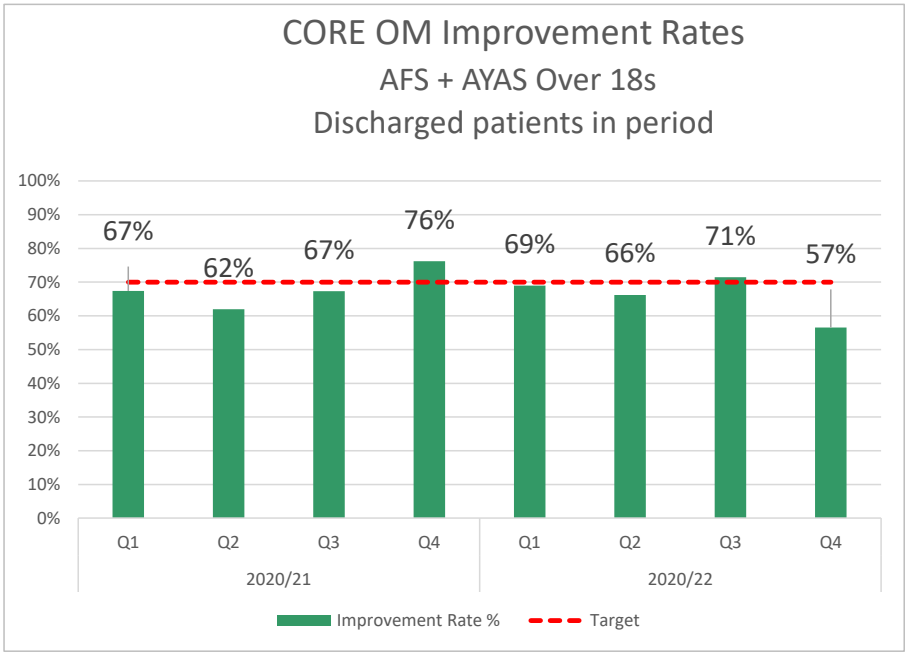
**DBS checks within our Trust are maintained to a high standard at 89.01%, not all positions will need a DBS. The need and level of check required depends on the activities and type of patient access an employee will have.**

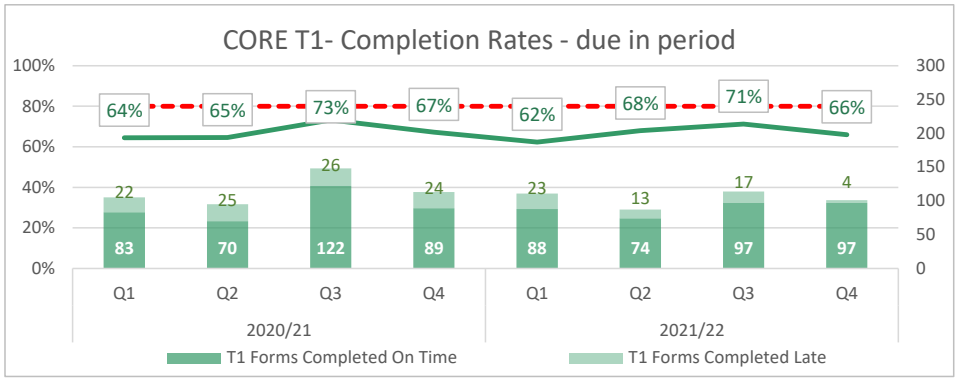
Data Source: Human Resources Department: 11/04/22

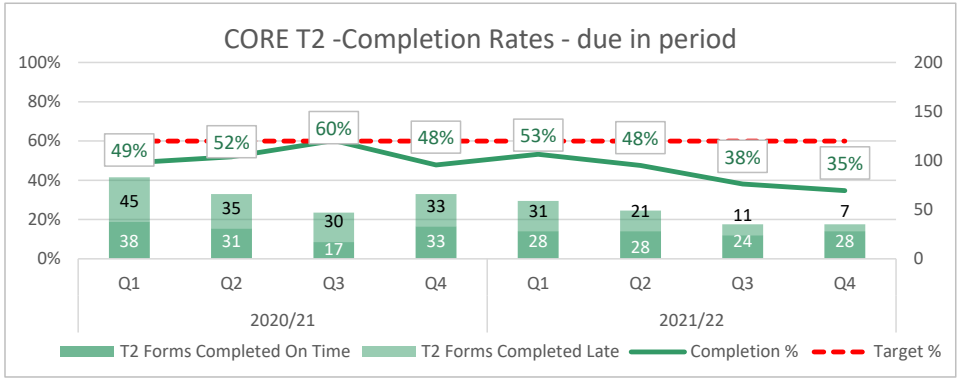
## Q4 2021/22: Quality Effective – Outcome Measures

### A F S and Adolescents over 18

CORE OM data is run including all contracts




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

We have a 57% improvement rates in Q4 which is a marked decrease from previous. This rate could be related to the usage of Qualtrics and the initial work with automated distribution lists. 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 report that the percentage of patients discharged with a minimum of 2 CORE OMs forms is gradually increasing over the last 3 quarters.

Completion rates include forms completed on time and late. As we are reporting 'due in period' the most recent quarter's compliance will be naturally lower as late forms are not created yet

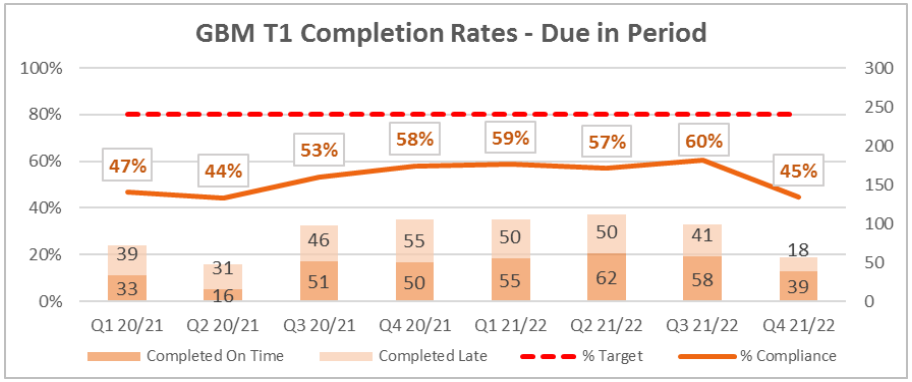
-**CORE T1 rates**: expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 the compliance rate was 66%. and the last 3 months average is 67%.

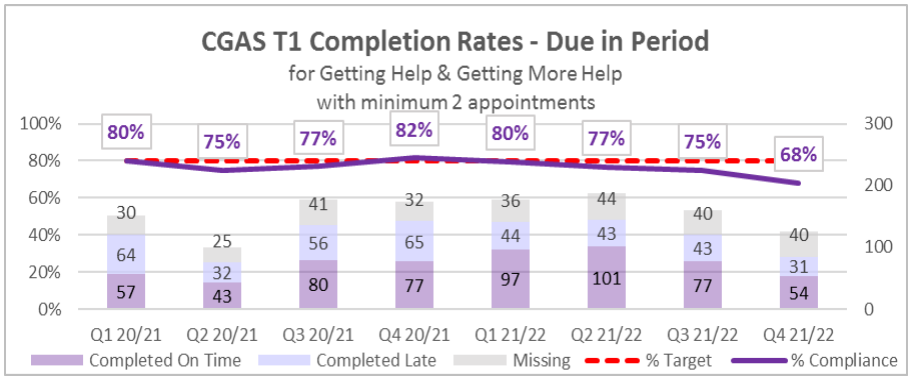
-**CORE T2 rates**: expected 6 months after T1, deemed as on time if within 7 months of T1. In Q4 we achieved 35%. and the last 3 months average is 46%. T2 forms are particularly challenging for teams that have a long waiting list.

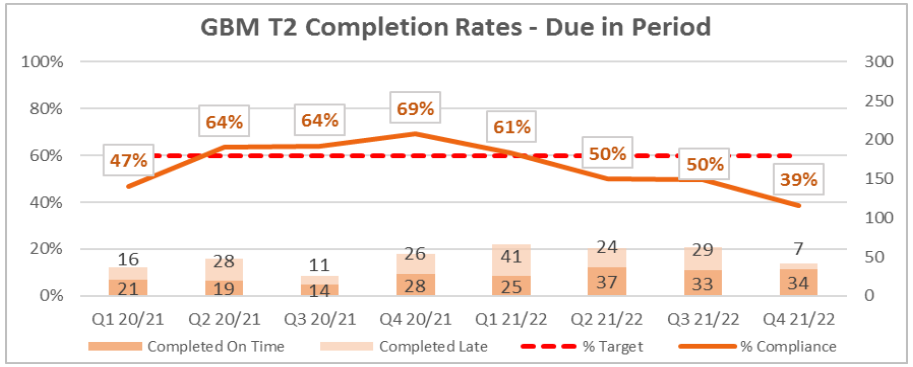
Data source: Data as recorded on 12/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team

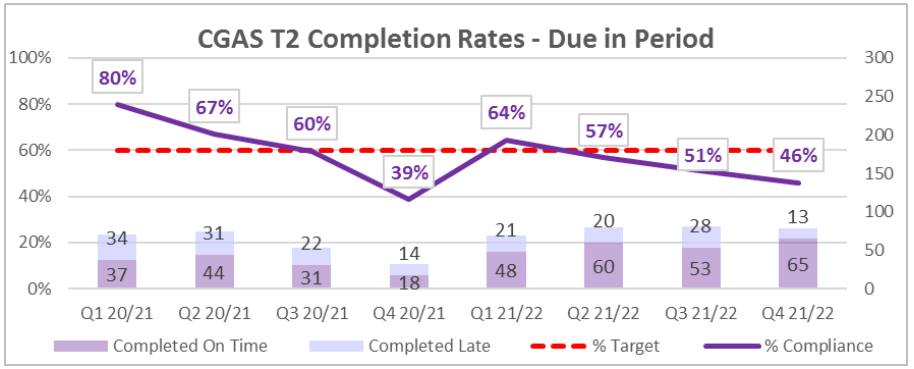
## Q4 2021/22: Quality Effective – Outcome Measures C Y A F - Under 18

GBM & CGAS completion rates are part of our KPIs and as such they include London Contracts only.
Cohort excludes following teams: Retuning Families, First Step and First Step Rehab, Gloucester House and Healios .




We have developed a new report that has improved our data accuracy and our internal reminder system. It also allows us to assess which forms were recorded on time or late. We now can retrospectively update previously reported quarterly data; this has an impacted in particular the last year's financial year's data. As we are reporting 'due in period' the most recent quarter compliance will be naturally lower as late forms are not created yet.

**-GBM T1** - expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 completion rates for due forms is 36% and the last 3 months average is 47%.

**-GBM T2** - expected 3 months after T1, deemed as on time if within 4 months of T1. We exclude discharged patients who were not seen after T1 -- In Q4 we achieved 39% compliance and last 3 months average is 46%.

Data source: Data as recorded on 07/04/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team

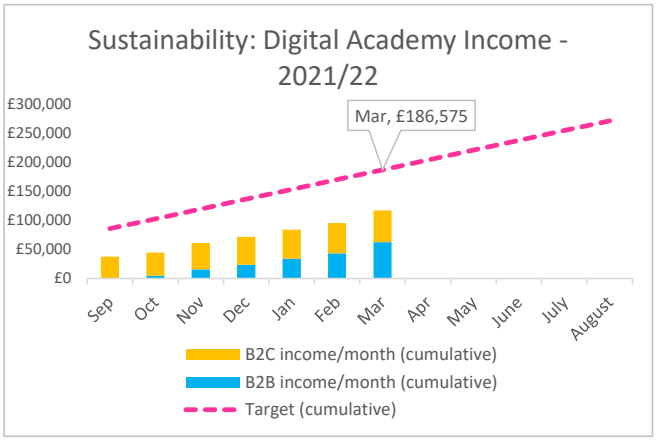
We have developed a new report that has improved our data accuracy and our internal reminder system. It also allows us to assess which forms were recorded on time or late. We now can retrospectively update previously reported quarterly data; this has impacted in particular the last financial year's data. As we are reporting 'due in period' the most recent quarter's compliance will be naturally lower as late forms are not created yet

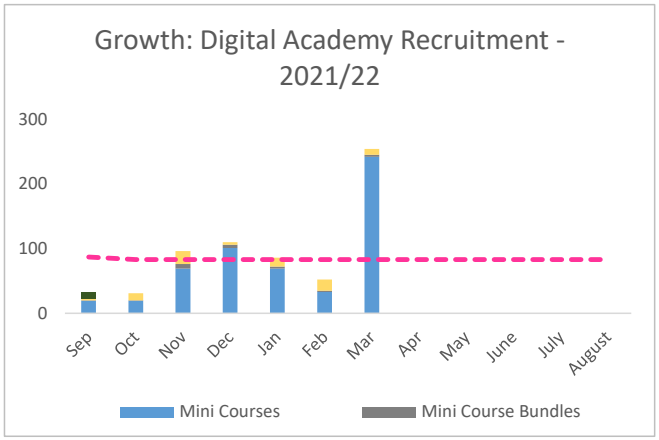
**-CGAS T1 rates**: expected after a second appointment, deemed as on time if within 1 month of that appointment. In Q4 the compliance rate was 68%. and the last 3 months average is 73%.

**-CGAS T2 rates**: expected 6 months after T1, deemed as on time if within 7 months of T1. We exclude discharged patients who were not seen after T1. In Q4 we achieved 46%. and the last 3 months average is 51%.

See Slide 37 for further GBM and CGAS information

## Q4 2021/22: Directorate of Education and Training (DET)

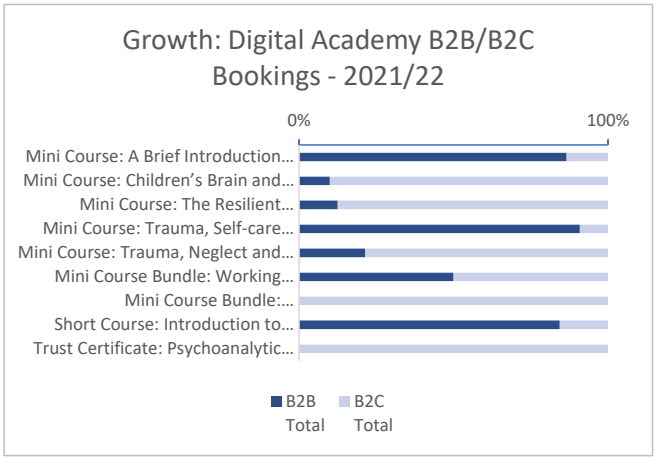


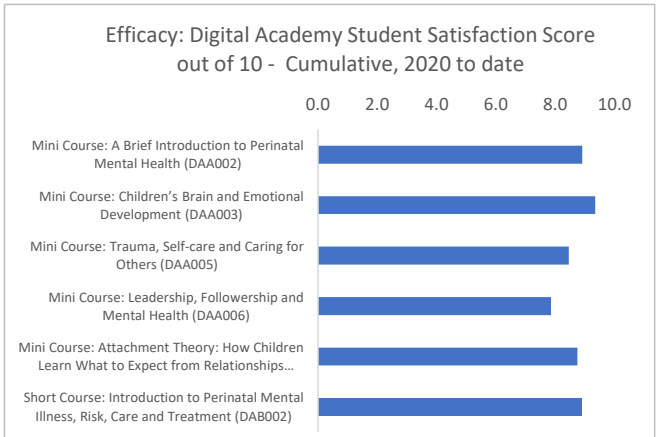




The 'Sustainability' graph shows cumulative individual booking income via the MyTAP system for all Digital Academy products in the 21/22 academic year from 1 Sep 2021 until 31 March 2022 (£116,989) against target (£186,575).

