The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 25th January 2022

Please refer to the agenda for timings.

Meeting held online

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 25th January 2022 2.00pm – 4.10pm
Via Zoom

		Presenter	Timing	Paper No
1. Administrative Matters				
1.1	Chair's opening remarks and apologies	Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Draft Minutes of the meeting held on 30 November 2021	Chair		1
1.4	Action log and matters arising	Chair		
2. Operational Items				
2.1	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.15pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	3
2.4	Quality report and dashboard Q3	Medical Director/Director of Quality	2.40pm	4
3. Items for approval				
3.1	Board Governance Review	Chief Executive	3.00pm	5
3.2	Race Equalities Strategy and Action Plan	Chief Executive	3.25pm	6
4. Items for information				
4.1	Serious Incident Quarterly Report	Medical Director/Director of Quality	3.50pm	7
4.2	Guardian of Safe Working (Q3)	Medical Director/Director of Quality	3.55pm	8
5. Board Committee Reports (for information)				
5.1	• Audit Committee • Education & Training Committee • Integrated Governance Committee	Chair	4.00pm	9
6. Any other matters				
6.1	Any other business	All	4.05pm	
7. Date, time and venue of Next Meeting				
	29th March 2022, 2.00 – 5.00pm, online/venue to be confirmed			

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Board of Directors Meeting Minutes (Part 1)
30th November 2021, 2.00pm-4.45pm,
Lecture Theatre, 120 Belsize Lane, London, NW3 5BA

Present:			
Paul Burstow Chair	Hector Bayayi Director Gender Services	Chris Caldwell Director of Nursing	Deborah Colson Non-Executive Director
Helen Farrow Non-Executive Director	Sally Hodges Clinical Chief Operating Officer	David Holt Senior Independent Director	Rachel James Divisional Director CYAF
Paul Jenkins Chief Executive	Aruna Mehta Non-Executive Director	Terry Noys Deputy Chief Executive / Finance Director	Brian Rock Director of Education and Training / Dean of Postgraduate Studies
Shalini Sequeira Non-Executive Director	Dinesh Sinha Medical and Quality Director	Tim Kent Divisional Director AFS	
Attendees:			
Fiona Fernandes Business Manager Corporate Governance	Freda McEwen Governor	Richard Murray Governor	Helen Robinson Interim Director of Corporate Governance
Gloria Taplin Business Manager Corporate Governance	Ian Tegerdine Interim Director of HR	Laure Thomas Director of Marketing and Communications	
Apologies:			
David Levenson, Non-Executive Director Ailsa Swarbrick, Director Gender Services			

Action Log

AP	Item	Action to be taken	Resp	By
27 July 2021				
1.	3.1.2	Amendments to the minutes of the meeting held 28 September 2021	FF	Immed
2.	5.1.2	There is a significant gap between the current risk rating and the target risk rating in the Board Assurance Framework Requested a debate at a subsequent Board meeting to look at this issue and the extent to which the Board was comfortable with this gap.(27 July 2021)	PJ / TN	Jan 22
28 September 2021				
1.	2.2.4	Education and Training Committee to report back to the Board with appropriate consideration and assurance around the impact that some of the constraints highlighted in 2.2.3 might have on our educational delivery	BR / DL	Open
2.	4.1.8	Investigate and advise on options for delivering Unconscious Bias training for the Board	IJT	Jan 22
3.	4.1.9	That the options are considered for providing additional support, coaching or otherwise to support Board members in leading the organisation to become anti-racist organisation in practice.	PJ	Open
4.	6.1.1	EDI Committee Minutes from the September meeting to be circulated to the Board	IJT	asap
5.	6.1.2	Create a process flow chart to map out the internal complaints process	PJ / AH	Jan 22

6.	6.2.4	A detailed report on FOIs to better understand the pressure and resourcing implications and how we mitigate the risks to be brought to a board meeting	FF / TN	Jan 22
30 November 2021				
1.	2.1.2	Information briefing session to be arranged for the whole Board on the relationship with the ICS	PJ / HPR	Open

1. Administrative matters

1.1 Welcome and apologies

1.1.1 Prof. Burstow welcomed all of those present and noted that this was the first in person meeting of the Board since the start of the covid pandemic in 2020. Apologies were noted, as above.

1.2 Declarations of interest

1.2.1 Ms Mehta declared that she was also a Non-Executive Director at Epsom St Helier NHS Trust and that there should be no perceived conflicts as it was an acute Trust with a different remit to the Tavistock and Portman NHS Foundation Trust.

1.3 Minutes of the previous meeting

1.3.1 The draft minutes of the 28 September 2021 were approved as an accurate record, subject to amendments.

1.4 Matters arising and action points

1.4.1 Prof Burstow noted that action point 4 to be circulated as soon as possible.

1.4.2 All other actions were noted as completed or carried forward.

2. Operational items

2.1 Chair and Non-Executives' reports

2.1.1 Prof. Burstow noted that since the last board meeting and following a lengthy recruitment process, there had been the appointment of 2 new Non-Executive Directors, Ms Aruna Mehta and Ms Shalini Sequeira.

2.1.2 There had been a range of engagements with the Integrated Care System (ICS) and a suggestion from Dr Caldwell to arrange an information briefing session for the whole Board on the relationship with the ICS **[AP1]**

2.1.3 Ms Farrow noted that she had attended the Medical (Clinical Staff) away day and, that the Q&A session had been very helpful and interesting. Ms Farrow noted that there had been a lot of anxiety about the Strategic Review and that staff has been missing the opportunity for face-to-face meetings.

2.1.4 Ms Farrow also noted that If meetings are going to be reverting back to face-to-face, NEDs should be given good notice of this. Prof Burstow responded that face-to-face meetings would be based on national guidelines in light of the new

Covid variant and will need to be kept under review the intentions to moving to face-to-face meetings.

2.1.5 Mr Holt noted that it would be useful for NEDs to know which service line meetings are being held online and/or face-to-face in order that NEDs can undertake their service line visits and have a presence.

2.1.6 Ms Sequeira noted that she chaired the Equality, Diversity and Inclusion committee meeting and following discussions at that meeting, it was clear that not everyone was aware of the lines of responsibility. It would be useful to have a visual of where the lines of responsibility are. Prof Burstow noted that this is going to be part of the Governance Review.

2.1.7 The board noted the verbal updates.

2.2 Chief Executive's report

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

2.2.2 **Covid Update**

- The Trust continues to remain vigilant and follows government, North Central London (NCL) wide IPC guidance.
- Clinical services and staff continue working to the blended model, however our aim is to deliver a higher proportion of face-to-face for improved communications, working with teams, team building, offering patient choice, staff wellbeing, etc and are not seeking at this point to return to pre-pandemic patterns of work/delivery.
- DET have continued with the hybrid model for the educational services following specific guidance as well as Trust IPC protocols/measures.
- The Trust continues to make concerted efforts to promote the Covid vaccination and boosters for staff through internal comms, all staff meeting and through the booster vaccination national programme.
- The flu vaccination programme has also been implemented and are working hard to ensure that staff take this up especially due to the dual risks of flu and Covid.
- The Trust's EPRR Gold group continue to meet fortnightly to take stock of the changing situation and, inform staff accordingly.

2.2.3 **Board Governance Review**

- The Office of Modern Governance have completed its board governance review and, the board is due to consider the findings at the December board seminar with the aim of agreeing the final recommendations at the January 2022 formal board meeting.

2.2.4 Responding to a question from Ms Farrow regarding the Covid vaccinations, Dr Sinha noted that the Department of Health and Social Care have formally announced that individuals undertaking CQC regulated activities in England (all

of our clinical work) must be fully vaccinated against Covid-19 no later than Friday 1 April 2022. This measure aims to ensure patients and staff are protected against infection. Health and social care workers will need to provide evidence that they have been fully vaccinated in order to be deployed. This means that staff will have to have had their first dose by 3rd February 2022 in order that they can have their second dose by the April deadline.

2.2.5 Mr Tegerdine reported that data shows a better uptake with the first dose as compared to the second dose (White staff at 90% and Ethnic Minority staff 80%). There is an ethnicity bias on uptake of the vaccination which is an issue across London and nationally. As we are not providing the vaccinations on-site, we are relying on staff to get this done at their GPs, vaccination centres, pharmacies, etc. There are challenges in getting accurate data as we rely on staff to inform us, however once it becomes law that people will have to prove that they have had the vaccination rather than just informing, the data will be more accurate. The data excludes visiting lecturers and honoraries. At present there is no record of 90 staff having had their second vaccination and as mentioned earlier, we are relying on staff to report back to us when they have had the vaccinations.

2.2.6 Mr Tegerdine informed the board that he had attended the HRD Seminar last week with the lawyers discussing the next stages of dismissal/redeployment of staff who have not had their vaccinations.

2.2.7 Mr Holt noted that it would be useful to get early sight at the Board (February/March) on what the proposal and profile looks like, and how the Trust is planning for this risk as 90 is a high proportion. There may be a significant impact on the Strategic Review.

2.2.8 Responding to a query from Ms Mehta, Mr Tegerdine noted that the 90 staff have been contacted and we continue to encourage them to have the vaccination. Dr Caldwell and Dr Sinha have both spoken and given them advice. Dr Sinha added that once the law passes staff will have to show evidence that they have had their vaccinations.

2.2.9 Ms James noted that there are mixed messages on the information regarding the vaccinations and the gap between the first, second and booster. It would be useful to do a communication drive linking it with the new information.

2.2.10 Prof Burstow noted that at an acute trust he had recently visited, they were gearing up to ensure that they have a designated person responsible for all the documentations on the organisation's response to the pandemic and how they complied with the guidance. He asked whether the Trust have someone designated to act in this role.

Responding to Prof Burstow, Dr Sinha noted that discussions and decisions had not been made yet however that there was an audit trail on any decision making by EPRR.

2.2.11 The Board of Directors noted the report.

2.3 Finance and performance report

2.3.1 Mr. Noys presented the report and noted that the forecast deficit for the year will be £8.8m. This includes writing off £1.4m of the expenditure which is related to the work on the Tavistock site rather than Jamestown Road and meeting exceptional pressures around the Strategic Review, the GIDS Transformation Programme and legal costs. We still estimate the underlying position to be a deficit of £5.5m. For the second half of the year, it is important to note that the second half year forecast had not been approved by the NCL ICS. The forecast also assumes a reduction on second half income of £0.8m.

2.3.2 Responding to a query from Prof Burstow, Mr Noys noted that there were 4-5 other Trusts in conversation with the ICS and that he would be meeting with the ICS Financial Officer on 10/12/22.

2.3.3 The Board of Directors noted the report.

2.4 Quality Report and Dashboard Q2

2.4.1 Dr Sinha presented the report and noted that the overall picture has slowed down since quarter one improvement. There are some areas that have seen improvement and some areas where there are no changes. Dr Sinha highlighted the salient points:

- Contact with service users has slowed down.
- Complaints - There is still a backlog, however work is progressing to address this.
- Ethnicity - Ethnicity completion rates have been one of the most challenging and data indicators show the target increased to 95%. The majority of our services are meeting the 95% requirement for data completion. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs.
- Adult Forensic Services have made good progress on outcome measures but still struggling with waiting times.
- Care as viewed outside the organisation shows a good breakdown of positive and negative items. There has been strong contribution from the educational services.

2.4.2 Discussion was held about appraisal, mandatory and statutory training following a query from Ms Sequeira. The following points were highlighted:

- The annual appraisal cycle was affected due to the pandemic and efforts were being made to get it back on track. A new appraisal cycle is going to be put in place starting in April 2022 which will be based more on development for staff to make it more meaningful.
- Despite reminding staff about mandatory and statutory training it was discussed at Executive Management Team that the final deadline for all staff to complete their training is 10/12/21.

- As staff are not all used to using the Electronic Staff Record (ESR) workshops are being arranged on how to access their mandatory and statutory training. After this any staff who have not completed their training it would become a conduct/disciplinary issue which would be the last resort.

2.4.3 Dr Colson noted that regarding outcome measures downward trend, it would be useful to go back to the consumer to collect what is more meaningful data by using questionnaires to get a better sense of what they are saying.

2.4.4 The board noted the report.

3. Items for discussion

3.1 Gender Identity Clinic (GIC) Transformation Programme

3.1.1 Mr Bayayi presented his report and highlighted the main areas of focus:

- GIC Transformation programme will be aligned to the Strategic Review and will be structured around four main workstreams (Managing Waiting Lists, Mapping the Pathway, CQC and Quality Improvement, and Equality, Diversity and Inclusion) and three enabling workstreams (Workforce, Communications and Digital). These workstreams will become a consistent framework for planning and monitoring the implementation of the programme, and be used across the programme governance to ensure the objectives of the programme are met. These workstreams will have significant interfaces and these will need to be managed by workstreams leads.
- To reduce the waiting list and times between appointments. At present there are 10000 on the waiting list with 5300 live cases which is difficult to manage with the current staffing complement.
- Development of robust governance structures relating to Clinical Governance, Reporting, Risk Management, Operational and Strategic management to support accountability and a cogent narrative to the Trust and stakeholders.
- Review of the workforce to ensure that they are working and focusing on the right things aligned to the strategic review, with particular focus on the ratio between clinical and admin staff, job planning and improvement of accountability and managerial hold.
- Focus on key deliverables aligned to service specifications and clinical pathways rather than a current focus the non-commissioned activity and change management of clinic's culture of exceptionalism. The biggest challenge is the national CQRG.
- Stakeholder engagement and development of intuitive comms framework in the context of unprecedented legal and public scrutiny of the service. Work is being done with the communications team to refresh the website. In relation to FOIs/complaints, we have uploaded a list FAQs and we have since seen a slight reduction in FOIs
- Governance and oversight will be through a GIC Transformation Steering Group who will report up the board via the Gender Oversight Committee (GOC) on which a NED and three execs sit.

3.1.2 Dr Hodges noted that the work is closely aligned with the Strategic Review and were taking a proactive approach in managing this. NHS England have been asking questions and we are talking to them about the proposals about dealing with the waiting times, etc.

3.1.3 A discussion was held on the workforce skill sets within GIC and the formal training that will be required for working in this specialist service.

3.1.4 Responding to Dr Colson and Mr Tegerdine on risk point 5.4, Mr Bayayi noted that with having a dedicated HRBP HR support had improved. We are developing a workforce strategy going forward as GIC had not had a recruitment/retention strategy.

3.1.5 The board noted the report and approved the GIC Strategic Review Transformation Programme approach and core propositions.

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3.2 Gender Identity Development Service (GIDs) Transformation Programme

3.2.1 Mr Jenkins presented the report in the absence of Ms Swarbrick. He noted that Ms Swarbrick would be leaving the Trust moving to a new role at NHS England and offered his appreciation of the contribution she had made in leading the improvement programme in GIDS and in her previous role leading the FNP National Unit. He informed the Board that Mr Bayayi's role would be expanding to cover GIDS.

3.2.2 Mr Jenkins highlighted the main areas of progress:

- Work continues to progress against the actions agreed in the CQC Action Plan and the CQC Waitlist Action Plan and report monthly to CQC.
- CQC Quality Summit held in October with system partners with system partners had been positive with some recognition of areas of improvement and a better sense of ownership of the issues in the wider care pathway.
- Work to revise safeguarding and consent SOPs
- Piloting a new, structured initial consultation for all GIDS patients which will produce an initial consultation summary report (which will include an initial care plan); and will also address a number of CQC actions
- Ongoing roll out of revised clinical review and decision making processes for endocrine treatment, to reflect legal and service specification changes.
- Working with NHSE/I to support the smooth implementation of the new Regional Professional Support Service and the National Referral Management Service.
- Introduction of new internal governance and accountability arrangements.
- Conducting a focused recruitment and retention drive, to build capacity in the service making comparisons with the regional teams.

3.2.3 The board noted the report.

3.3 Trust Priorities

3.3.1 Mr Jenkins noted that the priorities reflected the challenges that the Trust is managing reflecting on both the external and internal demands and objectives, that as a board need to focus on the management of this in the next six months. There are three categories of focus:

- Essential - largely reflecting our internally focused key objectives
- Other non-negotiable - including externally set priorities which will need to be addressed
- Watching brief - important issues which it is important we keep in view but where it is unlikely, we can do much proactive work in the next 6 months

3.3.2 A discussion on the priorities followed in relation to resources required, preoccupation of the Executive Team in light of the Strategic Review, imminent CQC inspection and the following comments were made:

- Mr Noys noted that ICS were undertaking a review of mental health commissioning. This had included significant requests for data which had been challenging to meet.
- Dr Hodges noted that both she and Dr Sinha would be attending provider meetings relating to adults and children's services. It has been difficult to get involved with the adult services however conversations have been taking place.
- Dr Sinha noted that the CQC have been very active making a number of unannounced inspections across the country. 10 weeks ago EMT activated the CQC action plan in anticipation in line for a well-led inspection. We have not been informed of the dates and it is assumed that it will happen in the New Year. We will know more following the GIDS Quality Summit. IGC have discussed a plan for preparations and have engaged an external consultant to undertake this.

3.3.3 The board noted the report and approved the recommendations on the proviso that there are enough resources put in place to undertake this.

4. Items for approval

4.1 Race External Review Update

4.1.1 Prof Burstow noted that this item will not be discussed as it needed a significant amount of time for meaningful discussion and approval. It will be carried forward to the January meeting.

5. Items for noting

5.1 Board Assurance Framework (BAF)

5.1.1 The report was taken as read and there was a discussion on the target risks 185 and 190 which are the Strategic Review operating risks and whether the board is confident and happy to accept the level that these risks carry.

5.1.2 Mr Jenkins noted that inn reality we are not going to know until the end of the Strategic Review. There is a solid plan for mitigating these.

5.1.3 Prof Burstow suggested that these two risk need to be put at the top of the narrative linked to the Strategic Review.

5.1.4 The board noted the report and agreed the priorities.

5.2 Guardian of Safer Working Hours (GOSWH) Q2

5.2.1 The board noted the information in the report.

5.3 Serious Incidents Report Q2

5.3.1 The board noted the information in the report.

6. Board committee reports

6.1 Audit Committee

6.1.1 Mr Holt stated that at the Audit Committee it was noted that, under the new Value For Money (VFM) regime, the external auditors would formally write to the Audit Committee during the year, and not simply wait until the year end if they considered there to be any risks to a positive year end VFM opinion.

6.1.2 The Board of Directors noted the report.

6.2 Education & Training Committee

6.2.1 Mr Rock presented the report and highlighted the following:

- Student enrolment and re-enrolment for long courses is around 620 which is on par with last year.
- There were discussions on returning to face-to-face training however a blended model of training will continue, and will be developing true distance learning with a more blended link with the digital academy
- Annual Student Survey completion rate was lower, however the overall satisfaction rate was 82%

6.2.2 Responding to a query from Ms Farrow regarding the M80 Child Psychotherapy tender, Mr Rock noted that the timing for the tender would be late January. The Trust is the longest standing provider of this training but we would need to demonstrate innovation and development in our tender response. Placements were also an issue.

6.2.3 The board noted the report.

6.3 Integrated Governance Committee (IGC)

6.3.1 Dr Sinha noted that a lot of the items in the report had been discussed through the agenda, he had nothing further to add.

6.3.2 The Board of Directors noted the report.

7. Any other matters

7.1.1 There was no other business raised.

7.1.2 The meeting closed at 4.45pm.

8. Date of next meeting

8.1 25 January 2022 at 2pm.

DRAFT

Report to	Date
Board of Directors	25th January 2022

Chief Executive's Report

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. Trust Chair

1.1 As Directors will be aware the Trust Chair, Paul Burstow, has announced his intention to step down from the end of April 2022. With the support of the ICS, we are proceeding to appoint a new Chair. We are also taking the opportunity to appoint to two NED vacancies which will occur by the end of the year.

1.2 Both appointments are led by the Council of Governors and the process for managing this has been agreed by the Nominations Committee. The exercise will be led by Gatenby Sanderson who have been appointed following a procurement exercise.

1.3 The timetable for the process aims to be completed for the new chair in the week commencing 28th March.

1.4 In looking at both appointments the following objectives have been agreed with the Nominations Committee:

- The importance attached to increasing the diversity of the Board, so it better reflects the population it serves.
- The significance of partnerships in the building a successful future for the Trust in the new environment of Integrated Care Systems.
- Specific requirements to increase specific clinical and higher education expertise on the Board.

2. Covid19 Update

2.1 The Trust continues to follow required measures and guidance in managing its services and staff to minimise the risk of Covid, while ensuring the continuing delivery of high quality clinical and educational services. The incidence and prevalence of community infection has continued to be tracked nationally along with its impact on serious illness. There remain pressures on health systems from a combination of ongoing pandemic and elective activity on several pathways.

2.2 We continue to follow NCL wide IPC (infection prevention and control) guidance including that relating to the wearing of masks, ongoing need for social distancing, use of testing etc and there Have been a number of changes in the period since the last update, including to self-isolation guidance.

2.3 We have chosen to be more cautious in the delivery of and proportion of face-to-face clinical services. This follows our approach to changing patterns

of infection throughout the pandemic. Particular attention has been continued for any group-based activities as these can lead to outbreaks. Colleagues will be aware of recent measures measures in the larger community including use of public transport and indoor spaces.

2.4 DET has continued with its hybrid model for educational services operating to a specific guidance, in line with the overall Trust IPC measures. There is also a plan for a further exploration of the future model of provision of our educational services, including face to face settings over the coming period.

2.5 There continue to be concerted efforts to promote the highest possible rates of vaccination for Trust staff.

2.6 The Trust has done additional communications to staff, including through a recent all staff meeting to ensure accurate knowledge of vaccination status, including take up of booster vaccination through the national programme.

2.7 The Trust has continued various comms regarding the approach to vaccination, the intranet has information re vaccination and there is shortly going to be an all staff meeting to discuss the impact of the changes in government policy on vaccination for healthcare staff.

2.8 The Trust EPRR Gold group has increased the frequency of its meetings to manage the demands from the heightened concerns form the omicron variant. We now meet weekly to take stock of the fast-changing situation, agree measures to ensure ongoing services in our clinical and educational settings and modify communications to the Trust using a variety of methods including all staff briefings, communication messages etc.

3. Mandatory Vaccination (VCOD)

3.1 Along with other NHS organisations we are implementing the new legal requirements for vaccination as a condition of deployment (VCOD). The timetable we are working to is:

January 2022	• Commence 1:1 discussions with staff • Formally inform staff of potential next steps • Continued education, support and signposting
February/March 2022	• Formal discussions/meetings with staff • Redeployment and/or Terminations
1st April 2022	• Fully implemented

3.2 We have the following resources in place to support this process

1. Flowchart of process

2. Occupational Health/Infection Prevention & Control Advice on Clinical/Medical Exemption
3. Mandatory COVID Vaccines Procedure
4. FAQs
5. Recruitment Information
6. Template Documents and Letters
7. Education and Support resources

3.3 The current information is that only staff engaged in CQC regulated activity (most of the Trusts staff but excluding some DET staff) who have direct face to face contact with patients will be in scope.

3.4 We will establish a panel compromising Operations, HR and Unions to review posts and to agree if they are in scope when measured against the most up to date NCL and national guidance.

3.5 Our internal dataset is reliant on people self-reporting their vaccine status and hence now we have access to the NIVs database we are reconciling the national vaccination records with our local one – this is still not a perfect dataset but gives a good base for us to commence work.

3.6 The data is evolving but as at mid Jan we have identified 69 staff (this excludes bank staff at present) where we have no record of double vaccination (the legal standard) and of these 42 appear to be front line clinical staff.

3.7 We are now contacting those staff to confirm that the information we hold is correct and continue to validate the bank staff data.

3.8 Once we have the best validated data we will review each role as per the panel process above to agree if the role is in scope and if so exploring any redeployment options before creating a list of potential staff dismissals on the basis of VCOD.

3.9 The experience of social care in compulsory vaccination is that many staff commenced vaccination only when served notice of dismissal, this may give us some short term logistical deployment issues (as we will be unable to deploy unvaccinated staff in certain roles after the legal deadline) but may reduce the number of final dismissals significantly.

4 GIDS

4.1 As highlighted at the November Board Ailsa Swarbrick has now taken up her new role at NHS England. Hector Bayayi has taken over the role as Divisional Director for both GIDS and the adult gender service.

4.2 Before the Christmas break, I wrote to CQC with our follow up to the last Quality Summit. In my letter I highlighted three priorities:

- Continuing to deliver tangible improvements in core processes, governance, workforce engagement and culture,
- Processing outstanding endocrine referrals including agreement from the Multi-Professional Review Group (MPRG) for referrals of patients aged under 16 and
- Maximising the capacity and in particular clinical capacity necessary to achieve sustainable reductions in waiting times.

4.3 A third Quality Summit is being arranged for the second half of March. It is likely that, following this, the service will be subject to a reinspection.

5 Student letter about remote teaching

5.1 A large group of students studying on five clinical programmes across a number of year groups have written to express a range of concerns about the lack of in person teaching and the possible detrimental impact on their learning and development. This has been made more salient in light of the fact that many, if not all, have resumed face to face clinical delivery. While they convey understanding of the decisions taken by the Trust, they raise questions about whether more can be done to facilitate a return to in person activity and also whether the Trust is using the pandemic and infection prevention control requirements to fundamentally change under cover our approach to teaching delivery in the future.

5.2 DET have been considering and implementing where possible returns to face-to-face teaching but progress has been slower because of the configuration of most of our teaching spaces in the building and also because of the prevailing social distancing guidelines – and the need to protect all users of the Trust (patients, students, staff and visitors).

5.3 Nearly half of our courses have had or are in the process of arranging face-to-face teaching both last term and this year. This has been complicated by COVID, as some events had to be cancelled at short notice for a variety of reasons – students not wanting to attend; COVID isolation; Omicron leading to new restrictions. Course Leads have been and continue to be engaged in conversations about what might be possible whilst there are still social distancing restrictions in place within the Trust. This has included looking at how the timetable can be adapted to allow face to face activities.

5.4 Due to contracting COVID in December Brian Rock was delayed in responding to the students but he and Elisa Reyes-Simpson met with two students from the group to understand their concerns more fully and to consider the best way of responding. This has included the intention to establish a task and finish group to further develop plans to return students over this term and, hopefully, more fundamentally, for the third term. There are a range of complexities to be addressed, including reviewing whether there is any flexibility in relation to the social distancing requirement. Hybrid delivering will continue to be required for the foreseeable future because individual learner and teacher preferences will continue to be a factor in the planning and delivery of activity.

5.5 Longer term we believe that blended delivery will be a significant part of our offer because we have seen benefits from online delivery. Proposals are being progressed through the Strategic Review consultation. It is our intention to consult with students too.

Paul Jenkins
Chief Executive
18th January 2021

Report to	Date
Board of Directors	25 January 2022

Report on Finances

Executive Summary

This paper provides details of the Trust financial performance for the 8 month period ended 30 November 2021.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

REPORT ON FINANCES

1. INTRODUCTION

1.1. This paper provides details of the Trust financial performance for the 8 month period ended 30 November 2021.

2. SUMMARY

£m	Act	Plan	Var	Full Year F'Cast
Income	40.0	40.2	(0.2)	59.8
Pay costs	(32.0)	(32.6)	0.6	(50.0)
Non-pay costs	(10.1)	(10.3)	0.2	(16.2)
Operating deficit	(2.1)	(2.7)	0.6	(6.5)
Other costs	(1.6)	(1.5)	(0.1)	(2.3)
Net deficit	(3.7)	(4.2)	0.5	(8.8)

Year To Date

2.1. For the first eight months of the year the Trust recorded a net deficit of £3.7m. This is slightly better than the forecast deficit of £4.2m.

2.2. Differences against Plan for income, pay and non-pay costs are all small (2% or less).

Result For The Month

2.3. For the month itself the Trust recorded a net deficit of £1.7m against a Planned deficit figure of £1.2m. The variance of £0.5m primarily reflects correction of over accrued income in October for DET (£0.2m) and Covid (£0.4m).

Full Year Forecast

2.4. Excluding non-recurring items, the full year deficit is expected to come in lower than the forecast £8.8m.

3. CASH FLOW

3.1. Cash at the end of November is £15.3m, which is £4m higher than the forecast. This reflects:

- Deficit better than Plan £0.5m
- Capex below Plan £0.3m
- Cash received in advance £3.2m.

3.2. Cash received in advance, is cash received in relation to activities due to take place later in the year and represents receipts as follows:

- HEE £1.0m
- Student fees £0.6m
- NHSE/I (various contracts) £1.4m
- Other £0.2m.

4. PLANNING FOR 2022/23

4.1. Guidance on this is not yet available, however, the current intention appears to be use the 2021/22 second half 'envelope' as the basis for the next year, in which case, without serious remedial steps, the Trust's deficit will increase further.

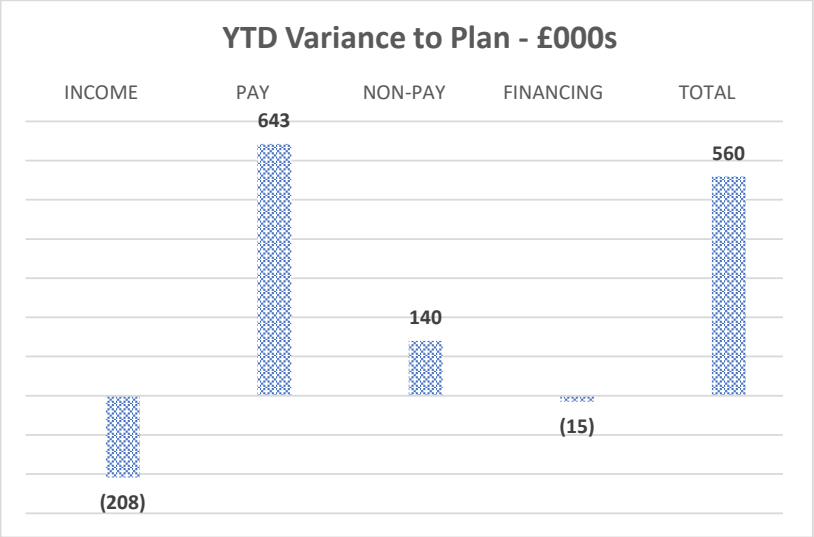
The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 8 8 **Nov-21**

Section **Page**

£000	Plan	Actual	Variance	Var %
INCOME	40,207	39,998	(208)	(1%)
PAY	(32,627)	(31,985)	643	(2%)
NON-PAY	(10,281)	(10,141)	140	(1%)
EBITA	**(2,702)**	**(2,128)**	**574**	**(21%)**
Interest receivable	0	0	0	
Interest payable	(20)	(22)	(2)	
Depreciation	(1,205)	(1,206)	(1)	
Dividend	(305)	(338)	(33)	
Net Surplus /(Deficit)	**(4,232)**	**(3,693)**	**539**	**(13%)**



Key Issues to be addressed

Performance is against H2 plan figures agreed with NCL.
Last quarter income often sees significant unforseen revenue as NHSE/HEE distribute unutilised funds.
This together with under recruitment against plan should see an overperformance against plan

Income **(208)** below plan

Due to unutilised Coivd funding paid back in Nov, Research funding deferred in line with spend, offset by higher tuition fees

Pay costs **643** less than plan

The plan now reflects H1 actuals, vacancies carried in the plan are the main cause of pay variances this month

Non-pay costs **140** less than plan

Relocation expenditure lower than H2 plan, expected to be fully spent by Mar, but further slippage possible

	Actual
Staff FTE	696
Cash balance - £000s	**15,276**
YTD Cash in/(out) flow - £000s	**501**
Capital Expenditure - £000s	**1,327**

Debtors > 90 days	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**
	£'001	£'001	£'002	£'002
NHS	141	122	148	100
Non-NHS	86	72	55	102
Student	230	210	225	255
Total	**457**	**404**	**428**	**456**

	Prior Year End £'000	Apr-21 £'000	May-21 £'000	Nov-21 £'000	Jul-21 £'000	Aug-21 £'000	Sep-21 £'000	Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000
Intangible assets	50	46	43	39	36	33	30	27	25				
Land and buildings	24,045	24,031	24,039	24,046	24,079	24,026	24,072	24,267	24,191				
IT equipment	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773				
Property, Plant & Equipment	25,818	25,804	25,812	25,819	25,852	25,799	25,845	26,040	25,964				
Total non-current assets	25,868	25,850	25,855	25,858	25,887	25,832	25,875	26,067	25,989				
NHS Receivables	6,494	5,331	5,290	5,022	7,458	5,115	5,528	5,310	4,982				
Non-NHS Receivables	3,322	2,475	3,172	3,404	2,946	2,683	4,154	3,722	4,215				
Cash / equivalents	14,775	17,175	15,659	15,228	13,734	14,348	11,846	15,330	13,532				
Other cash balances		(123)	(111)	(167)	(60)	1,130	1,606	1,653	1,744				
Total current assets	24,591	24,858	24,009	23,488	24,078	23,276	23,134	26,015	24,473				
Trade and other payables	(2,660)	(2,936)	(2,247)	(2,496)	(2,586)	(2,653)	(2,591)	(2,353)	(2,738)				
Accruals	(8,090)	(8,406)	(8,471)	(8,114)	(9,172)	(8,852)	(9,211)	(12,278)	(12,021)				
Deferred income	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)				
Long term loans < 1 year	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)				
Provisions	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)				
Total current liabilities	(18,623)	(19,215)	(18,590)	(18,482)	(19,631)	(19,377)	(19,674)	(22,503)	(22,631)				
Total assets less current liabilities	31,837	31,493	31,274	30,864	30,335	29,732	29,334	29,578	27,831				
Non-current provisions	(70)	(65)	(65)	(24)	18	18	18	20	20				
Long term loans > 1 year	(2,666)	(2,666)	(2,666)	(2,666)	(2,666)	(2,443)	(2,443)	(2,443)	(2,443)				
Total assets employed	29,101	28,763	28,543	28,175	27,688	27,307	26,910	27,155	25,408				
Public dividend capital	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)				
Revaluation reserve	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)				
I&E reserve	(11,546)	(11,207)	(10,987)	(10,619)	(10,132)	(9,751)	(9,354)	(9,599)	(7,852)				
	0	(0)	(0)	(0)	(0)	(0)	(1)	(1)	(1)				
Total taxpayers equity	(29,101)	(28,763)	(28,543)	(28,175)	(27,688)	(27,307)	(26,910)	(27,155)	(25,408)				
	(0)	0	0	0	0	0	0	0	0				

FINANCE AND PERFORMANCE REPORT **Section 3** **FUNDS FLOW** **Commercial: In Confidence** **Page 4**