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 unrecognised and invoice-pending B2B income for Sep 21 - Mar 22 stands at £52,460, which takes the total forecast Digital Academy income to £169,449 (9% under target). Discussions regarding a solution to reporting bookings/enrolment and invoice income in a more unified fashion are ongoing.

March 2022 was an exceptional month for the Digital Academy, hitting 306% of the bookings target and 130% of the income target for the month – the best month on record for the Digital Academy. March's results continue to be driven by large numbers of enrolments for the lower-price mini courses from B2B group bookings, combined with a financial year end pressure to use up budgets. (53% of total income for this academic year to date is from B2B group bookings; the remaining income comes from B2C or individual consumers.)




'The 'Growth' chart reflects the importance of B2B group bookings to the DA. 53% of income over the Sep 21 - Mar 22 period was from B2B bookings. This is driven by a high volume of B2B bookings being for the lower-cost mini courses. B2C activity for his period made up 39% of the total bookings and 67% of total income.

81% of all bookings in March 2022 were for the perinatal mini course, funded by NHS Improvement/NHS Midlands, Cambridgeshire and Peterborough NHS Trust and by Herts Valleys CCG; however, this contributed 64% of the month's total income.

The 'Efficacy' chart shows positive student satisfaction rates across all products, with the majority of respondents scoring their experience highly (8+). The Attachment Theory Mini Course, which was launched in November 2021, has received a positive 8.3/10 score so far. Improvements to communications are underway to improve the quantity of surveys completed by students, with student feedback being reviewed and actioned on a monthly basis.

Data & commentary source: DET Department 11/04/2022

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

| Waiting Times - feedback and action plan from Service Leads – CYAF Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adolescent /AYAS** | This quarter AYAS continue to meet the KPI requirements. The breaches were due to COVID related leave. | The referral rate is slowly returning to normal after a prolonged depression due to covid. The focus of the service is to continue to provide 1st and 2nd appointments in a timely manner. |
| **Camden CAMHS** | Camden CAMHS have continued to exceed the target for seeing patients for initial assessments within the required time period. It is noted that there is a slight reduction for this quarter. There were a higher number of cases where the 1st appointment target has been breached. Some work has been done by the Camden intake team to look at these cases that had been: it was identified that most of these cases were delayed due to waiting for responses from other services (see next section for plan).<br><br>The target for WT to treatment was achieved this quarter.<br>There continue to be significant staffing and recruitment challenges this quarter and it is commendable in this context that the service has continued to be able to respond to need in a timely way. | Learning continues to be implemented to learn from cases that were not seen in a timely way, including use of QI projects to reduce waiting times and optimise allocation processes to clinicians in teams. Team managers and admin leads continue to use a 'weekly waiter' report to monitor cases that are waiting for a 1st or 2nd appointment.<br><br>This work has identified some system issues around liaison with other services and a new process has been put in place to work with referrers and other teams to respond in a more timely way to reduce waiting times. |
| **Other CAMHS** | We are exploring the data in relation to the current waiting times compared to Q3 the compliance- the breaches have been a combination of internal and external breaches. For example - patients cancelling a number of 1st appointments which resulted in delays in offering the 2nd appointments. A number of appointments were not updated in Carenotes therefore the breaches are now cancelled and Carenotes updated e.g. staff attempting to contact the families. However the families are getting in touch before the breach dates. Measures will be put in place to remind Clinicians to update Carenotes with Patient contact activities. Therefore, the number of breaches<br>CWP – breaches cause by the CWP service not in operation for this financial year these cases were transferred to FMH Service hence the breaches.<br>ASF funding has been agreed and recruitment of clinician and operations manager this service is now operational and should see an improvement in the waiting times for the next quarter. | Continue to manage the compliance rates and follow up with team managers to increase compliance of waiting times in a timely manner. |

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

| **Waiting Times** - feedback and action plan from Service Leads – AFS Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adult Complex Needs** | We continue to struggle to meet the targets for 1st and 2nd appointment, particularly in our Trauma unit where we have a considerable waiting list. | Our plans for the next quarter are to;<br>- Continue to review our treatment pathways to ensure our capacity and demand are more aligned and to release capacity for those waiting to be seen.<br>- Review our staffing model as part of the strategic review and redirect resources where appropriate to help with the longer waits as well as review opportunities to source additional funding to further expand capacity, in addition to the 2 new trauma posts that started at the end of Q4. |
| **Portman** | We have minimal waiting times to see patients and the majority of patients are seen within 8 weeks. After a referral is received, a process starts which usually includes writing to referrers and waiting for them to provide more/the correct information necessary to progress the referral or waiting for patients to respond to our request to write in to us, both of which are an established and essential part of the intake process. A new referral form was implemented in the last six months to help referrers provide the required information early on in the process, however as our patient population present with such complex pathology we often have to seek information missing from initial referrals (eg. consent for and disclosure of probation reports) and then wait for this.<br><br>The majority of patients are seen for the second appointment within one month of their first appointment. Clinicians have been instructed to offer a second assessment appointment between 2-3 weeks after the first appointment, and so most second appointments will fall in the 2<4 week category in line with our clinic policies. | We will continue to ensure that patients receive their first appointment as soon as is possible, after all the initial enquires have been made on receipt of the original referral. All clinicians have been reminded of the target of seeing patients for their first appointment within 11 weeks.<br><br>We have reminded clinicians to offer second appointments between 2-3 weeks after the first appointment, and that the second appointment must occur within 18 weeks from the original receipt of referral. |
| **City and Hackney PCPCS** | We are pleased with PCPCS's waiting time figures for a first appointment in Q4. 98% of our patients were seen within the target time frame, which reflects the services commitment to respond to local demand in a timely manner. Although the majority of our patients also received their second appointment within the target time frame, we are disappointed that our compliance has dropped slightly since Q3. We recently introduced a new admin staff- led booking system, designed to reduce delays in patients starting their treatment. Unfortunately this new system has been adversely affected by extended sickness absence within the admin team, which has impacted on the teams' ability to establish the new system during Q4. | Due to the reduced administrative capacity at PCPCS in Q4, our clinicians have temporarily resumed their previous role of booking treatment patients' first appointments themselves. We are also in the process of recruiting temporary admin staff to help cover the current staff shortage and we hope this will enable us to re-introduce the new admin-led system during the next quarter. We are also prioritising the recruitment of new clinical and administrative staff, due to some team members moving on to new roles, either within the Trust or externally. |

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

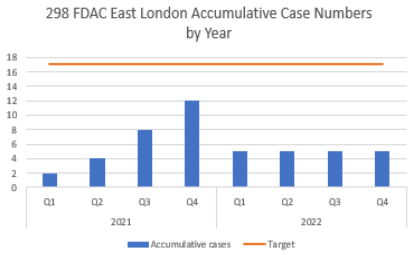
| **Waiting Times** - feedback and action plan from Service Leads – Gender Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **GIDS** | The drop in activity in Q4 is in part because the service where young people had a telephone assessment at 17 years and 6 months has stopped. The telephone assessments counted as activity for that patient. This service has transitioned to supporting the transfer of patients to an adult provider of their choice. Although activity is low, the bulk of the YP seen are the longest waiters.<br><br>The overall number of young people seen at 2nd appointments continues to fluctuate whilst performance against the target remains very low. | The low levels of assessment activity is being addressed through the implementation of the newly formed recovery plan for GIDS.<br><br>Introduce a revised clinical pathway to refocus activity on securing YP 1st and 2nd appointments in quick succession This is as part of the overall GIDS recovery plan. |
| **GIC** | We continue to receive a large number of referrals to the service and this is not in the long term sustainable as it has a direct impact on waits for the 1st appointments and wait between appointments.<br><br>We have commissioned some consultants to do some demand and capacity modelling to ensure that we have a clear trajectory of delivery for improving the those on the waiting list and between appointments<br><br>We also submitted a business case to NHSE (Feb 22) for the CX Clinic proposal which aims to increase the activity for 1st appointments but are yet to hear from NHSE on the outcome<br><br>We have revised our DNA policy to ensure that those not making use of the appointments they are offered are discharged if appropriate this freeing up clinicians time to focus on seeing more 1st appointments and shortening the gap between appointments | Commissioned modelling will start with view to establishing a trajectory and staff required as well as any system changes required to develop this work. |

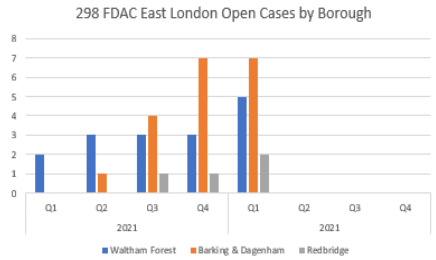
## 1.3 Waiting Times – Appendix

**Service metrics for teams that are not measured based on waiting times:**

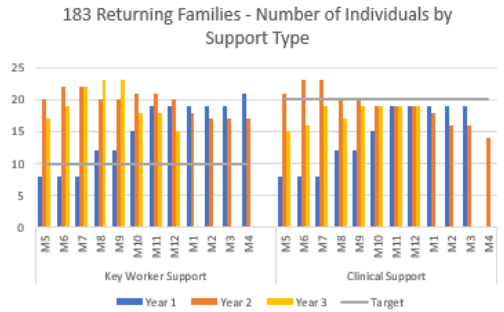
The following teams are not measured in WT metrics as they follow a different delivery model.
First Step, FDAC, Gloucester House, and Returning Families.
Please see below metrics used monitor for First Step, FDAC, Gloucester House and Returning Families.

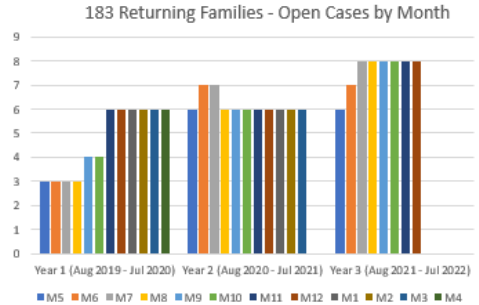
**298 - FDAC East London**



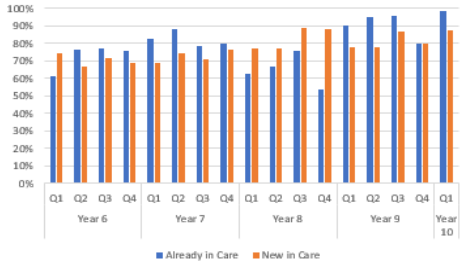




**183 - Returning Families Unit**

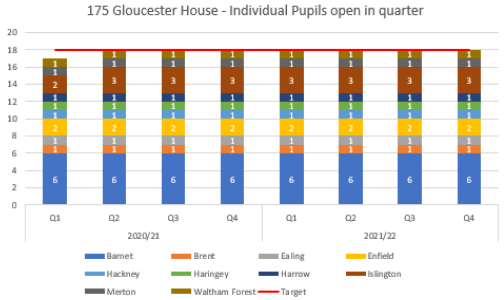


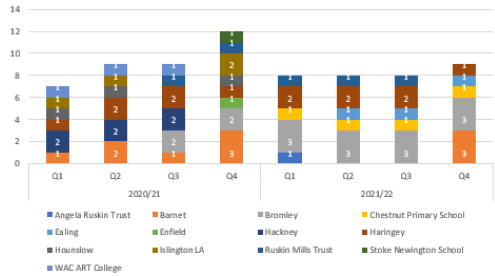




**060 - First Step**




**175 - Gloucester House**



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

| DNAs - Feedback and action plan from Service Leads – CYAF Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adolescent /AYAS** | The outcome of multiple strategies within AYAS has finally come to fruition with the DNA rate coming back below 10% following a long period of it being over this. | To maintain vigilance in relation to DNA's and ensure that the data is flowing from admin to clinical management to monitor this. |
| **Camden CAMHS** | DNA for Camden CAMHS continue to be consistently below the 10% | Team continue to implement strategies to reduce DNAs, including SMS reminder, agreeing appointment =s with YP/ families in advance.. |
| **Other CAMHS** | DNA rates have dipped slightly in since the last quarter. Current monitoring will be implemented to explore whether the DNA appointment are true DNA reasons. | Will explore the DNA rates with team managers and service manager to monitor the reasons behind the DNA's – Monitor whether the staff entering DNA using correct DNA reasons. Will email communications to staff advising that appointments marked as DNA should be marked when the time has elapsed during the appointment and no contact from the patient advising of the cancellation. |

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

| DNAs - feedback and action plan from Service Leads – AFS Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **Adult Complex Needs** | We're pleased that we continue to meet the target for DNA, and intend to maintain the performance going forward. | We intend to continue to meet out target by;<br>- Offering patients the choice of being seen remotely by zoom or telephone if they are unable to come to the building.<br>- Providing adequate admin cover for telephone lines and adult patient inboxes to take messages of cancellation or rescheduling of appointments<br>- Ensuring DNA policy is followed |
| **Portman** | Our DNA rate has risen from 10% in the last quarter to 12.7% in this quarter. Our target is 10% and below. | We have noted that as pandemic restrictions continue to be lifted, patients have been missing appointments to attend to other medical and personal issues, as well as for leisure and travel. Sometimes this has been without discussion with the clinician. We continue to address this issue with patients as it occurs, and all DNA appointments are addressed in the context of the psychotherapeutic treatment.<br><br>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 always have an impact on our DNA rates. |
| **City and Hackney PCPS** | There has been a slight rise in our DNA rate during Q4, which may be related to our introduction of a new booking system for first appointments. Previously, new patients were required to respond to an opt-in letter, before an initial appointment was offered. We noted that a number of patients were not opting in, although they did want to be seen. Therefore we have been trialling a new system whereby the 'opt in' step has been removed and the new patient is telephoned directly by an administrator with an appointment offer. | We will carefully monitor our DNA rate under the new booking system during the next quarter. We are aware that actively 'opting in' can increase motivation and compliance, and possibly those patients who do not opt in may be less invested in attending their appointments. |

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

| DNAs - Feedback and action plan from Service Leads – Gender Services | | |
|---|---|---|
| **Service line** | Commentary Q4 | Objective / plan for next Quarter |
| **GIDS** | DNA rates continue to be low, supporting the improvements made in the management of patient bookings. | Introduction of a revised booking process aims to reduce DNA further. |
| **GIC** | DNA's for quarter 3 were on a downward trend primarily due to more assiduous follow up of patients that DNA. Clinicians have been reviewing the patients for any risk, contacting them directly to understand reason for DNA and also discharging them if the service is no longer required and or the patient is pre-contemplative and has DNA'd several appointments but present no/very little clinical risk. | We are mobilising our DNA policy pilot, aligned to the work that we started in the last quarter. This effectively means that all clinicians will have additional number of appointments per month, pro rata that they can review and discharge if appropriate.<br><br>All staff will apply the same principles to patients who DNA and where there is nominal risk these patients will be discharged – see DNA policy and approach on website. Letters have also gone out to all patients who have appointments from the first week of April outlining the DNA policy<br><br>Where an appointment is still required the patient will be booked in after they have contacted the service but this must be within 6 months of DNA letter being sent |

| Report to | Date |
|---|---|
| The Board of Directors | 26.07.2022 |

People and Organisational Development Committee Highlight report

## Highlights from Committee

The Committee reviewed a draft of the Trust wide people strategy, which had been updated to reflect the staff survey results. The Strategy had also been amended to include the metrics by which the Committee will be able to monitor and oversee the improvements being made.