Period 8

Nov-21

	April Act £'000	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	Jan Act £'000	Feb Act £'000	Mar Act £'000	**YTD Act £'000**
Net Surplus/(Deficit)	**(338)**	**(220)**	**(368)**	**(487)**	**(381)**	**(397)**	**245**	**(1,747)**					**(3,694)**
Depreciation / amortisation	135	135	135	135	193	147	146	180					**1,206**
PDC dividend paid	41	23	32	76	43	41	82	0					**338**
Net Interest paid	2	2	2	2	5	0	5	2					**22**
(Increase) / Decrease in receivables	2,010	(656)	35	(1,978)	2,606	(1,885)	650	(164)					**620**
Increase / (Decrease) in liabilities	592	(625)	(108)	1,148	(254)	297	2,829	128					**4,009**
Increase / (Decrease) in provisions	(5)	0	(41)	(42)	0	0	(2)	0					**(91)**
Non operational accural movement	(44)	(25)	(34)	(78)	(33)	364	(87)	(2)					**60**
Net operating cash flow	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,180**	**(1,433)**	**3,869**	**(1,604)**	**0**	**0**	**0**	**0**	**2,470**
Interest received													**0**
Interest paid					(15)								**(15)**
PDC dividend paid						(405)							**(405)**
Restructuring													
Cash flow available for investment	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,165**	**(1,838)**	**3,869**	**(1,604)**	**0**	**0**	**0**	**0**	**2,050**
Purchase of property, plant & equipment	18	(4)	(4)	(29)	55	(42)	(192)	77					**(121)**
Depreciation	(135)	(135)	(135)	(135)	(193)	(147)	(146)	(180)					**(1,206)**
Capital purchases - cash	**(117)**	**(139)**	**(139)**	**(164)**	**(138)**	**(189)**	**(338)**	**(102)**	**0**	**0**	**0**	**0**	**(1,327)**
Net cash flow before financing	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**2,027**	**(2,027)**	**3,531**	**(1,706)**	**0**	**0**	**0**	**0**	**723**
Repayment of debt facilities	0	0	0	0	(222)	0	0	0					**(222)**
Net increase / (decrease) in cash	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**1,805**	**(2,027)**	**3,531**	**(1,706)**	**0**	**0**	**0**	**0**	**501**
Opening Cash	14,775	17,052	15,547	15,061	13,674	15,478	13,451	16,982	0	0	0	0	14,775
Closing cash	**17,052**	**15,547**	**15,061**	**13,674**	**15,478**	**13,451**	**16,982**	**15,276**	**0**	**0**	**0**	**0**	**15,276**
check	0	0	0	0	0	0	0	0	0	0	0	0	(0)

PROJECT	April Act £'000	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Fcst £'000	Jan Fcst £'000	Feb Fcst £'000	Mar Fcst £'000	**Full Yr Fcst £'000**	20/21 Bud £'000
Microsoft Office 365 E-Mail Migration	260	(252)	4	(4)	12	5	1	0	0	0	0	0	**27**	0
Endpoint Procure/Config/Compliance/Monitor	0	8	8	17	7	5	9	4	54	3	3	3	**121**	66
Tavistock Centre Data Centres Power Provision	0	0	0	0	0	0	0	0	0	0	16	16	**32**	32
Remote Working	(260)	260	0	0	0	0	0	0	0	0	0	0	**0**	0
Cyber Essentials	4	1	4	0	0	0	0	0	0	0	0	0	**10**	5
Health Information Exchange	0	0	0	0	0	0	2	1	6	6	6	6	**26**	0
MyTap Annual Upgrade 2019/20	3	0	0	0	0	0	0	0	0	0	0	0	**3**	0
Endpoint Replacement 2018/19	0	0	0	0	0	0	0	(71)	0	0	0	0	**(71)**	0
DET Record Management System	0	0	0	0	0	0	0	(3)	0	0	0	0	**(3)**	0
Scheduling & Robotic Process Automation	(0)	0	0	0	0	0	0	0	0	0	0	0	**(0)**	0
ICT Cyber Security Compliance 2020/21	1	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Core Infrastructure Update	0	0	8	10	(8)	0	1	1	18	8	5	3	**46**	63
Network - Upgrade (Wireless)	0	0	0	0	0	0	6	4	33	3	3	3	**53**	30
Cyber Essentials Plus	0	0	5	4	3	0	7	0	5	0	0	0	**23**	30
Endpoint Replacement 2021/22	0	0	0	2	34	33	42	0	51	2	2	22	**188**	200
ICT Cyber Security Compliance 2021/22	0	0	2	5	(4)	0	4	1	42	30	11	22	**112**	140
API for CareNotes Integration	0	0	0	0	0	0	1	1	3	3	63	3	**73**	0
Audio Video Upgrade for Remote Working	0	0	0	0	0	0	2	1	8	53	8	8	**81**	0
Connectivity Upgrade	0	0	0	0	0	0	2	6	8	58	8	8	**92**	0
Data Warehouse	0	0	0	0	0	0	1	3	15	20	15	15	**69**	0
Virtual Desktop Interface	0	0	0	0	0	0	1	1	6	91	5	5	**108**	0
IT	**9**	**18**	**31**	**34**	**43**	**43**	**79**	**(51)**	**249**	**278**	**145**	**114**	**991**	**566**
Ventilation	10	0	0	0	0	0	0	0	0	0	0	0	**10**	0
Pumps	0	9	2	0	0	0	0	0	0	0	0	0	**10**	0
Water	0	0	0	0	0	0	0	0	0	0	0	0	**0**	30
Electrics	8	(3)	3	8	16	13	68	6	105	31	41	12	**306**	223
PC Compliance	0	7	1	0	0	0	0	0	0	0	0	0	**8**	0
TC Compliance	1	9	3	6	(3)	(1)	0	19	0	0	0	0	**33**	0
GH Compliance	2	0	0	0	0	0	0	0	0	0	0	0	**2**	0
Finchley Road	1	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Fire Safety & Compliance	0	2	2	3	3	13	3	3	3	16	3	48	**97**	96
Roofing - GH	0	0	0	0	0	22	0	0	0	24	0	0	**46**	35
Catering Equipment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	20
Basement Sprinkler System	0	0	0	0	0	0	0	0	23	0	0	0	**23**	10
Toilets - Anti Ligature / Gender Neutral	0	0	0	0	0	0	0	0	0	0	0	10	**10**	50
ESTATES	**22**	**23**	**10**	**17**	**15**	**47**	**71**	**27**	**130**	**71**	**44**	**69**	**546**	**464**
Relocation	**85**	**99**	**86**	**125**	**80**	**99**	**171**	**104**	**167**	**201**	**270**	**326**	**1,814**	**2,901**
Digital Academy	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**3**	**0**	**5**	**24**	**122**
Projected Underspend / Contingency	**0**	**0**	**0**	**0**	**0**	**0**	1	**0**	**0**	**0**	**0**	**0**	**1**	**752**
TOTAL	**116**	**140**	**127**	**176**	**138**	**189**	**322**	**80**	**563**	**552**	**458**	**514**	**3,376**	**4,804**

The Tavistock and Portman NHS Foundation Trust

Board of Directors: Jan 2022

Report to	Date
Board of Directors	25/01/ 2022

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and analysis of Q3 21/22 quality metrics for the Trust. The commentary section provides service updates on waiting times and 'DNAs', which should be read in conjunction with the slide set. Updates are also included detailing the current position of Trust Quality Priorities.

Please note the data in this report is Trust-wide.

The report includes the following **highlights and improvements**:

- The number of Trust referrals continues to be above the last eight quarters mean, although a 10% decrease in numbers compared to Q1 and Q2 is noted. GIDS experienced the most significant drop which is understood to be attributed to the new NHSE GIDS referral management service for all new referrals.
- Last year CAMHS under-18s received a lower number of referrals and this helped maintain good waiting times. However a large influx of referrals since then has had a negative effect on waiting times.
- Waiting Times compliance rates for CYAF have continued to perform well, especially in referral to 1st appointment. Other CAMHS suffered a drop for waiting times to second appointment, which is positive.
- Trust-wide, a good DNA rate with compliance in Q3 at 8% is recorded. Only two service lines don't meet the 10% target: GIC and Adolescents.
- The MHSDS data for October 2021 shows a slight increase in ethnicity collection rates. The Trust has demonstrated a continuous and sustained improvement over the last two years. The Trust also meets the DQMI 95% target, reaching 97.2% in September 21. Employment and Accommodation also continues to improve but at a slower pace.
- The number of incidents remains similar to last quarter. Patient safety incidents have slightly increased but it is noted that some of the deaths flagged in Q3 actually happened in previous quarters. Incidents in Gloucester House decreased in Q3.
- The number of complaints in Q3 decreased to 26, compared to 45 in Q2. There is a marked decrease in Gender directorate complaints. This is understood to be related to improvements in communication and expectations with patients.
- The Trust has focused efforts on mandatory training and in December we saw a good improvement in compliance, reaching a 80.98% completion rate. This remains an area of focus, as appropriate for an NHS provider for numerous pathways.
- Outcome Measures - iIn Q3 improvements rates for CORE improved: 73% of discharged patients, with a minimum of two forms completed, have shown improvements in CORE scores. This quarterly report also now includes reporting on which portion of completed forms have

been recorded within the expected time frame. There has been and continue extensive work on the use of electronic methods, including qualtrix for improvement of feedback via outcome measures and ESQ.

- All the quality priorities are now being reviewed with the aim of agreeing a new set of priorities for the coming period. These will be brought in draft for the March Board.

There are also details of continuing **Challenges**:

- The number of individual patients seen in Q3 has decreased Trust-wide by 3%. Service lines like Adolescents and GIDS have a more distinctive decrease rate. In previous quarters, during lockdowns, it was noted that remote appointments had a positive effect on the number of patient seen. In Q3, where more face to face activity was recorded, lower attendance and higher cancellations and DNA rates were noted. It is also understood that the GIDS reduction could be influenced by the training period for new staff starters and the time demands of MDCR.
- Waiting Times compliance rates for AFS have decreased slightly at directorate level. It is believed that this is partially caused by staff retention issues and the SR demand. Adults Complex Needs have particularly longer wating times.
- Waiting Times for Gender Services continue to be lengthy and there are several ongoing efforts to improve productivity.
- The collection of ESQ forms decreased in Q3. During the last quarter the Trust prepared the ground to launch an electronic collection method (Qualtrics) for ESQs in Adults Complex Needs and the over 18s patients in the Adolescents service.
- There is a concern about DBS completions rates, specifically in AFS where the rate is 83.17%.
- Despite some improvements, as above, outcome measures continue to remain a focus of work as greater efforts are needed towards collection methods, inputting timings and staff engagement. CORE OM, GBMs and CGAS T1 and T2 completions are still under target.
- The Quality Priority 'Embed a revised job planning process within clinical services' has some risks regarding the implementation, as job planning for all staff will require a significant amount of management resource to implement. The mitigation plan includes implementing generic job plans, where appropriate, to ensure all managers have the opportunity to access good quality management training. The proposals include 2.0 WTE Programme Managers on fixed term contracts to manage the implementation of the SR.
- The Quality Priority 'Improve Waiting Times Across the Trust' is one of the most challenging areas the Trust is working on. There are discussions ongoing on a reset to the QP and the process around it. Several teams have taken different initiatives to approach this challenge however more coordination of this effort is required.
- CAMHS care plan compliance, which is a KPI, continues to remain below the 80% target for completion. The compliance rate for initial care plans is 53% and for the review care plans it is 23%. Improvements in reports and reminder systems are being reviewed to improve their efficiency. CYAF are taking steps to improve the efficiency of the Care Plan operational process; improvements are expected as changes are gradually implemented.

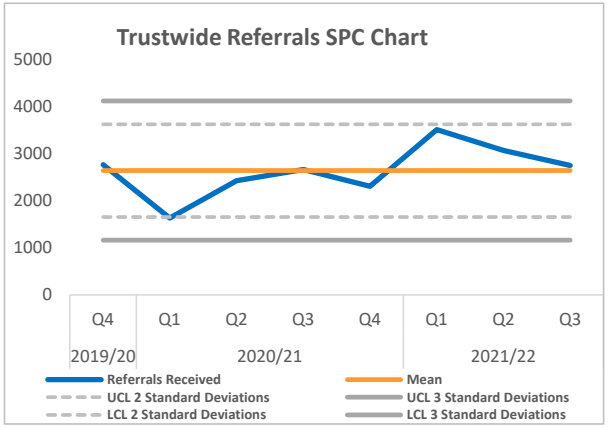
Recommendation to the Board of Directors

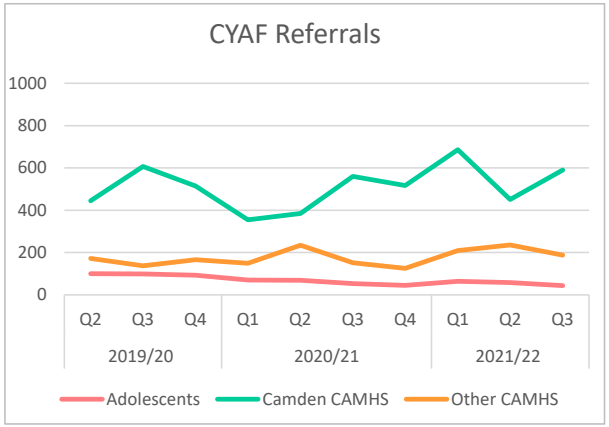
The Board of Directors is asked to discuss the report.

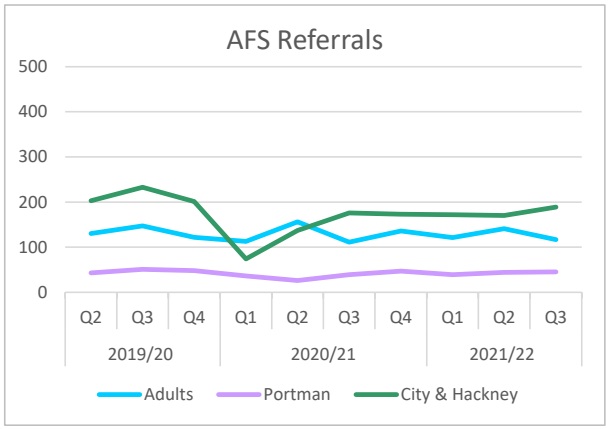
Trust strategic objectives supported by this paper

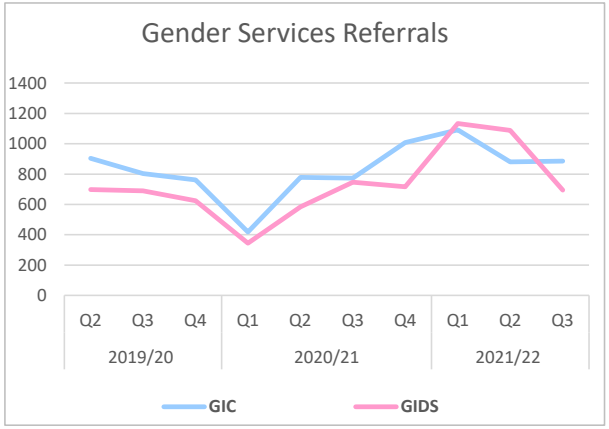
Finance and Governance	
Author	**Responsible Executive Director**
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q3 2021/22: Trust Reach – Access









Data source: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q3 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. Other historical data as reported in relevant earlier reports.

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 Q3 2753 referrals were received Trust-wide, 315 fewer than in Q2; a decrease of 10%. However, the Trust was 16% above the quarterly average number of referrals received during the last financial year.

Adolescents: in Q3 43 referrals were received, 15 fewer than in Q2. This quarter the service was 27% below the quarterly average number of referrals received during last financial year (59).

Camden CAMHS: in Q3 590 referrals were received, 140 more than in Q2. This quarter the service was 30% above the quarterly average number of referrals received during last financial year (454).

Other CAMHS: in Q3 188 referrals were received, 48 fewer than in Q2. This quarter the service was 14% above the quarterly average number of referrals received during last financial year (165). Teams like FS and FDAC have a delay in recording referrals due to their nature. This will affect previous quarters' figures after data has been re-run.

Adults Complex Needs: in Q3 117 referrals were received, 24 fewer than in Q2. This quarter the service was 9% below the quarterly average number of referrals received during last financial year (129).

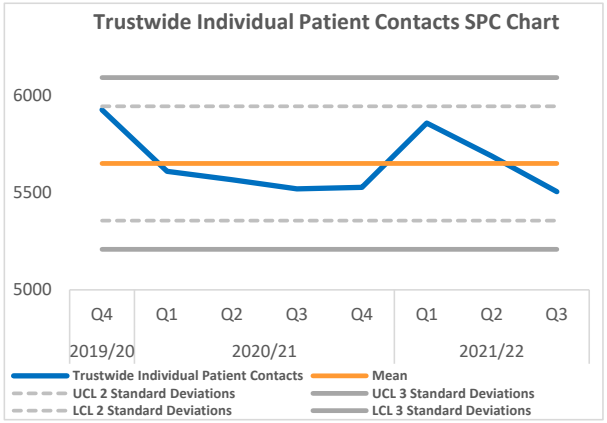
Portman: in Q3 45 referrals were received, 1 more than in Q2. This quarter the service was 22% above the quarterly average number of referrals received during last financial year (37).

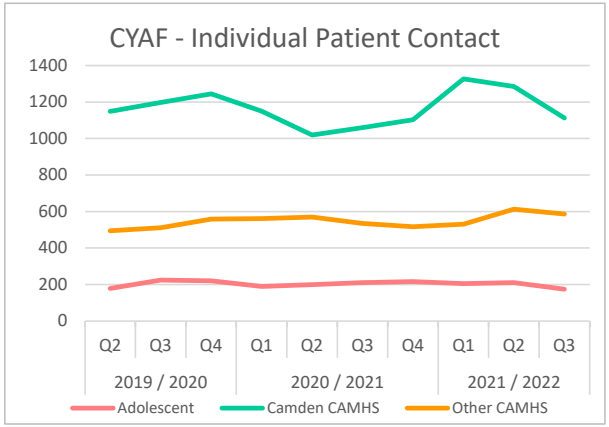
C&H PCPCS: in Q3 189 referrals were received, 19 more than in Q2. This quarter the service was 35% above the quarterly average number of referrals received during last financial year (140).

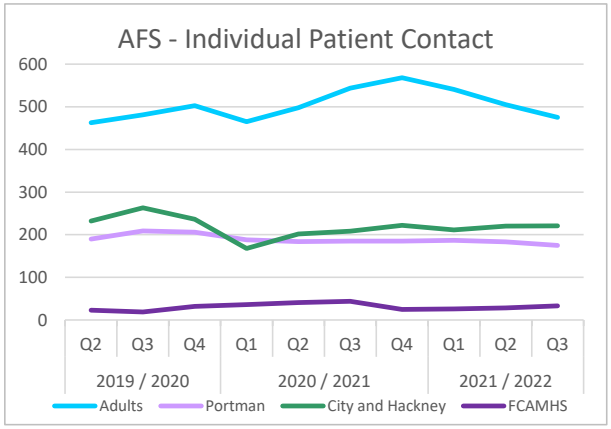
GIDS: in Q3 695 referrals were received, 393 fewer than in Q2. This quarter the service was 16% above the quarterly average number of referrals received during last financial year (598).

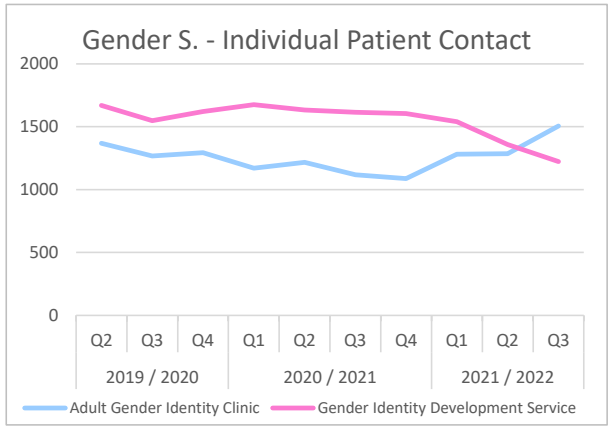
GIC: in Q3 886 referrals were received, 5 more than in Q2. This quarter the service was 19% above the quarterly average number of referrals during last financial year (744). Q2 backlog has improved but still experiencing staffing and work volume challenges.

Q3 2021/22: Trust Reach – Access









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, 5505 individual patients were seen in Q3, 183 fewer than in Q2 (3% decrease from Q2). The Trust was 1% under the quarterly average number of individual patients seen during last financial year.

Adolescents: in Q3 174 individual patients were seen, 36 fewer than in Q2. This quarter the service was 14% below the quarterly average number of patient contacts during last financial year (204).

Camden CAMHS: in Q3 1112 individual patients were seen, 173 fewer than Q2. This quarter the service was 3% above the quarterly average number of patient contacts during last financial year (1083).

Other CAMHS: in Q3 586 individual patients were seen, 27 fewer than in Q2. This quarter the service was 7% above the quarterly average number of patient contacts during last financial year (546).

Adults Complex Needs: in Q3 475 individual patients were seen, 30 fewer than in Q2. This quarter the service was 8% under the quarterly average number of patient contacts during last financial year (519).

Portman: in Q3 175 individual patients were seen, 8 fewer than in Q2. This quarter the service was 6% under the quarterly average number of patient contacts during last financial year (186).

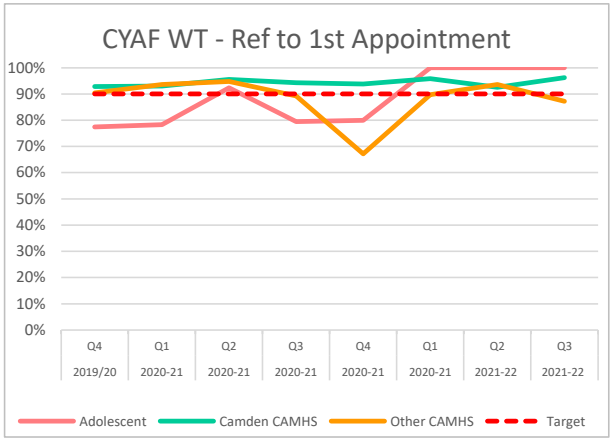
C&H PCPCS: in Q3 221 individual patients were seen, 1 more than in Q2. This quarter the service was 11% above the quarterly average number of patient contacts during last financial year (200).

GIDS: in Q3 1223 individual patients were seen, 135 fewer than in Q2. This quarter the service was 25% under the quarterly average number of patient contacts during last financial year (1632).

GIC: in Q3 1506 patients were contacted, 220 more that in Q2. This quarter the service was 25% above the quarterly average number of patient contacts during last financial year (1148).

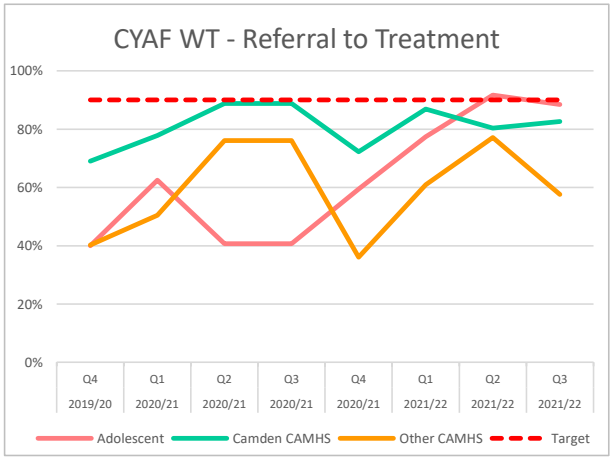
Data source: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q3 data has been run without meeting the threshold on a number of unoutcomed appointments. Q4 report will include a rerun of all 21/22 quarters.
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021. Other historical data as reported in relevant earlier reports.

Q3 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%**	2	1	1	0	0	0
Adolescents over 18	**100%**	4	3	6	4	0	0
Camden CAMHS	**96%**	199	105	53	4	7	3
Other CAMHS	**87%**	10	17	48	4	4	3

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	**75%**	1	1	1	0	0	1
Adolescents over 18	**91%**	1	4	5	7	3	2
Camden CAMHS	**83%**	69	74	94	21	18	11
Other CAMHS	**58%**	2	8	43	15	14	10

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: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q3 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. Other historical data as reported in relevant earlier reports.

CYAF Waiting Times:

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

Referral to 1st Appointment: In Q3 CYAF saw 95% of patients within the contractual waiting times. This is a higher rate compared to 93% in Q2.

Referral to Treatment: In Q3 CYAF saw 77% of patients within the contractual waiting times. This is a lower rate compared to 80% in Q2.

Adolescent services

Referral to 1st Appointment – in Q3 the whole service line saw 100% of patients within contractual waiting times; the same performance as in Q2.

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

Referral to Treatment– in Q3 the whole service line saw 88% of patients within contractual hours, a compliance decrease compared to 92% in Q2.

- Adolescents under 18 - 75%
- Adolescents over 18 - 91%

Camden CAMHS

Referral to 1st Appointment – has consistently met the target since 2017/18. The compliance rate in Q3 was 96%, an increase compared to 93% in Q2.

Referral to Treatment – in Q3 83% of the patients had an appointment within 8 weeks, an increase in compliance compared to 80% in Q2.

Other CAMHS

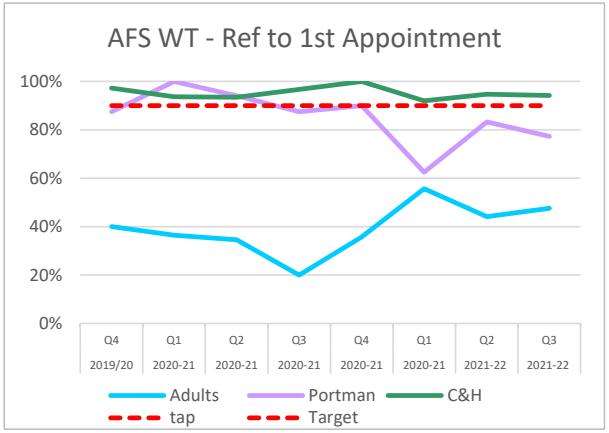
Referral to 1st Appointment – in Q3 they achieved 87%, a decrease in compliance compared to 94% to Q2.

Referral to Treatment– in Q3 58% of the patients had an appointment within the contractual waiting times, a significant decrease compared to 77% in Q2.

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

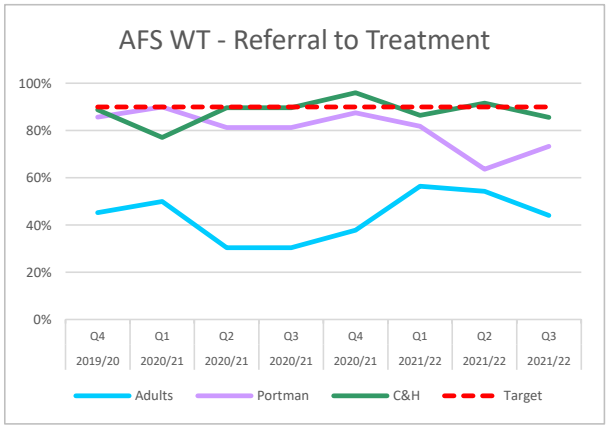
For further comments from service leads please see the commentary part of the report Page 20

Q3 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	**48%**	11	4	2	3	2	20
Portman	**77%**	4	4	7	2	2	3
City & Hackney PCPCS	**94%**	11	10	47	9	4	5

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	**44%**	0	8	1	2	4	19
Portman	**73%**	0	3	3	5	0	4
City & Hackney PCPCS	**86%**	6	6	27	13	13	11

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 Q3 AFS saw 79% of patients within the contractual waiting times. In Q2 this compliance was 82%.

Referral to Treatment : In Q3 AFS saw 73% of patients within the contractual waiting times. In Q2 this compliance was 78%.

Adult Complex Needs

Referral to 1st Appointment –in Q3 48% compliance was achieved, an increase on Q2 (44% compliance).

Referral to Treatment– in Q3 44% compliance was achieved, a decrease on Q2 (54% compliance).

Portman

Referral to 1st Appointment – in Q3 77% compliance was achieved, a decrease on Q2 (83% compliance).

Referral to Treatment– in Q3 73% of patients were seen within contractual times, an increase on Q2 (64% compliance).

C&H PCPCS

Referral to 1st Appointment – in Q3 94% compliance was achieved, a slight decrease on Q2 (95% compliance).

Referral to Treatment– in Q3 86% compliance was achieved, a decrease on Q2 (92% compliance).

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

Data source: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
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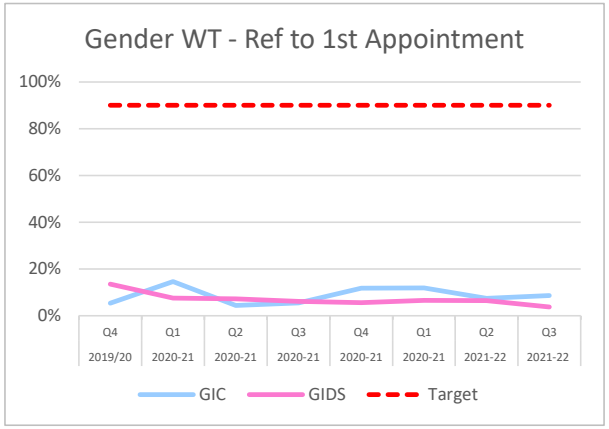
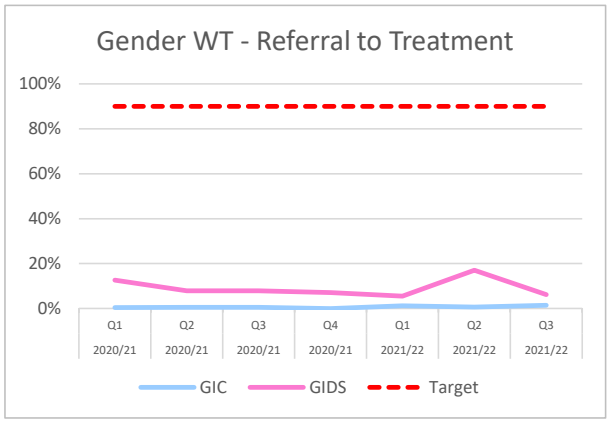
Q1 and Q2 21/22 data run on 30/12/21. Previous financial year data run on 14/06/2021. Other historical data as reported in relevant earlier reports.

Q3 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 +
GIDS	**4%**	4	1	3	1	0	230
GIC	**9%**	1	1	5	2	4	137

GIDS target within 18 weeks
GIC target within 18 weeks



Service Lines	% compliance	0 ≤ 2 wks	2 ≤ 4 wks	4 ≤ 8 wks	8 ≤ 11 wks	11 ≤ 18 wks	18 wks +
GIDS	**6%**	0	0	2	0	4	91
GIC	**1%**	1	1	0	0	1	205

GIDS target within 18 weeks
GIC target within 18 weeks

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 6% of patients within the contractual waiting times in Q3. This is a lower rate compared to 7% in Q2.

Referral to Treatment : Gender Services Directorate saw 3% of patients within the contractual waiting times in Q3. This is a lower rate compared to 4% in Q2.

GIDS: as a measure of awareness the GIDS website shares information about the WT issue; the current waiting time is advised on the website to young people and referrers. GIDS is currently seeing young people for their first appointment who were referred in 2018 and there were 5341 patients waiting at the end of Q3.

Referral to 1st Appointment – Q3 had 4% compliance, an decrease on 6% in Q2.

221 patients waited 52 weeks or longer to be seen.

Referral to Treatment – Q3 had 6% compliance, a decrease on 17% in Q2.

90 patients waited 52 weeks or longer to be seen.

GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals which is challenging within the current clinic parameters. At the end of Q3 there were 10748 patients waiting for a first assessment.

Referral to 1st Appointment – Q3 had 9% compliance, an increase on 8% in Q2.

129 patients waited 52 weeks or longer to be seen.

Referral to Treatment – Q3 had 1% compliance, the same as in Q2.

201 patients waited 52 weeks or longer to be seen.

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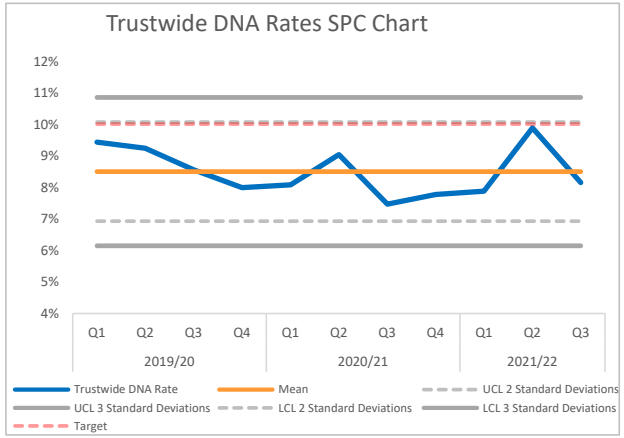
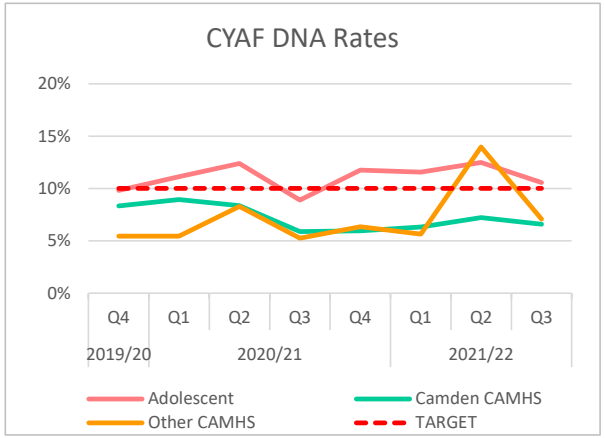
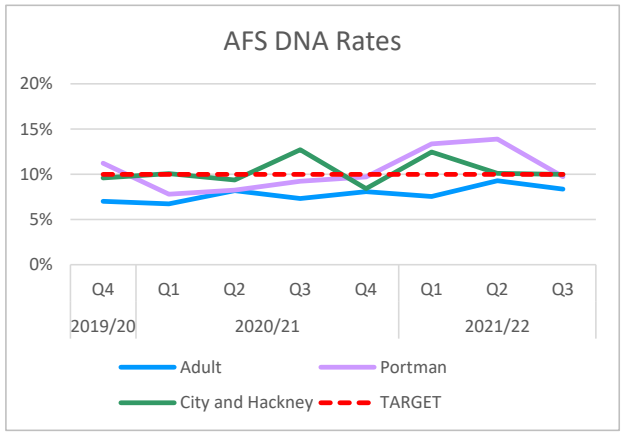
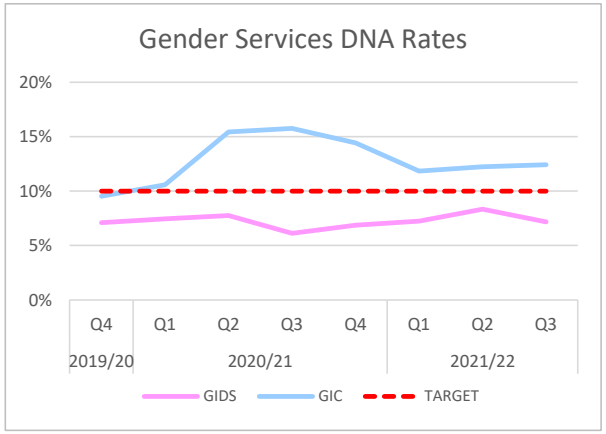
For further comments from service leads please see the commentary part of the report Page 22

Q3 2021/22: Quality Effective – Access









Did Not Attend (DNA)

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

We continue to meet the DNA target Trust-wide (8.15% compliance rate for Q3), 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: in Q3 had a DNA rate of 10.6% - 136 DNAs and 1151 attended appointments. The quarterly average during the last financial year was 11%.

Camden CAMHS: in Q3 had a DNA rate of 6.58% - 446 DNAs with 6330 attended appointments. The DNA average during last financial year was 7.3%. The target has been met for the last 2 years.

Other CAMHS: in Q3 had a DNA rate of 7.08% - 206 DNAs and 2705 attended appointments. The average during the last financial year was 6.3%.

Adults Complex Needs: in Q3 had a DNA rate of 8.35% - 289 DNAs and 3174 attended appointments. The average during the last financial year was 7.6%. The target has been met for the last 2 years.

Portman: in Q3 had a DNA rate of 9.73% - 135 DNAs and 1252 attended appointments. The average during the last financial year was 8.7%.

C&H PCPCS: in Q3 had a DNA rate of 9.99% - 84 DNAs and 757 attended appointments. The average during the last financial year was 10.1%.

GIDS: in Q3 had a DNA rate of 7.16% -214 DNAs out of 2773 attended appointments. The average during the last financial year was 7%.

GIC: in Q3 had a DNA rate of 12.43% - 275 DNAs and 1937 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 23, 24 & 25

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Q3 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 September 2021, with 96.4% against a target of 95%.

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

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 10 January 2019/20	Month 1 April 2020/21	Month 4 July 2020/21	Month 7 October 2020/21	Month 10 January 2020/21	Month 1 April 2021/22	Month 4 July 2021/22	Month 7 October 2021/22
Valid NHS number	95%	99.01%	98.97%	98.99%	99.16%	99.60%	99.50%	99.26%	99.30%
Valid Postcode	95%	99.71%	99.79%	99.70%	99.72%	99.53%	99.64%	99.65%	99.67%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.21%	99.14%	99.13%	99.14%	99.13%	99.04%	99.13%	98.88%
Valid Organisation code GP Practice	95%	98.46%	98.55%	98.28%	98.33%	99.12%	99.09%	99.03%	99.01%
Valid Gender	95%	99.41%	99.38%	98.80%	98.50%	99.98%	99.95%	99.96%	99.98%
Ethnicity	95%	77.79%	75.94%	75.82%	73.88%	88.77%	88.88%	90.94%	91.07%
Employment Status (for adults)	95%	56.67%	56.68%	55.94%	54.92%	66.98%	63.64%	66.44%	67.57%
Accommodation status (for adults)	95%	55.64%	55.48%	54.69%	53.63%	66.59%	63.31%	65.70%	67.01%
Primary Reason For Referral	n/a	99%	99%	99%		100%	100%	100%	100%
Ex-British Armed Forces Indicator	n/a	46%	48%	56%		64%	73%	77%	79%
DQMI -Data Quality Maturity Index The DQMI Indicator is not submitted in the same intervals.	95%		95.60%	95.70%		96.6%	96.4%	97%	97.2% (SEP)

Data source: Data warehouse, informatics team 10/01/2022

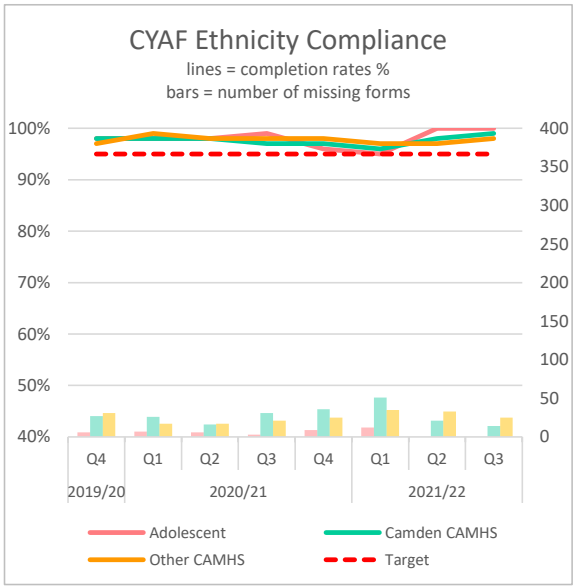
Q3 2021/22: Single Oversight Framework – Access

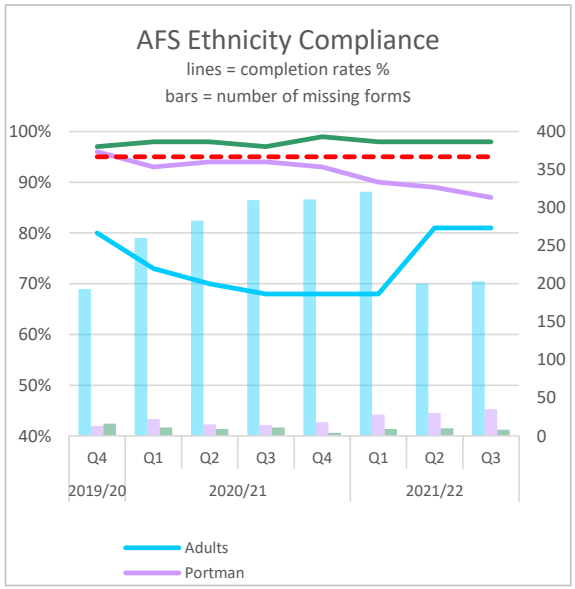
Ethnicity Rates Internal Reports

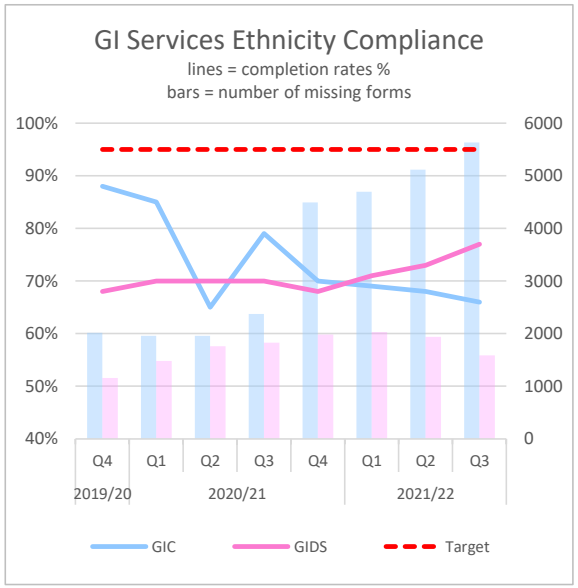
Ethnicity completion rates have been one of the most challenging MHSDS and DQMI data indicators as the target increased to 95%. The majority of our services are meeting the 95% ethnicity rate requirements. The services where we are experiencing difficulties are the Gender Services and Adult Complex Needs. 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. 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.

GIC has an increasing number of patients with missing ethnicity information. The service endeavours to collect all demographic data before the first appointment. The majority of the missing ethnicity data is for new referrals. There is an increasing number of patients on the waiting list and therefore the collection rate is declining. The GIC has an ambitious project to collect information from waiting list patients which is planned to start in Q4. Portman also has a decreasing trend on completion rates. The process in place is being discussed with an expectation on improving the trend soon.







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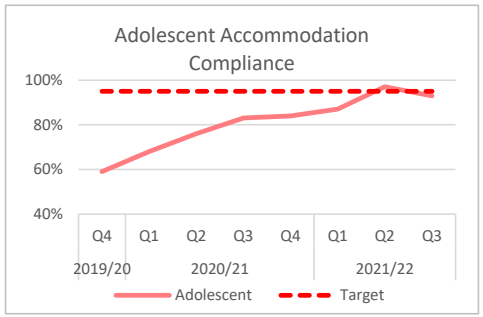
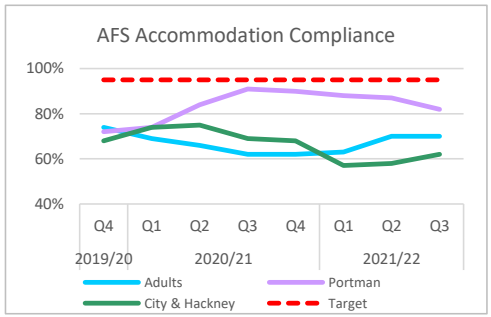
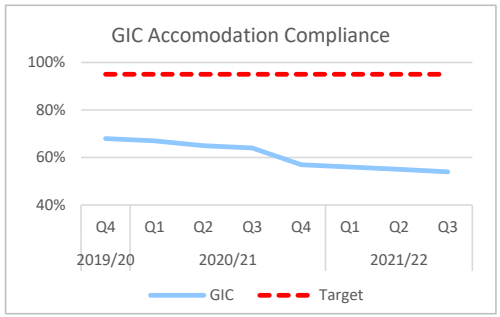
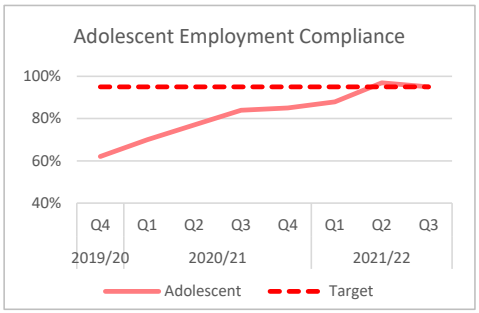
Previous quarters' data as reported in relevant earlier reports.

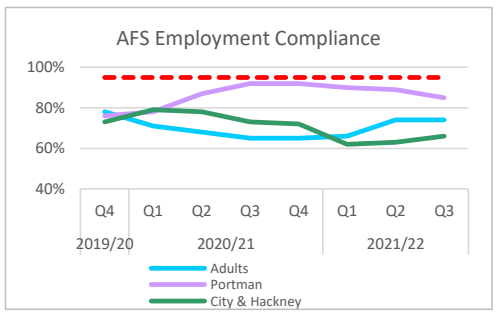
Q3 2021/22: Single Oversight Framework – Access

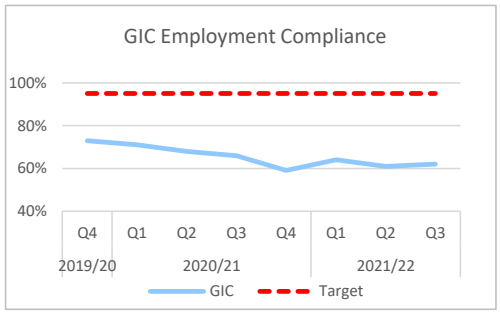


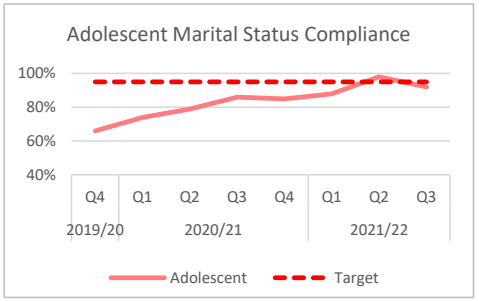


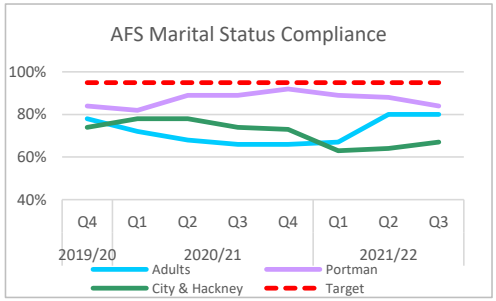


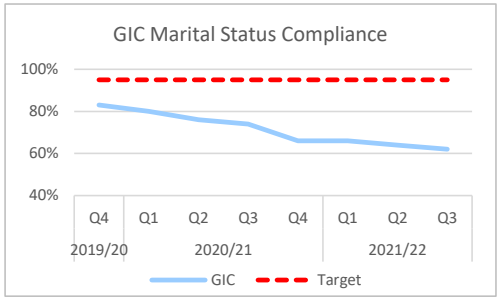












Data source: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q3 data has been run without meeting the threshold on number of unoutcomed appointments.
Previous quarters' data as reported in relevant earlier reports.

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.

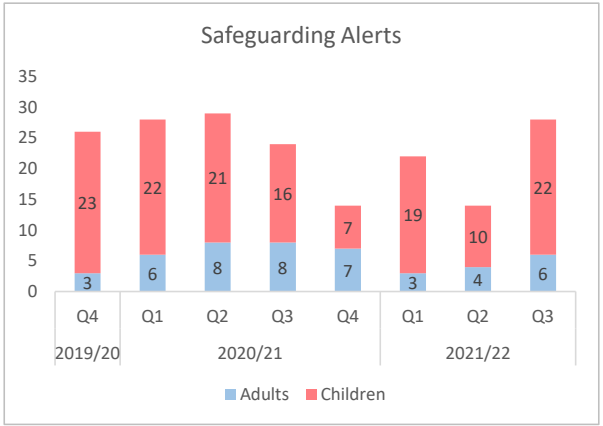
We are expecting that the 'patients detail forms' sent along with acceptance letters would start showing data improvement over the next few quarters.

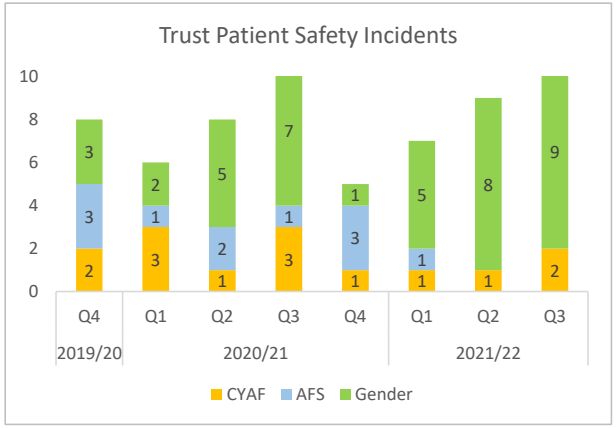
We are working on a solution to correct a minor glitch in the CareNotes report with regards to the information held on the Social Inclusion From. We have found a few cases where information has been provided but not included on the last social inclusion form, and the report is not counting this data.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

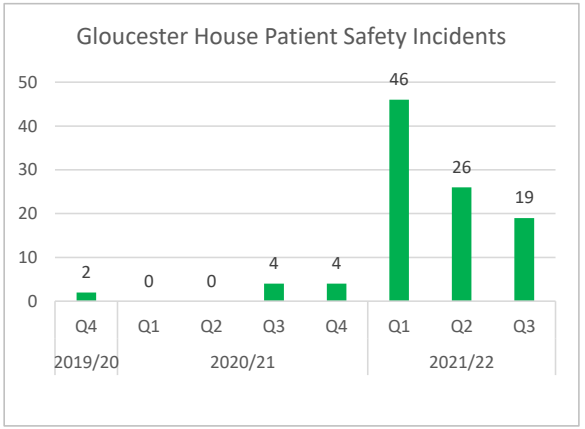
Q3 2021/22: Quality Safety – Care

Numbers of incidents logged in our QP system (all types)	Incidents Reported by Risk Level – Trust wide	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3
	1-4	60	37	33	32	62	64	38	29
	5-8	30	11	19	30	29	42	32	33
	9-12	18	3	3	12	20	14	5	15
	15+	1	1	2	1	3	2	1	1*
	Total	109	52	57	75	114	122	76	78

**Ongoing IT connection issues at Lief House*







The safeguarding adults concerns refer to 2 x emotional abuse; 1 x emotional and sexual abuse; 1 x physical abuse, emotional, domestic abuse and violence; 1 x physical and emotional abuse; 1 x emotional and radicalisation concern.
The safeguarding children alerts refer to concerns of sexual abuse, neglect of mental health, aggressive behaviour towards parents, ongoing level of need and support requirement, domestic abuse and violence, emotional abuse, physical abuse, self-harm, involvement with gangs, neglect and substance misuse.

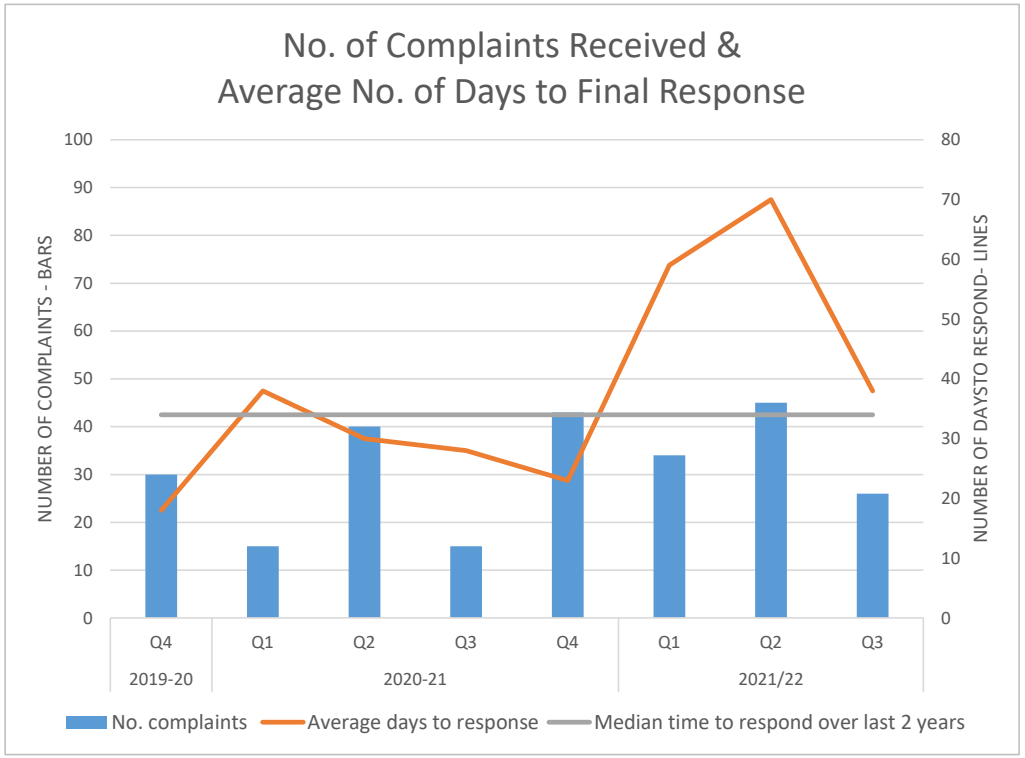
CYAF-
Family Mental Health – 2 x YPs attempted suicide
GIDS-
1 x YP attempted suicide
GIC-
7 x Patients died. Death was discovered as part of a larger data collection. Unknown cause of death.
1 x Patient died, death was discovered as part of a larger data collection. Suspected suicide.

Ongoing Incidents of violence towards staff and damage to property, a couple of children are not coming into school due to the risk to staff and other pupils, one child involves risk of self-harm and both with concerns of harm to family members, external agencies involved in those cases.
Home schooling via Zoom. Incidents taken to the Monthly Incident Panel by the Clinical lead for GH and also reported via the Patient Safety and Risk report.

Data & commentary source: Q1 , Q2 & Q3 data run by Health & Safety and Safeguarding Departments 12/01/2022
Other historical data as reported in relevant earlier reports.

Q3 2021/22: Quality Responsive – Care

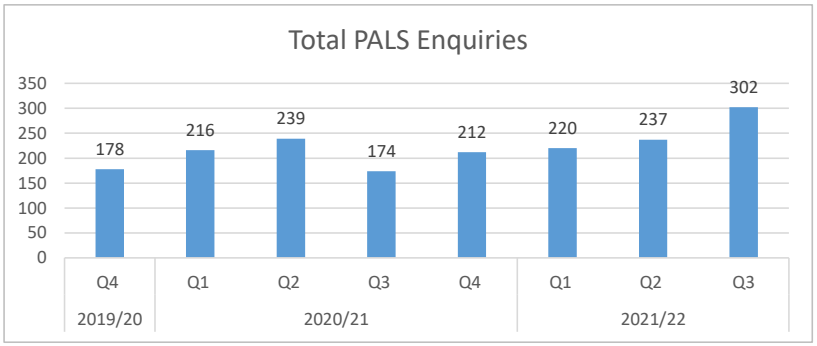
See Slide 33 for further KPI complaints information



This is a decrease in the number of complaints received during the previous quarter, 45 complaints were received in Q2, 2021/22. Of the 26 complaints received in Q3 3 had been responded to, leaving 23 open. The backlog of complaints is still being addressed following the 'pause' in the complaints process in place from the end of March 2020 due to the coronavirus crisis. We are working to address the capacity issues in terms of processing the number of complaints and backlog of complaints and extra resources are being allocated to complaints work. Through the strategic review we are pursuing various initiatives to improve our trajectory of completion. All complainants are advised to expect a delay in the response to their complaint and that it is not possible to say when we will be able to respond to a complaint.

Complaints by Directorate	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22
Children Young Adults and Families	4	0	1	0	3	1	5	3
Adult and Forensic	4	3	11	3	7	4	9	6
Gender	21	12	25	11	27	27	31	17
Corporate	1	0	3	1	7	2	0	0
Total complaints	**30**	**15**	**40**	**15**	**43**	**34**	**45**	**26**

Gender services have raised awareness of long waiting times via the website and other communication tools and increased transparency in this subject, this could be the reason for the decrease in number of complaints.



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 data run by Health & Safety and Safeguarding Departments 09/01/2022
Other historical data as reported in relevant earlier reports.

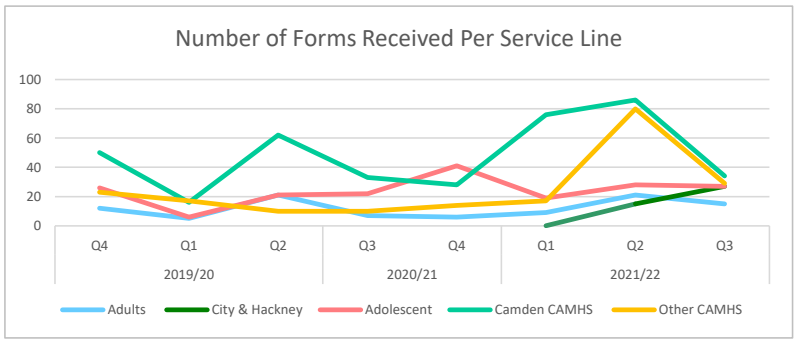
Q3 2021/22: Quality Responsive – Care

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%							
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%							
Q3 ESQ "How seriously were your views and worries taken?"	Quarterly	n/a	100	102	99%	202	204	99%	89	91	98%							
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%							
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%							
Q6 from ESQ "Would you recommend this service to friends and family?"	Quarterly	80%	91	96	95%	181	193	94%	88	91	97%							

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 Q1 21/22. Please note Q1, Q2 and Q3 21/22 data refers only to new forms (first form dated 16/04/2021), and prior data refers to the old forms. Despite the decline seen in Q3 21/22, it should be noted that the numbers are still above last year's levels. Please note, the City and Hackney started to collect ESQs forms in July 2021.

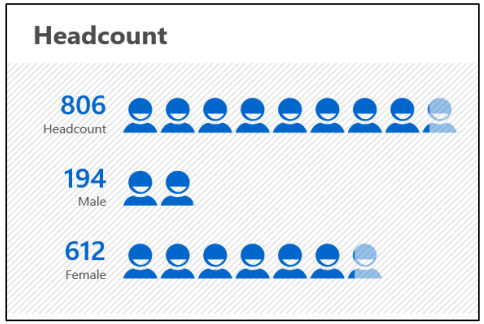
An online collection method (Qualtrics) is expected to be implemented in Q4; this methodology should increase the number of forms sent to patients and our return rate.

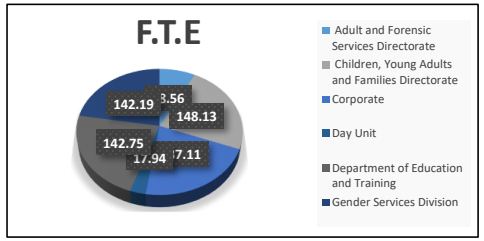


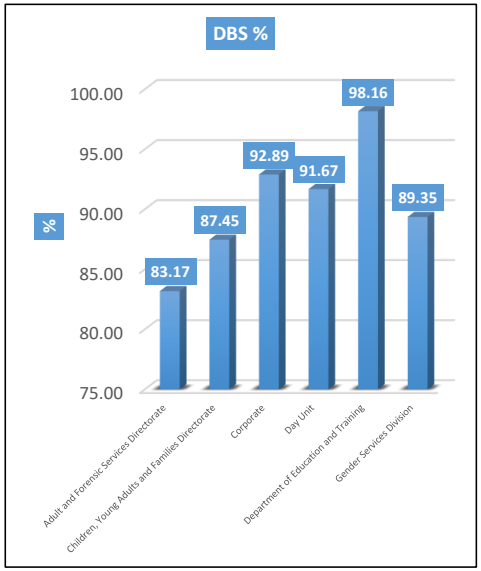
Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q3 data run on 07/01/22. Previous data run as reported in earlier reports.
*ESQ % = (Certainly true + Partly true)/(Certainly True + Partly True + Not True)

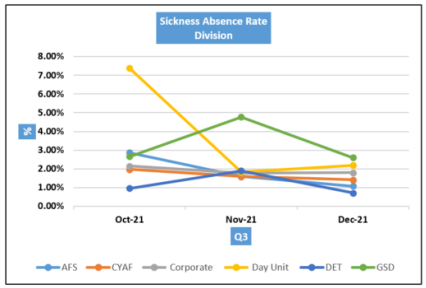
12

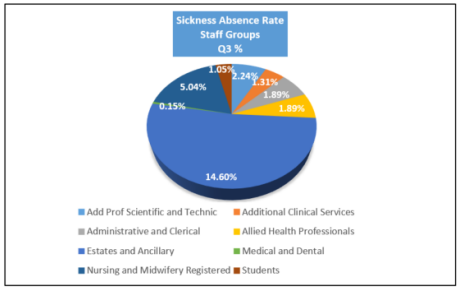
Q3 2021/22: Quality Well-Led

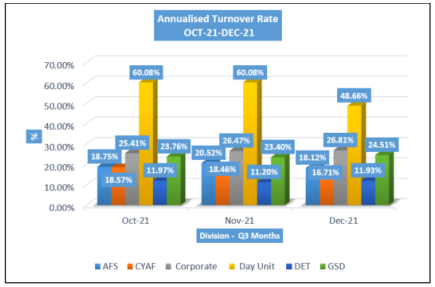


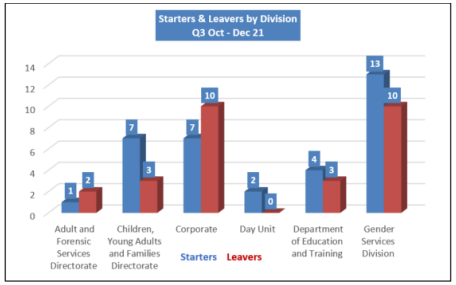


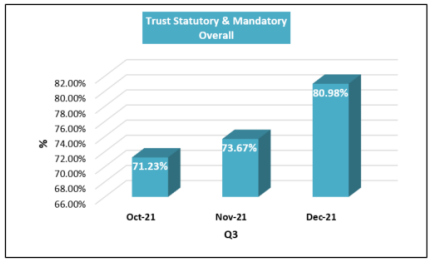


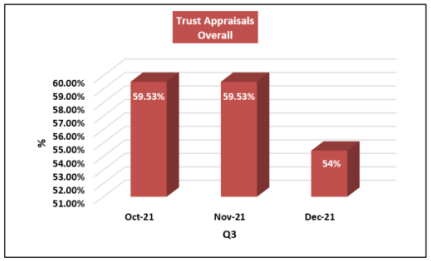












A number of positive changes has been noted in Q3 for the Trust. Turnover was at an increased rate for each division in August. There has been improvements at the end of Q3 for the divisions AFS, CYAF & Day Unit. Corporate, DET & GSD remain around the same turnover within Q3 by 1-2%.Headcount has been stable within the Trust for the past year on average around 800 active fixed term and permanent employees. We did start to see a decrease in July to 786, the lowest it has been within a year. However this has gradually increased through October to December 2021. Sickness Absence in the Trust had reached its peak in August at 3.53%, a great improvement at the end of Q3 in each division falling under the 3% mark. Compliance has been turned around in the past few months, this has improved dramatically. Trust overall in October was at 71.23%, this increased at the end of Q3 by 9.75%. Ending the year at 80.98%. The number of communications going out to employees, has assisted in ensuring the Trust complies with training needs. To maintain this, such measures as ensuring new employees who start within the Trust, should undertake statutory and mandatory training in the first week of employment to highlight the importance. Appraisals is slightly up from Q2, however room for improvement, as this has stayed the same in Q3, upon average of 59.53%. This can be highlighted by the communications team to ensure staff are being appraised. DBS Checks has maintained it's percentage at the end of Q3 at 92.83 %. This has been heading in the right direction from Q2Staff Survey has now come to a close. A comparison from last year's results will need to be reviewed. A further breakdown has been shown below on the number of employees who participated.

Data Source: Human Resources Department: 12/01/22

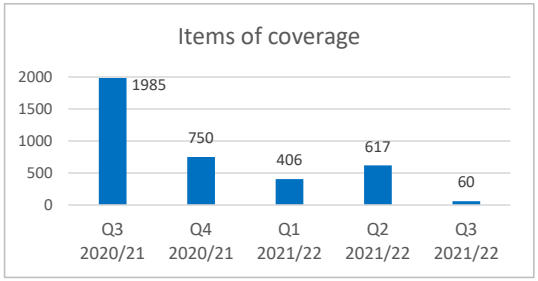
Q3 2021/22: Media & Digital – Care

Media overview

Q3 2021-22 saw 60 pieces of media coverage that mentioned our Trust: 31 in October, 12 in November and 17 in December. This is down from 617 in Q2, which was an abnormally high number caused by an employment tribunal and a judicial review appeal judgment falling in that quarter.

Notable media coverage in Q3 2021-22

- Dr Alison Berner from the GIC in *Pink News* commenting on a specialist cervical screening pilot for trans men and non-binary people
- Professor Andrew Cooper argued in *The Guardian* that sex offenders, such as Ghislaine Maxwell, have typically endured cruelty and neglect in their childhoods
- A set of new clinics for children with complications related to excess weight has been announced (we are part of the north London service, based in GOSH), this story ran in *The Guardian*, *I News*, *Daily Mail* and the *Telegraph*
- In *The Daily Mail* Camden Council said the Tavistock Clinic in part inspired the new LGBT road crossings in Tavistock Place
- *New Statesman* Medical Editor Phil Whitaker weighed the issues around puberty blockers for young people. We were not approached for comment
- The *Daily Mail* featured a non-GIDS ex-Tavistock staff member alleging that GIDS is pushing 'a form of conversion therapy' on gay children. We were not approached for comment.



Data & commentary source: Communications Department 14/01/22

Digital overview

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

- Website users **up 6.9%**: 135,339 vs 126,552
- Page views **down 35%**: 372,941 vs 576,095
- Sessions **up 6.6%**: 190,250 vs 178,369

Most-visited news stories:

1. Referrals to the Gender Identity Development Service (GIDS) level off in 2018-19, **436 views**
2. Accessible summary of the THRIVE Framework now available, **293 views**
3. Emotionally unstable personality disorder: finding a way forward, **277 views**

Most-visited course pages:

1. Child and adolescent psychoanalytic psychotherapy (M80), **4,963 views**
2. Working with children, young people & families: a psychoanalytic observational approach (M7 Daytime), **3,938 views**
3. Systemic psychotherapy (M6), **3,822 views**

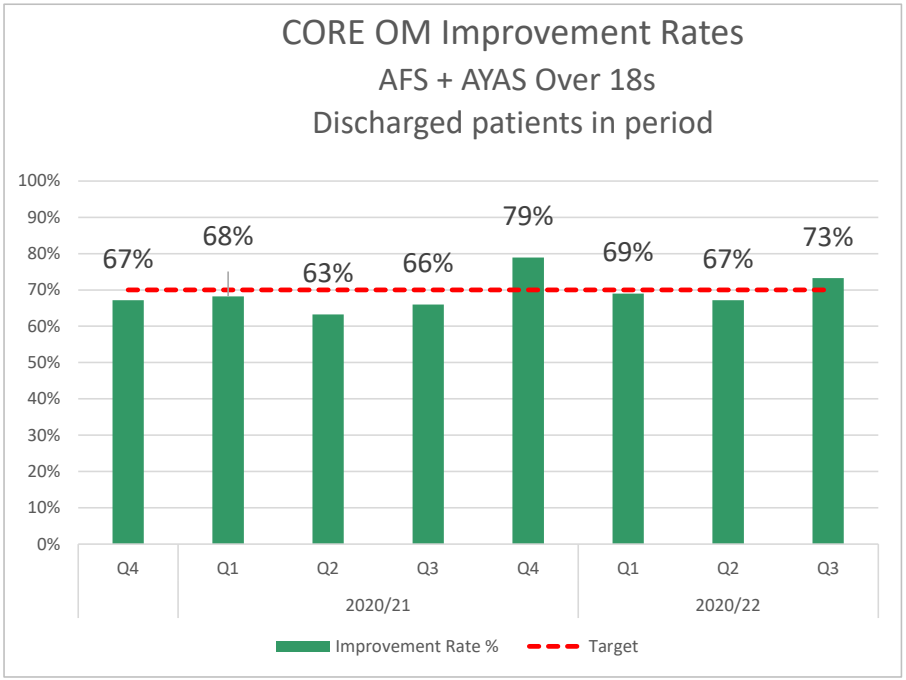
Social channels – followers compared to last quarter

- Twitter: **@taviandport:** 8,567, up from 8,399 (2% increase), **@tavitraining:** 5,625, up from 5,516 (2% increase)
- LinkedIn: 14,236, up from 13,716 (3.8% increase)
- Facebook: 7,595, up from 7,308 (3.9% increase)
- Instagram: 1,206, up from 1,159 (4.1% increase)

Q3 2021/22: Quality Effective – Outcome Measures

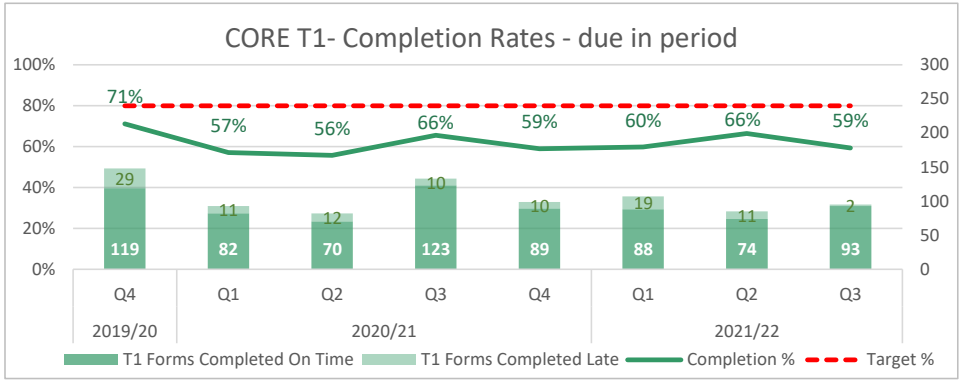
A F S and Adolescents over 18

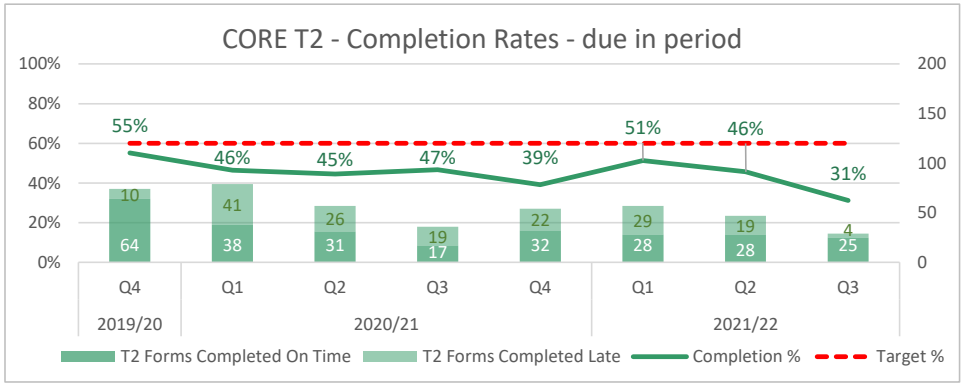
CORE OM data is run including all contracts



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 are pleased to see the improvement rates in Q3 exceed the 70% target, reaching a 73% improvement rate. 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.