The Committee discussed the four priorities which are:

- Valuing our people
- Developing our People
- Growing our workforce
- Delivering Excellent People Services

The Committee also reviewed the new freedom to speak up policy. The Trust previously had in place a whistleblowing policy but in line with national policy has moved to a freedom to speak up policy. The Introduction of this policy sets out the core principles of speaking up and the Trusts commitment to 'speak up, listen up and follow up' together with the four steps to resolving concerns including process, timescales (where agreed) and contacts. The Committee members will be reviewing the policy in detail and sending comments ahead of formal approval.

The Committee in response to concerns raised at an earlier Committee meeting had invited recruitment shared services to the meeting, to discuss a number of issues with the contract. The Committee received a presentation and was assured about the action plan in place to improve the service, this also included assurances around improved communication between recruitment shared services and the Trust. The Committee will continue to oversee the action plan in the coming months.

The Committee received an update from the Trusts new equality lead, Dr Mhlanga. Dr Mhlanga provided an update on the Race Equality Action Plan. The Committee shared there thanks with Dr Mhlanga for the progress made thus far. The Committee raised concerns about the number of actions which were included within the Race Equality Action Plan and asked that Dr Mhlanga and the Race network review the actions and separate them into priority years.

The Committee reviewed the workforce metrics report noting that for the four metrics monitored monthly (Sickness, Mandatory Training, Appraisal and Turnover) there has been a deterioration in performance for 3 out of the 4 with turnover recovering its position in May. The Committee discussed the workforce risks including the impact of the strategic review, and the accuracy of data captured within ESR.

| Recommendation to the Board |
| --- |
| The Board is asked to note the approach outlined in the report |
| **Trust strategic objectives supported by this paper** |
| People |

| Author | Responsible Director |
| --- | --- |
| Jenna Davies- Director of Governance | Chair of POD EDI Committee |

The Tavistock and Portman
NHS Foundation Trust

| Report to | Date |
|---|---|
| Board of Directors | 25th July 2022 |

Draft People Strategy and Implementation Plan

## Executive Summary

**Purpose:** The purpose of this paper is to present an overview of the draft Trust People Strategy and Implementation Plan for discussion. It will summarise the key sections of the strategy, the proposed strategic priorities, aims, main areas of focus and action and the key measures of success. Next steps in development and recommendations are also included.

**Key highlights**

- **Our People Strategy is a key enabler to modernising the Trust and enabling it to continually improve. It outlines our commitment over the next five years to making Tavistock & Portman a great and safe place to work and learn.** It summaries four interdependent strategic priorities(see slide 34) which collectively explain how The Tavistock and Portman will attract, recruit and develop a talented, diverse workforce committed to our vision and values and enabled through excellent people services. The four priorities are:
  - **Valuing our People**
  - **Developing our People**
  - **Growing our workforce**
  - **Delivering Excellent People Services**
- Delivering these priorities over five years will mean our staff survey, WRES and WDES results are among the top performing trusts, we will have ethnic minority representation across all pay bands in line with A Model Employer and we will achieve our performance targets as set out in the Trust Performance framework.
- The strategy provides an overview of the current national and regional strategic context and drivers and these can found on slide 5. These primarily focus on the long term plan and the national People Plan. Further work will be completed to reflect strategic drivers specific to our Education and Training provision
- There are 4 Trust strategic drivers outlined in slides 16-25which include:
  - Staff Morale
  - The Strategic Review

    - Freedom to Speak Up
    - Equality Diversity
- The Trust Strategic Drivers will be strengthened and developed in line with the planned work to develop the Trust Strategy, mission and values
- Chapter 8 (slides 27-29) outlines that this initial version of Our People Strategy has been developed to support the Trust in meeting its statutory responsibility to deliver against those priorities outlined in the NHS People Plan and those objectives outlined in the ICS People Plan. Its purpose and aims are focused on supporting the successful delivery of improvements in line with our strategic review and staff survey. The aim of which is to modernize and enable the organisation to continually improve thus securing the future sustainability of the organisation and its distinctive approach to understanding mental health and wellbeing.
- An early action outlined in the Year 1 implementation plan is to develop a comprehensive communications and engagement plan to ensure key stakeholders and in particular our staff continue to both shape and deliver our plans.
- Slide 29 describes the intended responsibilities of the People Directorate as a key enabler for delivering the People Strategy and Plan. An external review of the Trust People Services will be completed by the end of Q2 2022. The outcome of this review will include a revised operating model in line with national developments and aligned to the NCL ICB requirements, improvement plan for HR systems and processes and a professional and team development plan for people working in the Directorate.
- Chapter 9 (slide 30) describes our current workforce demographics. This will be updated regularly to ensure it remains accurate
- Our Vision and strategic priorities are described on slide 34 and a summary of the priorities, aims, key areas for focus and action and success measures can be found on slides 36 and 37.
- Each priority is broken down into key objectives and how we will know we have been successful in delivering these- both in terms of how it will feel for people and how we will know (quantitative metrics). Details are on slides 38-41.
- The final chapter presents details on the specific actions that will be taken in year 1 of implementation and includes some high-level longer-term actions.
- It is intended that the strategy will be delivered over 5 years with this first year's actions enabling the Trust to establish a benchmark in relation to people matters and from which we can further strengthen approaches in line with national and regional developments that demonstrate best

practice in years 2&3. The ambition will be to achieve excellence in year 5. An engagement plan will be developed to involve staff across the Trust in the co-design of the implementation plan for future years.

- Slide 44 outlines our approach to measuring success and as part of the engagement plan referred to earlier it is intended that we will work with staff across the Trust to establish a comprehensive set of performance metrics, targets and improvement trajectories. The success measures included in this initial draft are for year 1 only.
- Slide 45 provides an overview of governance with the CPO being the lead Executive and the PODED&I Committee responsible for monitoring the delivery and performance against the strategy and plans.

**Next Steps**

- A further review of the Strategy will be completed to ensure a cross reference with the Quality Priorities.
- A Communications and Engagement Plan will be developed and presented to the PODED&I in September- this will include engaging with staff in relation to the strategic priorities and in particular the action plan for years 2 onwards and further developing the performance framework.
- External Review and co design of an operating model for the People Directorate will commence in July and progress will be reported to the PODED&I Committee in September
- The People Delivery Group will be established in August 2022
- The Race Equality Accountability Group meeting in August 2022
- The priorities and actions outlined in this strategy will be integrated into the BAF

| Recommendation to the Board of Directors |
|---|
| The Board of Directors are asked to review the strategy, note the next steps summarised above and approve the priorities and proposed implementation plan. |

| Trust strategic objectives supported by this paper |
|---|
| People |

| Author | Responsible Executive Director |
|---|---|
| Helen Farrington CPO<br>Sarah Mountain Acting Head of Organisation Development, Culture and Engagement | Helen Farrington CPO |

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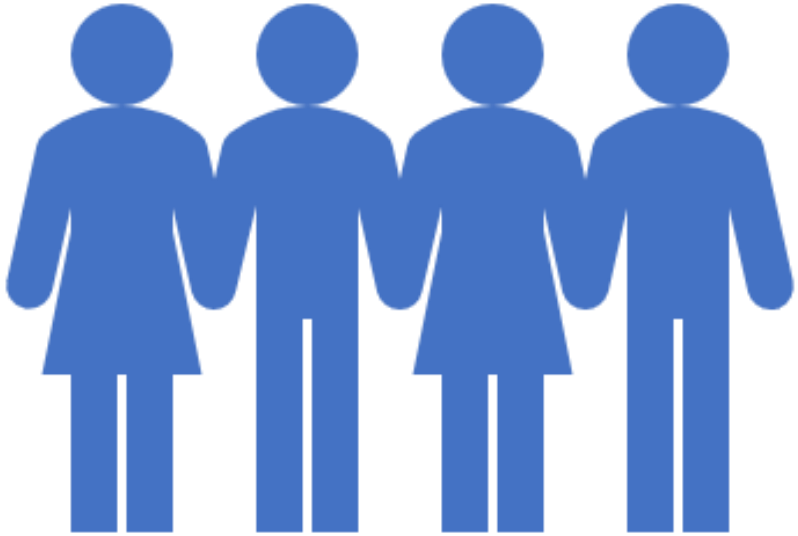
The Tavistock and Portman
NHS Foundation Trust



2022-2027

# Our People Plan

The Tavistock and Portman
NHS Foundation Trust



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# Foreword

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# National and Regional Strategic Context

# National People Context

In addition to understanding our organisation and workforce, it is imperative that this strategy reflects the priorities outlined nationally for the NHS.

The Long Term Plan sets out a key theme focused on workforce development which is:

*"More staff with greater flexibility of skills and more rewarding career structures and working conditions and targeting role development to the needs of the population and new integrated care models; encouraging greater breadth of competency; improved access to life long professional development."*

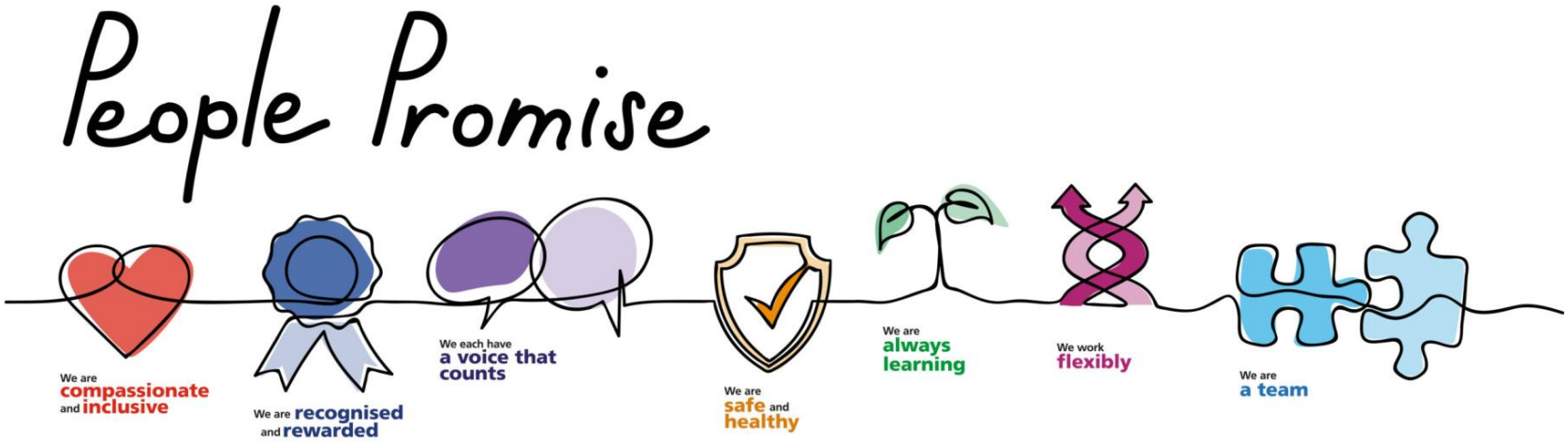
To deliver the promises set out in the Long Term Plan, NHS England published its interim People Plan (2019) which focuses on creating a more positive and agile culture across NHS employers in England. Proposals include a new leadership development framework and better flexible working options. The We are the NHS: People Plan for 2020-21-action for us (2020), Our People Promise and 2022-23 priorities and operational planning guidance detail actions for supporting local systems and organisations to deliver transformation across the whole of the NHS.

# National People Context

The NHS People Plan focusses on developing a culture of inclusion and belonging as well as action on growing the workforce, training our people and working together differently for the benefit of patients and service users.

The NHS People Plan sets out the actions for employers, systems, NHS England and NHS Improvement (NHSE/I) and Health Education England (HEE) for 2020-21. These priorities have been updated in the NHSE/I 2021-22 priorities and operational planning guidance issued on 25th March 2021.

Following an independent review into leadership across health and social care, led by General Sir Gordon Messenger More, Leadership for a Collaborative and inclusive Future was published in June 2022. All 7 recommendations in the report have been accepted by the government and an implementation plan will follow. recently (June 2022). The 7 recommendations focus on; collaborative leadership and organisation values, positive equality, diversity and inclusion (ED&I) action, management standards delivered through accredited training, simplified appraisal system, career and talent management, recruitment and development for Non Executive Directors (NEDs) and encouraging top talent into challenged parts of the NHS.




The themes and words that make up the People Promise have come from those who work in the NHS. People in different healthcare roles and organisations have made it clear what matters most to them, and what would make the greatest difference in improving their experience in the workplace. This is what we should all be able to say about working in the NHS, by 2024.

The annual NHS Staff Survey has been redesigned to align with Our People Promise.

The Staff Survey is our principal way to measure progress in delivering against our People Strategy will enable teams and departments, as well as the whole organisation, to see progress and take action to improve.

# NCL Workforce Programme

Our North Central London Integrated Care System vision for workforce is for our community to receive high quality health and care services delivered by a representative and diverse workforce, in which people are supported to achieve their full potential in an inclusive and compassionate environment free from racism or other discrimination.

Our **mission** is to support North Central London (NCL) health and social care organisations to:

- **be excellent employers**, developing and supporting the wellbeing of existing staff and attracting new people to live and work in North London
- **plan their workforce and development needs** to deliver new care models in new settings, including in integrated care systems
- **be socially responsible organisations**, using our influence and decision making to best serve the interests of our communities and **reduce inequalities**

The NCL Workforce Programme, comprises several projects and workstreams that are underpinned by the **programme high-impact priorities**:

1. Staff wellbeing and tailored programmes
2. Talent management, progression, and career pathways
3. Local workforce recruitment routes into health and care employment
4. Workforce planning and modelling based on population
5. Working with and across sectors
6. Equality, diversity and inclusion

This is under review with the appointment of the new Chief People Officer

# Strategy impact on NHS People Plan priorities

| NHS Long Term Plan priority | Our People Plan will deliver or contribute to delivery |
|---|---|
| Responding to new challenges and opportunities: continuing to build on and deliver the profound changes already implemented during the Covid-19 pandemic. | ✓ |
| Looking after our people: sets out our People Promise to everyone who works in the NHS and focusses on the actions we take to ensure our people are safe, healthy and well - physically and psychologically - and able to work flexibly. | ✓ |
| Belonging in the NHS: actions to ensure the NHS is inclusive and diverse and creating work places where discrimination, violence and bullying do not occur - this includes recruitment practices, enabling opportunities for health and wellbeing conversations, people confident to speak up, use their voice for improvement, learning and embedding compassionate leadership. | ✓ |
| New Ways of working and delivering care: making use of the skills and experience of our staff, continuing to enable working differently through upskilling and strengthening multi-disciplinary teams, supporting volunteers, expanding routes into careers and supporting staff's learning and development. | ✓ |
| Growing for the future: building renewed interest in health and social care careers and high numbers of applications to education and training through recruitment into entry level roles, return to practice, training places, international recruitment and retaining our people. | ✓ |

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# 3

# Our Mission, Aims and Values

# Our Mission and Our Aims

## Our mission

For 100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and emotional wellbeing. Working with children and families and adults, our approach brings together psychoanalytic, psychodynamic and systemic theory and practice and other approaches and seeks to understand the unconscious as well as conscious aspects of a person's experience and places the person, their relationships and social context at the centre of our practice.