This quarter we are pleased to be able to report on which portion of completed forms have been recorded within the expected time frame. Previous quarters include forms completed late therefore current quarter compliance will be naturally lower as late forms are not able to be included yet.

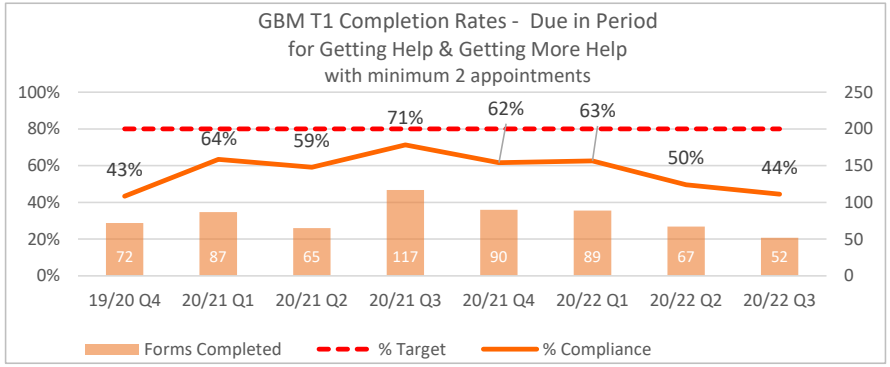
-CORE T1 rates:. in Q3 the compliance rate was 59% (incl. all forms). Please note that T1 is seen as due contractually after the second appointment therefore we allow a month for the postage and administrative process.

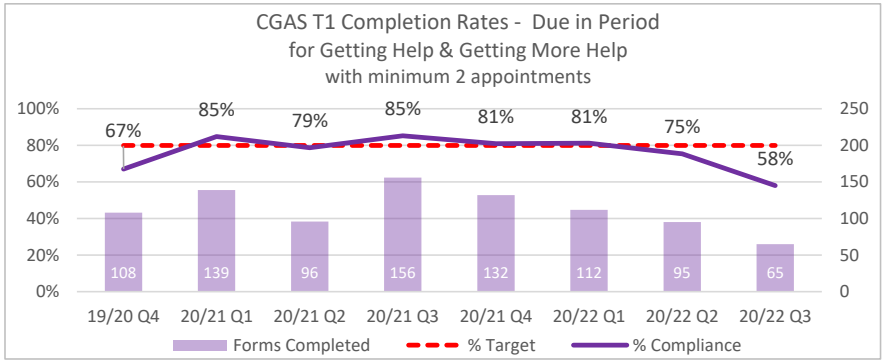
-CORE T2 rates: in Q3 the compliance rate was 31% (incl. all forms). Please note that T2 is due contractually 6 months after T1 completion date. There is also a one month grace period added for the postage and administrative process. T2 forms are particularly challenging for teams that have a long waiting list.

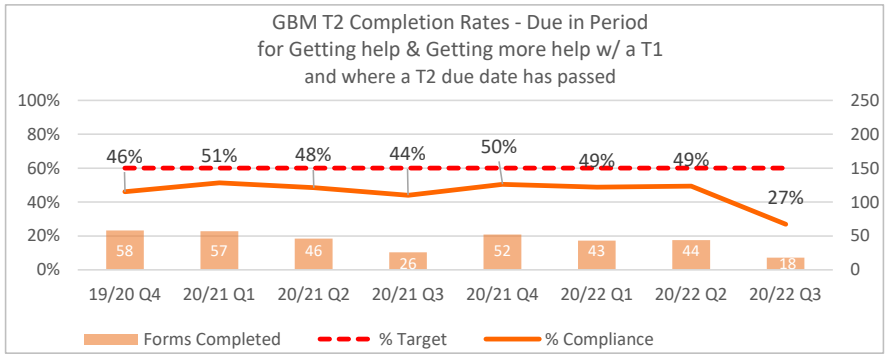
Data source: Q1, Q2 and Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous financial year data run on 15/06/2021. Other historical data as reported in relevant earlier reports.

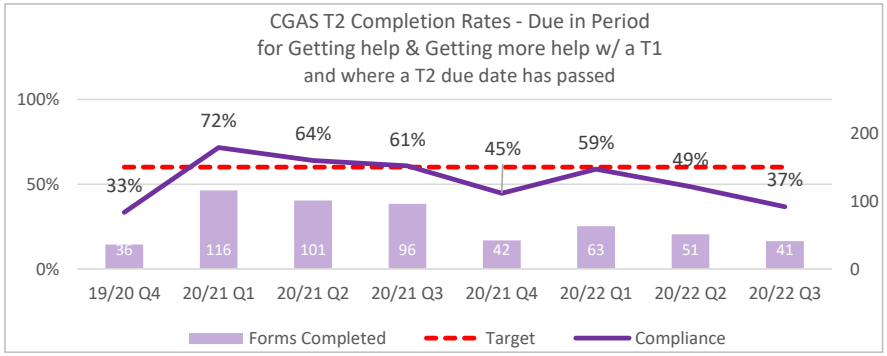
Q3 2021/22: Quality Effective – Outcome Measures

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









GBMs are part of our KPIs data and as such they include London Contracts only. The GBM T1s are expected to be completed after a second appointment and GBM T2s are expected 3 months after T1. Previous quarters include forms completed late. Current quarter compliance will be naturally lower as late forms are not able to be included yet.

-GBM T1 rates: in Q3 completion rates for due forms is 44%. Q1 & Q2s combined average (including late inputting) was 56%. The last financial year's average was 64%.

-GBM T2 rates: in Q3 completion rates have reached 27%. Q1 & Q2s combined average (including late inputting) was 49%. The last financial year's average was 49%.

CGAS are part of our KPIs data and as such they include London Contracts only. The CGAS T1 forms are expected to be completed after a second appointment and T2s are expected 6 months after T1. Previous quarters include forms completed late. Current quarter compliance would be naturally lower as late forms are not able to be completed yet.

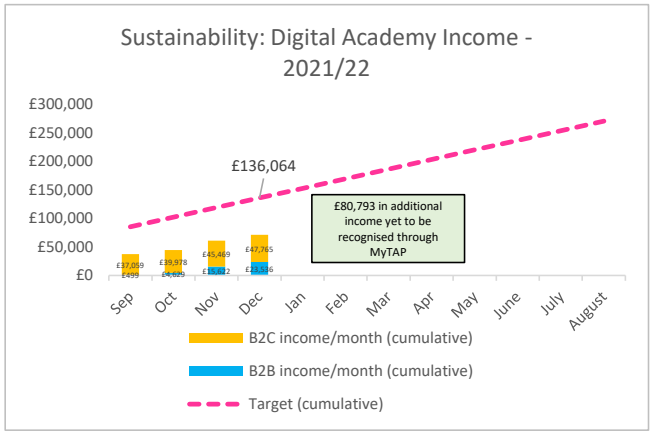
-CGAS T1 rates: in Q3 the compliance rate was 58%. Q1 & Q2s combined average (including late inputting) was 78%. The last financial year's average was 82%.

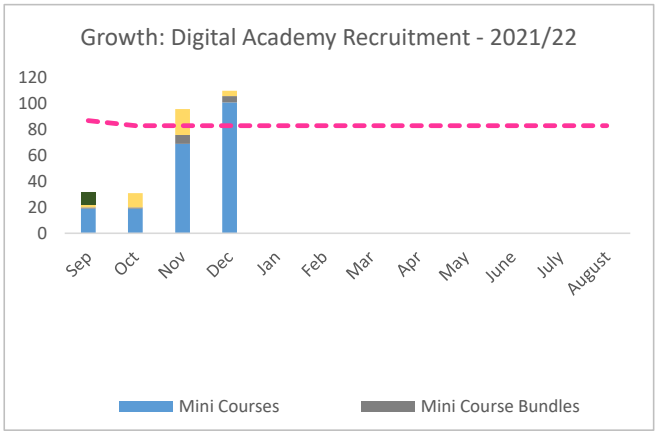
-CGAS T2 rates: in Q3 the compliance rate reached 37%. Q1 & Q2s combined average (including late inputting) was 54%. The last financial year's average was 60%.

Data source: Q3 data as recorded on 07/01/2022 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Q1 and Q2 data run on 06/01/2022. Previous financial year data run on 01/07/2021. Other historical data as reported in relevant earlier reports.

See Slide 37 for further GBM and CGAS information

Q3 2021/22: Directorate of Education and Training (DET)

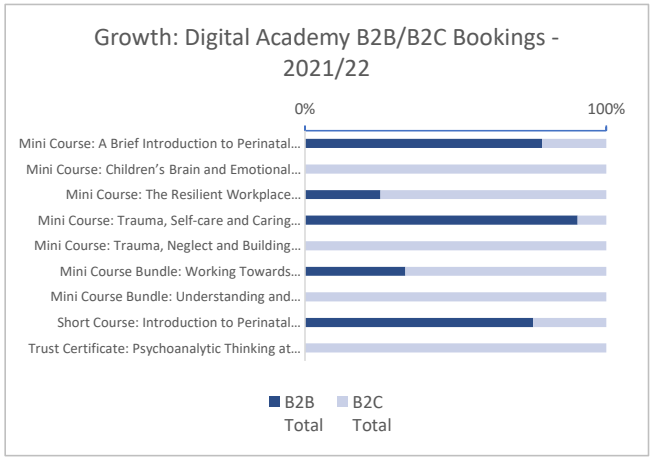


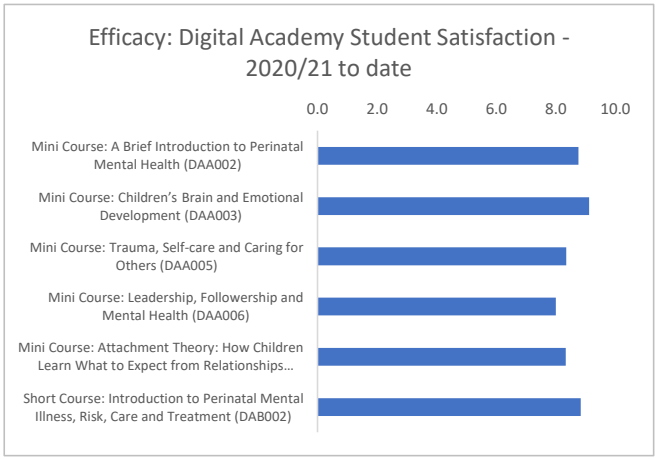


The 'Sustainability' graph shows cumulative individual booking income via the MyTAP system for all Digital Academy products in the 21/22 academic year from 1 Sep 2021 until 31 Dec 2021 (£71,301) against target (£136,064).

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-Dec 2021 stands at £80,793, which takes the total forecast Digital Academy income to £152,094 (12% over target). Discussions regarding a solution to reporting bookings/enrolment and invoice income in a more unified fashion are ongoing.

The 'Growth' chart shows a Digital Academy milestone - November 2021 was the first month since launch to exceed the monthly booking target. This has been driven by large numbers of enrolments for mini courses from B2B group bookings. Several hundred places that have been funded by organisations but not yet booked by individuals remain to be used, so bookings are set to remain high for the early-2022 period.





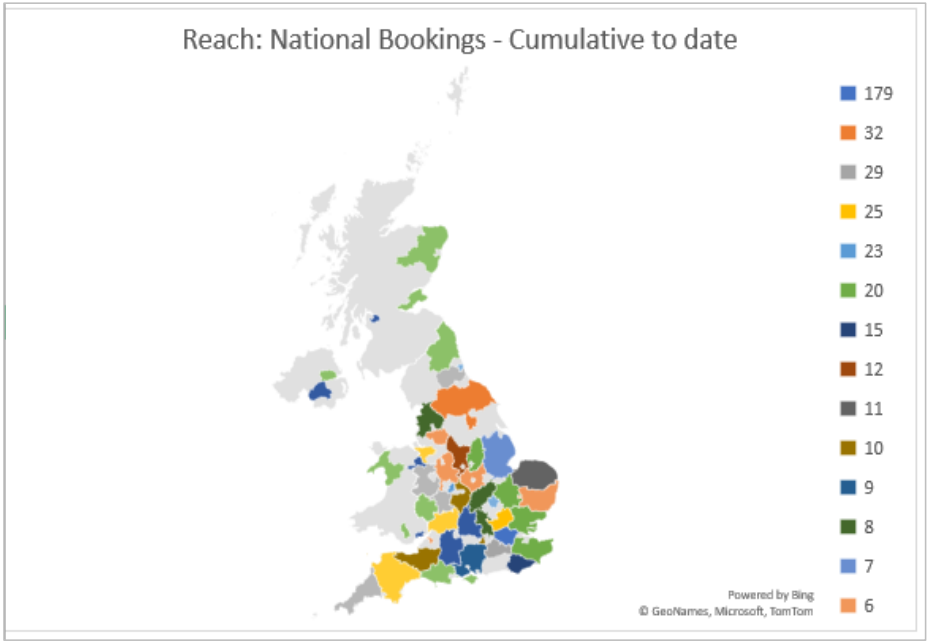
'The 'Growth' chart reflects the importance of B2B group bookings to the DA. 61% of bookings over the Sep-Dec 2021 period were from B2B bookings, although only 33% of the income was generated from these. This is driven by a high volume of B2B bookings being for the lower-cost mini courses. B2C activity for his period made up 39% of the total bookings and 67% of total income.

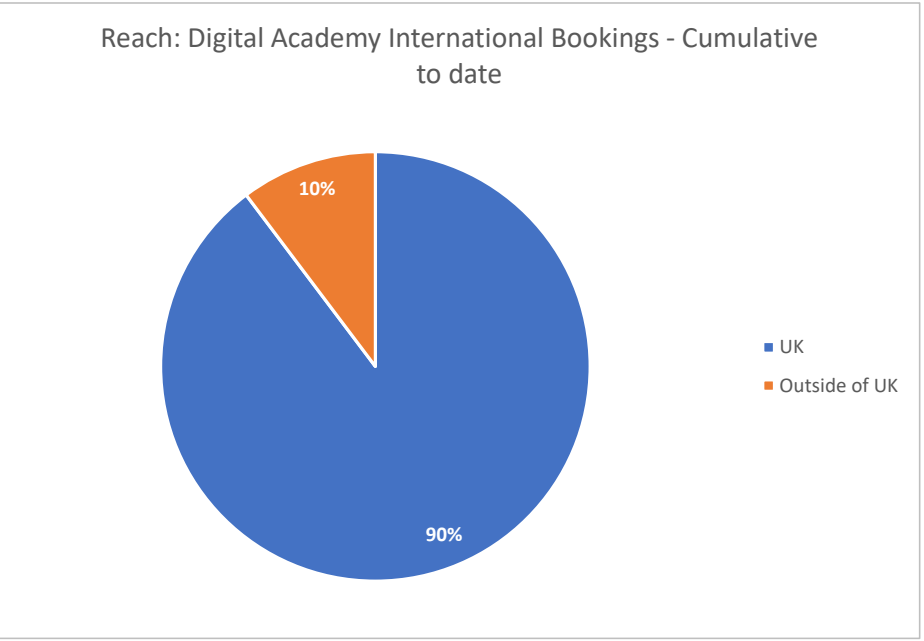
The courses delivering the most growth over the Sep-Dec 2021 period are the Perinatal Mini Course (79% of bookings/income from B2B sources and contributing 12% to total income); the Perinatal Short Course (76% of bookings/income from B2B sources and contributing 26% to total income); and the Trust Certificate (100% B2C bookings/income but contributing 49% to 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 12/01/2022

Q3 2021/22: Directorate of Education and Training (DET)





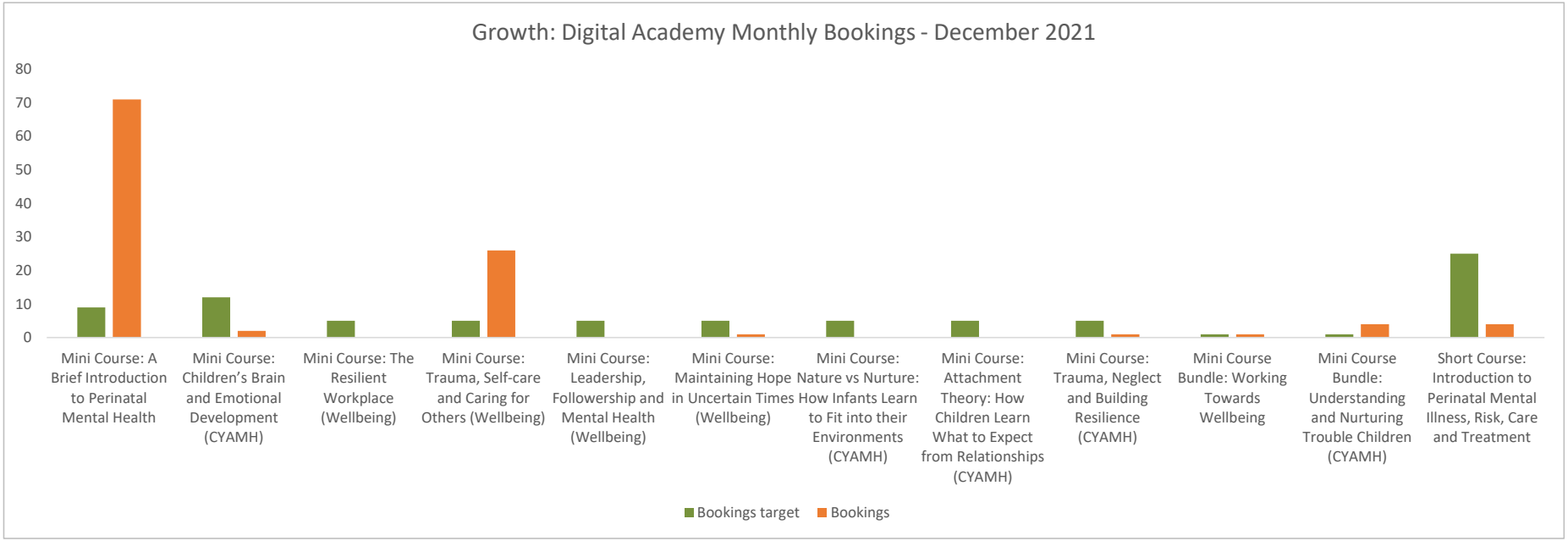
The 'Reach' chart displaying the map shows the national spread of DA bookings, which continues to grow each month. 86% of total DA bookings originated from England, with the next biggest source countries being Ireland and Scotland with 2% of bookings.

Nationally, there is healthy spread of bookings, with engagement strongest in the south east of England. 31% of bookings have come from the London/Greater London area, with strong results from the Home Counties. The next biggest source of bookings is Yorkshire with 6% and Surrey with 5% to date.

Internationally, the DA continues to perform well, with web engagement from 100 countries. As the 'Reach' pie chart shows, the majority of bookings originate from the UK, with 10% from international sources. Marketing activity is planned to expand the DA's international reach in the coming year.

Data & commentary source: DET Department 12/01/2022

Q3 2021/22: Directorate of Education and Training (DET)



This 'Growth' chart indicates bookings per course for the entire month of December 2021. The Perinatal and Trauma Mini Courses both performed above target, bucking the trend for low booking activity in this month in the lead up to Christmas

Data & commentary source: DET Department 12/01/2022

Quarterly Quality Report Commentary Q3 2021/22

Introduction

As requested by the Board of Directors the following paper provides additional commentary and narrative from the Q3 Quarterly Quality Dashboard, specifically commentaries form Service Leads on Waiting Times and DNAs which covers the reporting period and plans for the following quarter.

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

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

The following metrics are summarised below:

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

Waiting Times - feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adolescent /AYAS	This quarter AYAS has continued to perform well in achieving the 90% target for seeing patients within the expected time frame. This is the third quarter at 100%. In terms of 2nd appointments this has been a priority since Q2 which has resulted in a significant improvement. As the number of under 18's we see are quite low the reason behind the & compliance dropping is that seeing 1 under 18 later results in this being a relatively high percentage. Of note this patient was seen within the YPCS service which is not attached to the PAC process we run in the rest of the service and this would explain why this outlier occurred. The other 2 patients whose second appointments were delayed was for one due to them spending an extended period of time outside of the UK over the summer and the other being particularly hard to engage.	To continue to follow the services plans for managing intake and 1st and 2nd appointments as it is providing meaningful results.
Camden CAMHS	Camden CAMHS have continued to exceed the target for seeing patients for initial assessments within the required time period. There were only a small number of cases where the 1st or 2nd appointment target has been breached (only 4 cases seen between 8-11 weeks). There have been staffing and recruitment challenges in the last quarter and this is commendable that the service has continued to be able to respond to need in a timely way. Camden CAMHS have shown a slight improvement towards target for referral to treatment in the last quarter.	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.
Other CAMHS	We are pleased to see that we have continued to achieve target for referral to First Appointment. We are looking into some of the data regarding second appointment – new staff requiring induction, delays in gaining funding for ASF cases and several cases where we have been unable to contact the patients have caused difficulties. We are also looking at the patient data as we think there may be some anomalies in the data.	Continue to monitor key issues regarding compliance to ensure timely action if required.

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

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adult Complex Needs	This is a significantly poorer that we would normally expect in previous quarters and previous years, the primary reason is a significant reduction in staffing due to a number of staff retiring and leaving and not all of these posts being possible to replace within the reduced budget.	The trustwide strategic review process will likely effect the staffing structures and team make up further which could have some bearing on productivity and wait lists. The department is undertaking a significant review and overhaul of its treatment length in order to support more optimal flow of referral and timely discharge in line with contracts specifications.
Portman	We have minimal waiting times to see patients and the majority of patients are see within 8 weeks. The delays to first appointment after initial referral have been looked into closely by the Intake Team, and they have conveyed that these can be attributed to waiting for referrers to provide more/the correct information necessary to progress the referral or when waiting for patients to respond to our request to write, both of which an essential part of the intake process for some of our patients to gather more information and assess motivation for treatment. Whilst we do have a new referral form for referrers to complete, some of our patients present with such complex pathology that we need to get further information. Sometimes case files have been kept open when a response has not been forthcoming, and the team have been working on closing these referrals where appropriate. 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. There is an increase to 73% compliance in this quarter.	With regards to 1st app - 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. With regards to 2nd appt - We will remind clinicians to offer second appointments between 2-3 weeks after the first appointment, and certainly before 18 weeks from the original receipt of referral.
City and Hackney PCPCS	It is encouraging to see that in City and Hackney the waiting times for first appointment have remained above target over the course of the last quarter. This is a testament to the hard work of both the admin team (who process referrals and book assessment appointments) and the clinicians on the ground. It is disappointing to see that the waiting times from referral to treatment have fallen slightly below the usual target in the last quarter. A number of variables may impacted this including the following: delays in issuing trainee psychologist's honorary contracts, which meant a delay in them starting treatment with their allocated patients, staff sickness & staff having to temporarily prioritise assessments vs treatment due to leave arrangements. As a service, we are aware that there can be delays in taking up available treatment slots due to difficulties in getting hold of patients/patients turning down offered appointments due to clashing commitments and having to return on the w/l.	We are in the process of changing the treatment appointment booking system, which will mean that Admin will take responsibility for contacting the patients at the top of the treatment waiting list and offer an appointment with a clinician. Admin will have access to a "pool" of available appointments. We hope that this will reduce delays in patients starting their treatment . We have also recruited/are in the process of recruiting additional bank clinicians/clinical hours which should also reduce waiting times for treatment.

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

Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q3	Objective / plan for next Quarter
GIDS	The impact of the improved Intake Referral Programme at GIDS along with the agreement with NHSE to ask GPs and non-NHS professionals to re-refer young people to the NHSE Gender Development Referral Support Service (GDRSS) from July 21 onwards, has continued for GIDS to see a higher rate of referrals rejected. This has led to an overall decrease in the number of patients waiting for a first appointment. Volumes of patients has reduced in Q3 for those waiting 0 – 140 weeks, however numbers over 140 weeks has grown. This is partly due to a renewed focus on booking young people in chronological order with the finite capacity available. Whilst overall number of young people waiting continues to fluctuate there has been a decrease in Q3 of patients waiting more than 24 weeks.	Draft plans have been created for sign off to focus on increasing activity overall and booking the longest waiting patients, reviewing the pairing of clinicians and revising the clinical pathway in Q4 and beyond. This is as part of the overall GIDS recovery plan.
GIC	As the wait list continues to grow, the wait time climbs. Until we have funding to develop services to support the wait list, we will struggle to hit targets. Different service models have been developed in house to respond to the ever-growing waiting list. We are hoping with the continuing conversations with NHSE and the development of the Strategic Review to realise some of these developments. We are also working with the new emerging pop-up clinics to pass groups of appropriate patients off our waiting list. There is a wider dormant case project which began in Q3. All cases which have not engaged in services are being reviewed by senior clinicians with a view to discharge or offer the next available appointment. The cases which are listed here are all on the review list and are being dealt with in order of length of time dormant.	We will work within the parameters of the Strategic Review to try and evolve the services to better meet the needs of our patient population. The Strategic Review will focus on developing more resilient and efficient admin and clinical workforce and will also pivot the current workforce recruitment approach to increasing the number of clinicians to harmonise the clinical vs admin ratio. We plan to continue to discharge the dormant cases where acceptable to do so in order to make more space in the clinic for the patients on the waiting list. Hopefully by engaging more clinicians in the project in Q4, the list will see a more impactful decline in gaps.

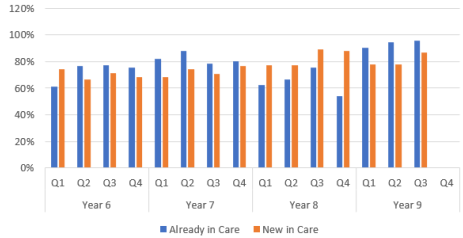
1.3 Waiting Times – Appendix

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

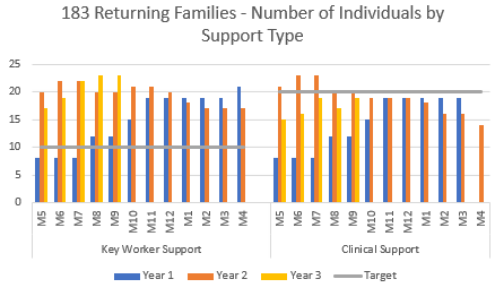
See Slide 3 for main CYAF WT data

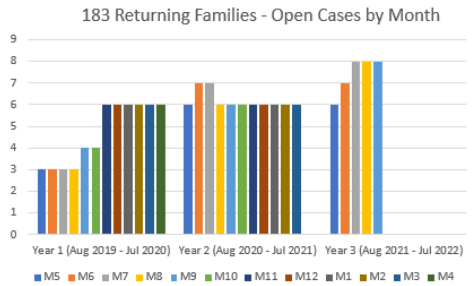
The following teams are not measured in WT metrics as they follow a different delivery model.
First Step, FDAC, Gloucester House, and Returning Families.
Please see below metrics used monitor for First Step, FDAC, Gloucester House and Returning Families.

060 - First Step

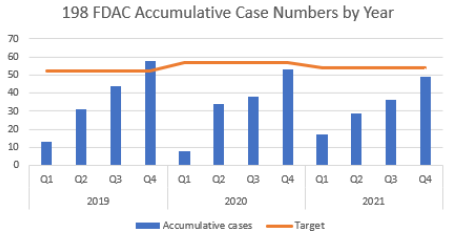


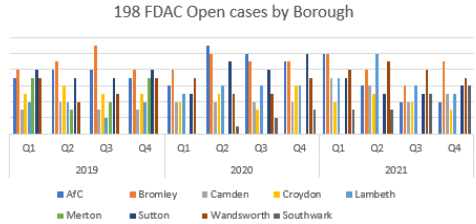
183 - Returning Families Unit



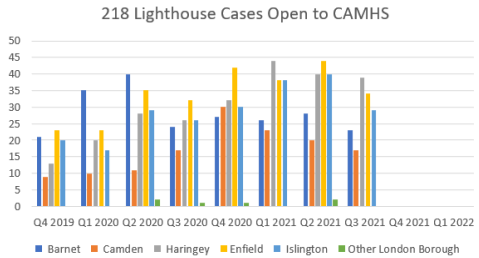


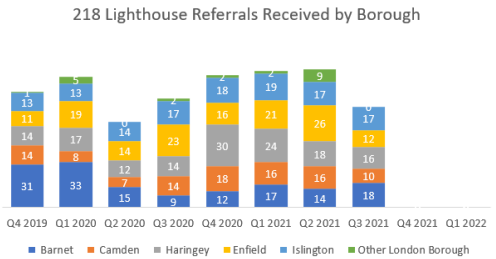
198 - Family Drugs and Alcohol Court (FDAC)



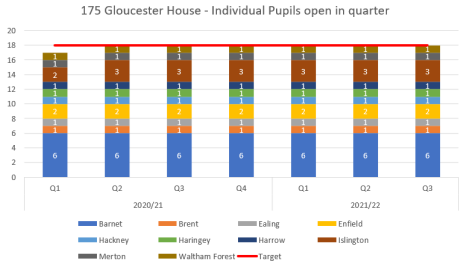


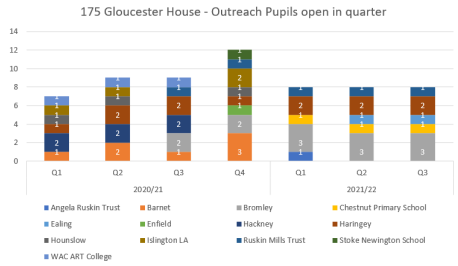
218 - The Lighthouse





175 - Gloucester House





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

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adolescent /AYAS	Our DNA rate has reduced over the quarter from a very high 12.4% in Q2. This is still above the KPI.	To ensure that the service manager receives regular DNA reports from Admin lead. To review report and implement plans around repeated DNA's.
Camden CAMHS	DNAs for Camden CAMHS have been consistently below the 10% target.	Teams continue to implement strategies to reduce DNAs, including SMS reminders, agreeing appointments with YP/families in advance.
Other CAMHS	The DNA rate has again dropped below target. We are pleased that we have been able to maintain this and continue to monitor to enable a timely response to any variation.	Continue to monitor the reasons for DNAs.

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

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q3	Objective / plan for next Quarter
Adult Complex Needs	We are pleased with the Q3 DNA rates with a significant shift in the right direction at Portman and a continuation of healthily low rates at PCPCS and ACXN. It is difficult pin down reasons for fluctuation during a global pandemic with variances from 'normal' including changes in remote or face to face settings, illness for both patients and staff and staffing changes. We have remained focussed on effective and safe governance during this period.	Pour aim in to maintain and progress the current levels notwithstanding the comments made about context and variables.
Portman	Our DNA rate rose in the previous two quarters, but has encouragingly fallen down to 10% for the last quarter. Our target is 10% and below.	We have noted that as pandemic restrictions have lifted, patients have been missing appointments to attend to other medical and personal issues, as well as for leisure. Sometimes this has been without discussion with the clinician. After addressing this issue where appropriate, we are pleased to see the DNA rate falling. 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	Again, we are pleased to see that the DNA rate has remained on target. We are in the process of introducing a change to the booking of assessment appointments. This will involve discontinuing the current procedure of sending opt-in letters to patients who have been accepted for an assessment; instead, once a referral has been accepted, admin will contact patients by phone and book their appointment. It is predicted that this may affect the DNA rate – ie patients who opt in are generally considered as more invested in the possibility of psychological change and hence more likely to attend. However, currently, a large number of patients do not opt in but are re-referred some time later, claiming not to have received the opt in letters.	We aim to monitor closely the DNA rates and should we observe an increase, we aim explore whether these coincide with the introduction of the new system and whether they relate to assessment appointments/first appointments.

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

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q3	Objective / plan for next Quarter
GIDS	DNA rates continue to be low supporting the improvements made in the management of patient bookings.	As part of the CQC Waiting List Action Plan group, work will continue in the next quarter to reduce DNA waits through the sustained implementation of the revised access and management policy and the review of the text reminder service.
GIC	The DNA percentage remains similar to the previous quarter. We are planning on becoming stricter with our serial DNA patients, whilst being aware of clinical risk, to make space for the patients who are serious about attending their appointments.	We are going to be implementing the consecutive DNA report in order to concentrate our efforts on those patients with a number of DNAs. The patients continue to be reminded of their appointments 6 weeks, 1 week and 1 day before the appointment date and have many ways to contact the Clinic to cancel or reschedule. We have started posting DNA information on the website in hopes this inspires patients to attend their appointments and highlight to others that this occurring. Patients who DNA 2 consecutive appointments across the clinic are reviewed for discharge. This is being reviewed to become more strict if possible.

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 have been established for each divisions. The general managers are also working with HR to produce a trust wide job planning policy, which is currently at draft phase to align with national NHSE approach to job planning and ensure consistent language and approach across the organisation. Work is also underway to identify a suitable job planning software to support the trust process going forward.	On going
Ensure all clinical staff across the Trust have an initial job plan and review these at a divisional level to identify areas that reduce clinical capacity *e.g. supervision, team meetings etc…*	Currently there are draft plans on file for ~80% of CYAF & AFS and ~100% for Gender. We are waiting for the updated guidance to be finalised before completing the remaining Job plans in CYAF/AFS so they don't need to be repeated soon after completion. Once the new policy and guidance are confirmed for the trust, a round of job plan reviews will take place for the existing job plans.	On going
Implement the agreed principles and review job plans accordingly	This is due to take place in Q4 2021/22 and Q1 2022/23. This may need to be reviewed in line with the strategic review consultation outcome.	On going
Agree standard timescales and mechanism for reviewing job plans and monitoring capacity on an ongoing basis	The suggested timescales and mechanisms for review and monitoring are mentioned in the divisional guides and will be confirmed in the trust job planning procedure. 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.	On going

Implementation Risks and Strategic Review (SR): There are risks regarding the implementation on some of the changes which has been captured in the SR risk register. Job planning for all staff will require significant amount of management resource to implement. The mitigation plan includes to implement generic job plans where appropriate, to ensure all managers have opportunity to access good quality management training and the proposals includes 2.0 WTE Programme Managers on fixed term contracts to manage the implementation of the SR.

3. Quality Priorities

3.1 Quality Priority 1

Quality Priority	2. Improve the collection of race and equality data	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
Complete report of ethnicity data completion rates within each of the clinical divisions (AFS, CYAF and Gender)	A monthly report is in place. Performance has improved in 3/4 divisions but does still vary significantly both within and across divisions: CYAF ~ 99% in November 2021 up from 96% in April 2021 AFS ~ 89% in November (Portman 87%, Complex Needs 81%, PCPCS 98%) up from 86% in April GIDS in November – 77% up from 68% in April GIC in November – 69% down from 70% in April	**Achieved**
Provide a baseline of Experience of Service Questionnaire (ESQ) completion by ethnicity (Q1) and provide comparative data analysis during 2021/22	The new shortened ESQ was launched in April/May and a new Carenotes report has been developed that reflects the new questions as well as adding in a breakdown of completion and experience by ethnicity. Work is still needed to create a process to analyse and share this information by ethnicity. This is expected to start in Q4 alongside a project to increase completion rates using Qualtrics, which will also help reduce potential bias in the service user population invited to provide feedback.	**On going**
Clarify the current initial data collection methods and processes for updating based on changed situation	All services have shared their current practices and a summary document was circulated in July so learning could be shared. Some new practices based on the learning as well as a QI project were implemented in Q2 resulting in improved collection rates in most services. A working group will also be established to explore collection processes further in Q4.	**Achieved**
Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review	Guidance on collection processes will be drafted in Q4 following the working group meetings.	**On going**
Implement guidance and report again across the directorates to monitor adherence and make adjustments where needed	As mentioned above, some initial learning has been implemented in advance of the guidance being drafted. Monitoring has been ongoing via the report each month and any specific QI projects will measure their direct impact separately.	**On going**

3.4 **Quality Priority 4**

Quality Priority	3. Improve Waiting Times Across the Trust	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
Review waiting times across Trust services and identify range, variation and areas of good practice in waitlist management, based on Trust data (Q1)	It has been difficult to develop and deliver a clear plan relating to improving waiting times in the Trust over the past few quarters due to capacity issues in the context of developing the programme of work relating to the strategic review, CQC action plans as well as significant operational challenges within the service lines. In Q3, service lines have been working toward improving waiting times with nominal results due to lack of staff and the impact of covid. The delivery approach has been undertaken in silos across the divisions and has lacked a cohesive narrative and framework that pulls together the programme of work across the services. **Actions taken by AFS** Capacity vs demand reviews have taken place in services with excessive waiting times such as Trauma and PCPCS. Action plans have also been put into place in a number of service to reduce waiting including: • Agreeing short term funding for additional roles • Review of treatment allocation and booking processes to improve efficiency and equality of access as well as reducing unwarranted variation • Additional regular reports and a dashboard made available that highlight long waiting patients for review • Review of treatment pathways, including treatment length to help align capacity with demand and contracting expectations **Actions taken by GIC** • Through the strategic review finding more resources in an effective way • Updating our screening process to collect relevant data before the patient is seen ensuring preparedness using a questionnaire with view to automation • We have improved communication with people that are waiting and increased comms to every 6 months starting Q4 • Reviewed the bulk transfer of cases off our waiting list to localised services project • Updated information on website re: sign posting people to relevant information • We are reviewing a Dormant case project and a multiple DNA process, Harm reviews for those on waiting list with view to discharge. This also includes patients that have not been seen in 36 months and numbers are coming down **The plans to progress this QP in the next quarter** involve the Divisional Directors resetting this quality priority based on the following; • Review all of the waiting list initiatives currently being implemented in the trust to ensure they align with best practice n-ensuring that this is embedded in BAU supported by appropriate reporting and monitoring mechanisms • Agree a framework that supports a cohesive delivery of this priority that can be scaled up or down depending on the service line • Have a named person within each service line to have oversight of the reporting required for board assurance and delivery within the service • Agree shared metrics against which to measure success • Monitoring the link between referral volume and waiting times. • In Q4 AFS are proposing to introduce 'patient tracking list (PTL)' meetings which will ensure individual patients waiting times are reviewed on a more regular basis, in line of best practice. This should result in greater understanding of route causes of delays and help prevent delayed treatment. Harm reviews for patients waiting more than 52 weeks for treatment will also be introduced to ensure we understand the impact of waiting on our service users and can make adjustments to risk ratings and prioritisation where needed.	On going
Agree key areas of focus and hold workshops to develop plans and QI projects to address wait times, ensuring that work aligns with strategic review changes (Q2)		On going
Implement, monitor & review these plans, based on agreed measures for waitlist reduction (Q3 and Q4)		On going

3.4 **Quality Priority 4**

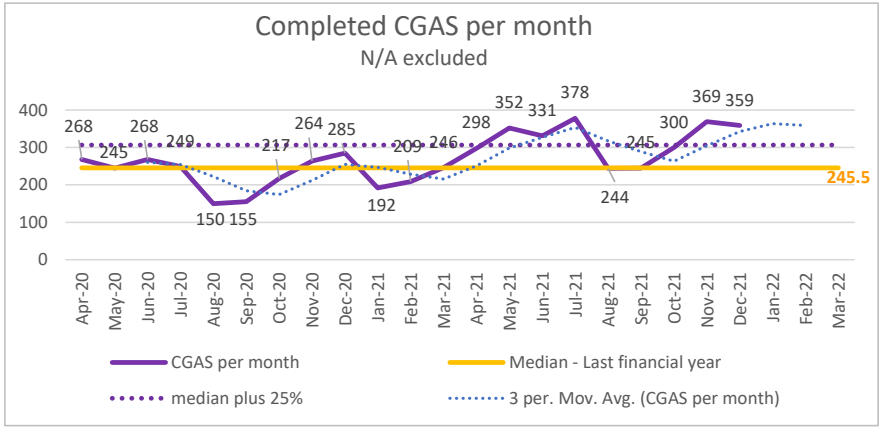
Quality Priority	4. Embed meaningful use of outcome measures across the Trust	Quality Priority
Key Workstreams	**Quarterly Narrative Updates**	**RAG Rating**
To complete a pilot of an appropriate software solution for OM data e-mail out and return that is compatible with Carenotes data. To reduce administrative time in manual data input	Project update & improvement by measure. • A pilot project has been successfully trialled in Adults Complex Needs using a software to send CORE OM forms in an automatic way. However, there is still similar level of administrative time required to do the manual data inputting of data received back and recording of when the forms were sent. • We are happy to report that the number of sent and received forms has increased significantly. • The project is now embedded in governance processes and has started to show real results across the majority of fields	**Achieved**
To increase OM returns across all services by 25% above baseline by year end	We are half way towards our target and in a much better position than last year with some significant improvement. For Q4 we recommend each directorates clinical governance committee examine any triangulating factors that limit or effect variability and dips in return rates. • The RAG rating represents at least an Amber state with some promising change with 50% of OM fields now at the target of 25% over median for 21/22 • Both CGAS and CORE were above the target (i.e. 25% above the baseline) by December 2021 • GBM peaked above the 25% uplift in November and then dipped below the 25% in December, we will need to interrogate this data to see if it follows other data trends , our suspicion is referral rate fluctuations but will aim to confirm for Q4. • Finally, ESQ's returns over the year so far have performed better than in 20/21, we would put this down to a mixture of a committed working group focussing on governance across each directorate and the introduction of administratively operated electronic collection systems. After an initial improvement the ESQs have now dropped to similar levels as before the new system was put in place. Investigation is required to understand this better.	**On going**
To pilot brief and STP wide OM feedback (e.g. dialogue) OR for specific clinical services (e.g. Trauma) nationally benchmarked OM	This has not been achieved and is for future development, perhaps as part of the 22/23 QP but will likely depend on the degree of realistic integration available from STP systems.	**On going**

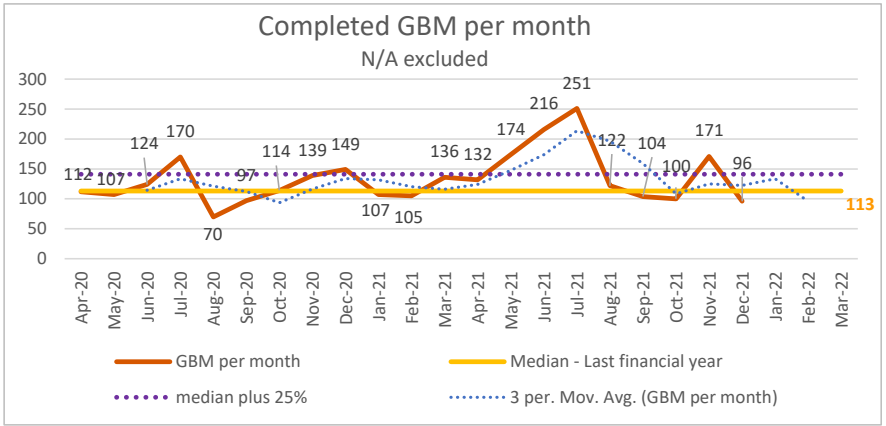
3.3 Quality Priority 4

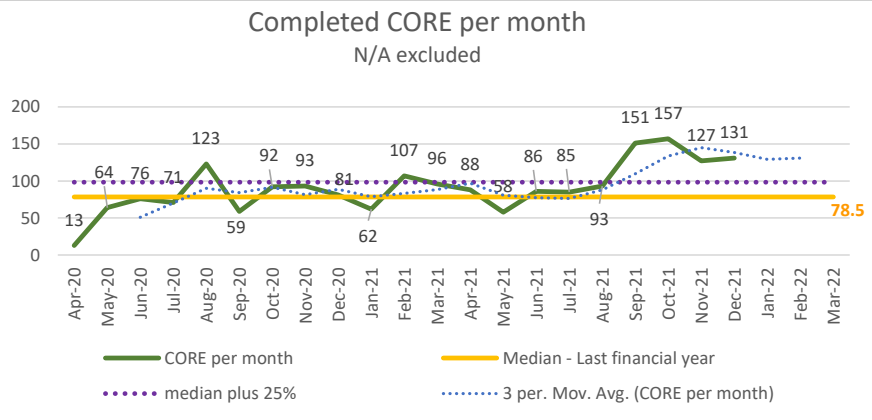
QP4 Supporting information:

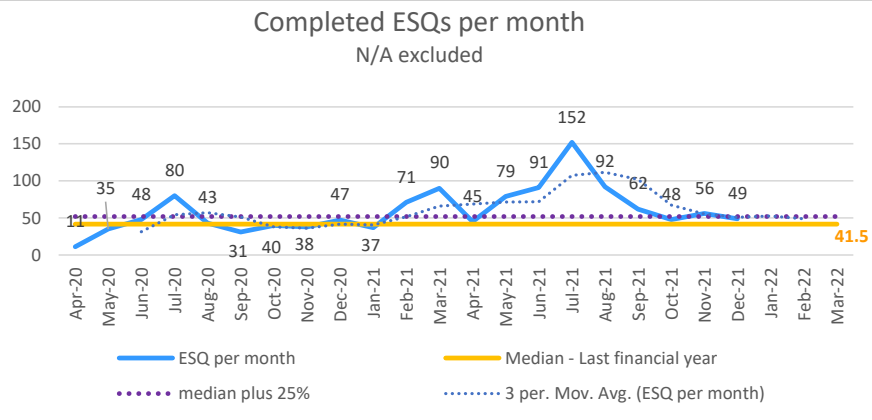
This a trust-wide data report that includes the total number of forms completed in period, for all contracts, excluding forms marked as N/A. It measures the usage of OM forms in period.

- The yellow lines shows last financial year median, when the number of completed forms is above the median this means an improvement on the previous year's performance.
- The dotted line represents the 25% improvement on last year's performance, when the number of forms is above the dotted line it shows we have met the QP target.









Data source: 05/01/2021 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 A - 90% of complaints acknowledged within 3 working days.	Quarterly	>90%	97%	91%	92%					
B - 80% of complaints responded to within 25 working days. We are including closed rather than open, recent open complaint might not have been open for 25 working days.	Quarterly	>80%	10%	3%	33%					
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	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					
F - Evidence of relevant complaint action plan implementation	Quarterly	n/a	yes	yes	yes					
Complaints: A - Provide quarterly complaints and claims update to include: i) no. of complaints where response is outstanding at 3 months and reasons why	Quarterly	n/a	22 Pressure of work on staff	22 Pressure of work on staff	22 Pressure of work on staff					
ii) Number of complaints reported to CQC	Quarterly	n/a	0	0	0					
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	0	0	0					
iv) Number of re-opened complaints.	Quarterly	n/a	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 Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	2.99%	2.22%	3.59					
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes.	Q4	n/a								
Clinical Audit A - Provide CCGs with copy of Trust wide audit programme in Q2.	Q2	n/a		See attached clinical audit paper Microsoft Word Document						
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	Q2 & Q4			See attached clinical audit paper Microsoft Word Document						
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Q4									
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	Q2 & Q4	n/a		See attached clinical audit paper Microsoft Word Document						

Data source: previous quarter attached document visible only in previous report

Section Five: Trust Targets – KPI

See Slide 13 on HR for graphical representation

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target	Monitoring	Target%	% Progress 21/22				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Appraisal/ Personal Development Plan Quality and Development of staff: Target 90% of staff to have a PDP.	Quarterly	90%	24%	24%	49%					
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%	1%	1%	3%					
Staff Training % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red	Annually	>95%								
Mandatory Training % of eligible staff are currently compliant on all of their mandatory training	Quarterly	>95%	75%	74%	70%					
DBS checks - Standard and enhanced % of staff that require an Enhanced DBS check and have one within the 3 year renewal period	Quarterly	100%	98%	92%	93%					
Enhanced DBS Checks: The DBS is not 100% because the report will account for staff who are on career break, long-term sickness absence, career breaks and maternity leave. In addition the report will not be reflective of staff who have expired and currently going through the re-check process. The process still remains where the team will produce monthly DBS reports and contact staff who are due for renewal and chase those that require renewals.										

Section Five: Trust Targets – KPI – London Contracts

Target	Detail of indicator	Reported	Target %	% Progress 21/22	RAG Progress Q1	Q2	Q3	Q4
CAMHS Transformation Targets Run for London Contracts only	80% initial completed care plans	Q1-Q4	80%	**Q3 compliance 53% -- out of 90 assessment summaries completed, 48 initial care plans were created** Unfortunately the current reminder system hasn't impacted the number of care plans created and there has been a decrease this quarter. In late January a more efficient process will come into place following changes to the assessment summary forms. This new so we anticipate significant improvement in the next quarter. process will help ensure care plans are completed and sent out for all assessed children and young people and				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	**Q3 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%+** The same process change will be implemented for the care plan reviews so performance should also increase significantly next quarter.				
	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%	**Q3 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'** It is nice to see again that our ESQ's indicates that we above our targets for another quarter. Although the number of responders have decrease from Q2. As a division we can see here that the pandemic has disrupted our service but we are still able to deliver a safe service for our service users. We also are trialling using a new survey software to send and receive ESQs from January for one of our services, which if successful will be rolled out across the division.				

Data source: 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Section Five: Trust Targets – KPI – London Contracts

See Slide 16 for OM graphical representation

Target	Detail of indicator	End of Year Target %	% Progress 21/22	RAG Progress Q1	Q2	Q3	Q4
CYAF Outcome Monitoring **GBM** - Goal Based Measure **CGAS** - Children's Global Assessment Scale Run for London Contracts only	**GBM** Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q3 compliance 44% -- 52 GBM T1's out of 117 due in period were completed** The figures for the GBM T1 for this quarter have decrease since last quarter. Mid Q3 it was identified that there has been a reduction of the number of GMB compliance. In light of this, the monthly reports were sent out to fortnightly to explore if this would increase the compliance rate. We will continue to send the GBM reports on a fortnightly basis and hope to see and increase for Q4.				
	GBM Time 2 % 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%	**Q3 compliance 27% -- 18 GBM T2's out of 67 due in period were completed** This is a significant decrease in the compliance rate for T2 GBM. As mentioned above reports will be sent out on a fortnightly basis, monthly compliance checks will be explored to find out if this process has made any difference to our compliance rates.				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	**Q3 compliance 58% -- 65 CGAS T1's out of 112 due in period were completed** There seems to be a drastic decrease in the number of CGAS T1. This could be leaning towards a rise in the referrals for one of our specific clinical teams where patients are being assessed before the patient is allocated to a worker along with staffing issues. Which could be affective the compliance this quarter. CGAS compliance will be monitored during Q4 in attempt to increase the number of completed forms. Improvement plan to run the reports on a regular basis by the Service Manager.				
	CGAS Time 2 % 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%	**Q3 compliance 37% -- 41 CGAS T2's out of 112 due in period were completed** This decrease in the T2 and the compliance here is extremely low. One the improvement plan here would be to monitor and run the reports on a regular basis by the service manager which will be sent to clinicians as a prompt that T2 CGAS need to be completed.				

Data source: 07/01/2021 SRRS (Internal Reporting System) Reported by the Quality Team

Report to	Date
Board of Directors	January 25th 2022

Board Governance Review and Implementation Plan
Executive Summary
This report provides presents the report of the Board Governance Review prepared by OMG and an outline Implementation Plan for agreement by the Board of Directors.
Recommendation to the Board
The Board of Directors are asked to note the paper and the conclusions of the Board Governance Review, to agree its recommendations and to agree the Implementation Plan set out at Annex B.
Trust strategic objectives supported by this paper
All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Board Governance Review and Implementation Plan

1. Introduction

1.1 Alongside the Strategic Review and in line with corporate governance good practice, the Board of Directors commissioned in 2021 an external Board Governance Review. Following an external procurement, this was carried out by the Office for Modern Governance (OMG).

1.2 Beyond a general desire to review corporate governance against wider best practice a key objective of the Review was to ensure that the Trust's governance arrangements are effectively aligned with the objectives and changes the Trust is seeking to achieve through the Strategic Review.

2. Governance Review

2.1 OMG completed their work in the autumn of 2021 and the Board had the opportunity to discuss their findings with the Review Team at a Board Seminar on 7th December.

2.2 Their final report is attached at **Annex A**.

2.3 Their key conclusions are:

- In line with the boards of all NHS providers the Tavistock and Portman has a substantial and challenging agenda to address over the next few years.

- Alongside a range of Trust specific issues, there are external challenges around addressing the regulatory landscape, operating in a post pandemic world, and operating within the ICS.

- For the Trust Board to successfully address this agenda will require effective and sustained Board leadership.

- The review has identified a number of important development areas, but also identified many positive examples to demonstrate that there is a

very exciting agenda available to the Trust Board if it focuses on the right things.

- The Trust Board has all the constituent elements to be effective and is serious about board leadership, board processes and effective governance.

- The review presents a unique opportunity to further renew and reinvigorate the governance arrangements within the Trust based on the recommendations in the concluding section of the report.

- By addressing the areas for development identified as part of the review in a systematic manner, building on progress to date and drawing on learning from other sectors the Trust can noticeably accelerate Board leadership and governance arrangements at the Trust.

2.4 The Review makes 22 recommendations (pages 16-17) set out against the CQCs 8 KLOEs for the well led domain.

2.5 At the Board Seminar the Board of Directors concluded that the analysis presented by OMG was fair and that the Trust should accept their recommendations in full. In particular a number of themes were highlighted:

- The value of resetting Board Committees (Recommendation 8) to help address the areas of development set out in the Review. This would include giving a greater focus on workforce through the creation of a People and Equalities Committee and performance management through the creation of a Quality, Performance Management and Finance Committee.

- The importance of investing in a structured programme of Board Development (Recommendations 1a,1b,1c and 4)

- The need, alongside the resetting Board Committees, to develop an overarching Trust wide accountability and performance framework (Recommendation 11) and revisit the reporting requirements to support this (Recommendation 12) with the aim of ensuring a consistent approach to performance and risk management across the Trust.

- Reinforce through Board leadership, action and behaviours changes in Trust culture, aligned to the objectives of the Strategic Review.

- The need to strengthen the resources committed to corporate governance.

3. Implementation Plan

3.1 Work has started to develop an implementation plan to take forward the delivery of the Review's recommendations. An outline implementation plan with target dates and lead accountability highlighted is set out in **Annex B**.

3.2 It is proposed taking forward the recommendations grouped in four workstreams. These are:

- Resetting our decision making and assurance arrangements.
- Resourcing implementation and new BAU
- Board and Council of Governors development
- Creating a Cohesive Trust Culture

3.3 While the Board is asked to confirm its acceptance of all the recommendations made by OMG it is considered that a number are best taken forward as part of other areas of work. This is addressed at the end of **Annex B**.

Oversight of implementation

3.4 It is proposed creating a time limited task and finish group (end April) to support implementation. Its members will be:

- Trust Chair
- Chief Executive
- Committee Chairs including designated leads for People and Equalities and Quality, Performance Management and Finance.
- Medical Director and Director of Quality
- Interim Director of Corporate Governance

3.5 As a key next step, the Trust Chair will confirm, by the end of January, proposed arrangements for the chairing and membership of the revised committee structure.

Longer term resourcing

3.6 The Strategic Review is identifying steps to strengthen the resources to support corporate Governance across the Trust. Proposals were highlighted in the papers which went to the special meetings of the Board on 15th and 22nd December. These proposals will be included in the consultation document to be issued to staff on 31st January.

4 Recommendations

4.1 The Board of Directors are invited:

- To note and accept the report provided by OMG of their external review of Board Governance in the Trust.
- To agree the recommendations made in paragraph 16-17 of OMGs report.
- To discuss and approve the outline Implementation Plan.

Paul Jenkins
Chief Executive
18th January 2021

Office of Modern Governance

Tavistock and Portman NHS Foundation Trust

Well Led Review

Final Draft Report

3 December 2021

1. Context

1.1 The Trust is a specialist mental health trust with a focus on training and education alongside a full range of mental health services and psychological therapies for children and their families, young people and adults.

1.2 With 700 plus staff across a number of sites, the Trust is committed to improving mental health and emotional wellbeing, believing that high quality mental health services should be available for all who need them.

1.3 For 100 years, the T&P clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and emotional wellbeing. Working with children, families, and adults, the approach of the Trust 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 its practice.

The Trust has five stated aims:	**The Trust has six stated values:**
1. Continue to deliver and develop high quality and high impact patient services 2. Offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors 3. Develop its presence as a centre of excellence in research 4. 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 5. Use its insights and expertise to contribute to the development of national debate and public policy	1. We work with people with lived experience to co-create and improve our services and inform our decision making 2. We are caring and compassionate 3. We are passionate about the quality of our work and committed to openness, the use of evidence and the application of improvement science 4. We value all our staff, are concerned for their wellbeing and seek to foster leadership, innovation and excellence in our workforce 5. We embrace diversity in our workforce and work to make our services and training as accessible as possible 6. We work with others, in the UK and internationally, who share our values and can enable us to achieve our mission

1.4 The last full Care Quality Commission (CQC) inspection of the Trust took place in 2016 when the Trust was rated as "good" overall. The domains of effective, caring, responsive and well-led were rated as good.

1.5 The Trust has a sizeable agenda to deliver. Alongside the priorities all NHS organisations face around delivering safe and high-quality services within a challenging financial climate against the backdrop of the Covid-19 pandemic, the Board alongside that, and in part in response to that, created its own ambition in several areas. So in addition to the governance review we are undertaking, there have been a number of key developments including the Trust's Strategic review and its commissioning of an independent review of race equality in the Trust, which have collectively provided an important backdrop to our review.

1.6 The nature and breadth of the Trust services and its education and training provision means that in addition to the CQC, the Trust has additional regulatory bodies and assessments it has to undergo. This additional contextual piece and the work it entails at the Trust needs to also be acknowledged.

1.7 The Strategic Review takes account of the changing financial and operational circumstances in which the Trust finds itself. It will address every aspect of the Trust's work: clinical services; training and education; and corporate services, including the Board of Directors and senior management.

1.8 The Strategic Review recognises that the Trust faces five specific challenges - financial, operational, system, data, and diversity. The Programme has published the vision and principles guiding the Strategic Review. The Programme's objectives are framed around these five challenges, with a hard deadline of bringing the Trust to a breakeven financial position by April 2023.

1.9 The Programme is the first step in a longer journey to transform the Trust. Its aim is to understand the Trust's strategic goals and its managerial and operational structures and to reconfigure these structures in such a way that start to address the five identified challenges and facilitates future changes to address them further through the development of a wider programme of transformation.

1.10 This transformation programme will take over from the SR programme once the new structures are implemented in August 2022, though initially this was due to be in December 2021.

Race equality

1.11 The Trust commissioned in 2021 an external consultancy, Colour Brave Avengers, to undertake a comprehensive diagnostic piece of work about the experiences of BAME staff at the Trust which goes further than the NHS staff survey and other informal approaches which have been used to date, to understand such issues. This work involved staff at every level of the organisation to understand their lived experiences and consider the impact of the Covid-19 pandemic on this group.

1.12 This report by Colour Brave Avengers' identifies a series of recommendations and actions for the Trust to follow in order to fulfil its journey of becoming an anti-racist organisation. It is complemented by a Race Action Plan that combines the actions from the overall audit process.

Provision of high-quality education and training

1.13 The Trust is a substantial provider of postgraduate teaching and education across a range of therapies and is the only NHS provider in England registered with the Office of Students and which provides regulatory oversight in this area.

Relocation

1.14 The Trust is one of a number of NHS trusts seeking to access national monies for long-standing capital development/new build plans which would see it move to new purpose-built facilities.

Gender identity services

1.15 The Gender Identity Service (GIDS) is commissioned by NHS England. The service is commissioned to provide assessments of young people, refer young people for medical treatment when appropriate and provide some continuing support when this is required. It is a national specialist service and is the only service available in England for children and young people with gender dysphoria. The service also treats children and young people from Wales.

1.16 The CQC undertook a focused inspection of the service in October 2020 and the report, published in January 2021, rated the service "inadequate", driven by "inadequate" ratings for the 'responsive' and 'well led' CQC domains.

1.17 The GIDS Judicial Review around capacity and consent of children receiving hormone intervention for gender dysphoria has furthermore been a significant focus for the Trust and has resulted in significant media scrutiny on the Trust. The Trust successfully appealed a High Court ruling at the Court of Appeal in September 2021.

1.18 The Trust is also working closely with the NHS England commissioned Independent Review being led by Dr Hilary Cass, former President of the Royal College of Paediatrics and Child Health which is looking at the wider care pathway for young people with issues about gender identity.

Financial health

1.19 Whilst the Strategic Review is a response in part to the financial challenges facing the Trust, financial sustainability and viability represents a specific contextual matter for the Trust.

2. Methodology

Our review

2.1 Our review was predominantly undertaken remotely because of the Covid-19 pandemic and comprised the following key stages:

Background documentation

2.2 We reviewed a range of background documentation which we requested of the Trust and which included past Board and Committee papers, terms of reference, work programmes, standing orders, relevant risk and strategy documents.

Meeting observations

2.3 We observed two meeting of the Board of Directors on the following dates:

Board of Directors, 7 September 2021	Board of Directors, 28 September 2021

2.4 We also observed the following Committees of the Board:

Equality Diversity and Inclusion Committee, 9 September 2021	Education and Training Committee, 7 October 2021
Integrated Governance Committee, 15 September 2021	Audit Committee, 14 October 2021

2.5 We were scheduled to observe a Strategic and Commercial Committee on the 14 October 2021 but this meeting was subsequently cancelled.

2.6 We also observed the Trust Wide Forum on the 9 September 2021 (which is a mechanism for the Trust to formally engage and hear the views of service users) and the meeting of the CoG on the 9 September 2021. We also observed two operational management meetings:

Operations Delivery Board, 14 September 2021	Executive Management Team (EMT), 21 September 2021

2.7 All our observation of meetings were undertaken virtually, other than the EMT meeting we observed. We recognise that virtual meetings have stifled the natural flow of conversation - and deprived Board members and attendees of visual cues that are a key feature of Board and Committee meetings. Our observation of Board and Committee meetings and the conclusions we have drawn need to be read within that context.

Focus groups

2.8 We undertook a series of focus groups to gain a further granular understanding of the Trust. These are listed below:

Group	Date
Students - Focus Group 1	05/10/21
Students - Focus Group 2	05/10/21
Service Users - Focus Group	05/10/21
CoG - Drop-in Session	20/10/21

2.9 We did not undertake focus groups with staff given that extensive staff engagement work had already been undertaken recently by the Trust as part of the SR. We drew upon that work and the most recent NHS Staff Survey (2020) results as part of our review.

Board member interviews

2.10 We undertook 1.5-hour confidential non-attributable interviews with all Board Members and a number of senior managers in the Trust.

Stakeholder interviews

2.11 We undertook confidential and non-attributable interviews lasting up to 1 hour with a range of external stakeholders which were identified by ourselves in conjunction with the Trust.

Board member questionnaires

2.12 Board members or attendees completed a confidential questionnaire to which we received fifteen responses. The survey focused on Board member perceptions of each of the eight KLOEs within the Well Led Review Framework.

3. Key Findings

3.1 Our developmental review of the leadership and governance of the Tavistock and Portman NHS Foundation Trust (referred to hereafter as the Trust or T&P) was undertaken using the Well-Led Governance Framework produced by NHS England, which is focused on the following eight key lines of enquiry (KLOE):

KLOE 1: Leadership Capacity and Capability Is there the leadership capacity and capability to deliver high quality, sustainable care?	**KLOE 2: Vision and Strategy** Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	**KLOE 3: Culture** Is there a culture of high quality, sustainable care?	**KLOE 4: Roles and Governance** Are there clear responsibilities, roles and systems of accountability to support good governance and management?
KLOE 5: Risks and Performance Are there clear and effective processes for managing risks, issues and performance?	**KLOE 6: Information** Is appropriate and accurate information being effectively processed, challenged and acted on?	**KLOE 7: Staff, External Partners Engaged** Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	**KLOE 8: Learning, Improvement and Innovation** Are there robust systems and processes for learning, continuous improvement and innovation?

Source:

(https://www.england.nhs.uk/wp-content/uploads/2020/08/Well-led_guidance_June_2017.pdf)

3.2 We want to thank the Trust for commissioning ourselves to undertake this review and we thank the Trust, the Board senior management team, and particularly the Chairman, Chief Executive and Corporate Governance Team for their support throughout our review, as well as to service users and their families, members of the Council of Governors (CoG), students and stakeholder organisations for taking the time to participate in our review.