Our creative and skilled staff continue to build on these approaches, welcoming new ideas and developing innovative interventions, services and models of care which respond to contemporary challenges.

Our goal is that more people should have the opportunity to benefit from our approach. We seek to spread our thinking and practice through devising and delivering high quality clinical services, the provision of training and education, research, organisational consulting and influencing public debate.

## Our aims

The Tavistock and Portman will:

- continue to deliver and develop high quality and high impact patient services
- offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors
- develop its presence as a centre of excellence in research
- lead the development and evaluation of new models of care and innovative approaches to addressing systemic issues in the delivery of care and other services
- use its insights and expertise to contribute to the development of national debate and public policy.

# Our Values

## Our values

As an organisation:

- we work with people with lived experience to co-create and improve our services and inform our decision making
- we are caring and compassionate
- we are passionate about the quality of our work and committed to openness, the use of evidence and the application of improvement science
- we value all our staff, are concerned for their wellbeing and seek to foster leadership, innovation and excellence in our workforce
- we embrace diversity in our workforce and work to make our services and training as accessible as possible
- we work with others, in the UK and internationally, who share our values and can enable us to achieve our mission.

# Trust Primary Strategic Drivers for Change

Strategic Review

Staff Morale

Freedom to Speak Up

Equality, Diversity and Inclusion

## Strategic review

- In 2020 the Trust commenced the Strategic Review (SR) to respond to a number of challenges and with the aim of modernising and enabling the organisation to continually improve thus securing the future sustainability of the organisation and its distinctive approach to understanding mental health and wellbeing.
- The SR is the largest change programme the organisation has experienced. Five challenges were identified through the development work which provided the rationale for change
- The outcomes from the SR aim to restructure the organisation creating a consistent and effective management and leadership structure whilst also protecting and enhancing the Trust's important contribution to mental health

## Staff Morale

- The staff survey results have been declining in recent years and the 2021 Staff Survey reported the worst scores in several areas and particularly relating to morale and highlighted the challenges the organisation faces and how our staff are feeling.

## Freedom to Speak Up

- Our staff survey results along with the report from our Freedom to Speak up Guardian have highlighted that the Trust does not have a culture where staff feel empowered to raise concerns nor do they have the faith that concerns will be fairly addressed.

## Equality Diversity and Inclusion

- In 2020 the Trust committed to becoming an anti-racist organisation and in April 2021 commissioned the Colour Brave Avengers to carry out an external review of the experiences of Black, Asian and Minority Ethnic (BAME) staff in the Trust. Their report was presented to the Board of Directors and shared with staff in September.
- The Board signed up to delivering 7 objectives which were identified following the recommendations from the report

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# Strategic Review

# Trust Strategic Review

**The Strategic Review (SR) was launched in 2020** with the aim of **modernising and enabling the organisation to continually improve** thus securing the future **sustainability** of the organisation and its **distinctive approach to understanding mental health and wellbeing**.

This includes our **response to our underlying financial pressures** but, significantly, the creation, for the first time, of **a consistent and effective management and leadership structure** across the organisation which will strengthen our ability to succeed in our mission and ensure effective channels and a better dialogue between the Board and front-line staff.

# Trust Strategic Review

Since the launch there have been some significant developments which strengthen the need for change, in particular to address our underlying financial challenges and strengthen our operational and clinical management.

**SOF3**

The Trust is now subject to a programme of mandated support, reflecting our move from level 1 to level 3 in the System Oversight Framework (SOF). This includes support linked to the aims and actions of the Strategic Review and the Board Governance Review, however there is now an additional level of scrutiny on this programme and the desired outcomes.

**Financial deficit**

The financial challenge faced by the Trust continues. We are budgeting a deficit of £4million for 2022/3 with an underlying problem of £5-7m. This requires us to take clear action to improve our financial performance.

**ICS**

Alongside the financial scrutiny from within the ICS, there is a clear shift to reviewing service provision to ensure there is equity, fairness and transparency of pathways across the system. The main imperative is to ensure services are fit for purpose across the wider footprint, and therefore the Trust position of providing quality services within our patch for which we hold a waiting list or are only provided in specific geographies may face significant scrutiny.

**Relocation**

It is now clear that the opportunity to acquire the Jamestown Road site is no longer affordable. It continues to be the case that staying in the Tavistock Centre does not meet our long-term needs. The longer-term location of services and estate requirements will form part of the SOF3 support provided by NHSEI.

**Staff Survey**

The national NHS Staff Survey results for 2021 were published at the end of March and the Trust results, whilst not surprising, were disappointing and highlight a number of issues, particularly in relation to staff morale. Strengthening effective management across the organisation is a key part of our response.

# Trust Strategic Review

The Trust identified five specific challenges that set the imperatives for the Strategic Review as follows:

1. **A financial challenge** – a number of the Trust's traditional sources of income such as the National Training Contract (NTC) have declined significantly, and the pandemic has had a major impact on our ability to generate additional income through areas such as short courses. At present, this points to a financial gap of an underlying £5-7m if we are to return to meet the requirement to break even

2. **A system challenge** – around us the health and care system is moving rapidly to a more integrated model of provision based on an Integrated Care System (ICS). This means we need to work closely with other providers and ensure our activities are relevant to emerging priorities and needs as care pathways are reviewed across the sector

3. **A diversity challenge** – our work and the shape of our workforce does not reflect the needs of the populations we serve. We need to become more inclusive and improve the experience of patients, students and staff from black, Asian and minority ethnic, and other diverse backgrounds

4. **An operational challenge** – a number of our activities are too fragmented to be operationally viable and in other cases we have struggled to respond to the challenges of operating at greater scale. To address this, we need to have consistent and more sustainable management structures to ensure we can consistently deliver the requirements of commissioners and regulators

5. **A data and impact challenge** – we are not always able to evidence, internally and externally, the impact of our activities and the distinctive value of our specialist work

# Rationale for Change

Focusing on the challenges facing the organisation we have identified through the Strategic Review a clear rationale for change. At the essence of this is a belief that to remain sustainable and relevant the Trust must:

- Develop a **greater focus on people in the organisation** with a clearer and more **effective leadership and management structure and culture** which can both better support staff and deliver organisational objectives and meet regulatory and other external requirements
- As part of this, become **better at operational management** with greater **valuing of the skills** of how we organise and deliver programmes of work which complement the skills and work of individual clinicians and educators
- Put **equality, diversity and inclusion at the heart of our decision making**, including the commitment to achieve our ambition of becoming an **anti-racist organisation**.
- Grow alongside this a stronger culture of **organisational and individual performance management and assurance**, driven by data, focused on improving outcomes for patients and students and the value our services offer commissioners and beneficiaries
- Improve our systems and management of time so we can **increase productivity** while not neglecting the **development and support of our staff**
- Put in place **corporate services** which are good enough to **support our work** and help to meet regulatory and other external requirements
- Be **outward looking** in our approach and connect our services to better **support our partners in the ICS and beyond**

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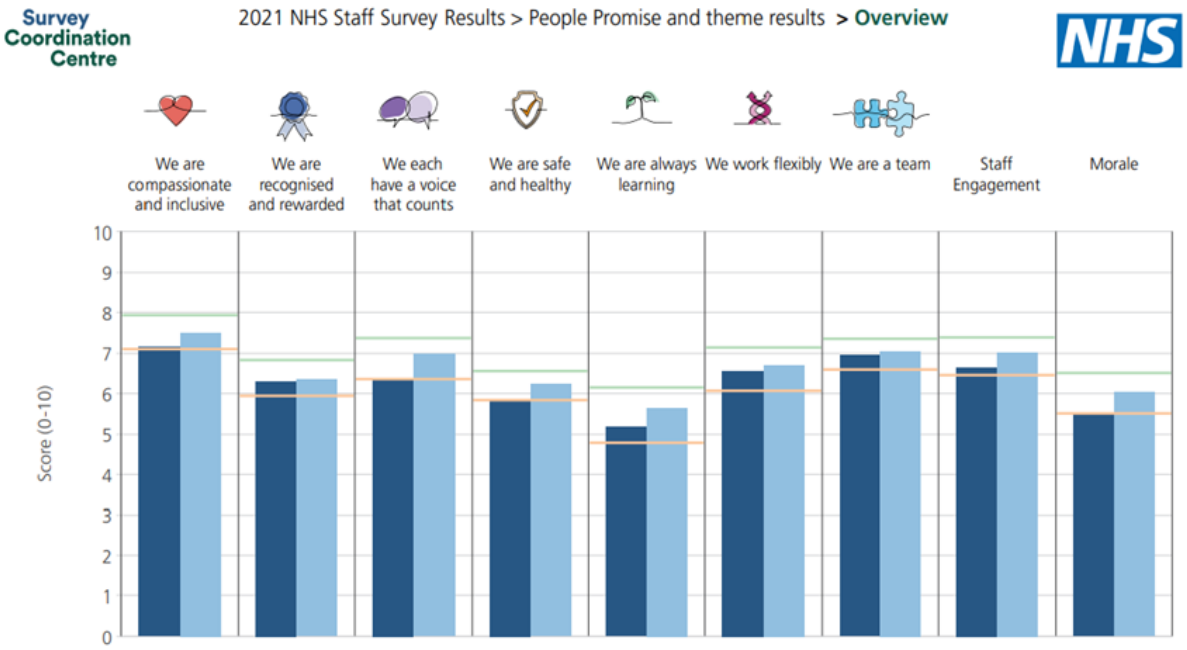
# 5

## Staff Morale

# Staff Survey Results

The staff survey results have been declining over the past few years. The 2021 results further highlight the low morale and poor experience of our staff. Below is the summary overview of the 2021 results as compared to our benchmark group. Staff experience at Tavistock and Portman is below average for all nine themes.




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Best | 7.9 | 6.8 | 7.4 | 6.6 | 6.1 | 7.1 | 7.4 | 7.4 | 6.5 |
| Your org | 7.2 | 6.3 | 6.4 | 5.9 | 5.2 | 6.6 | 6.9 | 6.6 | 5.5 |
| Average | 7.5 | 6.3 | 7.0 | 6.2 | 5.6 | 6.7 | 7.1 | 7.0 | 6.0 |
| Worst | 7.1 | 5.9 | 6.4 | 5.8 | 4.8 | 6.1 | 6.6 | 6.5 | 5.5 |
| Responses | 411 | 419 | 408 | 411 | 397 | 416 | 414 | 420 | 419 |

# Staff Survey Results

**The areas with the greatest decline and agreed by the Board as the key areas for targeted action are as follows:**

**Compassionate & Inclusive (equality, diversity and inclusion)**

Staff reported that they do not feel we act fairly with regard to career progression regardless of ethnic background. Staff also reported an increase in their experience of discrimination at work from a manager/team leader or other colleagues. The organisation received the lowest score nationwide for respecting individual differences.

**We are safe and healthy (Supplies, materials, resources and equipment to do the job)**

There was a significant decline in staff reporting that they have adequate materials, supplies and equipment to do their work. Additionally, staff reported that they do not feel there are enough staff to do their job properly.

**We each have a voice that counts (speaking up and psychological safety and service improvement and quality development)**

There has been a decline in staff feeling secure about raising concerns about unsafe clinical practice since 2018. There is also a lack of belief amongst staff that the organisation would address their concerns. This has been declining since 2017. The organisation scored the lowest nationally for staff feeling confident that the organisation would address their concerns.

Staff feeling as though they are involved in the work they do and the changes that happen in their department or team has been declining since 2019. However, staff reported a significantly lower experience of being able to make suggestions to improve the work of their team and feeling involved in the changes that are introduced. Staff also felt that they were not able to make improvements happen in their area of work.

**Appraisal (appraisal and development planning)**

Staff reported that although the majority of staff had an appraisal the content of the appraisals was not helping them to improve how they do their job. There were significant drops in satisfaction from staff regarding if they'd had clear objectives set for them and if they had felt valued by the organisation.

**We are always learning (training and development)**

Although staff report that they find the work they do challenging they do not feel that there are opportunities to develop their career in this organisation nor do they have the opportunity to improve their knowledge and skills

**We are a team (team working and functioning)**

Staff reported that the teams they are in have little freedom as to how they do their work. Teams do not feel they have a set of shared objectives and are not able to meet to discuss their effectiveness. The organisation scored the lowest in relation to teams working well together to achieve their objectives. The staff have cleared highlighted the separation in the cohesion of the services at the Trust.

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# 6

## Freedom to Speak Up

# Freedom to Speak Up

Up

The National Guardians office has the aim to make speaking up business as usual in healthcare. Making speaking up business as usual will enhance the working life of the healthcare workforce and improve the quality and safety of care.

Our guardians report into Freedom to Speak Up evidences that the organisation has not yet achieved this objective and highlights the concerns staff in our organisation have both about raising concerns and having confidence that concerns will be handled effectively by management and the leaders in the organization.

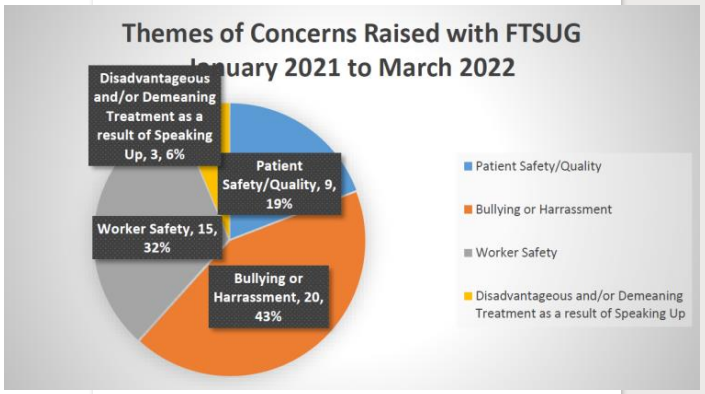
The numbers of cases brought to the Guardian have slightly risen the Trust and the Guardians report indicates that there is a consistent message of enthusiasm and support expressed by senior leaders across the organisation when discussing speaking up and other key initiatives related to staff wellbeing, Trust culture, EDI, and the race action plan.

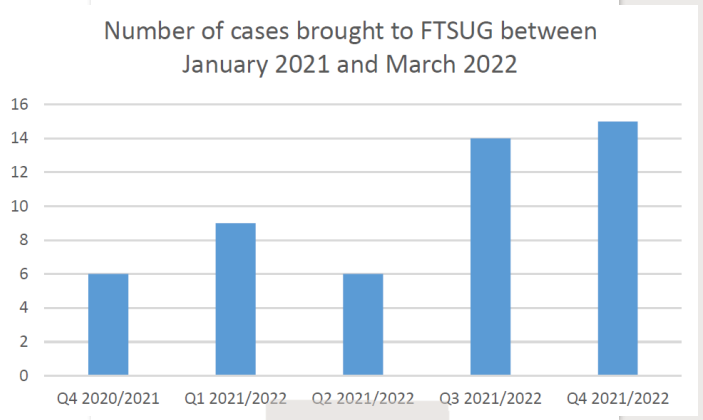
However, cases show that concerns are being raised through the Guardian that relate to effective management and in some cases with regards to bullying and harassment within management relationships. These are being escalated through to the Guardian rather than being effectively resolved through management channels or where not possible through mediation.