3.3 We have during our review observed several areas of good practice at the Trust. For example:

KLOE 1: Leadership, Capacity and Capability	▪ The desire and resilience of the Board collectively and in particular of the executive leadership team to continue to progress a sizeable agenda during a period of considerable public scrutiny of the Trust and its decision making is to be commended ▪ Overall the Board is cohesive and displays a consistent focus on the delivery of high quality care and the provision of education and training. The desire and resilience of the Board collectively and in particular of the executive leadership team to continue to progress a sizeable agenda during a period of considerable public scrutiny of the Trust and its decision making is to be commended ▪ NEDs are knowledgeable and well-motivated and the EMT have a good understanding of the Trust's risks and issues and have performed well in keeping on top of their responsibilities when under severe capacity pressure. The Executive Team has also played an active and engaged role within the ICS, strengthening the profile and reputation of the Trust. Within the Trust EDs have been highly visible and approachable through the pandemic and are viewed as compassionate leaders by their teams. The Chief Executive runs regular all staff webinars which are well regarded and well attended
KLOE 2: Vision and Strategy	▪ The desire of the Trust to use the Strategic Review (SR) to address long standing and deep-seated issues within the Trust ▪ The depth of the work commissioned by the Trust to create a clear baseline understanding around race equality in the Trust and the experiences of Black and Minority Ethnic (BAME) staff is to be commended
KLOE 3: Culture	▪ An inclusive leadership style modelled by the Board ▪ The Board is to be commended on the rigorous and high-profile commitment it has made to be an anti-racist Trust and the openness it has shown to address the concerns of staff in relation to workforce inequalities
KLOE 4: Roles and Governance	▪ The positive and inclusive way in which Board meetings are chaired ▪ The accessibility of the Trust executive leadership to the divisional leadership team
KLOE 5: Risks and Performance	▪ Board focus on risks is good and the overall Trust approach to risk management is sound, as is the construction of the Board Assurance Framework (BAF) and Operational Risk Register (ORR) ▪ Good evidence of engagement by the Trust in the internal audit programme and ownership of findings with no evidence of action drift ▪ The Trust has an established and impactful clinical audit programme

KLOE 6: Information	▪ There is good evidence of engagement by the Trust in the internal audit programme and ownership of findings with no evidence of action drift. The contributions and input of the Director of Finance has been particularly instrumental in creating this positive climate. The Trust is to be commended for this as they are not features we always see in other parts of the NHS with whom we have worked ▪ Patient and staff stories to the Board (pre Covid-19) valued by all Board members
KLOE 7: External Partners Engaged	▪ Strong engagement with the Integrated Care System (ICS) which is reflected in positive ICS stakeholder views of the Trust and in particular of the Chief Executive and other members of the Executive Team, with a recognition amongst ICS stakeholders of the need to value and protect the uniqueness of T&P within an ICS ▪ The process of engagement under the leadership of the Board, of staff, of service users, of the CoG, and of stakeholders has been very good during a period when the Trust has been addressing a sizeable strategic and operational agenda ▪ Strong and positive relationships with the CoG ▪ Positive views of the Trust, the way it which engages and the services it provides expressed by service users and their families who we spoke to ▪ The scope and depth of the Patient & Public Engagement Strategy 2021-23
KLOE 8: Learning, Improvement and Innovation	▪ The Trust remains committed to improving mental health and emotional wellbeing, believing that high quality mental health services should be available for all who need them. The Trust brings a distinctive contribution based on the importance it attaches to social experience at all stages of people's lives, and its focus on psychological and developmental approaches to the promotion of health and the prevention and treatment of mental ill health ▪ We heard during the course of our interviews with ICS stakeholders in particular that this unique blend of services and leading-edge thinking is valued. We also heard that it is one of the reasons that the Trust continues to attract students to its training and education provision ▪ During the course of our review we have been signposted to many examples of good practice. The above examples show that the Trust continues to take a proactive approach to innovation and improvement and the creation of best practice where it does not exist, and that senior leaders have created a safe and hospitable environment for experimentation and learning ▪ The Trust record of delivery and ongoing ambition around education and training

KLOE 8: Learning, Improvement and Innovation continued	▪ The uptake by Trust staff of the Covid-19 vaccinations is high when compared to other parts of the NHS and this is in no small part due to a really effective campaign to promote vaccine uptake and which one of the Non-Executive Director (NED) has heavily been involved in

3.4 In any review there are always areas for development and we have set out below the principal ones:

KLOE 1: Leadership, Capacity and Capability	▪ The Board does not have a structured development programme in place focused on developing its collective skill set ▪ Current Board seminar time has been used to focus on operational issues and not on more strategic content ▪ Board induction programmes are poor and do not enable an effective on-boarding process for new NEDs joining the Board ▪ Current Board skill set lacks higher education and clinical experience ▪ Absence of a Board Skills Framework ▪ Chief Executive and Executive Directors (ED) are often dragged into operational activities and which is impacting on their overall effectiveness ▪ Lack of substantive senior HR and corporate governance support ▪ Tensions between some clinicians and senior management at the Trust and which has not always been addressed ▪ We observed a lack of challenge and effective scrutiny of the executives by NEDs, and not enough evidence of holding to account. NEDs are skilful and knowledgeable about the Trust but often very ready to accept positive assurances without always fully testing and probing. This point was made to us on a number of occasions and we were able to directly observe that ourselves in meetings
KLOE 2: Vision and Strategy	▪ Lack of a clear shared understanding amongst the Board of the Trust strategy ▪ Lack of clear understanding amongst external partners of the Trust strategy or vision ▪ Board understanding of the ICS needs to be enhanced ▪ The Board needs to receive assurance on risks to quality arising from costs reduction and transformation schemes in the SR and once the SR has been approved, the Board will need to receive qualitative as well as quantitative reporting on progress against costs reduction and transformation schemes and establish clear assurance quality impact assessment routes

KLOE 3: Culture	▪ Chair and NED visibility with staff and service users has been particularly impacted by the Covid-19 pandemic ▪ Concerns that the recent safeguarding Employment Tribunal has impacted the ability of staff to be able speak up if they have concerns ▪ Review the Freedom to Speak Up (FTSU): Raising Concerns and Whistleblowing Procedure in the light of the recent Employment Tribunal and use this as an opportunity to ensure the new process is communicated to staff across the Trust ▪ A considerable amount of the SR is about addressing deep seated cultural issues and given its scale and ambition in this regard, this will need significant investment in capacity and capability, particularly in relation to Human Resources (HR) and Organisational Development (OD) ▪ Board oversight processes and mechanisms for providing insight and assurance on people and culture could be strengthened ▪ The external review of race equality has yielded an outpouring of emotion that suggests many BAME staff do not feel consistently supported, respected or valued. There is now a key question about how the Board responds with pace to the deliverability of that change
KLOE 4: Roles and Governance	▪ A number of Board Committees have a number of features that are not consistent with governance good practice, particularly in relation to the role of NEDs. and the rigour with which these Committees conduct their business. As configured they are not providing a robust assurance route to the Board ▪ While recognising some current gaps in resources supporting these Committees several aspects of the way the current Committees operate - limited papers at several of the Committee meetings we observed, a heavy reliance on verbal assurance, lack of oversight and scrutiny, lack of focus on risk, limited evidence of linkage between Committees, poor reporting to the Board, is not consistent with governance good practice or what we have observed elsewhere in the NHS ▪ Committee reporting to the Board is in our view weak as currently established and fails to provide the level of assurance they should ▪ Consideration should be given to the sequence of Committee and Board meetings to promote more timely reporting and upwards assurance to the Board ▪ Our review of the current terms of reference of all Board Committees suggests that they need further review and enhancement ▪ The Committee structure in our view needs to be reconfigured so that it can better provide effective oversight of the key themes emerging from the SR

KLOE 4: Roles and Governance Continued	▪ The scale of the corporate governance issues we have identified across the Trust are multiple and suggest that the Trust needs to strengthen the corporate governance function and that this cannot await conclusion of the SR ▪ Furthermore, governance support and advice to the Board and its Committees needs to be delivered to a consistent high set of standards by a single central well-resourced corporate governance function ▪ Some NEDs are currently involved in activity that supports the work of the Committees but is far more operational than we would have expected to see ▪ EMT meetings to ensure all key programmes of work are effectively managed in a structured way take place for less time at the Trust than we have observed elsewhere in the NHS ▪ Meetings to hold divisional leadership to account for delivery across all key work streams need to be strengthened
KLOE 5: Risks and Performance	▪ Committee focus on risks are weak ▪ Executive and divisional focus on risk would benefit from a more consistent rhythm ▪ Board understanding of the key risks issues facing the Trust are variable and more could be done to use risks in a more dynamic way to drive Board and Committee business ▪ A number of improvements that could be made to the compilation of both the BAF and ORR ▪ As recognised in the SR, there is not a sufficiently well embedded performance management and accountability culture at multiple levels within the Trust. This needs to start from the Board holding EDs and senior management to account for delivery and then flowing through the EDs to senior management and the divisional structures to ensure an effective accountability within each division for performance and delivery
KLOE 6: Information	▪ While the Board does have a performance dashboard this could be better developed to enable the Board to better drive action to improve the quality and performance of services provided ▪ Patient and staff stories to the Board have halted during the Covid-19 pandemic ▪ A material and recurring theme across the reports we reviewed is that they need to adopt an 'exception-based reporting approach' and would benefit from shifting the emphasis from 'what has happened' to 'what is being done', to include greater focus on 'action planning and monitoring' as well as a more 'forward-looking perspective' ▪ The size of papers at Committee meetings (other than at the Audit Committee) is very low but to the point where we believe full and detailed reporting is arguably being sacrificed in favour of brevity

KLOE 7: External Partners Engaged	▪ The Trust has not leveraged the support potentially available within its ICS partners to address a range of areas where the skill set in a small specialist trust is always going to be limited (for example, demand management, waiting lists modelling, data quality) or to help with back-office functions (for example, HR, corporate governance) that could enable the Trust to draw on the expertise and depth that will exists across its ICS partners and which could help to deliver these functions in a more costs effective way ▪ There is a perception amongst some stakeholder organisations that the Trust in their dialogue can seek to accentuate the positive and not necessarily draw out key risks issues ▪ The lack of a structured development programme for the CoG and limited member engagement are also further gaps that need focus, particularly given key knowledgeable and hard-working individuals on the CoG will leave shortly as their terms of office end ▪ Staff engagement is a double-edged sword. There has been extensive staff engagement as part of the SR and in work undertaken by the external consultancy on race equality. The extent and breadth of these discussions is to be commended but they raise significant issues around staff perceptions and concerns. Alongside the feedback from the Staff Survey 2020, the people agenda represents a sizeable challenge for the Trust to address ▪ Member engagement is limited
KLOE 8: Learning, Improvement and Innovation	▪ For the SR to succeed though, the Trust and the Board in particular need to ensure that the SR is not only now completed in a timely manner but that it is accompanied by a prioritised implementation plan ▪ Students we spoke to as part of this review were far more negative than reported in students surveys and this needs better understanding ▪ Education and training - need greater visibility at the Board and at the Audit Committee and in the internal audit programme ▪ The student voice/experience needs directly feeding into the Education and Training Committee ▪ Ambitions around Degree Awarding Powers needs a detailed gap analysis, drawing on the experience of the Trust's higher education partners

3.5 We anticipate the Board will want overall visibility of progress against the action plan. Furthermore, we expect that the Board will want to assure itself that the recommendations we have set out in this review are implemented.

3.6 We recognise these recommendations will take time to implement, as it will take time to embed effective governance structures and processes and a change in culture will not happen overnight.

3.7 The actions have a 'priority' rating. This reflects the degree of urgency with which we believe the actions needs addressing. We have not allocated owners to actions but this is an essential first task for the Board to oversee in order to ensure delivery of the actions.

3.8 As the Trust makes progress on the actions we have set out, then in twelve months' time, the Trust should be looking to progress a further programme of work which we believe will enable the Trust to replicate not only governance best practice but create a high performing board and reap the benefits that will flow thereafter.

4. Concluding Remarks and Recommendations

Concluding remarks

4.1 The boards of all NHS providers have a substantial and challenging agenda to address over the next few years.

4.2 Alongside a range of Trust specific issues, there are external challenges around addressing the regulatory landscape, operating in a post pandemic world, and operating within the ICS.

4.3 For the Trust Board to successfully address this agenda will require effective and sustained Board leadership, using the recommendations we have made as the primary focus for that.

4.4 Whilst our review has identified a number of development areas, we also observed and heard many positive examples to demonstrate that there is a very exciting agenda available to the Trust Board if they focus on the right things.

4.5 We also strongly believe that the Trust Board has all the constituent elements to be effective and is serious about board leadership, board processes and effective governance.

4.6 In that sense, this review presents a unique opportunity to further renew and reinvigorate the governance arrangements within the Trust and our recommendations in this concluding section of this report seek to do that.

4.7 Addressing the areas for development that we have identified as part of this review in a systematic manner, building on progress to date and drawing on learning from other sectors will, we have no doubt, noticeably accelerate Board leadership and governance arrangements at the Trust.

Recommendations

4.8 In taking the issues we have identified in our report forward, the Trust the Board should take the following recommendations we have set out below forward.

4.9 We suggest that the Chairman and Chief Executive, consider the findings outlined within this report and support the Governance Team to develop an implementation plan to take our recommendations forward for final approval by the Board.

4.10 This should also set out how the Audit Committee will on behalf of the Board monitor on-going progress and embeddedness.

4.11 We have given each recommendation a priority and a suggested timescale for implementation, but recognise that the Board will wish to review these carefully to ensure that the subsequent implementation plan is owned and deliverable.

	Actions to be implemented within 4 months of this review	Actions to be implemented within 8 months of this review	Actions to be implemented within 12 months of this review
KLOE 1: Leadership, Capacity and Capability	**Recommendation 1a:** The Chair should oversee the design and commence the early stages of implementation of a structured Board development programme aimed at improving Board impact and effectiveness. This should reflect the development areas identified throughout this report, including those related to increasing Board impact and providing effective scrutiny and challenge; and improving the effectiveness of Board member contributions **Recommendation 2:** The CoG should consider, in consultation with the Chair, the possibility of co-opting on to the Board NEDs with clinical and higher education backgrounds. This should include engagement with ICS partners around drawing on skills that may exists in the ICS already in these areas and should be a precursor to recruiting NEDs with these skills substantively, informed by a Board Skills Framework **Recommendation 3:** The Chief Executive should consider ahead of completion of the SR, the appointment of a substantive Director of HR, which needs to be accompanied by a clear focus on OD and bring forward proposals to enhance the corporate governance function, including the appointment of a substantive Director of Corporate Governance (drawing on skills that may exists in the ICS) **Recommendation 4:** The Chair, working closely with the Corporate Governance Team should lead the development of a robust NED induction programme	**Recommendation 15:** The Chief Executive should reflect on ongoing actions and behaviours aimed at promoting team building and influencing multi-disciplinary executive working, with a view to incorporating this within a formal programme of development	
KLOE 2: Vision and Strategy	**Recommendation 5:** The Chair should consider what further work needs to be undertaken by the Board as part of a structured programme of Board development to agree a common understanding of the vision and long-term strategy for the Trust to provide direction and further meaning to the SR **Recommendation 6:** The Board should ensure that the SR is accompanied by a clear investment and implementation plan and the development of a quality impact process to assess costs reduction and transformation schemes in the SR and which has clear Board visibility	**Recommendation 16:** The Board should ensure that ICS partners are actively engaged to understand the Trust strategy, vision and how it fits within the overall ICS	
KLOE 3: Culture	**Recommendation 7:** The Board should consider developing an engagement plan aimed at improving perceptions regarding the level of organisational engagement and visibility. This should give consideration to improve physical presence as well as refinements to the Trust approach to digital media and corporate communications	**Recommendation 17:** The Board should ensure a review of the FTSU: Raising Concerns and Whistleblowing Procedure in the light of the recent Employment Tribunal and use this as an opportunity to ensure the new policy is communicated to staff across the Trust	**Recommendation 21:** The Board should commence as part of the SR a piece of work to develop a cohesive Trust culture. This should include programme of work that address clinical and management relationships within the organisation

	Actions to be implemented within 4 months of this review	Actions to be implemented within 8 months of this review	Actions to be implemented within 12 months of this review
KLOE 4: Roles and Governance	**Recommendation 8**: The Board should more closely align its Committee structure with its strategic priorities, potentially to include a refocused Audit and Governance Committee and a new Quality, Finance and Performance & People Committees. Alongside this work, plans need developing to address gaps and issues we have already identified around the Committee structure at the Trust as a whole **Recommendation 9:** The Board should seek to revisit the structure and format of the EMT, Operations Delivery Board and divisional accountability arrangements in light of our findings		
KLOE 5: Risks and Performance	**Recommendation 10**: The Board should consider the various observations made within our review regarding refinements to the BAF and ORR and that there is greater consistency in practices across the Trust, including frequency of reviewing the BAF and ORR at Board, Committee and at the operational management level **Recommendation 11:** The Board should consider accelerating work underway to implement the Trust wide accountability and performance frameworks and increase executive focus on this area. This recommendation should be implemented in conjunction with the roll-out of a consistent suite of performance reports across the Trust **Recommendation 1b:** The Board should explore as part of a structured development session how it could make far more effective and meaningful use of the BAF/ORR to drive debate, provide assurance, and ensure a clear and consistent understanding of the key risks issues facing the Trust		
KLOE 6: Information	**Recommendation 12**: The Board should fundamentally revisit its approach to reporting throughout the organisation to promote a more integrated, focused, consistent, less fragmented and streamlined format of reporting at all levels of the organisation. The current Quality Dashboard should be used as the 'anchor point' from which to design, develop and ultimately role out a consistent suite of reports across the Trust	**Recommendation 18:** The Board should reintroduce service user and staff stories to the Board, and consider widening this to include Student Stories	
KLOE 7: External Partners Engaged	**Recommendation 13**: The Board should explore a programme of support to the Trust from ICS partners for a range of back office and support functions and draw on intensive support around demand management and capacity modelling from NHS England for GIDS	**Recommendation 1c:** The Board should explore as part of a structured development programme stakeholder perceptions of the Trust and how comments and feedback in our review can be built upon positively **Recommendation 19:** The Board should in collaboration with the CoG, commission a programme of development for the CoG	**Recommendation 22:** The Board should develop a plan for member engagement, in conjunction with the CoG

	Actions to be implemented within 4 months of this review	Actions to be implemented within 8 months of this review	Actions to be implemented within 12 months of this review
KLOE 8: Learning, Improvement and Innovation	**Recommendation 14**: The Board should establish as a sub-committee of the Education and Training Committee a student experience group that enables the Committee to directly hear the experience and voice of students	**Recommendation 20:** The Board should enhance the 2022/23 internal audit programme and within that include a substantial element of audit activity focused on independent assurance around education and training	**Recommendation 23:** The Board should undertake a detailed gap analysis around the Trust attaining Degree Awarding Powers, draw on the experience of external education partners

Annex B - Board Governance Review – Implementation Plan

Review Recommendations	Workstreams			
	Resetting our decision making and assurance arrangements	**Resourcing Implementation and New BAU**	**Board and Council Development**	**Cohesive Trust Culture**
	Recommendation 8 Introduce new Board Committee structure (Chair) **April 2022**	**Recommendation 3** Develop proposals to enhance corporate governance function including appointment of a substantive Director of Corporate Governance. (Chief Executive) **January 2022**	**Recommendation 2** Consider co-opting NEDS with clinical and higher education backgrounds as precursor to recruiting NEDS substantively informed by a Board Skills Framework. (Chair/Interim Director HR) **February 2022**	**Recommendation 7** Agree an organisational engagement plan. (Director of Communications and Marketing) **March 2022**

	Recommendation 9 Review structure and format of EMT and other Executive Groups (Chief Executive) **April 2022**		**Recommendations 1a,b,c and 4** Design and commence implementation of structured Board development programme. (Chair/Interim Director of HR) **March 2022**	**Recommendation 18** Reintroduce service user, staff and student stories (Chief Executive) **March 2022**
	Recommendation 10 Refine BAF and ORR framework including frequency of review at Board, Committee and in operational management groups. (Chief Executive) **March 2022**		**Recommendation 5** Design robust NED induction programme. (Chair/Interim Director of Corporate Governance) **March 2022**	**Recommendation 21** Take forward work to develop a cohesive Trust culture. (Chief Executive) **April 2022**

	Recommendation 11 Develop Trust wide accountability and performance framework (Medical Director and Director of Quality) **April 2022** **Recommendation 12** Revisit approach to reporting and develop consistent suite of reports. (Medical Director and Director of Quality) **July 2022**		**Recommendation 15** Develop EMT development programme focused on team building and multi-disciplinary working in context of new SR structures. (Chief Executive) **March 2022**	**Recommendation 22** Develop a plan for member engagement. (Director of Corporate Governance) **September 2022**

	Recommendation 14 Consider establishment of a student experience as a sub-committee of the Education and Training Committee (Chair of Education and Training Committee/Director of Education and Training) **April 2022** **Recommendation 20** Enhance Internal Audit Plan to reflect greater priority on education and training. (Director of Finance/Director of Education and Training) **February 2022**		**Recommendation 19** Commission a programme of development for the CoG. (Director of Corporate Governance) **September 2022**	

Recommendations addressed elsewhere

Recommendation 6 Strategic Review to be accompanied by an investment and implementation plan – **Strategic Review implementation**

Recommendation 13 Seek Back Office Support from ICS partners – **NHS Provider Alliance**

Recommendation 16 Ensure ICS are actively engaged to understand the Trust strategy and vision - **Ongoing**

Recommendation 17 Review FTSU, Raising Concerns and Whistleblowing Procedures – **Being taken forward as part of work on People Strategy and link to the Race Equality Action Plan**

Recommendation 23 Undertake a detailed gap analysis around the Trust attaining Degree Awarding Powers – **ETC work programme**

Report to	Date
Board of Directors	25th January 2022

Race Equality Strategy and Action Plan
Executive Summary
This report seeks the Board's agreement to a refreshed Race Equality Strategy and Action Plan.
Recommendation to the Board
The Board of Directors are asked to agree the Strategy and Action plan
Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Chief Executive	Chief Executive

Race Equality Strategy and Action Plan

1. Introduction

1.1 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 in September.

1.2 Since then, we have working to produce a refreshed Race Equality Strategy and Race Equality Action Plan which address the issues identified in the Colour Brave Avengers report. We have been supported in doing so by MRL Public Sector Consultants, an independent consultancy working in the area of equalities.

1.3 We are now presenting these documents to Board for agreement. The paper also covers the proposed arrangements for accountability and assurance for this work.

1.4 The Race Equality Strategy is set within a wider commitment to equalities, and we are planning to bring a wider equalities strategy to the Board in due course. However, given the work of the Colour Brave Avengers and the expectations of change in this area, it is crucial that we progress this strand of activity with some urgency.

2. Background

2.1 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.

- A need is identified for greater focus on staff and management training to enable staff and managers to better identify and manage issues relate to race equality.

2.2 There was recognition that diversity and inclusion was more on the agenda at the Trust, but this was matched by a desire for more concrete action to address concerns with clear leadership from the top of the organisation and clear accountability for delivery.

3. 2017 Strategy

3.1 As a first attempt to develop a wholistic approach to ending racial discrimination at the Tavistock and Portman, the Trust published a Race Equality Strategy in 2017. The strategy has delivered some successes, for instance in reducing gaps in student recruitment and attainment in DET and improving the ratio of BAME staff appointed at interview. However, it failed to deliver sufficient momentum to deliver change across the organisation and to shift the dial in terms of the experience of BAME staff.

4. Strategy and Action Plan

4.1 In considering the Colour Brave Avengers report in September the Board recognised the importance of taking action to address these issues and tasked the Executive with producing an action plan.

4.2 Assisted by MRL Public Sector Consultants, a specialist consultancy operating in the field of equalities, work has been undertaken to refresh the Trust's Race Equality Strategy and develop an action plan to address the issues identified by the Colour Brave Avengers. These documents are attached at **Annex A**.

4.3 The Action Plan which includes an allocation of lead responsibility and milestones for completion, focuses on 7 objectives:

- Creating an inclusive culture including a gap analysis against the NHS Culture and Leadership Framework and the commissioning of leadership and management training for all management staff including the Board of Directors and EMT.

- Strengthening key governance arrangements.

- Increase the diversity of the work and support the career progress of BAME staff including the implementation of NHS "De Bias" procedures and other changes to the management of recruitment.

- Remove the barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination including the root and branch review of "employee dispute resolution" procedures and the introduction of a "near miss" procedure for informal reporting and monitoring of racist incidents.

- To increase engagement and communicate progress on racial equality.

- To extend the use of EDI data to monitor and improve race equality the Trust.

- To embed responsibility for racial equality at all management and administrative levels of the Trust.

4.4 The Action Plan covers Trust wide actions. There will also be a requirement for individual Directorates to produce their own plans for more local action along the lines which has already been demonstrated in DET.

5. Accountability and Assurance for delivery

5.1 A key reason for the lack of success was the absence of sufficient accountability across the organisation for delivery.

5.2 In developing this strategy, we have reviewed arrangements for accountability and assurance for delivery. These are set out in the strategy but are also summarised in the chart at **Annex B**.

5.3 As part of these arrangements, we are proposing that:

- The Chief Executive takes accountability for the overall strategy with the Acting Director of HR and Associate Director of Equalities accountable for the day-to-day management of the programme. The Chief Executive will hold a monthly review meeting to ensure key milestones on track including those actions which sit with the HR Directorate.

- All Executive Directors will have clear objectives for the delivery of this agenda within their Directorates and will designate staff in their structures who can work with the Associate Director of Equalities to support this agenda. DET already provide an effective model for this.

- The Board of Directors will hold the Executive to account for delivery. In doing so it will be supported by the Equalities, Diversity and Inclusion (EDI) Committee (to become the People and Equalities Committee subject to the approval of changes in the Governance Review). The chair of this Committee will act as the Board's Race Equality Champion.

- In turn the EDI Committee will seek assurance Race Equality Accountability Group which will include representatives from all Directorates in the Trust and the Race Equality Network and will be chaired by the Associate Director for Equalities.

- We will develop a standard scorecard through which we will routinely report progress to the Board and other groups.

6. Launch

6.1 Subject to its agreement by the Board it is planned to launch the Strategy and Action plan at an all staff meeting on 21st February. A communications plan to support this is in development.

7. Recommendations

7.1 The Board of Directors is invited:

- To reaffirm the Trust's commitment to become an anti-racist organisation.

- To consider and agree the refreshed Race Equality Strategy and Race Equality Action Plan set out **Annex A**.

- To consider and agree the arrangements for accountability and assurance for delivery set out in the strategy and summarised in the chart at **Annex B.**

Paul Jenkins
Chief Executive
18th January 2021

The Tavistock and Portman NHS
NHS Foundation Trust

Race Equality Strategy and Action Plan

2022- 2027

Draft Document

Draft V 1.0

Tavistock and Portman NHS Mental Health Foundation Trust

Draft Race Equality Strategy and Action Plan – 2022 - 2027

Foreword by Paul Burstow Chair and Paul Jenkins CEO on behalf of the Board of Directors

It is fair to say that as a Trust we are collectively perturbed by racism. However, for far too long we have thought that racial inequality would fade without sustained efforts to challenge and eradicate it. To address this inequality, we face in the Trust and more widely, we must all work together to change perceptions, cultures and actions. In many ways we have become conditioned to living with racial inequality. It is a self-perpetuating aspect of reality that has blighted the lives of Black, Asian and Minority Ethnic people in society and within our Trust.

The review of Race Equality led by the Colour Brave Avengers and the development of a Race Equality Strategy and Race Action Plan (RAP) supersedes the previous strategy and plan to reflect recent developments in the fight against racism, our commitment to ensuring action yields a substantial improvement in the experience of our staff and we adopt an active anti-racist approach to engender genuine equality. It builds on previous work undertaken by the Trust and puts in place the governance structures which will ensure the Trust delivers on its ambitions.

The urgency of the Race Action Plan was laid bare by the impact of COVID-19 and felt intensely since the unparalleled visibility and reaction to the murder of George Floyd. The Colour Brave Avengers report clearly highlighted the limited progress made so far by the Trust in addressing racism. This was supported by data from annual NHS Staff Survey and the Workforce Race Equality Standards (WRES) reports which highlighted experiences of racism within the Trust whilst acknowledging progress that has been made over the past five years in this area.

This Strategy and accompanying Race Action Plan builds upon the recommendations made by the Colour Brave Avengers and is underpinned by the values of anti-racism to bring about a change. This means that a common theme that runs across all the chapters of this strategy is the desire to strive for a Trust in which there is zero tolerance for racism in all forms. This is crucial given the clear emotional impact of racism which has persisted because being non-racist is not enough. Negative racial stereotypes of ethnic minority groups can often be activated in ways that influence behaviours unconsciously. Conversely, anti-racism is a conscious position wherein individuals commit to thinking actively and responding to the potential impact of existing structures, processes, policies, and practises on racial and ethnic minorities.

The second factor that distinguishes this strategy and plan is the ability to build on the work we have done in the last year to better understand the views and experiences of staff through the Colour Brave Avengers report and other channels with the aim of creating a strategy and plan that are realistic and implementable.

The final feature that distinguishes this document is the emphasis of closing the implementation gap. In developing it, we were guided by the knowledge that the previous Race Equality Strategy, while full of good ideas and positive intentions, did not result in meaningful improvement in the experience of Black, Asian and Ethnic Minority staff in the Trust. This is why we have dedicated considerable focus to ensuring the resourcing and governance structures attached to this strategy will enable its delivery and actively course correct if planned actions are not having the desired transformational effects.

We believe that the successful implementation of this strategy and plan will benefit all staff now and in the future. In this regard, the imperatives for fully implementing this strategy and plan are derived not just from the moral and legal requirements, but also from the mutually beneficial nature of the outcomes: we all stand to benefit from racial equality and it is all of our jobs.

Acknowledgements

When the Trust's first formal Race Equality Strategy was created in 2017 we started our journey towards understanding and accepting the impact of racism as a feature of our society and culture in the UK and therefore inevitably a feature of any organisation which reflects society at large, when we created our first formal Race Equality Strategy in 2017.

This has been a difficult journey for this organisation particularly for our people from Black, Asian and other non-UK majority ethnic backgrounds, who have experienced direct and indirect racism from their colleagues and clients, but also for all staff who considered themselves part of a fair, thoughtful reflective and supportive organisation which had to come to terms with new information and evidence which challenges their strongly held beliefs and personal values.

The 2017 strategy expired in 2020 and we have spent 2021 working together to review and critically reflect on the impact and successes of that strategy as well as taking stock on how much there is still to achieve.

It is very important that we recognise the enormous contribution of people from the Trust who have bravely stood up and relived and recounted their stories and experiences of racism in the organisation. These stories, recounted in meetings and committees and though the research we have commissioned, have been emotional, challenging but most importantly impactful in driving change. It is impossible to overstate the importance and impact of these testimonies and we thank everyone involved for sharing the stories with us, even when there was personal impact in having to relive past trauma in order to do so.

We give thanks to the organisations, and the passionate individuals within them, who have helped us explore and understand the issues we jointly face and have helped us find language, structures and processes to address our concerns.

The 'Colour Brave Avengers' organisation undertook a review of the impact and reach of our existing 2017 race strategy and plan and created spaces to listen and hear sympathetically and supportively the stories of our colleagues who had experienced racism during their time at the Trust. This analysis was presented to us in a number of forums and, although challenging to hear, and triggering for those who had experienced racism we felt it important to our new narrative that we listened as an organisation to the findings and insights of these external experts in an unfiltered and unvarnished manner to move our new strategy forward.

We went further with the work of the Colour Brave Avengers and undertook further work with them in commissioning their 'Reporting, Action, Composition and Education 'RACE' code' analysis of our governance structures, functions, activities and impacts, again to help us develop and hone our strategy for the next five years.

In developing this strategy we commissioned MRL Public Sector Consultants to provide us with best practice examples and critical analysis of our work to date and

this strategy is supported by their knowledge and expertise in the field. In particular MRL have:

- Undertaken a review of the Trust's Race Equality Strategy with aims to improve the representation, progression and success of Black, Asian and UK Minority Ethnic staff through the creation of an even more culturally inclusive and diverse Trust's community.

- Engaged with our people, in particular key staff networks, in reviewing the Trust's Race Equality Strategy and developing a Race Action Plan, in particular suggestions as to the priority actions.

- Worked with the Trust's EDI team to develop a Race Action Plan triangulated with the Workforce Race Equality Standard (WRES) and based on the independent review, including all lessons learned, findings, 'must do actions', early actions, and recommendations from an independent review of the Trust's Race Equality Strategy and activity and informed by the findings and learnings from the London Workforce Race Equality Strategy (October 2020).

Abbreviations

BAME	Black, Asian and UK Minority Ethnic
ED&I	Equality, Diversity and Inclusion
NHS	National Health Service
RECA	Race Equality Code Assessment
RACE	Reporting, Action, Composition and Education
RAP	Race Action Plan
WRES	Workforce Race Equality Standard
REN	Race Equality Network
RES	Race Equality Strategy

Executive Summary

The issue of race equality is not one the Tavistock and Portman can ignore.

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.

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 to be unhelpful 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.
- A need is identified for greater focus on staff and management training to enable staff and managers to better identify and manage issues relate to race equality.
- While there was recognition that diversity and inclusion was more on the agenda at the Trust, but this was matched by a desire for more concrete action to address concerns with clear leadership from the top of the organisation and clear accountability for delivery.

As a first attempt to develop a wholistic approach to ending racial discrimination at the Tavistock and Portman, the Trust published a Race Equality Strategy in 2017. The strategy has delivered some successes, for instance in reducing gaps in student recruitment and attainment in DET and improving the ratio of BAME staff

appointed at interview. However, it failed to deliver sufficient momentum to deliver change across the organisation and to shift the dial in terms of the experience of BAME staff.

In considering the Colour Brave Avengers report in September the Board recognised the importance of taking action to address these issues and tasked the Executive with producing an action plan.

Assisted by MRL Public Sector Consultants, a specialist consultancy operating in the field of equalities, work has been undertaken to refresh the Trust's Race Equality Strategy and develop an action plan to address the issues identified by the Colour Brave Avengers. The Action Plan which includes an allocation of lead responsibility and milestones for completion, focuses on 7 objectives:

- Creating an inclusive culture including a gap analysis against the NHS Culture and Leadership Framework and the commissioning of leadership and management training for all management staff including the Board of Directors and EMT.

- Strengthening key governance arrangements.

- Increase the diversity of the work and support the career progress of BAME staff including the implementation of NHS "De Bias" procedures and other changes to the management of recruitment.

- Remove the barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination including the root and branch review of "employee dispute resolution" procedures and the introduction of a "near miss" procedure for informal reporting and monitoring of racist incidents.

- To increase engagement and communicate progress on racial equality.

- To extend the use of EDI data to monitor and improve race equality the Trust.

- To embed responsibility for racial equality at all management and administrative levels of the Trust.

A key reason for the lack of success was the previous strategy absence of sufficient accountability across the organisation for delivery. In developing this strategy, arrangements for accountability and assurance for delivery have been review and strengthened. In implementing the strategy:

- The Chief Executive will take accountability for the overall strategy with the Acting Director of HR and Associate Director of Equalities accountable for

the day-to-day management of the programme. The Chief Executive will hold a monthly review meeting to ensure key milestones on track including those actions which sit with the HR Directorate.

- All Executive Directors will have clear objectives for the delivery of this agenda within their Directorates and will designate staff in their structures who can work with the Associate Director of Equalities to support this agenda. DET already provide an effective model for this.

- The Board of Directors will hold the Executive to account for delivery. In doing so it will be supported by the Equalities, Diversity and Inclusion (EDI) Committee. The chair of this Committee will act as the Board's Race Equality Champion.

- In turn the EDI Committee will seek assurance Race Equality Accountability Group which will include representatives from all Directorates in the Trust and the Race Equality Network and will be chaired by the Associate Director for Equalities.

- A standard scorecard will be developed through which progress will be reported to the Board and other groups.

The Board of Directors recognises the seriousness of these issues and the need for urgent action and is committed to leading this work within the Trust. Our ambition to become an anti-racist organisation requires the engagement of all staff. In working together on this agenda, we not only address an injustice, but we also take actions which will improve the experiences of staff, students and patients and ensure the Tavistock and Portman is in place to reflect the needs of the 21st century communities it serves.

Section 1 Background, Research and Evidence

1.1 The Context

The need for a structured and deliberate approach to addressing issues of racism and discrimination in the workplace has never been more essential than now. Awareness of the nature and impact of racism on individuals and communities is higher than ever, fuelled by the liberal exchange of information across geographical space and facilitated by the internet. Several high-profile incidents of racism and discrimination in recent years (most notably those related to police brutality and violence in the US) and subsequent outrage and protests that have followed have compelled governments and organisations to reaffirm their commitments to action for racial equality.

This has occurred even in societies that had previously demonstrated significant appetite for systematically stamping out racism through laws and conventions that affirmed the identity and equality of marginalised groups.