The staff survey results further evidences a significant lack of distrust in how the organisation handles concerns.

Cultural change is required to address these issues and improve the working environment for staff. Key priorities are as follows:

- Ensure there is adequate financial resource for the Speaking Up Project Plan.
- Ensure there is ring-fenced time within an HR/People Management colleague's job plan in order to rapidly and effectively progress speaking up initiatives in collaboration with FTSUG and other key colleagues.
- Prioritise interim training for all managers and senior leaders given the severity of the current situation.
- Commission and deliver leadership and management programme
- Ensure adequate access to mediation



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# 7

# Equality, Diversity and Inclusion

# Equality, Diversity and Inclusion

- In 2020 the Trust committed to becoming an anti-racist organisation and April 2021 the Trust commissioned the Colour Brave Avengers to carry out an external review of the experiences of Black, Asian and Minority Ethnic (BAME) staff in the Trust. Their report was presented to the Board of Directors in September 2021.
- Like many other NHS organisations, the Trust has a long way to go to become a fully diverse and inclusive organisation in respect of race. Specifically, we know from the work undertaken by the Colour Brave Avengers, our staff survey and the WRES data that:
- The profile of our organisation, especially at more senior levels, does not reflect the population we serve
- While WRES data shows some improvement in the ratio of BAME staff appointed at interview, there is a clear perception amongst BAME staff that they are disadvantaged in opportunities for development and promotion compared to white colleagues.
- A significant number of BAME staff in the Trust feel their ethnicity is a barrier to being themselves at work and too many staff are experiencing microaggressions and other examples of discrimination.
- The Trust's processes for raising concerns and issues are felt not to be helpful with insufficient opportunities to raise issues at early stage and formal processes which have been perceived as heavy handed.
- There is a view that the brand and culture of the trust is insufficiently inclusive
- There needs to be a greater focus on staff and management training so that staff and managers are better able to manage issues
- The recommendations and actions from the Colour Brave Avengers report have been shaped into an action plan. Although this is a stand alone plan, the actions have been incorporated into this strategy and implementation plan. They focus on the following 7 objectives:

1. **Creation** of an **inclusive culture**
2. **Strengthening** of key **governance structures**
3. **Increasing diversity of the workforce** and **career progression of BME staff**
4. **Removing barriers** that compromise **reporting**
5. **Increasing engagement** and **communication**
6. **Effective use** of **EDI data** and **improving race equality**
7. **Embedding responsibility** for **racial equality** at **all levels**

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# 8

# Developing our People Strategy

# Developing our People Strategy and Services

**Our People Strategy outlines our commitment to making the Tavistock and Portman NHS FT  a great and safe place to work and learn and we will do this through an inclusive, compassionate and collaborative culture.  Its vision, aims and objectives are for five years.**

Our people are our greatest asset and are key to maximising future opportunities. They are an essential part of designing and delivering innovation and providing high quality care that meets patients, families, communities and our partners expectations. We will invest in  equipping our people with the skills, knowledge and resources they need to create outstanding teams.

Our culture will support valuing diversity and strengthening inclusion in a way that demonstrates to our staff that they feel listened to and included and we will  prioritise health and wellbeing. We will encourage our people to speak up and we will demonstrate learning and improvement from this.

This initial version of Our People Strategy has been developed to support the Trust in meeting its statutory responsibility to deliver against those priorities outlined in the NHS People Plan and those objectives outlined in the ICS People Plan. **Its purpose and aims are focused on supporting the successful delivery of improvements in line with our strategic review and staff survey. The aim of which is to modernize and enable the organisation to continually improve thus securing the future sustainability of the organisation and its distinctive approach to understanding mental health and wellbeing.**

An early action outlined in the Year 1 implementation plan is to develop a comprehensive communications and engagement plan to ensure key stakeholders and in particular our staff continue to both shape and deliver our plans.

# Developing our People Strategy and Services

**In line with the NHS People Plan and the Future of NHS Human Resources and Organisational Development Report, the People Directorate is responsible for delivering people services that play a critical role in supporting staff across the Trust and in the wider health and care system to improve health outcomes by providing the highest quality of care.**

**It is intended that as a key enabler to the delivery of the Trust People Plan, our People services will be responsible and will focus on the following:**

- Taking a positive and proactive role in prioritising the health and wellbeing of staff and enabling flexible and agile working
- Supporting and developing a culture of compassion, belonging and inclusion where all staff feel safe and confident to express views and raise concerns
- Supporting the development of inclusive and compassionate leadership, outstanding teams, effective performance management and professional development.
- Growing and shaping the workforce so that it meets the needs of all teams and enables people to work differently; focussing on making the best use of technology and digital solutions and attracting, recruiting and retaining talent
- Supporting and developing the staff working in the People Directorate to deliver excellent, innovative services that is evidence based and reflect best practice.

An external review of the Trust People Services will be completed by the end of Q2 2022. The outcome of this review will include a revised operating model in line with national developments and aligned to the NCL ICB requirements, improvement plan for HR systems and processes and a professional and team development plan for people working in the Directorate.

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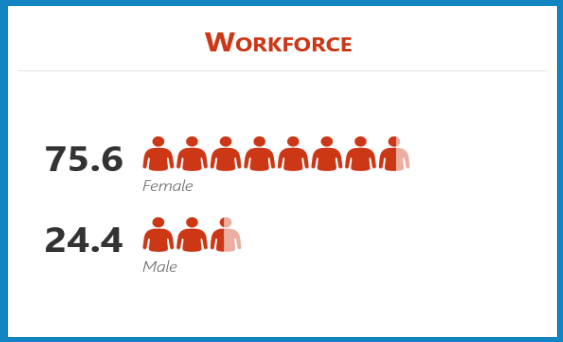
# 9

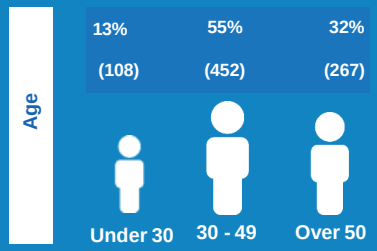
# Workforce Profile

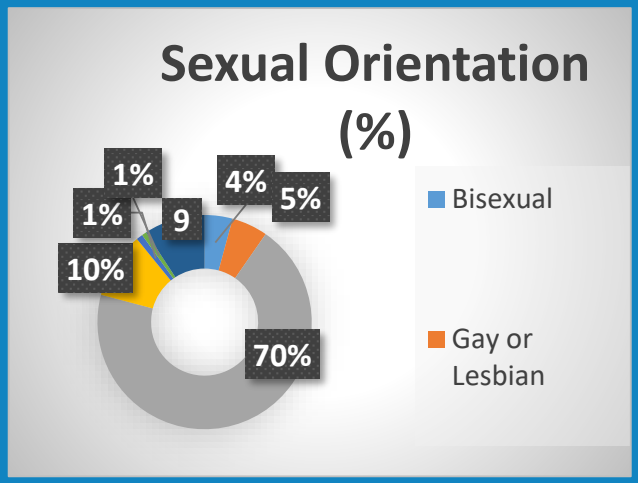
# Workforce Demographics April 2022

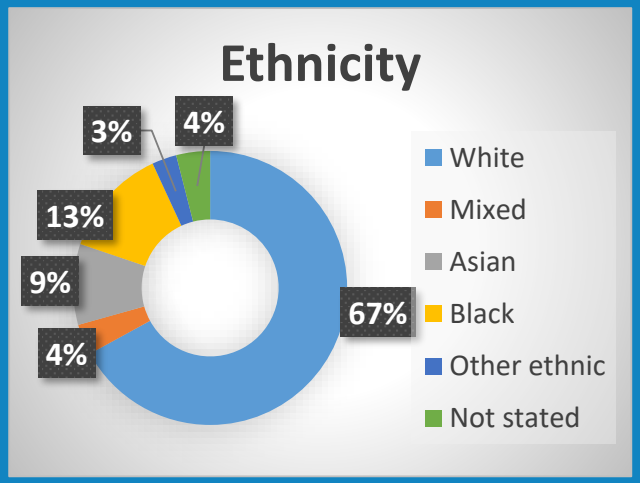
**826** employees

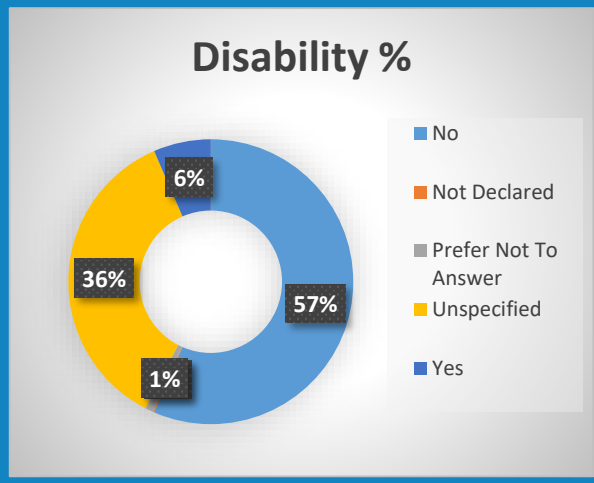
**(685.38 fte)**



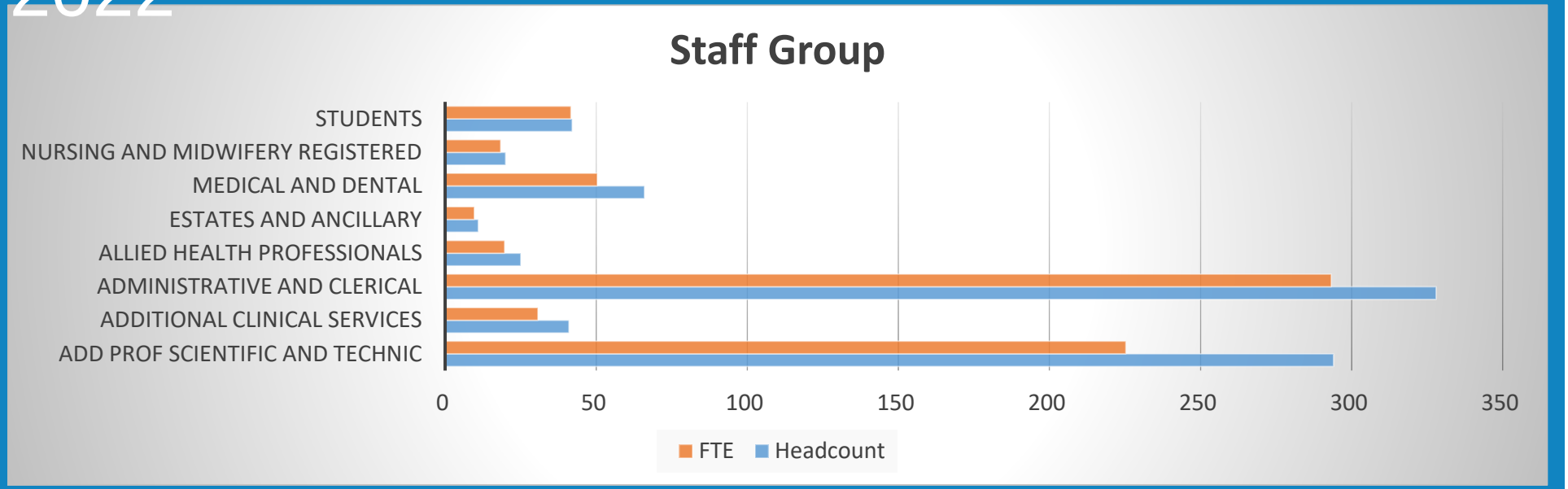



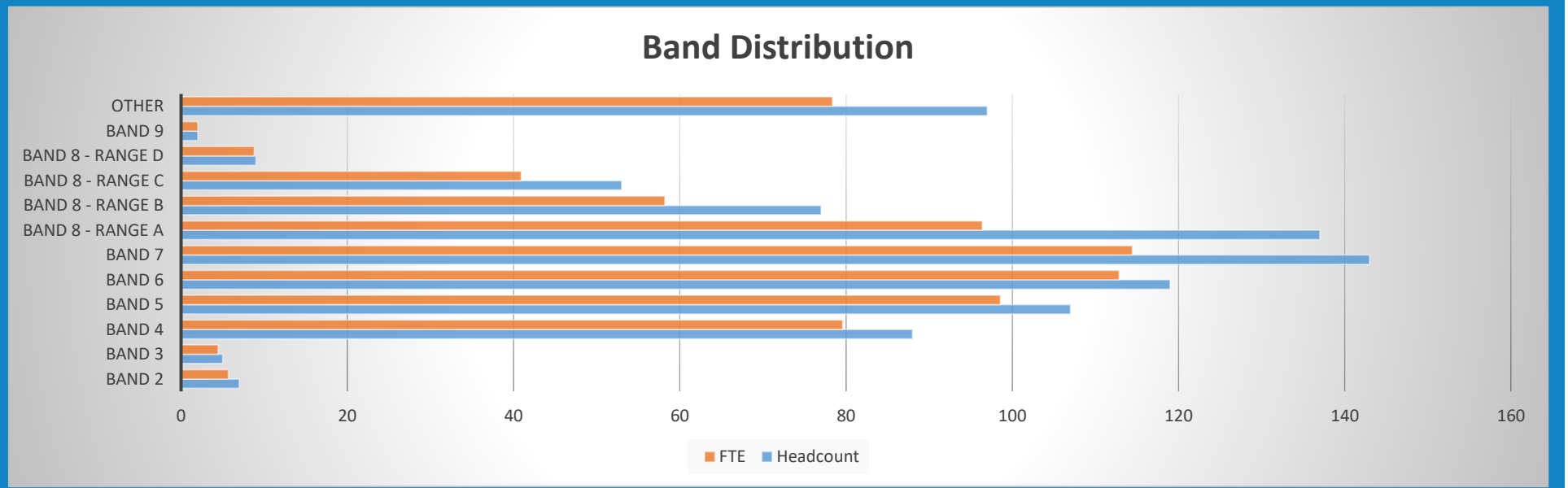



# Workforce Demographics April 2022



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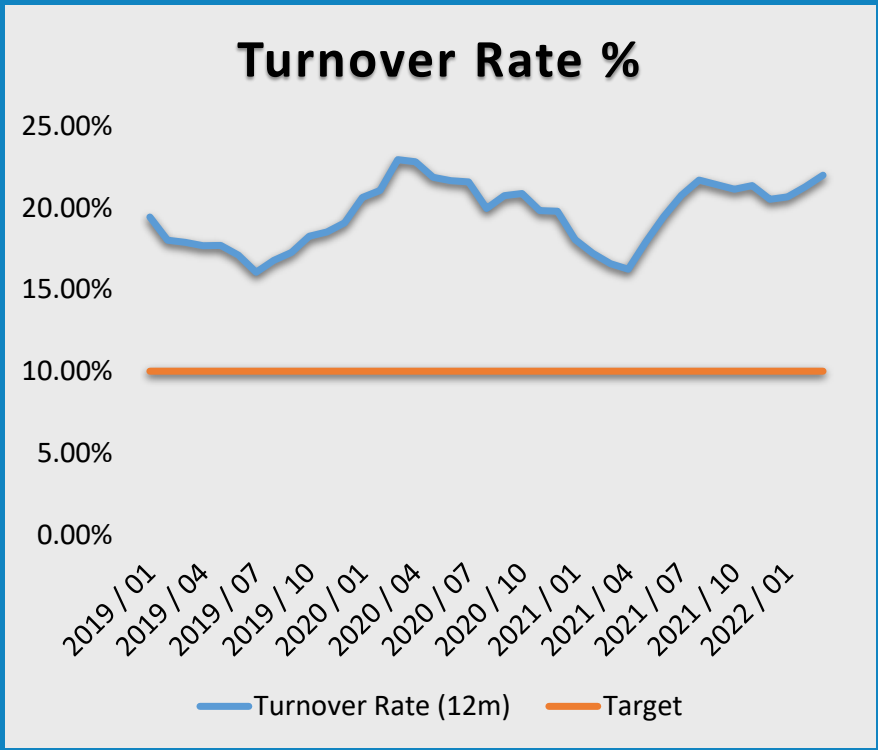
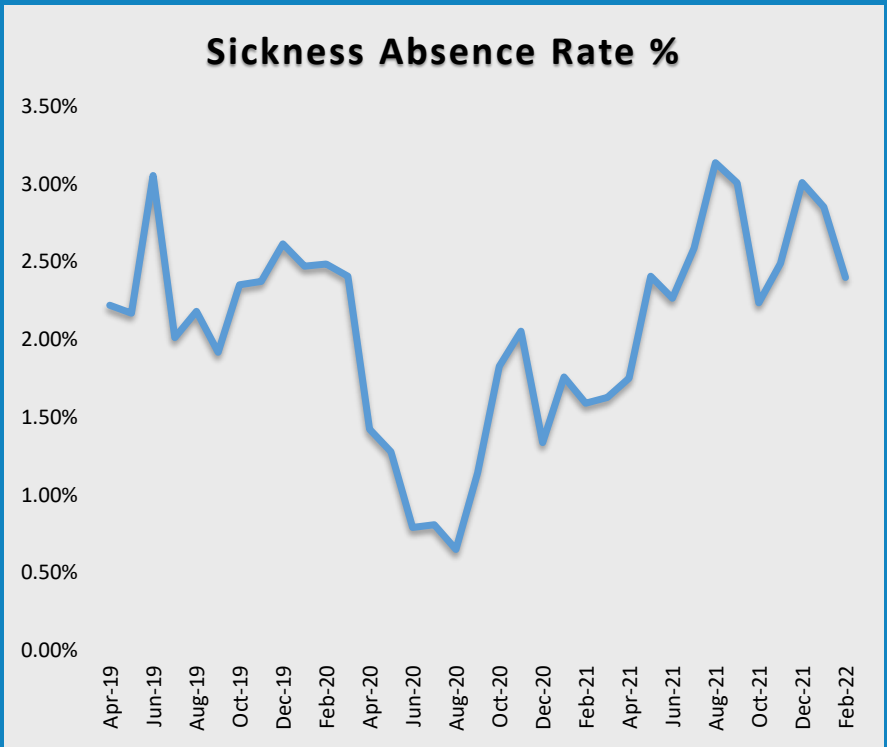
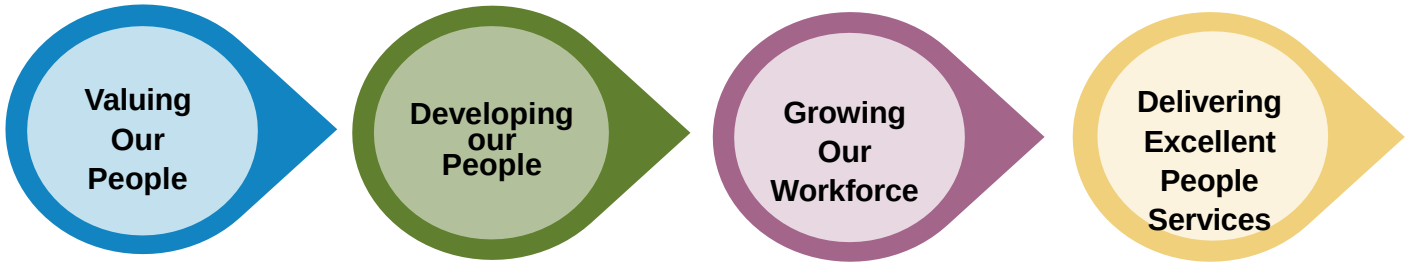


# Our People Plan 2022-2027

**Our People Strategy is a key enabler to modernising the Trust and enabling it to continually improve. It outlines our commitment over the next five years to making Tavistock & Portman a great and safe place to work and learn.** It summaries four interdependent strategic priorities which collectively explain how The Tavistock and Portman will attract, recruit and develop a talented, diverse workforce committed to our vision and values and enabled through excellent people services.

Delivering these priorities over five years will mean our staff survey, WRES and WDES results are among the top performing trusts, we will have ethnic minority representation across all pay bands in line with A Model Employer and we will achieve our performance targets as set out in the Trust Performance framework.




We will ensure our staff are healthy, engaged and able to work flexibly, enabled through an inclusive , compassionate and collaborative culture where all staff feel safe and confident to express their views and feel a sense of belonging

We will be individually accountable for ensuring we are all able to thrive through inclusive compassionate and collaborative leadership, outstanding teams, effective performance management and personal and professional development

We will grow and shape our workforce so that it is responsive to our immediate and future needs through a focus on planning, transformation, recruitment, retention and working collaboratively across the system

We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value.

# Our People Plan- Overview

Our People Plan outlines our commitment over the next five years to making Tavistock & Portman a great and safe place to work and learn; a place whereby working together our staff, patients, their families, community and our partners will experience a culture of inclusivity, compassion and collaboration; a place where we can all thrive and feel proud.

| Priority | Aim | Area of focus | Measuring success (how will we know) |
|---|---|---|---|
| **Valuing our People** | We will ensure our staff are healthy, engaged and able to work flexibly, enabled through an inclusive , compassionate and collaborative culture where all staff feel safe and confident to express their views and feel a sense of belonging | • Creating an open, transparent and learning culture through our values<br>• Effective engagement and communication<br>• Inclusive, diverse and equitable culture<br>• Safe and secure environment<br>• Supporting Health and Wellbeing<br>• Flexible and agile working | • Staff survey and Pulse Surveys<br>• WRES, WDES, Gender Pay Gap<br>• Increase in attendance<br>• Feedback and reporting to F2SU Guardian<br>• Turnover rates<br>• COVID and Flu vaccination rates<br>• Risk Assessments<br>• Reduction in grievance cases<br>• Well-led outcome KLoE 3 and 7<br>• Representation across all pay bands in line with Model Employer |
| **Developing our people** | We will be individually accountable for ensuring we are all able to thrive through inclusive compassionate and collaborative leadership, outstanding teams, effective performance management and personal and professional development | • Inclusive, compassionate and collaborative leadership<br>• Opportunities for people with lived experience<br>• High performing multi-disciplinary teams<br>• Learning, education & professional development<br>• Effective management practice and high quality, values based appraisals | • Mandatory and statutory training compliance<br>• Appraisal compliance and quality<br>• Supervision compliance<br>• Staff survey, WRES, WDES<br>• Participants in and measurable outcomes from leadership, management and improvement programmes<br>• Number of clinical placements and students<br>• Well-Led outcome KLoE 1 and 8 |

# Our People Plan- Overview

Our People Plan outlines our commitment over the next five years to making Tavistock & Portman a great and safe place to work and learn; a place whereby working together our staff, patients, their families, community and our partners will experience a culture of inclusivity, compassion and collaboration; a place where we can all thrive and feel proud.

| Priority | Aim | Area of focuss | Measuring success (how will we know) |
|---|---|---|---|
| **Growing our workforce** | We will grow and shape our workforce so that it is responsive to our immediate and future needs through a focus on planning, transformation, recruitment, retention and working collaboratively across the system | • Attraction, recruitment and retention<br>• Talent, succession and career management<br>• Digital enablement and competency<br>• New ways of working, new roles and role designs that offer flexibility and embed the learning from COVID<br>• Strategic Workforce Plan | • Apprenticeship starts and levy spend<br>• Recruitment plans performing against trajectory<br>• Number of new roles deployed<br>• Improvements in time to fill rates<br>• Reduction in vacancies<br>• Bank and agency spend<br>• WRES, WDES, Gender Pay Gap and Staff Survey<br>• Representation across all pay bands in line with Model Employer |
| **Delivering Excellent People services** | We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value | • Strategic partners with customer service structure and operating model<br>• Professional development enabling delivery of innovative and effective services<br>• Accurate, real-time, intelligent and predictive workforce information<br>• Person centred effective, efficient and innovative workforce systems | • Staff survey scores for those working within the function<br>• External Review and Operating Model in place<br>• Feedback from stakeholders and partners<br>• Benchmarking our practice with national comparators<br>• National recognition for good practice |

# Our People Plan- Alignment

| Tavistock and Portman People Priority | NHS People Plan | NCL People Priorities | Staff Survey | Strategic review |
|---|---|---|---|---|
| **Valuing our People** | • Looking after our people<br>• Belonging in the NHS and addressing inequalities<br><br>Our NHS People Promise: *We are safe and healthy and we are recognised and rewarded & We have a voice that counts, we are compassionate and inclusive and we work flexibly* | • Staff wellbeing and tailored programmes<br>• Equality, Diversity and Inclusion | • We are recognised and rewarded<br>• We are safe and healthy<br>• We are compassionate and inclusive<br>• We have a voice that counts<br>• We work flexibly<br>• Staff Engagement<br>• Morale | • Diversity challenge |
| **Developing our People** | • Belonging in the NHS and addressing inequalities<br>• New ways of working and delivering care<br><br>Our NHS People Promise: *We have a voice that counts and we are compassionate and inclusive & We work flexibly and we are always learning* | • Talent management, progression and career pathways<br>• Equality, Diversity and Inclusion | • We are always learning<br>• We have a voice that counts<br>• We work flexibly<br>• We are compassionate and inclusive | • System challenge<br>• Diversity challenge<br>• Financial challenge |
| **Growing our Workforce** | • Growing for the future<br><br>Our NHS People Promise: *We are a Team* | • Local workforce recruitment routes into healthcare employment<br>• Workforce planning and modelling based on population | • We are a team<br>• We are always learning<br>• We are recognised and rewarded | • System challenge<br>• Data and impact challenge |
| **Delivering excellent people services** | • New Ways of Working and delivering care<br><br>Our NHS People Promise: *We are always learning and we are a team* | • Working with and across sectors | • Staff Engagement<br>• Morale<br>• We are always learning<br>• We are compassionate and inclusive | • Operational challenge<br>• Data and impact challenge |


# Strategic Priority One

## Key Objectives

- We will create an **open, transparent and learning culture** where we all act consistently with our values
- We will have an **engaged workforce** where staff feel connected to and able to shape the way things get done
- We will have **inclusive and diverse culture** where equal opportunities are available for all without discrimination
- We will create a **safe** and secure **environment,** where staff are safeguarded against abuse, aggression and violence
- We will ensure we take action to keep staff **healthy** and well both **physically** and **psychologically.**

## What does success look like?

### How will it feel?

- Staff are and believe others are living our values and behaviours (staff survey, WRES, WDES and pulse checks; employee relations cases)
- Staff say they are able to shape decisions and are supported to implement new ideas (staff survey and pulse checks)
- Staff feel confident that they can raise concerns and that they will be listened to and acted upon (F2SU feedback and reporting and Staff Survey)
- Staff will feel supported to work more flexibly and tell us that our approach is fair and equitable (ER cases, staff survey, workforce demographics)
- Staff tell us that they feel more resilient and that their health and well being is our priority (Staff survey and pulse checks)
- Staff feel supported by their managers (staff survey and pulse checks; employee relations (ER) cases)

### How will we know?

- Fewer staff become unwell (sickness rates)
- Staff recommend Tavistock and Portman as a place to work and receive care and/or study (staff survey and pulse checks)
- Fewer staff will intend to leave or leave the Trust due to poor experience (turnover and exit interviews)
- No staff report having experienced discrimination, violence, harassment or bullying (staff survey, pause checks, ER cases, F2SU reporting)


# Strategic Priority Two

## Key Objectives

- We will strengthen **inclusive, compassionate and collaborative leadership** for **continually improving** and **high-quality care**
- We will become a more **inclusive education provider** with more proportionate numbers of students from minoritised backgrounds enrolled and **close the Award Gap for Black, Asian and Minority Ethnic and Disabled students**.
- We will enable access **to high quality training** and **CPD** that ensures safe and high-quality services of the future
- We support staff to perform at their best through **effective management**, **high quality appraisals** and **regular feedback**.

## What does success look like?

### How will it feel?

- Through a high quality at least once a year appraisal, all staff are clear about their contribution to our vision, values and strategy and feel that their role makes a difference to our service users (Staff Survey, Quality Audit)
- Staff feel supported and valued by their managers and have equal access to and opportunity for development (WRES, WDES and Staff Survey)
- Staff feel our leaders are inspirational, compassionate and lead the development of outstanding teams (Staff Survey)
- Staff feel they have access to supportive supervision that supports wellbeing, job satisfaction and retention ( Compliance and Quality Audit)
- Staff are encouraged and feel able to work collaboratively across the health and social care system (collaborative partnerships, networks and shared services).

### How will be know?

- Fewer staff will intend to leave or leave the Trust due to lack of development or opportunity (turnover and exit interviews)
- Increased ethnic minority representation across all pay bands in line with Model Employer (workforce demographics, WRES)
- Appraisal compliance will meet Trust targets (compliance and staff survey)
- Staff supervision reporting and compliance in line with Trust targets (compliance rates)
- All staff will have completed their mandatory training (compliance rates)
- Participants in and measurable outcomes from leadership, management and improvement programmes (attendance, evaluation and staff survey results)

Growing our Workforce

# Strategic Priority Three

## Key Objectives

- We will **attract and recruit** across all roles and professions to address current challenges, meets future demands and ensure we make the most of the skills and energy of our wider workforce
- We will embed **talent and succession management** that improves career development and increases diversity of our senior leadership
- We will **develop new ways of working, new roles and role designs that offer flexibility,** make the greatest use of people's skills and experience, **release time** and **increase productivity** and **improve job satisfaction**
- We will develop **competency-based workforce modelling** and planning, which allows us to predict our future workforce needs, is fully aligned to operational and financial planning and shapes integrated workforce planning and education commissioning and funding across ICBs.