These scenarios are evidence of the intractability of issues of racism and discrimination so far, despite well-meaning efforts towards their eradication. Nevertheless, continuing changes in the wider policy and service context has meant that as an NHS Trust we continue to review and update our equality and diversity priorities as we strive towards ending racial discrimination and ensuring that our staff, patients and students are confident that they are valued, and will be supported and treated fairly. Our approach is shaped by several national frameworks, which we are also mandated to comply with. These include:

a. The Equality Act 2010 is the basic UK legislative framework that protects people from discrimination in the workplace and society. More specifically, the Public Sector Equality Duty (PSED), as set out under Section 149 of the Act, requires that public sector organisations like ours adhere to the general equality duty by demonstrating ‘due regard’ in eliminating discrimination, harassment and victimisation; promoting equal opportunity; and fostering good relations across divides.
b. The Workforce Race Equality Standard (WRES) was introduced to help NHS organisations implement a data-driven approach for assessing racism within their organisations and producing action plans to eliminate variations in workplace experience between white and Black, Asian and Minority Ethnic (BAME) staff. It requires us to publish data benchmarked against nine indicators of racial equality in the workplace, including ethnic representation of staff and the Board, opportunities for professional development, and the elimination of harassment, abuse and discrimination.

c. The Equality Delivery System 2 (EDS2) aim is

> "*To help NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010*" (NHS, 2013, pg. 4).

In essence, it is a self-assessment tool for measuring performance and progress towards attaining the requirements of the Equality Act 2010.

Within the Trust, we have adopted several initiatives and processes in the past few years in order to keep up with the obligations highlighted above. Examples include the Race Equality Strategy 2017-2020, appointing Race Equality Champions, encouraging the Race Equality Networks and the Allies Group, and celebrating Black History Month among others.

Our Race Equality Strategy 2017-2020 outlined our organisational approach for: -

'Localising' the demands of these national frameworks

Ensuring racial equality among our workforce.

Documenting our commitment to adopt best practices in monitoring and assessing our performance.

Consequently, we regularly issue formal reports of our progress through the annual Equalities Report and maintain an open-door policy for suggestions and improvements. It is in light of this that we commissioned an independent review of the Trust's anti-racism work by the Colour Brave Avengers to properly understand and address persistent complaints regarding race. The outcome of this review is summarised in Section 1.3 below.

1.2 The Colour Brave Avengers Independent Review and Report

The Colour Brave Avengers were commissioned by the Trust to "undertake research as part of the ongoing Tavistock and Portman NHS Foundation Trust's Anti-Racist Strategy work". The organisation was tasked to conduct an Independent Review with the following Terms of Reference:

- "Undertake a comprehensive diagnostic regarding the experiences of diverse and marginalised staff, going further than the NHS Staff Survey, in order to fully understand the issues being faced, involving members of staff at every level.

- Examine the systems and processes of the Foundation Trust (including HR) to ascertain and understand the culture of the Foundation Trust which create difficulties and challenges for diverse and marginalised staff.

- Deliver a written report and make a presentation to the Foundation Trust Board providing an outline of the findings, with an action plan to move forward in becoming anti-racist.

- Work closely with the leadership at strategic and senior operational level to ensure racism is understood and explaining what an anti-racist organisation looks like. In addition, to provide assistance in terms of strategy, action planning and evaluation mechanisms.

- Support and work with the Race Equality Strategy Group to develop/propose suitable mechanisms for holding leaders to account, ensuring the delivery of the commitments made" (The Colour Brave Avengers, 2021, pg. 2).

The organisation subsequently designed and implemented a comprehensive and robust quantitative and qualitative process comprising an all-staff survey with 500+ respondents, three focus group discussions with 22 participants, 22 on-to-one interviews, and a diagnostic document and governance review.

The analysis of the data revealed the existence of significant incidences of racism in the Trust that manifested in the form of several barriers to racial inclusion, a lack of diversity at higher levels, and prevalent racist behaviours that were aggravated by the absence of accountability structures.

Following these revelations, a proprietary Solutions Collaboratory process was deployed to identify relevant solutions and strategies for delivering on them. This was followed by the deployment of the RACE Equality Assessment (RECA) process that strategically assessed the overall governance structure and advanced several recommendations for addressing cultures, policies or practices that result in the underrepresentation and repression of Black, Asian and other ethnic groups in the organisation. These recommendations were further condensed into a series of 26 actions, with 10 of these prioritised as *must-do actions*.

The recommendations are appended to this Race Equality Strategy and the must-do actions are incorporated into the Action Plan 2021 - 2025.

1.3 'Must-do' Actions

The 10 must-do actions identified by the Colour Brave Avengers are:

- To create an active statement of which clearly identifies the current position, the performance and aspirations, identifying progress against targets and including criteria on race including ethnicity pay gap using the four principles of the RACE Equality Code (Reporting, Action, Composition, and Education).

- To continue to educate staff on the importance of reporting and use positive resolution of issues to improve the reporting rates for staff and patients by also providing examples of what the data is used for.

- To document the roles of the board and executive level sponsors on EDI and race, create a robust evaluation framework against the responsibilities of both roles and ensure the roles are integrated in the overall governance framework.

- To explore what objectives should be used to evaluate board performance in the area of improving race equality and be more intentional about using the data that is being collated.

- To examine the processes for job evaluation and re-branding in regard to race and review opportunities for career development for underrepresented groups in the higher levels ensuring it is fair for all. To be open and transparent about any barriers and how the work carried out will eliminate them.

- To use the information derived from an end-to-end review of talent management activities to design activities that will lead to an improvement in the outcomes for those underrepresented groups with positive action and support for managers.

- To ensure there is a consistent approach across the organisation that satisfies Equality Act 2010 obligations and encourages employees to comply with reporting initiatives by educating everyone as to the purposes and benefits of inclusion and belonging and encouraging a culture that goes beyond the law.

- To create brave, ambitious targets and a culture of gathering and diligently monitoring the required data in order to create meaningful, measurable outcomes. Key performance indicators should be introduced and performance objectives for set leaders and managers with a focus on increasing the diversity and inclusivity of services and improving outcomes for patients, students and staff.

- To build new structures for communicating, educating and ensuring staff feel safe across the whole organisation, this is to help in the objective of an anti-racist, inclusive and safe culture and will involve revising how the Trust values are embedded and consistently monitored and invest in ensuring all employees have a deeper understanding and appreciation of the topic of race and the link between overall performance and inclusivity and belonging.

- To the data collection as a tool to tackle the areas that demonstrate systemic racism by collecting enough relevant data across a comprehensive data set which includes ethnicity pay.

These actions form the basis of the programme of work set out in this Strategy document and Action Plan.

1.4 Actions Following the Colour Brave Avengers Report

In light of the findings and recommendations of the Independent Review, the Trust stated its commitment to implementing the recommendations and building an inclusive and anti-racist culture in the organisation.

This Race Equality Strategy and develop a Race Action Plan, which is one of the 'must-do' actions emerging from the Colour Brave Avengers Independent Review.

1.5 Racism and the Trust

We acknowledge this is a complex narrative, however it is important, that those who are disadvantaged do not experience institutional discrimination due to their ethnic origin or culture. The promotion and implementation of fair and equitable policies and processes for Black, Asian and Minority Ethnic individuals within the Trust should be actively implemented and achieved, which the Race Equality Strategy and Action Plan aims to do over the next five years.

The strong case for action on race is positive, and we have set out some key evidence of disparity in experiences and outcomes that demonstrate these challenges within this Trust in Section. Future progress on race discrimination by the Trust is likely to result in better treatment for all disadvantaged groups by making systems fairer and more transparent and the services offered by the Trust more responsive, and person focused. Furthermore, there is also work to do to fully address and ensure the Race Action Plan properly responds to the needs of Black,

Asian and Minority Ethnic including women, people with disabilities, and takes into account other protected characteristics such as sexuality and gender identity to ensure we are addressing areas of intersectionality.

For the purposes of developing this strategy, following discussions and the review of various documents, MRL Public Sector Consultants Ltd have identified five main manifestations of racism in the Trust. These are identified as follows:

- Racist harassment
- Microaggressions
- Discrimination
- Stereotyping
- Institutional (or systemic) racism system

The purpose of the Race Equality Strategy and Action Plan is not to revisit these, but to put forward concrete actions that can address these challenges within the Trust.

1.6 Anti-racism

Anti-racism is about institutions and individuals consciously raising their awareness of how negative stereotypes of ethnic minority groups, historically embedded to justify colonialism and slavery still persist. These stereotypes are inevitably deficit-based and see minority groups as '*less than*' and as '*others*. These stereotypes can become ingrained in societal and organisational cultures in ways that become taken for granted, and guide behaviours in everyday life.

Anti-racism is usually structured around conscious efforts and deliberate actions to provide equitable opportunities for all, on an individual, organisational, and systemic level. It requires individuals to scrutinise the stereotypes they and others hold, and to understand how their actions may impact people of Black, Asian and Ethnic Minorities. Anti-racism at organisational and institutional levels requires a careful audit of policies, practises, functions and processes to uncover whether and how practices and behaviours which may seemingly appear non-threatening may inadvertently discriminate against ethnic minority groups.

1.7 Terminology and key concepts

1.7.1 Terminology Several terms are used in public policy, and in wider society, to refer to collective ethnic minority populations. These include black, Asian and minority ethnic (BAME), black and minority ethnic (BME), people of colour, and racialised minorities.

During this work, we came across some strong views on the use of terms such as BME and BAME. All of these terms have their limitations, including: Implying that BME/BAME individuals are a homogeneous group, Singling out specific ethnic groups, which can be divisive and exclusionary and Being a label applied from the

outside that limits the ability of people to choose how to identify themselves We recognise that this is a complex and multifaceted debate, For the purpose of this strategy we will be using the term BAME to describe groups of people whose ethnicity or racial background is a key factor in their experience or risk of discrimination at work in the NHS. This is not an endorsement of this term into the future, but an effort to ensure consistency with other NHS workforce race equality publications. We note that for our people they my not be in a minority at all hence we qualify the term BAME to mean Black, Asian and UK Minority Ethnic groups.

1.7.2 Racism is often misunderstood as treating someone unfairly or holding prejudiced views. Racism is a combination of racial prejudice plus the power – whether through authority or social structure – and conventions to act on the prejudice. When we think about racism, we tend to consider individual racism, meaning the behaviours (including discrimination) arising from an individual's racist assumptions or beliefs.

This strategy though, focuses primarily on the eradication of systemic racism, where established policies and practices result in advantage or disadvantage to specific racial groups. This is different from individual racism because there may not be individual intent. Systemic racism can be viewed as Institutional racism. The individuals involved may not themselves have racially prejudiced beliefs or behaviours, but are carrying out policies, processes, or procedures that disadvantage people from specific racial groups. The Macpherson report's definition of institutional racism is "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people"

1.7.3 Structural racism – inequality rooted across the operation of a system or society that excludes and/or has a significant negative impact on large numbers of a particular racial group and their ability to participate Therefore, it is not enough to simply not be racist as an individual, there is a need for a conscious and deliberate effort to promote racial tolerance and dismantle racist structures, becoming an active agent of change, rather than a passive bystander. This is commonly referred to as being anti-racist and is a fundamental part of being an authentic ally. Equally, it is important that white allies do not fall into the trap of paternalistic racism, whereby the 'majority race has the right to define what is good for the minority race'. There is a risk that, even when trying to improve the working lives of BAME people or fight discrimination, white leaders impose policy change, as opposed to working alongside BAME people to co-design that change.

1.7.4 Discrimination - discrimination happens when someone is treated unfairly or less favourably due to an actual or perceived protected characteristic and is unlawful under the Equality Act 2010. There are four types of discrimination as set out below. Examples given are in the race context:

1. Direct discrimination – Treating someone worse than someone else, for example not inviting someone for an interview because you believe them to be from a particular racial background

2. Indirect discrimination – Rules, policies, or ways of doing things which have a worse impact on someone with a particular characteristic than someone from another group, for example Friday team meetings taking place in a pub

3. Harassment – violating someone's dignity; creating a hostile, humiliating, degrading or offensive environment. For example, making fun of someone's name or how it is pronounced

4. Victimisation – This is treating someone unfairly if they are taking action under the Equality Act or supporting someone else who is doing so. For example, a white ally can be victimised if they are supporting someone bringing a harassment claim

1.7.5 White Privilege Coined by the black civil rights activist William Du Bois in the 1930s and later coming to further prominence in Peggy McIntosh's 1988 ground-breaking paper White Privilege: Unpacking the invisible knapsack, the term white privilege is used to describe how having white skin gives an individual an advantage in life. White privilege does not mean that white people have never struggled, but in Britain they do not experience racial discrimination on an institutional or societal basis. Having white privilege and recognising it is not racist. But white privilege exists because of historic, enduring racism and biases and is the "power of accumulated power"

1.7.6 White Fragility The term white fragility was devised by Sociologist Robin DiAngelo after her experiences when facilitating diversity workshops in the US. It's defined as discomfort and defensiveness on the part of a white person when confronted by information about racial inequality and injustice. In her book, White Fragility: Why It's So Hard for White People to Talk About Racism, she describes in depth the phenomenon and explains that "responses include emotions such as anger, fear, guilt and behaviours such as argumentation, silence and withdrawal from the stress-inducing situation…though white fragility is triggered by discomfort and anxiety, it is born of superiority and entitlement." Within NHS organisations, it is necessary to explore how white privilege has been exerted in day to day life and the impact on career progression.

1.7.7 Colourism Colourism, also known as shadeism, is defined as "prejudice or discrimination against individuals with a dark skin tone, typically among people of the same ethnic or racial group."This kind of discrimination, based on skin colour, often sees members of the same race treated differently based on the social implications which are attached to their skin colour. In our society, the default for good, well educated, capable and acceptable is white. White people are accepted as the norm when it comes to beauty norms as well cultural norms, thus the further you are away from that norm, the more you are discriminated against, not only by people from white backgrounds but by BME people who have less melanin in their skins and are nearer to the default position of being white. Colourism is a seed that was planted by white

colonists, used to divide and rule black populations, with lighter skinned slaves being used in the big plantation houses to serve and darker skinned people in the fields. Colourism is very much alive today, with sales of skin lightening and bleach creams booming worldwide. Its roots lie in the mainstream idea that the lighter you are the better. This myth is replicated in society every day. Skin tone affects employability rates, promotion prospects, being stopped by the police, and suspension rates from school. With women's worth so heavily tied to appearance, and lighter skin so heavily tied to beauty standards, it is not surprising that it is usually women of colour who are hit hardest. In the NHS, we are not immune from this phenomenon. Many of our most senior BME leaders have lighter skins, however we have no way of quantifying this phenomenon and the impact it has as we do not categorise individuals by skin tone

1.7.8 Hierarchy of Preference The 'hierarchy of preference' describes the way our unconscious preferences and biases affect how we relate to people. Stereotypes, and people's beliefs about different groups of people, play a large part in how those groups are perceived and reacted to. For example, we are all aware of the much-used harmful stereotypes of the aggressive black woman and the passive Asian woman. These stereotypes matter and they carry weight. Our beliefs shape our attitudes and ultimately our behaviours. In the NHS, it isn't something that is often spoken about but, in 2015, Professor Michael West and Professor Jeremy Dawson's Document Making the difference brought the issue into popular consciousness. It showed that, by far, the people that reported being discriminated against the most in the NHS were people from black backgrounds, followed by people of Asian origin, though we know that people of Indian descent are discriminated against less than those of Pakistani or Bangladeshi descent. We also recognise within the hierarchy of preference the impact on people of East Asian and Southeast Asian descent of being seen as 'model minorities'. It is important that the complexity of the issue of race is understood by us all, that we understand how it manifests itself in all corners of our daily and work lives, and how it impacts people from all races and all sections of society

1.7.9 Internalised Racism Internalised racism is defined as acceptance and belief by members of stigmatised races of negative messages about their race's own abilities and intrinsic worth. Williams & Williams-Morris have also added that it is "the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves.". This is characterised by people not believing in others who look like them and, more importantly, not believing in themselves. It involves accepting limitations to one's own humanity, including one's dreams, one's right to self-determination, and one's range of allowable self-expression. It saps an individual's self-esteem and lowers their confidence in themselves and in their own race. It often manifests as the embracing of "whiteness" as being the ultimate and the best. Self-devaluation is common, and many will use derogatory and deeply offensive terms about themselves and others of their own race. They might disown their own cultures on the basis that the white man's world is better, and aspire to being a part of that world.

Internalised racism often leads to resignation, helplessness, and hopelessness and can lead to people engaging in risky health practices, dropping out of education and not engaging in society. The evidence suggests that internalised racism is more common than we think, with a third of people from BME backgrounds having some level of internalised racism in their makeup. The concept is explored in Camara Jones' 2000 paper entitled Levels of Racism: A Theoretic Framework and a Gardener's Tale. Despite this landmark piece of work, the concept is rarely spoken about. Biological Weathering In her work, "Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, Arline Geronimous showed that chronological age doesn't only capture the length of time you have been alive, but also the experiences you have had during that time. She found that black people experienced greater physiological "wear and tear", and were ageing, biologically more rapidly than white people. This effect is driven by the cumulative impact of repeated exposures to psychological, social, physical, and chemical stressors in their residential, occupational and other environments. She found that coping with these stressors, now commonly called microaggressions, meant that, compared to white people, black people had many more negative experiences. The accumulation of these experiences ultimately weakens them physiologically. The impact of discrimination can be physically observed in telomere length. Telomeres are sequences of DNA at the end of chromosomes. Telomere length is viewed as an overall marker of biological ageing. In her study, Arline Geronimous found that black women had shorter telomeres than white women, meaning that at the same chronological age, black women had accelerated biological ageing of about 7.5 years more than their white counterparts. Arline Geronimous called the phenomena "biological weathering" – the wearing out or erosion of an individual physiologically, leading to more susceptibility to illness and death at a much younger age than their white counterparts. Understanding this concept is essential when considering the impact of discrimination and inequality in the NHS.

1.7.10 Micro aggressions Derald Wing Sue has defined microaggressions as everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. It is possible that perpetrators of microaggressions are often not aware that they are engaging in communication that is derogatory to people from the BME communities. Whether intentional or not, microaggression is a form of racism that has negative impact on those impacted and is a significant risk factor for diminishing wellbeing and productivity at work

2.0 The Background to this strategy

In the year since the expiry of the last Race Equality Strategy we have we have undertaken a further assessment of key processes and structures within the Trust:

- We have commissioned an independent review of the existing strategy and plan and the current 'state of play' within the organisation by the by the Colour Brave Avengers in order to incorporate its recommendations into the strategy and action plan.

- The Colour Brave Avengers undertook staff engagement activities and using their framework and their research and experience from other organisations, explored a series of ideas and possible actions to which the Trust staff involved then gave a priority score. The engagement work also included the 'solutions collaboratory' approach which identified and prioritised a number of actions against each of the key findings of the review.

- We have reviewed the report and recommendations of the further Colour Brave Avengers assessment against the 'RACE' Code. (Reporting, Action, Composition, Education). The RACE code draws together over 200 recommendations outlined in reports, charters and pledges which aim to tackle diversity and inclusion challenges the RACE code evaluation process measures the organisation against these 200 recommendations. The RACE code evaluation resulted in a 102-point action plan, these have helpfully been themed and grouped and combined with the findings of the RES & RAP review.

- Comprehensively review and analyse the Trust's EDI data.

- Identify the gaps and limitations in the existing Race Equality Strategy and Action Plan.

- Put forward recommendations as a precursor to developing the monitoring and evaluation framework for the Race Action Plan.

- Reviewed key documentation on addressing issues of racism in the Trust, including the previously mentioned Colour Brave Avengers' Independent Review Report. We have also consulted several guidance frameworks for developing strategic responses to racism, particularly those developed by the NHS and other Foundation Trusts.

- Collected and analysed primary data through 20 one-on-one interviews with Trust staff in key management positions.

- Reviewed the NHS Staff Survey data for EDI performance related metrics.

- Carried out a Social, Technological, Economic, Environmental, Political, Legal and Ethical 'STEEPLE' analysis to provide context to the ongoing anti-racism strategy work.

- Conducted a Vision, Mission, Objectives, Strategy and Tactics 'VMOST' analysis to assess the fitness of the core aspects of the Trust's Race Equality Strategy 2017-2020.

- Conducted a targeted resource analysis to determine the sufficiency of resource allocation towards achieving the Trust's anti-racism agenda.

2.2 Sources of evidence and insight

2.2.1 The Race Equality Strategy 2017 - 2020

The Race Equality Strategy 2017 - 2020 represented our first attempt at a wholistic approach to ending racial discrimination in the Trust. The rationale for the strategy was established by credible evidence of racism and discrimination within the Trust based on anecdotal reports and the findings from the NHS Staff Surveys. These we considered to be particularly challenging given the type of services we provide and the diversity of the communities that we serve. Additionally, the well-established benefits of inclusivity in an organisation meant that there were the Trust would realise significant gains from a systematic approach to addressing racism and discrimination.

The aim of the strategy was "to end racial discrimination at the Tavistock and Portman and to do all we can to ensure that all staff are confident that they are valued, that they will be treated fairly and supported to their full potential." In appreciation of our reputation as a respected teaching organisation, it also aimed "to ensure that our students no matter what their background, race, ethnicity, nationality or culture, do not face discrimination. The strategy had eight objectives which were:

a. To achieve a reduction in bullying and harassment which places the Trust in the top ten NHS organisations as measured by staff survey results.

b. To achieve an equal proportion of staff appointed following shortlisting for Black, Asian and Minority and white staff across all bands.

c. To achieve an improved level of confidence amongst Black, Asian and Minority staff and that all staff will be treated fairly, measured through the staff survey.

d. To achieve a high level of confidence that all staff, irrespective of grade, will have access to training and development opportunities, measured through the staff survey.

e. We will invest in developing our more junior staff by determining their needs through robust appraisals, reviewing personal development plans (PDPs), feedback from ongoing discussions and commissioning education and training which will create our future leaders. Each year we will audit our PDPs across all staff levels to ensure that agreed development is implemented and track progress through the annual NHS staff survey.

f. To increase the proportion of Black, Asian and Minority staff in 8a posts and above, to be one of the ten most representative Trusts in London.

g. To increase Black, Asian and Minority representation in both executive director and non-executive director roles on the board of directors to be proportionate and representative.

h. To collect and report on data to identify areas where change is required and/or where it has been achieved. This means having more detailed information available about each area of the Trust and involving each discipline and profession in reporting on the profile of their discipline or profession and any barriers to race equality specific to these areas.

These were supported with a strategic outline of thematic areas for focused intervention and an indicative action plan for meeting the needs that had been identified under each theme.

While we consider the strategy gave us a good start for focused action against racism and discrimination in the Trust, it still contained some fundamental weaknesses that, in hindsight, limited its impact and affected our momentum towards achieving our aims. These include:

1. The strategy has not provided an explicit vision for racial equality in the Trust, which has ramifications for stakeholder support and communications.

2. Ideally, a clearly articulated mission statement that expresses the purpose of the strategy and its benefits for all staff, especially those from Black, Asian and Minority groups, and stakeholders should have been included.

3. Furthermore, the strategy did not clearly distinguish between aims and objectives as it had two sets of aims. This likely affected our capacity to define metrics for monitoring implementation and measuring progress.

4. The rationale for the strategy was based on a limited marginal use of the WRES and NHS Staff Survey data which provided a limited view of the depth of the challenge relating to race equality. This further compounded the challenge of developing a suitable monitoring and evaluation framework.

5. The action plan in the strategy was indicative and accompanied by a stated intention to be further developed into a delivery plan. However, this was not implemented and resulted in a strategy that lacked a vehicle for implementation, ownership of actions, associated timelines, and accountability in the form of definitive roles and measurable outcomes.
6. The strategy did not create an opportunity for the culture of the Trust to be developed alongside the changes proposed.

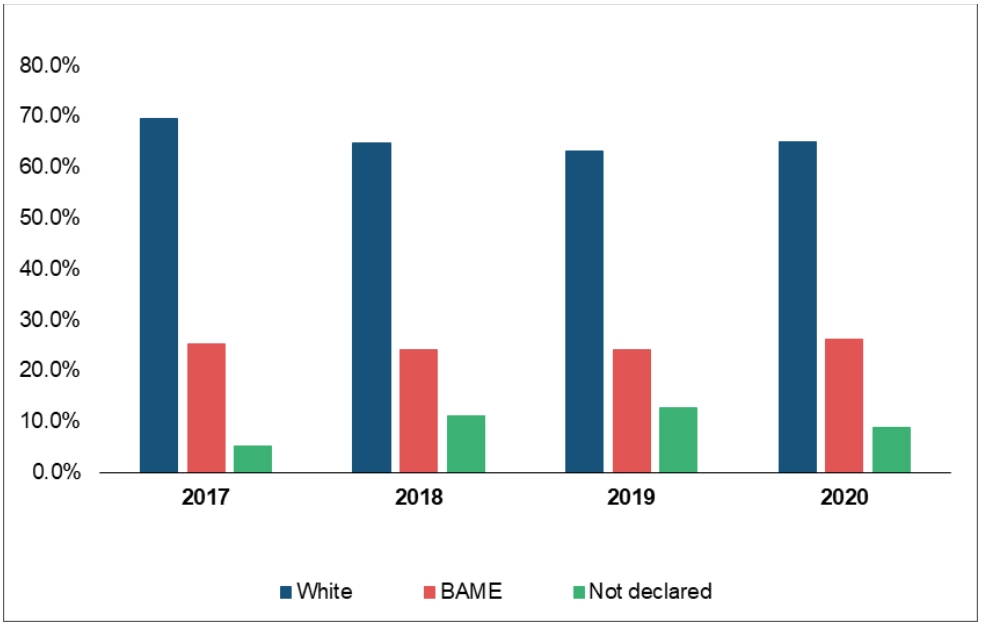
We have subsequently assessed the effectiveness of the strategy by analysing our performance on the WRES indicators and EDS2 goals by extension. The results are presented below.

It should be noted that a significant focus will need to be given to improving and collecting data to support and monitor the 2022 RES and impact measurement of the 2017 RES and RAP is limited by the paucity of data available to date.

2.2.2 Summary of National Staff Survey and Workforce Race Equality Standards (WRES) Data

Trust data from the NHS Staff Survey and the Workforce Race Equality Standards (WRES) indicate some progress in promoting Black, Asian and Minority representation in the workforce and reducing the level of negative experiences for Black, Asian and Minority staff. In the period between 2017 and 2020, the proportion of Black, Asian and Minority staff increased by 0.9 percent from 25.3 percent to 26.2 percent (Figure 2.1). Thirty-nine Black, Asian and Minority staff were recruited into the Trust within the period resulting in a headcount increase from 179 in 2017 to 218 in 2020. This represented an average annual growth of 7 percent. Furthermore, the proportion of Board Members from a Black, Asian and Minority background increased from 7.1 percent to 21.4 percent during this period.

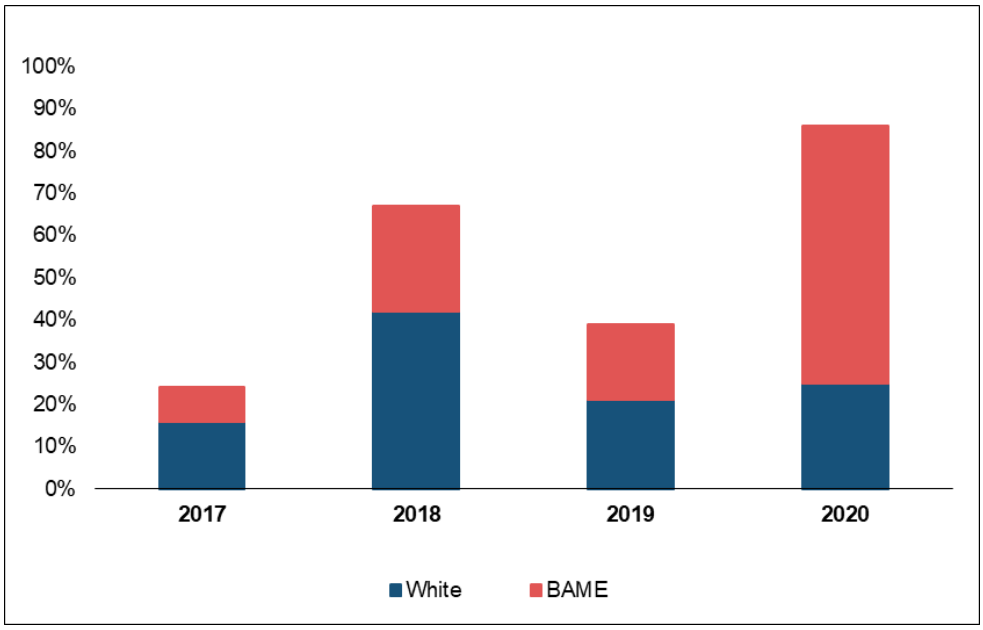
Figure 1.1 Percentage of Staff by Ethnicity from 2017 to 2020



Source: WRES Raw Data, 2017-2020

More information from the WRES reports indicated that the proportion of Black, Asian and Minority applicants that had been appointed following shortlisting increased from just 8 percent in 2017 to 61 percent in 2020 (Figure 2.2). This was a significant as it also showed that the relative likelihood of White applicants being appointed following shortlisting had declined from 2.0 in 2017 to 0.41 in 2020. In other words, whereas the Trust saw the appointment of two new White staff for every Black, Asian and Minority staff appointed, that number had now reduced to less than one. Additionally, compared to White staff, only 0.46 percent of Black, Asian and Minority staff entered the formal disciplinary process in 2020 (Figure 2.3). Though this was an increase from zero in 2017, it still indicated a decline by more than half from 1.2 percent in 2018 and 1.05 percent in 2019. When compared to White staff, the relative likelihood of Black, Asian and Minority staff entering the formal disciplinary also declined in 2020 relative to the value in 2018 and 2019.

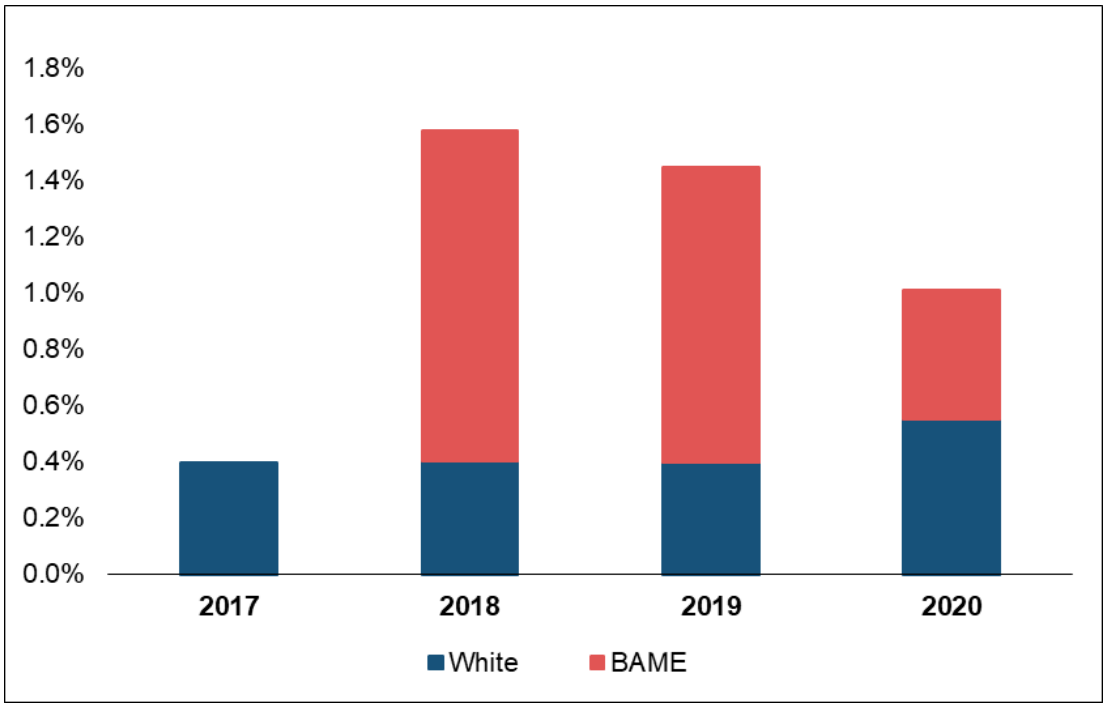
Figure 1.2 Percentage Appointed Following Shortlisting



Source: WRES Raw Data, 2017-2020

Of further interest was the review of performance for WRES Indicators 5 to 8 which measure harassment and discrimination experienced by workers in the Trust (Figure 2.4). Between 2017 and 2020, the proportion of Black, Asian and Minority staff that had experienced harassment, bullying or abuse from other staff (in the 12 months preceding the survey) (Indicator 6) had declined from 27 percent to 25.7 percent. Additionally, during this period, 5 percent fewer Black, Asian and Minority staff had experienced discrimination at work from a manager or colleague(s) (Indicator 8), while those that believed the Trust provided equal opportunities for career progression or promotion increased from 45 percent to 49.10 percent (Indicator 7). Of concern was the result from indicator 5 which showed that 18.80 percent of Black, Asian and Minority staff experienced harassment, bullying or abuse from parents, relatives or the public in the preceding 12 months. However, this could be considered a marginal (though significant) increase from 18 percent in 2017.

Figure 1.3 Percentage of Staff Entering the Formal Disciplinary Process



Source: WRES Raw Data, 2017-2020

Thus, the evidence indicates that the Trust has made progress in creating opportunities for and limiting the discrimination of Black, Asian and Minority staff at the macro level.

However, feedback from the interviews and focus groups conducted by the Colour Brave Avengers and the MRL team indicate that significant discrepancies still exist at the micro level that impacts on the experience of Black, Asian and Minority staff in the Trust.

We must also consider our performance in the context of the wider NHS, For instance, while the proportion of Black, Asian and Minority staff has grown on average at a higher rate than others, it has only increased by less than 1 percent since 2017 in the Trust. Meanwhile, for NHS England in general, the proportion of Black, Asian and Minority staff increased by a 2.9 percent margin during the same period.