## What does success look like?

### How will it feel?

- Staff will feel confident and able to develop their skills and implement new ways of working (staff survey and pulse checks)
- Staff will feel they have enough resources (people) to enable them to do their jobs and deliver high quality and safe care (staff survey)
- Staff feel that there are equal opportunities for career development and progression (WRES, WDES, Gender Pay Gap, and Staff Survey)

### How will we know?

- There will be fewer vacancies, fewer staff leaving the Trust and less reliance on bank and agency staff (recruit to fill rates, vacancies, turnover rates and agency spend)
- Workforce and senior leadership will be representative of our diverse communities in line with model employer goals
- More new roles will be introduced across the Trust to create more opportunities for career progression and improved skill mix (workforce demographics)

Delivering Excellent People Services

# Strategic Priority Four

## Key Objectives

- We will create a thriving People function and **upskill managers in people management capabilities**
- We will strengthen the service as strategic partners who are responsive and deliver value
- We will provide access to professional development that enables the delivery of **innovative and effective services**
- We will ensure **workforce information** is **accurate, real-time, intelligent and predicative**
- We will be proactive in the adoption of **person centred effective, efficient** and **innovative workforce systems**, processes and digital technologies.
- We will invest in **Organisational development and our Learning & Development function** to enable our workforce to develop their skills and expertise

## What does success look like?

### How will it feel?

- Those working within the People team will feel confident and able to deliver a high-quality service (staff survey and pulse checks)
- More staff will say that they receive effective strategic and expert advice and guidance across the whole organisation and employee lifecycle (revised operating model and customer feedback)
- Staff feel a just and learning approach is applied across the delivery of people services, policies and procedures (reduction in formal ER cases, up to date policies and procedures)
- Effective and efficient delivery of employee transactional ICS shared services (SLA and performance reports)

### How will we know?

- Staff will report positive experience as measured by the staff survey
- A new operating model codesigned with stakeholders (People service Review and Development Plan)
- We will be compliant against our statutory reporting requirements (statutory reporting in line with national timelines and targets)
- We will benchmark our use of digital technology and data analytics with national comparators
- More staff will report fair and equal outcomes across the employee lifecycle (reduction in ER cases, payroll errors and overpayments)
- Accurate and predicative workforce performance and information reports

The Tavistock and Portman
NHS Foundation Trust

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# Action Plan

# Delivering Our People Strategy

This Strategy applies to all staff, trainees and students and will underpin and inform the strategic decisions on workforce across the Trust. The following implementation plan sets out the actions we will complete in Year 1 and our high level actions for year 2.

The implementation plan will be further developed as part of the communications and engagement plan that will be developed in Q2 2022-23. The Communications and Engagement Plan will also include engagement with the development of the Trust's ED&I strategy. All actions will the be included in the revised BAF and objectives for EMT.

Our People Strategy is an key enabling strategy to delivering against

The following plan incorporates the primary activities outlined on the Race Equality Plan presented to the POD&EDI Committee on the 14th March 2022.

## The Strategy has three phases of delivery

- In year one we will aim to address the current challenges, strengthen and build a solid foundation.
- In years two and three we will ensure the way we do things demonstrates best practice and improvement in outcomes
- In year four and five we will be leading the way in innovative practice and culture change. We will be setting a standard for other Trusts to follow.

# Measuring our success

The following implementation plan sets out the actions we will complete in Year 1 and our high level actions for year 2.

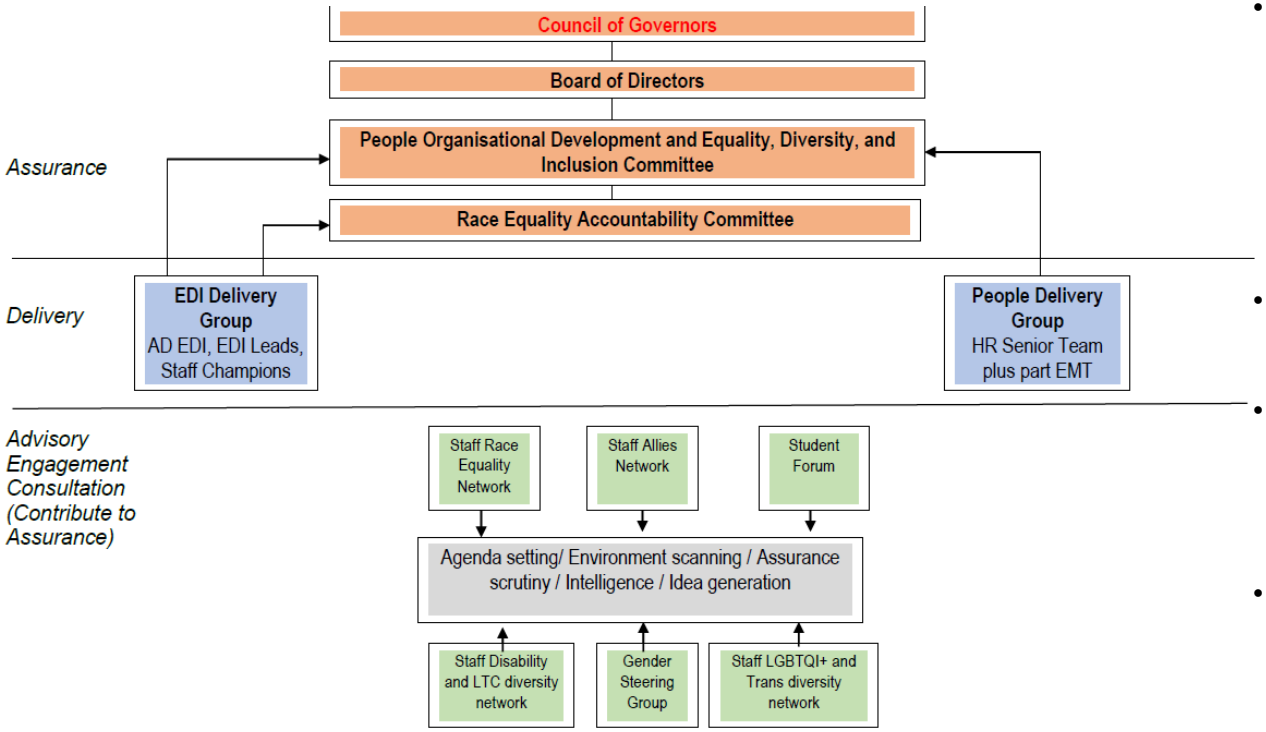
The success measures outlined in the implementation plan are for the first year only and will support the Trust in establishing a clear benchmark from which to measure and seek assurance on performance and reducing risk around people matters ie 'Setting the Standard'.

A year one outcome will be to have an agreed set of workforce performance metrics, targets and improvement trajectories that are regularly reported to the Board. Our performance framework will reflect our ambitions set out below.

It is expected that by the end of Year 3, the Trust will be meeting its targets and will be benchmarking at least average or wherever possible above average against its benchmark group ie 'Delivering Best Practice'

By the end of year 5, it is intended that the Trust is consistently meeting its targets and where possible exceeding these.
ie 'Achieving Excellence'

# Governance and Accountability




- This is Trust wide enabling strategy and therefore ownership for its priorities and actions is distributed across the who Executive Team and will be reflected in the BAF and Executive Director personal Objectives.
- However, the CPO is the Lead Executive for the strategy
- Monitoring of delivery and performance against the People Strategy and Plan will sit with the POD&ED&I Group.
- Oversight for the operational delivery and performance of the strategy and plan will sit with the ED&I Accountability Group (for ED&I) and the People Delivery Group


## Strategic Priority One

We will ensure our staff are healthy, engaged and able to work flexibly, enabled through an open and inclusive culture where all staff feel safe and confident to express their views

| Key Objective | Actions 2022-23 | Longer Term | Success Measures (Year1) |
|---|---|---|---|
| Creating an open, transparent and learning culture where we all act consistently with our values | Aligned to the NHS Culture and Leadership Programme, the Trusts Race Equality and Inclusion commitment and strategic direction following the Strategic Review define the desired culture for T&P<br><br>Ratification and implementation of new Freedom to Speak Policy in line with national guidance and race equality action plan<br><br>Deliver training in 'Freedom to speak up' for all staff members involved in management, supervision, or leadership. This would include training on effective policy usage with information on supportive escalation structures for difficult situations included.<br><br>Harmonise the terms and conditions across the Tavistock and Portman, consolidating all salaries onto nationally agreed pay frameworks.<br><br>Develop Just and Restorative Culture framework for the Trust and review HR policies against it. | Review Trust Values in line with Trust Strategy Refresh<br><br>Review and evaluate Just and restorative culture programme implementing learning and further actions. | Culture clearly defined and communicated<br><br>Reduction in staff entering formal grievance and disciplinary processes<br><br>Reduced staff turnover<br><br>Improved outcomes of the staff survey results specifically relating to raising concerns |

| Key Objective | Actions 2022-23 | Longer Term actions | Success Measures (Year1) |
|---|---|---|---|
| An engaged workforce where staff feel connected to and able to shape the way things get done. | Deliver and evaluate 2021-22 Staff Survey action plan<br><br>Implement and Review quarterly pulse check reports<br><br>Induction redesign including both Trust and local induction including staff handbook<br><br>Maintain strong effective partnership working with Joint Staff Committee colleagues through on-going, honest and constructive dialogue and open sharing of information and constructive feedback to support consultation and decision making. To include a review of staff side partnership and negotiating arrangements.<br><br>Establish and support the staff networks BME, LGBTQI+ and Disability networks<br><br>Co-produce and deliver a Communications and Engagement programme to improve engagement | Gather and share emerging best practice and lessons learned to embed better engagement and shape new models of practice<br><br>Review outcomes of staff survey, SFFT and , WRES and WDES data and revise action plans and practice models | Improved staff survey specifically relating to staff engagement and morale<br><br>All new starters complete a corporate induction |


## Strategic Priority One

We will ensure our staff are healthy, engaged and able to work flexibly, enabled through an open and inclusive culture where all staff feel safe and confident to express their views

| Key Objective | Actions 2022-23 | Longer Term actions | Success Measures (Year 1) |
|---|---|---|---|
| An inclusive and diverse culture where equal opportunities are available for all without discrimination | Co-design and approve a Trust ED&I Strategy<br><br>Implement and deliver the WRES and WDES action plans and ensure Trust meets EDS2 Goals<br><br>Publish progress against the Model Employer goals to increase representation in leadership.<br><br>Review Employee Relations processes against Fair Experience for All and in line with the principles of Just and Restorative cultures to reduce the ethnicity and other protected characteristics gap when entering a formal disciplinary process.<br><br>Implement priorities identified in the Race Equality independent reviews<br><br>EDI Accountability Group, Staff Networks, EDI Champions and Reps to identify areas requiring improvement and 'dig under' the behaviours that cause differentials in experience and drive culture change to continue to move to a compassionate and inclusive culture.<br><br>Review of infrastructure supporting networks based on national best practice from NHS and other organisations<br><br>Rollout local level training and discussions about Micro-aggressions putting a formal plan/approach in place by October 2022 - liaising with stakeholders to prioritise teams.<br><br>Rollout and evaluate of Allyship and Cultural Intelligence programme trustwide | Review impact of interventions and approaches from Year 1 and complete the PDSA cycle to build on the work for Year 2 | Reduction in staff with protected characteristics entering formal grievance and disciplinary processes<br><br>Improvements in WRES and WDES results<br><br>Increase in workforce representation in line with national targets |


## Strategic Priority One

We will ensure our staff are healthy, engaged and able to work flexibly, enabled through an open and inclusive culture where all staff feel safe and confident to express their views

| Key Objective | Action 2022-23 | Longer Term actions | Success Measures (Year 1) |
|---|---|---|---|
| Positive action to support the health and wellbeing of staff | Trust H&WB Guardian in place<br><br>Transfer of Occupational Health Services to NCL Shared Services<br><br>Health and Wellbeing conversations embedded in induction and appraisal processes<br><br>Enable those in sedentary roles to access physical activity during the course of their working days<br><br>Review attendance management policy and practices to ensure staff are supported when they go off sick and return to work.<br><br>Ensure people working from home can do safely and have support to do so, including having the equipment they need.<br><br>Support staff to use other modes of transport and identify a cycle-to-work lead.<br><br>Review Corporate and Local Induction to embed Trust vision and values, incorporating a health and wellbeing induction and flexible | Review support for carers and roll out the new working carers passport to support staff with caring responsibilities<br><br>Evaluate and review opportunities to improve H&WB including the uptake of new practice models led by local and national evidence based practice and initiatives.<br><br>Expand mediation and coaching services and access to resilience training to support staff H&WB and staff with mental health issues.<br><br>Establish H&WB Steering Group to lead on the delivery and evaluation of action plan. | Increase in attendance<br><br>Referrals into EAP<br><br>Improvement in Staff survey results specifically related to H&WB)<br><br>COVID risk assessments<br><br>Flu and Covid Vaccination Targets met<br><br>No disruption in OH service following transfer |


## Strategic Priority Two

We will be individually accountable for ensuring we are all able to thrive through inclusive, compassionate and collaborative leadership, outstanding teams, effective performance management and personal and professional development

| Key Objective | Actions 2022-23 | Longer Term Actions | Success Measures (Year1) |
|---|---|---|---|
| Strengthen inclusive, compassionate and collaborative leadership for continually improving and high-quality care and education and training | Deliver actions to meet CQC Well Led requirements and specifically relating to KLOE 1 Leadership, Capacity and Capability<br><br>Identify and introduce opportunities to increase access to leadership development of underrepresented staff groups<br><br>Co-produce, design and implement a leadership and management development programme to embed outcomes from the strategic review and cultural and ED&I objectives (aligned to NHS Culture and Leadership Framework)<br><br>Extend participation in the NHSE Allies training to all Board and EMT<br><br>Establish an Inclusion and Race Equality themed all staff engagement and development session – to be held at least once a year<br><br>Strengthen governance structures in line with Race Equality review recommendations and including publishing Trusts Race Equality Statement, ensure authorisation of Race Equality Assurance Group and distribute responsibility for ED&I across departments | Monitor access and evaluate impact of leadership and management development to inform the introduction and commissioning of new offers | Participants in leadership, management and improvement programmes<br><br>Board and EMT attendance in Allies training<br><br>Diversity of participants on development programmes<br><br>Leadership and Management Development evaluation |


## Strategic Priority Two

We will be individually accountable for ensuring we are all able to thrive through inclusive, compassionate and collaborative leadership, outstanding teams, effective performance management and personal and professional development

| Key Objective | Action 2022-23 | Longer Term Actions | Success Measures (Year 1) |
|---|---|---|---|
| Access to high quality education, training and CPD that ensures safe and high quality services | Develop and implement an open, transparent centralised CPD approvals process<br><br>Expand access to CPD, supportive supervision and ensure protected time for learning and development<br><br>Deliver an accessible and relevant Mandatory Training Programme that matches best practice and ensures compliance meets Trust Target. Include Management training for new managers in the framework.<br><br>Complete Mandatory Training audit to seek assurance on compliance and in line with race equality action plan. | Maximise the benefits of national funding in increases in education and training posts eg clinical psychology, child and adolescent psychotherapy, psychiatry | Mandatory and statutory training compliance<br><br>All new managers complete management training<br><br>CPD Approval process in place<br><br>Supervision compliance |
| **Key Objective** | **Actions 2022-23** | **Longer Term Actions** | **Success Measures (Year 1)** |
| Supporting staff to perform at their best through effective management, high quality appraisals and regular feedback | Evaluate and review the appraisal process to improve the forms, the conversations that managers are having and ensuring they are aligned to the strategic aims of the organisation.<br><br>Deliver appraisal training to managers to ensure they can have effective conversations with their staff | Roll out quality of appraisal audit implementing actions for improvement<br><br>Explore options for a digital appraisal process that improves quality, enables Trust training needs analysis and learning and development plans. | Appraisal compliance and quality<br><br>Improvements in Staff survey specifically relating to appraisal |


## Strategic Priority Three

We will grow and shape our workforce so that it is responsive to our immediate and future needs through a focus on planning, transformation, recruitment, retention and working collaboratively across the system

| Key Objective | Actions 2022-23 | Longer Term Actions | Success Measures (Year 1) |
|---|---|---|---|
| Attraction and recruitment that addresses current challenges and meets future demands | Complete assessment to better understand the challenges to attracting and recruiting substantively to vacancy hotspots e.g. GIDS<br><br>Review resourcing and recruitment model and processes to improve time to fill rates, functionality and benefits of TRAC in collaboration with the recruitment shared services<br><br>Pilot and evaluate inclusive and values based best practice to ensure selection processes are more equitable and new starters are recruited to Trust values and in line with the NHSE 'De Bias' Recruitment procedures<br><br>Develop a system of Retention interviews of all new starters within 1st year of service and routinely co-ordinate exit interviews for all leavers | Coproduce and test an on- boarding process aligned with the implementation of the national roll out of a digital passport<br><br>Expand and monitor the effectiveness of attraction and recruitment campaigns<br><br>Scope retention initiatives and implement expanded and enhanced NHSE/I retention programme | Reduction in vacancies<br><br>Reduction in turnover in areas where turnover is above the Trust target<br><br>Improvement in Time to fill rates<br><br>Candidate satisfaction during the recruitment process<br><br>Short and medium term recruitment targets and achievement against trajectories.<br><br>Exit interview process and reporting in place |


## Strategic Priority Three

We will grow and shape our workforce so that it is responsive to our immediate and future needs through a focus on planning, transformation, recruitment, retention and working collaboratively across the system

| Key Objective | Actions 2022-23 | Longer Term Actions | Success Measures (Year 1) |
|---|---|---|---|
| Talent and succession management that improves career development and increases diversity of senior leaders | Implement recommendations from Board skills mix review to support future Non-Executive recruitments and any further development requirements<br><br>Commence data collection on gaps in inclusive career progression and talent Management trustwide and agree timetable for action with Services<br><br>Review of career pathways and training and development for Bands 2 – 5 | Design, test and evaluate a talent management and succession planning process<br><br>Roll out talent and succession planning process to those in formal leadership roles and for those staff groups underrepresented in leadership roles.<br><br>In partnership with the ICS and in line with WRES and WDES plans embed an 'end to end' approach for developing representative workforce at all levels equipped with the skills and knowledge to advance health and in particular mental health equalities | Succession plan in place for Executive and Non Executive Directors<br><br>Representation in Leadership roles in line with national targets<br><br>Improvements in staff survey, WRES and WDES results specifically relating to equal opportunities |
| **Key Objective** | **Actions 2022-23** | **Longer Term Actions** | **Success Measures (Year 1)** |
| Workforce planning, which predicts our future workforce needs, aligned to operational and financial planning and shapes integrated workforce planning across the ICS. | Embed the new establishment following the Strategic review<br><br>Follow the HEE STAR methodology for workforce planning<br><br>Implement actions following ESR audit ensuring ESR provides up to date and accurate workforce data<br><br>Review and strengthen an Establishment and staff control process and oversight group<br><br>Report in line with ICS and OfS requirements operating and workforce plans | Implement e-rostering and introduce a job planning system and supportive infrastructure<br><br>Develop predictive workforce modelling techniques to understand how changes in care delivery will impact our future workforce requirements.<br><br>Increase recruitment to entry level roles highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other more specialist roles. | All senior leadership roles recruited to substantively<br><br>Reduction in vacancies<br><br>Reporting in line with ICS and national statutory requirements<br><br>WTE/pay costs in line with financial trajectories |


## Strategic Priority Four

We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value.

| Key Objective | Actions 2022-23 | Longer Term Actions | Measuring success (Year1) |
|---|---|---|---|
| Create a thriving People function and upskill managers in people management capabilities | Review and action plan to improve people processes and systems completed<br><br>Review all existing SOP's and ensure they are up to date and in line with best practice<br><br>Review our HR policies and procedures ensuring they are in line with our strategic aims, national inclusive best practice and guidance, just and learning principles and as set out in the Race Equality Action Plan<br><br>Ensure the probationary procedure is utilized effectively and links closely to induction<br><br>Monitor and audit the use of Fixed term contracts and long-term bank assignments to ensure all who should fall within the Tavistock and Portman's employment governance framework are recorded as such.<br><br>Explore the use of more flexible benefit options and salary sacrifice schemes that reflect the needs and wants of a diverse workforce. | We will develop a pool of mediators and implement an internal disputes resolution framework to negate the need for formal employee relations policy uptake | People review completed and operating model in place<br><br>Policies up to date and ratified<br><br>All new starters complete Induction<br><br>Audit plans and progress reports in place |


## Strategic Priority Four

We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value.

| Key Objective | Actions 2022-23 | Longer Term Actions | Success Measures (Year 1) |
|---|---|---|---|
| Strengthen the service as strategic partners who are responsive and deliver value | Embed the new People Directorate following the Strategic review<br><br>Lead and work collaboratively across the system to deliver on the People Plans<br><br>Operating model co-designed with services<br><br>People governance structure that monitors the delivery of the People Plan | Ensure that all staff who are in leadership or managerial positions are trained in our HR polices, processes and systems, such that they can be confident and self-sufficient.<br><br>Work with partners across the ICS to design and implement health and social care career pathways | Governance and the controls, management and monitoring arrangements are in place that provide assurance and reduce risk scores.<br><br>Feedback from services and teams on whether they feel appropriately supported by the People and OD service<br><br>Operating Model in place |
| Access to professional development that enables the delivery of innovative and effective services | Establish and action a professional and team development programme to strengthen capacity, capability and leadership across the people and OD function | Continue to gather feedback on an on-going basis on the effectiveness of our workforce and education functions and use this to drive continuous improvement. | Development plans in place for all staff through their appraisal<br><br>360 degree appraisals completed for senior managers<br><br>Improvement in Staff survey scores for those working in the Directorate |


## Strategic Priority Four

We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value.

| Key Objective | Actions 2022-23 | Longer Term Actions | Success Measures (Year 1) |
|---|---|---|---|
| Workforce Information that is accurate, real time, intelligent and predictive | Maximise the benefits of ESR and information on our workforce by ensuring staff are supported to maintain accurate records and are trained appropriately.<br><br>Ensure Workforce KPI performance reporting meets Trust governance requirements and includes monitoring performance on inclusion and race equality and read across from WRES, WDES, staff survey | Implement ESR employee self service. | Significant assurance through internal audit<br><br>Schedule of statutory reporting requirements in place and compliance against requirements demonstrated<br><br>Workforce Performance metrics, targets and improvement trajectories agreed by the Board and regularly reported on. |
| Proactive in the adoption of effective, efficient and innovative workforce systems, processes and digital technologies. | Benchmark and learn from People and OD practices from health, social care and other sectors<br><br>Review Workforce systems and develop business case for implementation of fit for purpose digital solutions<br><br>Modernise HR processes to ensure a more collaborative, inclusive and person centred learning approach aligned to the Just Culture Guide and Fair Experience for All | Implement workforce systems solutions as recommended from business case that ensures data driven decisions and efficient service delivery<br><br>Invest in a self-service People and OD portal | Benchmark our use of digital technology and data analytics with national comparators.<br><br>All policies and procedures are reviewed in line with just and learning practices |


## Strategic Priority Four

We will develop a People and OD service that is responsive to current and emerging strategic challenges, is innovative and delivers value.

| Key Objective | Objectives 2022 | Longer Term Actions | Success Measures (year1) |
|---|---|---|---|
| We will invest in Organisational development, ED&I and our Learning & Development function to enable our workforce to develop their skills and expertise | Establish the new structure of the People Directorate following the SR<br><br>Appoint to new roles<br><br>Start to embed the cultural changes and changes to working practices following the SR<br><br>Review the learning and development portfolio and expand the offer to ensure the L&D team are meeting the training and development needs of the organisation<br><br>In line with the Race Equality Action Plan ensure adequate support and funding is in place to deliver the ED&I strategy | Evaluate and further strengthen People services operating model to ensure it remains fit for purpose and in line with national developments | Staff survey results<br><br>All roles appointed to<br><br>People Directorate development plan implemented and evaluated |

| Report to | Date |
|---|---|
| Board of Directors | 26 July 2022 |

**Committee Chair Report:**
Education and Training Committee Highlight Report

## Executive Summary

The Education and Training Committee (ETC) met on 7th July conducting its normal business obtaining assurance and updates in relation to various workstreams.

- **Staffing:** The Committee noted it was Brian Rock's last meeting in role and thanked him for his leadership and contribution to the development of the Directorate of Education and Training. The Committee welcomed Elisa Reyes-Simpson in her new role as Interim Chief Education & Training Officer/Dean of Postgraduate Studies (Interim CETO).

- **Governance**: The Committee discussed progressing the time-limited task and finish group in relation to governance in education and training, which had been paused whilst the Interim CETO was recruited. The Committee agreed that a specific person should be identified to drive this work, and to work with external partners as stakeholders, through input at specific points.

- **Risk Management in DET**: The Committee received an update on the identification, logging and monitoring of risks within the Directorate, in particular the risk associated with government delays in issuing visas to international students (linked to the situation in Ukraine), and the risks associated with online versus hybrid or face to face delivery through the ongoing pandemic.

- **Customer Relationship Management**: The Committee was updated on the proposed capital plan for a CRM system, which was not approved by the Change Board. The Committee agreed that the business case needs to be re-visited as the original criteria may have changed since the original proposal was made. It would be important to get feedback from the Change Board in order to progress planning for the future with a viable, up-to-date proposal.

- **SOF3 and the Implications for the Office for Students**: The Committee discussed the framework for reporting on material changes to the Office for Students (OfS), and whether the Trust's SOF3 status constituted something that would materially affect our registration. The Committee agreed that SOF3 was not a Reportable Event, according to OfS guidelines. The Committee was content with the draft letter from the CEO updating the Office for Students and noted that the OfS had been informed of the change of Chair and will need to be informed of the change in CEO as accountable officer when that arises.

- **Strategic Review**: The Committee discussed the outcome of the Strategic Review in relation to DET and noted that the majority of staff are pleased to have some certainty. The Committee noted the risks associated with the narrow window in terms of carrying out interview processes with the pressures from the academic year commencing in September. There is a significant risk as a number of Course Leads need to be appointed to ensure continuity of our course provision.

- **Recruitment**: The Committee was updated on student recruitment, with 778 applications having been received as at 7th July, which is ahead of this time last year. However, there have been fewer offers to this time last year. In part, this is due to applications being received later. However, the Strategic Review has also impacted on Course Leads and teams engaging in processing applications and interviewing. The Recruitment Team are actively working to remove blocks to processing, and to further train Admissions Advisors to be able to advise where applications should be rejected without a Course Lead having to review (in liaison with Portfolio Managers).

  The Committee noted that rising costs of living are having an impact on prospective students' decisions to take up their offers.

  The Committee registered its concerns in relation to recruitment and the impact of the Strategic Review, and agreed the priority was to implement the strategic review and transition to the new academic year as smoothly as possible. The Committee agreed, in terms of resource, it would be useful to draw on visiting lecturers to provide additional interview capacity.

- **Annual Student Survey Recommendations**: The Committee received an update on the progress of the recommendations from the Annual Student Survey Overview Report. The Committee agreed steps to make the action plan more functional, including specific timelines, targets, and responsible persons, and will receive a further update at its next meeting.

- **Equalities, Diversity and Inclusion**: The Committee confirmed that all of the objectives on the DET EDI road map had been met, and expressed their thanks for Paul Dugmore's leadership in this area, and the significant input from the DET EDI Leads. The Committee had a detailed discussion about the areas for concern, which included the increase in rejection rates for Muslim applicants, and an increase more generally in the award gap. The Committee noted the areas of focus for the upcoming period of advancing the work on making the curricular more inclusive. Additional resource is being identified to help course teams review their reading lists. The Committee noted the increase in complaints being in part due to students feeling more able to make a complaint.

- **Standing Items and the work of the ETC**: The Committee briefly discussed the planned agenda items for next academic year (2022/23) and where

Tavistock Consulting (TC) and the Workforce Innovation Unit should report in the future. The Committee noted that the education and training elements of TC have been incorporated into portfolios, and the National Workforce Skills Development Unit has been situated in a different division, and therefore the ETC should have oversight rather than regular reporting on delivery.

- **Reflection**: The Committed reflected on the need to extend the duration of ETC meetings to enable a full and useful discussion about each agenda item. The Committee reflected on the significant risks around the implementation of the strategic review connected with the approaching academic year.

- **Next meeting**: At the next meeting the Committee will consider the following topics:

- *Director's Report*
- *Annual Student Complaints Report*
- *Academic Outcomes from previous A/Y (numbers of completions, proportions of distinction, merit, pass, fail, at course and portfolio level)*
- *Annual Student Survey Summary Report*
- *Summary of Student Recruitment*
- *Digital Academy Performance Update*
- *Nursing Portfolio - business case (with progress monitored at future meetings)*
- *Risk Management in DET*

## Recommendation to the *committee/board*

The Board of Directors are asked to:

- **Note the following**:
  - The agreement to notify the Office for Students of the Trust's SOF3 status.
  - The assurance received in relation to ensuring applications are progressed, and steps being taken to upskill Admissions Advisors to be able to be more active in rejecting applicants who clearly do not meet the entry requirements.
  - The significant risks around the implementation of the strategic review in relation to the start of the new academic year, the impact on recruitment, and need for resources to ensure applications are progressed.
  - The decision to re-visit the Business Case for CRM in order to re-present an up-to-date, viable proposal to the Change Board.
  - The progress against the DET EDI action plan, under the leadership of Paul Dugmore and the EDI Leads.
  - The agreement to have a dedicated session around opportunities within Short Courses, Digital and Academy and the international arena.

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| ○ The assurance received in relation to developing a coherent agenda plan for the next academic year and continue to review the effectiveness of the work of the Committee.<br>• **Confirm**:<br>○ It's support for drawing on Visiting Lecturer resource to increase capacity to interview applicants in the recruitment pipeline.<br>○ The Committee's agreement that it should have oversight of the work of the Workforce Innovation Unit's work, rather than reporting, but that this should be considered in the governance review. |
| Trust strategic objectives supported by this paper |
| **(2021/2022) Corporate Objective/Associated BAF risks:**<br>Obj 1,/ Risk ref 189(7) Obj 6,/Risk Ref 189(7), Risk Ref 108(6) Obj 11,/Risk Ref 187(4) |

| Author | Responsible Executive Director |
|---|---|
| David Levenson<br>Elisa Reyes-Simpson | Chair ET Committee<br>Interim Chief Education & Training Officer/ Dean of Postgraduate Studies |