Figure 1.4 Percentage of Staff that Experienced Harassment and Discrimination

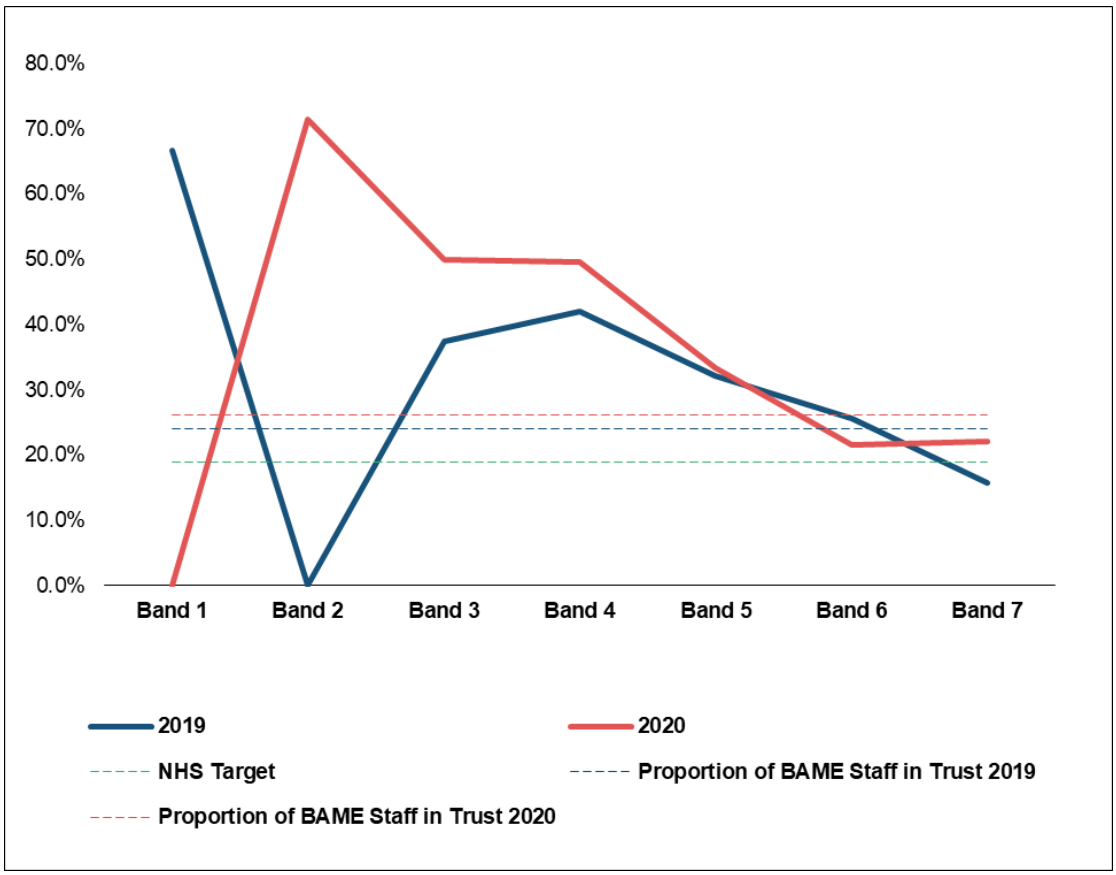
WRES Indicator	Description	2017	2020
Indicator 5	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	18%	18.80%
Indicator 6	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	27%	25.70%
Indicator 7	KF21. Percentage believing that trust provides equal opportunities for career progression or promotion	45%	49.10%
Indicator 8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	22%	17%

Source: Tavistock and Portman NHS Foundation Trust Race Equality Strategy 2017-2020, NHS Staff Survey 2020

In addition, disaggregating the data at Trust level reveals discrepancies in the representation of Black, Asian and Minority staff across the various pay bands and roles.

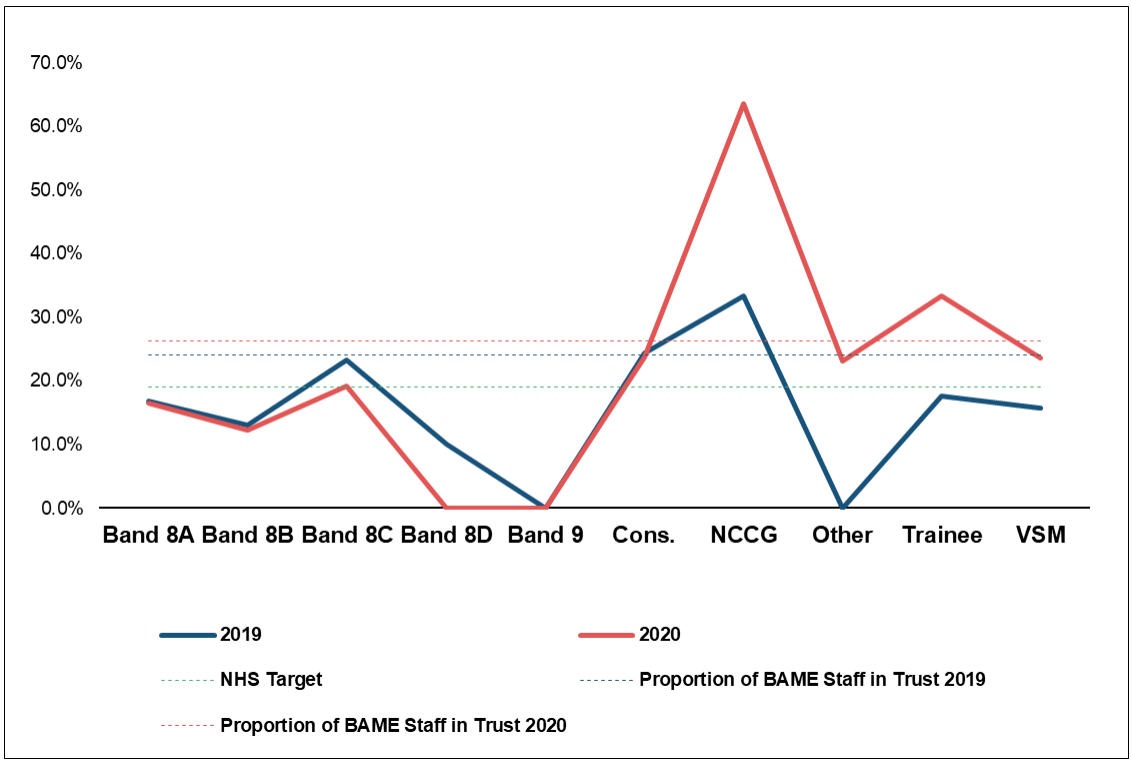
The Standards recommend a minimum representation of 19 percent across Black, Asian and Minority all pay bands. While this figure is fundamentally aspirational, Trust data shows that in 2020 Black, Asian and Minority representation fell below this benchmark in 5 of 17 pay bands (i.e., including AfC and medical pay bands). Alternatively, when compared to the Trust's average of 26.2 percent representation, as many as 11 pay bands fall below this threshold. We further find that only staff in support (Band 2 - 4) and lower middle (Band 5) bands, and Non-Consultant career grade doctors and trainee grade doctors are above this threshold (Figures 2.5a and 2.5b).

Figure 1.5a: Black, Asian and Minority Staff Representation across Pay Bands 1 - 7



Source: WRES Raw Data, 2017-2020

Figure 1.5b: Black, Asian and Minority Staff Representation across Pay Bands 8a - VSM



Source: WRES Raw Data, 2017-2020

2.2.3 Recruitment

Following the outcomes from the analysis of WRES data, we reviewed the recruitment practices and processes in the organisation. This was also done in light of EDS2 requirements that advocate for the fairness of recruitment and selection processes (Goal 3.1) and prescribe minimum EDI training requirements for line managers and recruitment panel members.

Feedback from the review demonstrated that the Trust has instituted a systematic recruitment and selection process with relevant hardware for eliminating discrimination in hiring choices. EDI references are included in job adverts and descriptions, diversity reps are included in hiring panels, and shortlisting for roles is done without access to personal data thereby eliminating potential discrimination.

However, the output from the data raises concerns with regards to the effectiveness of the recruitment process to not just increase the proportion of Black, Asian and Minority staff in the workforce but also to ensure that their distribution across pay bands is representative of trends in the local populace and overall workforce. It strongly indicates that while significant numbers of Black, Asian and Minority staff are coming into the Trust at the support and middle bands, there is more to do in ensuring representation in senior and Very Senior roles.

2.2.4 The findings and recommendations of the Colour Brave Avengers Review of our 2017 RES and RAP

The Colour Brave Avengers summarised their findings in terms of the 'State of play' in the organisation under four main themes

The presence of Racist Behaviours:

- Those behaviours reported during the review were categorised: 50% as overt racism 33% as microaggressions
- The perception of how racism and microaggressions are dealt with (or not dealt with)
- The fear to speak up and lack of feeling safe
- The perceived lack of support to speak up and that issues were dismissed

The level of Racial Diversity:

- The levels of Diversity at all levels but especially at senior leadership levels

The Barriers to Racial Inclusion:

- The impact of historic privilege and power in society
- The Perceptions of the Trusts Recruitment processes – Perceived as biased, unfair, unequitable
- The access to personal development opportunities
- The perception of how people are treated and made to feel
- The lack of resource and capacity to tackle race inequality
- The lack of meaningful targets with accountability to tackle race inequality
- The lack of buy-in by middle management to change

Understanding the Impact and costs of Racism:

- On how people are made to feel
- On mental health and wellbeing
- On productivity

3.0 Our Vision

This vision reaffirms the Trust's commitment to continuing to change race equality within the Trust for the better, and to make the Trust a place where people can work together regardless of their race or ethnicity.

> ***Our Race Equality vision is to have a workforce that is reflective of the communities we serve and an environment where the principles of the equality legislation are fully embraced and where everyone feels respected, valued and treated with dignity and respect and where we can actively pursue our commitment to be an anti- racist organisation***

We believe that having a more diverse and representative workforce will enable us to better serve our patients, students and other stakeholders.

The overarching vision of the Trust is to ensure that we create an environment that is free from racism, microaggressions and discrimination at all levels. The Trust therefore becomes a safe and pleasant working environment where staff are happy and fulfilled thus enabling them to deliver excellent patient care.

3.1 Our Organisational Values

As an organisation our values are:

- 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

3.2 Guiding Principles to our Strategy and Plan

Based on our values as a Trust, we have defined the following principles to guide the development and implementation of the Race Equality Strategy and Action Plan. These include:

- ***Respect and Appreciation***
- ***Coherence and Coordination***
- ***Communication and Engagement***
- ***Opportunity and Preparation.***

3.3 Our Race Equality Purpose

The purpose of our Strategy and plan is to create an urgency for cultural change within the Trust, and to make the organisation more accountable in addressing issues relating to race and delivering on promised actions to reduce inequalities.

The purpose will be achieved through a clearly defined mission statement, aims and objectives, specific goals which can measured based on a set of success factors which must be in place and the outcomes can be measured based on a definitive set of performance measures over the duration of the strategy and action plan that can be implemented to demonstrate change within the organisation.

As previously highlighted, the new Racial Equality Strategy for 2022 - 2025 takes into account the Colour Brave Avengers recommendations, the Race Code the current Strategic Review taking place within the organisation and the Review of the Governance structures and other changes but retains where applicable and builds on the good aspects of the previous strategy, the action Plan, Race Code, and reflects on the many comments during the interviews to develop the current document.

3.4 The Duration of the Race Review Strategy and Race Action Plan

To ensure the proposed actions are actively implemented to achieve the desired organisational and cultural changes in terms of race relations within the trust, the strategy and associated action plan will cover a period of five years, from April 2022 to March 2027. Whilst the commencement of the strategy is in April 2022, we have already begun to implement actions to bring about change within the Trust.

During the life of the strategy, progress towards meeting the overarching aims and objectives will be measured regularly. The Race Action Plan will be reviewed every six months with outcomes measured against progress made, taking into account the outcomes of the annual NHS Staff Survey and WRES Report.

4.0 Our Race Equality Mission Statement, Aims and Objectives

4.1 Our Race Equality Mission Statement

Our mission statement reflects the overarching vision of the organisation and is: -

"To be an organisation free of racism."

4.2 Our Race Equality Aim and Objectives

4.2.1 Our Race Equality Aim

The aim of the strategy is as follows: -

To build upon progress made within the Trust in eliminating racial inequality and discrimination, and promote opportunities for Black, Asian and UK Minority Ethnic staff with accountability and transparency at all levels.

While the duration of the strategy is from 2022 - 2027, as a Trust, we aim to see immediate differences within the next six months following the implementation of the plan. Change is a gradual process, but we aim to improve the culture and eliminate racism in the Trust.

We believe that the Strategy provides a framework for the Trust to tackle racial inequalities and to promote and encourage good race relations and social cohesion.

While we do not wish to have a proliferation of strategies or a strategy for every minority ethnic group, we recognise there may be a need to develop and implement specific programmes of work to address particular challenges and vulnerabilities facing particular groups. The Trust Board's planned People Committee and its Equality, Diversity and Inclusion Committee will consider these strands of work within their programmes of activity.

4.2.2 Our Race Equality Objectives

To achieve the aim of the Race Equality Strategy and Action Plan, the following objectives have been defined.

1. *To create an inclusive culture that promotes respect at all levels and fosters a sense of belonging among all staff.*

2. *To strengthen the key governance structures and networks for race equality to provide better leadership, buy-in, advocacy and support and to ensure ongoing external scrutiny of these arrangements.*

3. *To increase the diversity of the workforce and support the career progression of Black, Asian and UK Minority Ethnic staff though the use of Talent management approaches.*

4. *To remove barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination.*

5. *To increase engagement and communicate progress on racial equality across all levels of the Trust and in particular to publicly acknowledge to staff the findings of racial inclusion barriers, racist behaviours, and lack of diversity.*

6. *To extend the use of EDI data to monitor and improve race equality in the Trust in particular to create active statements which clearly identify the current position, the performance and aspirations, to identifying progress against targets and including criteria on race including ethnicity pay gap using the four principles of the RACE Equality Code (Reporting, Action, Composition, Education).*

7. *To embed responsibility for racial equality at all management and administrative levels of the Trust through training to provide appropriate EDI support, training and guidance to management and staff at all levels*

5.0 Governance structures and processes for Implementation

Mainstreaming race equality involves the incorporation of racial equality considerations into all policies, programmes, practises, and decision making, so that at every stage of development and implementation, an analysis is made of the effects of different racial groups and appropriate action taken. Crucially, it involves the Trust and each part of the Trust accepting responsibility for promoting equal opportunity and challenging racism.

If the strategy is to make an appropriate difference to the lives of Black, Asian and UK Ethnic Minorities here it must prompt action across the Trust to tackle racism and racial inequalities on the ground. Full and effective implementation of the Race Equality Strategy will only be achieved by the different directorates working together and, where appropriate, in partnership with NHS England, government and other NHS Health Trusts within the region.

This will not happen unless there are clear lines of responsibility and accountability. In essence, there must also be appropriate structures in place to achieve a joined up targeted approach. This is necessary to achieve change. There must be clear and robust governance structures whilst also recognising the need for a specific focus on racial equality and good race relations within the Trust.

5.1 Governance Principles

Work on race equality will be taken forward in line with the following principles:

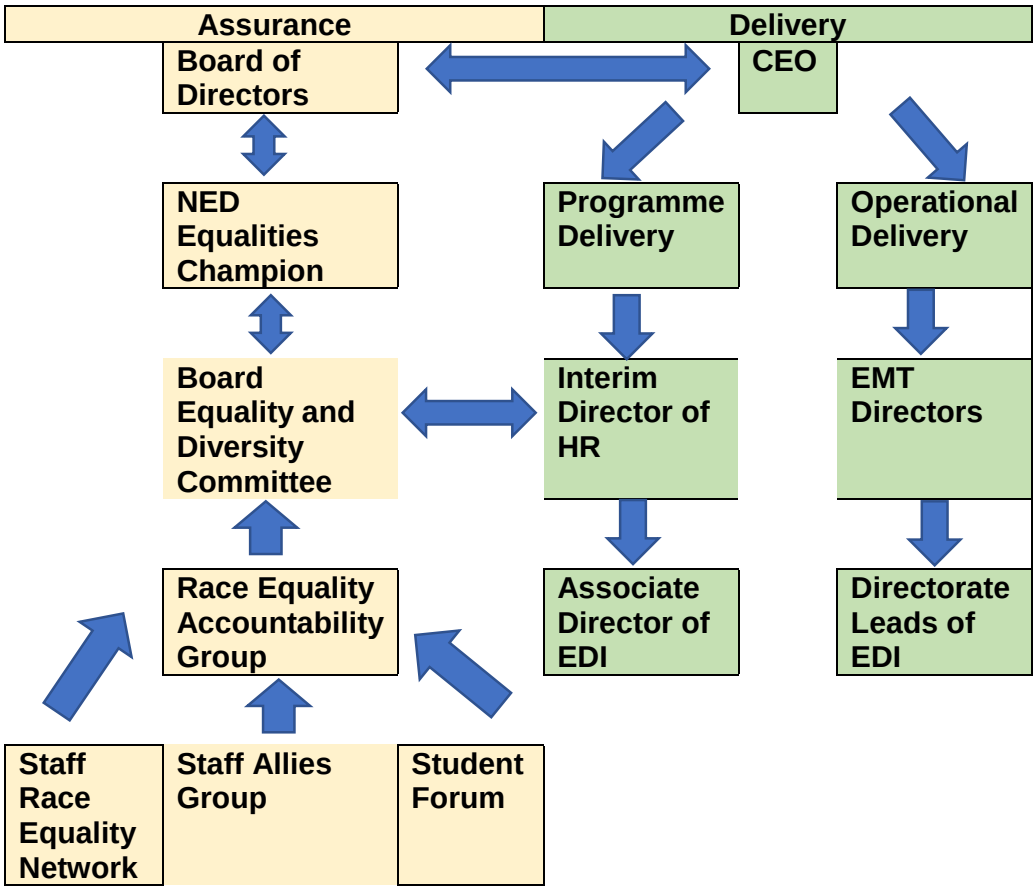
- There is clear leadership and focus on this issue from the Board of Directors supported by the Equalities Committee.
- There is clear accountability in the Executive Team for delivery.
- The strategy is appropriately resourced.
- Responsibility for equalities should be clearly visible across the organisation with each Directorate accountable for developing and local plans to support Trust wide aims and objectives.
- The Board of Directors will agree and publish a data set through which it will monitor performance.
- Lived experience of people with protected characteristics whether staff members, patients or students will be central to judging progress.
- All staff will be responsible their part in the delivery of the Trust's objectives on equalities and this will be reflected in individual JDs, objectives and appraisals.

5.2 Race equality – a framework for delivery

In line with these principles, the chart below sets out the accountability arrangements for work on race equality. These arrangements reflect the use of a 'RACI' framework to help clarify who is:

- **R**esponsible – does the task
- **A**ccountable – has to answer for delivery of the task
- **C**onsulted – is consulted about the task

Informed – is kept informed about the task



5.2.1 Assurance

- The **Board of Directors** has responsibility for agreeing the Trust's strategy on race equality and has overall **accountability** for delivery.

- In doing so it will be supported by the Board Planned **People Committee** and **Equality and Diversity Committee** who, in turn will seek assurance from a (New) **Race Equality Accountability Group** including

representatives from the Directorates in the Trust and the Race Equality Network and will be chaired by the Associate Director for Equalities.

- The **NED Chair of the Equalities Committee** will act as the Board Champion on race equality and will be responsible for providing the Board with an independent assessment of progress.

5.2.2 Delivery

- The **Chief Executive** has **overall accountability** for the delivery of the race equality strategy and action plan and for the Trust's progress towards being an anti-racist organisation.

- The **Interim Director of HR** will be the **accountable Executive Director** for work on race equality and will be **responsible** for delivery They will be supported in this responsibility by an **Associate Director of Equalities** who will be **responsible** for the overall work programme to deliver the strategy.

- All **Executive Directors** will be **responsible** for performance on race equality within their portfolios and will accountability for the delivery of Trust wide objectives within their Directorates and will ensure there

5.2.3 Managers and staff

- All managers and staff will have an **individual responsibility** for supporting the delivery of the Trust's race equality strategy and its aim to be anti-racist organisation. This will be reflected in JDs, objectives and appraisals. Our plans for management and leadership training will address the needs of managers for support in how they can better manage issues relating to race and other aspects of diversity.

5.2.4 Support for staff

- The Trust's Race Equality Champion will be responsible for championing the needs of BAME staff, patients and students within the Trust.

- The Trust will support networks for BAME staff, students and patients to come together to share experience, identify issues of concern which need to be escalated and provide support. The Trust will also support a Race Equalities Network Allies Group.

- The Race Equality Champion and the staff, student and patient networks should expect to be consult on all key aspects of work on the Race Equality Strategy and its implementation.

5.2.5 Consultation and Information

- Staff will be consulted formally as required via the existing partnership arrangements with Unions. Specific engagement, involvement and consultation on RES and RAP matters with be via the Staff Diversity Race Equality Network and the Race Equality Accountability Group in the first instance. This will be alongside wider consultation and information sharing with the whole staff group.

6.0 Our Race Action Plan

Our Race Action Plan has been developed with clear actions that are specific, measurable, action oriented, realistic and can be achieved within the timeframe of the plan, i.e., April 2022 to March 2027.

The plan has been developed following the learning from the review of the 2017 Race Equality Strategy and Action plan, hence it has been developed against the four themes, the eight recommendations and the ten 'must-do' actions of the independent review

We have taken into account the best practice described in the NHSE Race Quality strategy and plan for London and working with the expertise of MRL have distilled all of this information into seven action area themes:

Objective 1: Create an inclusive culture that promotes respect at all levels and fosters a sense of belonging among all staff.							'Due -RAG' 22/23			
Ref	**Activity area**	**Action detail**		**Lead**	**Timeframe**	**Success Measure**	**Q1**	**Q2**	**Q3**	**Q4**
1.1	Adopt the NHS Culture and Leadership programme as a framework for transforming the culture of the Trust.	1.1.1	Establish the existing culture of the organisation by conducting a gap analysis against the NHS Culture and Leadership framework	HRD/ AD	April 2022	The culture of the Trust clearly defined	D			
		1.1.2	Determine the desired culture to foster the changes in Race Equality	EDI	April 2022	The required culture clearly articulated	D			
		1.1.3	Define specific actions to develop the cultural change as part of the overarching Strategic Review Manager Development programme		May 2022	Required actions clearly defined in line with the Strategic Review.	D			
		1.1.4	Commission the required Leadership Programme		June 2022	Tender spec completed and commissioned	D			
		1.1.5	Commence implementation of the Leadership Training programme		July 2022	The NHS Culture and Leadership		D		

		1.1.6 All existing management staff to complete training by March 2023 and all new management staff to undertake training as a mandatory requirement.		End March 2023	programme commences All management staff are trained				D
1.2	Seek to extend participation in NHSE Allies Training to all Board and EMT members by end March 2023.	1.2.1 Participation in NHSE Scheme investigated	HRD /AD EDI	June 2022	Participation options established	D			
		1.2.2 If possible and appropriate all members attend	CEO	March 2024	All Board & EMT members attend				
1.3	Develop Training and development for all Board and EMT members	1.4.1 In line with NHS Culture and Leadership programme framework to develop Race equality training for all Board and EMT members	HRD / AD EDI	June 2022	Training developed	D			
		1.3.2 All board and EMT members attend	CEO	March 2023	All Board & EMT members attend				D
1.4	Implement examples of good practice at addressing race based bullying and harassment	1.4.1 Undertake good practice review	HRD	Sept 2022	Policy ambitions and headlines described		D		
		1.4.2 Undertake policy overhaul, communication and associated training		March 2023	Policy implemented and enacted				D

1.5	To hold a Race Equality-themed all-staff meeting to be held annually as part of an overarching ED&I schedule of events.	1.5.1 To develop and hold all staff meeting	Dir Coms	March 2023	Meeting held				D
Objective 2: ***To strengthen the key governance structures and networks for race equality to provide better leadership, buy-in, advocacy and support and to ensure ongoing external scrutiny of these arrangements.***									
2.1	The Board should make a clear signed statement of its commitment towards improving racial equality in the Trust, which should be actively promoted within the organisation	2.1.1 Board agenda time give to this work in Q1 22/23.	Chair / CEO	Feb 2022	Agenda time given	D			
		2.1.2 The statement to be approved by the Board in March 2022.	Chair/ CEO	March 2022	Statement approved	D			
		2.1.3 The statement to be communicated to all staff as part of the launch of the Race Equality Strategy and Action Plan.	Dir Coms	April 2022	Statement and strategy communicated	D			
		2.1.4 A copy of the statement should be placed on the Trust's website and Intranet	Dir Coms	April 2022	Statement on Website / intranet	D			
2.2	Establish and authorise the Race Equality Assurance Group (REAG) to review progress against the delivery of the Race Equality Strategy and Action Plan.	2.2.1 Meetings of the REAG to be held quarterly with clearly defined remit to review progress against the implementation of the Strategy and Action Plan, report and the authority to raise issues and concerns with the Board EDI committee and Board Equalities Champion.	CEO	June 2022	Quarterly meetings held, reports developed	D			

2.3	Cascade race equality responsibility through all levels and departments of the Trust by mandating Directors to appoint an EDI representative for each service / team under them,	2.3.1 to undertake a review of all existing 'EDI representatives / leads'' across the Trust	HRD / AD EDI	Sept 2022	Review competed		D		
		2.3.2 To develop and propose a new standardised role, responsibility and reward description for all EDI leads/ representatives		Oct 2022	New role, responsibility and reward description developed			D	
		2.3.3 To develop and implement and new EDI lead arrangements		Dec 2022	New arrangements in place			D	
2.5	Establish formal channels for receiving input from the Race Equality Network (REN), REN Allies group and REAG at executive and non executive levels in the Trust	2.5.1 Communication channels agreed and put in place	HRD / AD EDI	Aug 2022	Channels agreed and in place		D		
2.6	Develop Terms of Reference for Race Champions and EDI Reps with clearly stated reporting lines to the Associate Director Equalities.	2..6.1 Terms of reference developed in line with wider EDI rep and champions activity	/HRD AD EDI	Aug 2022	New TOR agreed and signed off		D		
2.7	Increase awareness of EDI governance	Develop, document, and share the accountability framework (organogram) for race equality governance and demonstrate its linkages to the Trust's overall governance structure.	HRD/ Dir Corp Gov	June 2022	Organogram widely understood	D			

2.8	Provide a budget and support staff for the Assistant Director Equalities.	2.8.1 EDI network / Champion budgets established	CEO	April 2022	Budget agreed	D			
		2.8.2 AD EDI support structure agreed	HRD	April 2022	Structure included in SR proposals	D			
		2.8.3 Other areas for EDI investment identified and budgets proposed	AD EDI	Sept 2022	Investment identified and agreed		D		
2.9	To ensure there is external accountability to complement the current governance framework and support for the implementation of the recommendations and action plan.	2.9.1 To identify peer review or to procure external support to review the Race Action Plan	CEO	March 2023	External review commissioned				D
2.10	To develop a comprehensive organisation wide equality Impact Assessment Process	2.10.1 To develop a structure and process for EQIA supported by advice and information from staff networks	HRD / AD EDI	March 2023	EQIA process developed				D
Objective 3: Increase the diversity of the workforce and support the career progression of Black. Asian and UK Ethnic Minority staff.									
3.1	Revise guidance and procedures for recruitment by taking into account procedures and learning included in good	3.1 1 Implement the NHSE 'De Bias recruitment procedures	HRD	Sept 2022	Debias standard adopted		D		

	practice guides like *'No More Tick Boxes'* and *'If Your Face Fits'*.				Checked against other good practice guides				
3.2	Develop plans to increase the proportion of underrepresented BAME staff in all pay bands to represent London census levels	3.2.1 Analysis if staff by pay band competed on quarterly basis	HRD / AD EDI	June 2022	Analysis complete	D			
		3.2.2 Plans to identify and support BAME candidates in underrepresented pay bands developed		Dec 2022	Plans developed and agreed			D	
		3.2.3 Plans implementation commenced		March 2023	Implementation commenced				D
3.3	Increase the proportion of BAME applicants to jobs.	3.3.1 To consider and report candidate progression EDI data from application, to shortlisting to appointment	HRD / AD EDI	June 2022	Reports developed	D			
		3.3.2 To review job descriptions and adverts to eliminate any language that implicitly conveys bias		Sept 2022	JD and advert review process developed		D		

		3.3.3 To review social media advertising, local school careers information and community engagement to promote jobs at the Trust		Sept 2023	Review and actions developed				
		3.3.4 To explore collaborations with local councils and community hubs to better target job adverts to the local BAME community.		Sept 2023	Collaborations explored and actioned				
3.5	To develop a talent management approach for the Trust with a focus on EDI	3.5.1 Asses the benefit of a mentorship / coaching scheme to facilitate mobility of BAME staff internally	HRD / ADI EDI	Dec 2022	Scheme assessed and action planned as appropriate			D	
3.6	Ensure a minimum required recruitment panel members of three with at least one-third of panel members required to be a trained diversity rep	3.6.1 To develop the role description and associated training for Trust recruitment diversity reps	HRD/ AD EDI	April 2023	Rep role defined, training developed and delivered, data produced				
		3.6.2 To report on recruitment panel membership on quarterly basis		Sept 2022			D		
3.7	Ensure all managers and staff involved in shortlisting, recruitment, and pay progression reviews receive diversity recruitment training.	3.7.1 Training developed and delivered as part of line manager training programme	HRD / AD EDI	April 2023	Training developed and delivered				
3.8	Conduct annual reviews of recruitment activity focused the application of good diversity recruitment practices.	3.8.1 Develop review process and targets	HRD / AD	April 2023	Process developed				

		3.8.2 Provide feedback to line managers on whether the Trust attained its diversity recruitment targets for the year.	EDI		Feedback given				
3.9	Ensure visibility of BAME role models in senior management positions to boost morale and encourage others to aspire to such levels.	3.9.1 Communication plan regarding aspirational role models to be developed	HRD / AD EDI	April 2023	Communication pan and delivery				
3.10	Evaluate BAME candidates experience of recruitment and selection processes	3.10.1 Develop a template and pilot a post-interview survey for applicants to better understand their experience of the application process and generate insights for improving the process for BAME applicants.	HRD / AD EDI	Dec 2022	Process and reports completed on quarterly basis			D	
Objective 4: Remove barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination.									
4.1	To complete the root and branch review already underway of our 'employee dispute resolution' policies such as grievance, bully and harassment and freedom to speak up with a view to their race equality impact.	4.1.1 specify the length of time from when a grievance is reported to when it should be resolved.	HRD / AD EDI	Dec 2022	Timescales specified			D	
		4.1.2 Create and distribute a simplified version of the grievance and disciplinary procedure. Ensure it is made available to all staff and included in induction packs.		Dec 2022	Procedures overhauled and communicated			D	
4.2	Ensure that staff feel more comfortable to report instances of racist behaviour.	4.2.1 Develop a 'near miss' procedure for informal reporting and monitoring of racist incidents	HRD / AD EDI	Dec 2022	Procedure developed			D	
		4.2.2 Explore the development the informal dispute resolution processes and courageous conversations across all of our policy and procedures.		June 2022	Informal procedures evaluated	D			

		4.2.2 Develop communications and feedback to support reporting		June 2022	Communications developed	D			
		4.2.3 Maintain a log for incidents of racism categorised by origin (department where incident occurred), type, impact, and initial action taken. Provide monthly progress updates on the progress of resolution of these incidents and disciplinary outcomes.		Sept 2022	Log created and reports developed		D		
Objective 5: I To increase engagement and communicate progress on racial equality across all levels of the Trust and in particular to publicly acknowledge to staff the findings of racial inclusion barriers, racist behaviours, and lack of diversity.									
5.1	To develop a Race Equality Communications and Engagement Strategy and support its implementation across the Trust.	5.1.1 All staff and stakeholder groups within and external to the Trust for the purposes of the Race Equality Communications and Engagement Strategy identified	HRD AD EDI DCM	April 2022	Groups identified	D			
		5.1.2 The appropriate messages and communication mediums for those in 5.1.1 above to be defined	ED	April 2022	Coms plan developed	D			

		5.1.3 The timeframe for messages to be defined.		April 2022	Forward timeframe defined	D			
		5.1.4 The impact of the messages should measured and evaluated.		June 2022	Impact measurement and reported developed	D			
		5.1.5 Launch the Race Equality Communications and Engagement Strategy following the release of the Race Equality Strategy and Action Plan to all staff.	DCM AD EDI	April 2022	Communications strategy launched	D			
5.2	Create a forum for collaboration and learning between the Race Equality Network (REN) and the Race Equality Network Allies (REN Allies) groups.	5.2.1 Forum Created	HRD / AD	Sept 2022	Forum in place		D		
		5.2.2 Establish regular and formal opportunities for both network groups to share their learning and insight with the rest of the organisation	AD EDI DCM	Sept 2022	Sharing opportunities created		D		
Objective 6 To extend the use of EDI data to monitor and improve race equality in the Trust in particular to create active statements which clearly identify the current position, the performance and aspirations, to identifying progress against targets and including criteria on race including ethnicity pay gap using the four principles of the RACE Equality Code (Reporting, Action, Composition, Education).									
6.1	To develop comprehensive Race equality and EDI performance monitoring report and process to be managed by the Assistant Director Equalities.	6.1.1 Comprehensive regular report formats developed	HRD / AD	July 2022	Reports developed		D		
		6.1.2 Create a dashboard for monitoring the Trust's performance on race equality based on the EDS2 goals, outcomes and grading; provide monthly performance updates to the Board	EDI	Sept 2022	Dashboard developed		D		

		6.1.3 Standardise the Equalities Annual Report template to ensure consistency in the use and presentation of indicators and metrics. In addition to existing levels of granularity, race equalities data should also be disaggregated by service units when presented in monthly and annual reports		March 2023	Report standardised				
		6.1.4 Ensure read across from WRES, Staff Survey and other sources of EDI data		March 2023	Comprehensive read across developed				
Objective 7 To embed responsibility for racial equality at all management and administrative levels of the Trust through training to provide appropriate EDI support, training and guidance to management and staff at all levels									
7.1	Conduct a training audit to determine the Trust's EDI training, development and awareness needs. disaggregated by department and ethnicity.	7.1.1 The audit should identify how many staff have accessed mandatory EDI training with the results	HRD / AD EDI	Sept 2022	Audit completed report received		D		

Key

CEO Chief Executive

HRD – Interim Director of HR

AD EDI – Associate Director for Equalities

DCM – Director of Communications and Marketing

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Appendices and Annexes

Appendix A Relevant Legislation

The timeline below shows the main pieces of legislation combined in the Equality Act 2010

Legislation	Overview
The Equal Pay Act 1970	The less favourable treatment of men and women in terms of pay and conditions of employment was prohibited.
The Sex Discrimination Act 1975	Men and women were protected from discrimination on the grounds of sex or marital status, with regard to employment, training, education, harassment, the provision of goods and services, and the disposal of premises.
The Race Relations Act 1976	This legislation made it illegal to discriminate against a person because of their nationality, ethnic background or colour of their skin. It applies to housing, the provision of goods and services, education, employment and job seeking.
The Disability Discrimination Act 1995	This Act made it illegal for service providers to discriminate against service users with disabilities, and for employers to discriminate against job-seekers end employees with disabilities.
Race equality duty	This came from the Macpherson Report on the murder of the black teenager, Stephen Lawrence. Following failures of the investigation into Lawrence's murder, the report revealed institutional racism in the Metropolitan Police. It was clear that a radical rethink was needed in the approach that public sector organisations were taking towards addressing discrimination and racism. Prior to the race equality duty, the emphasis of equality legislation was on rectifying cases of discrimination and harassment after they occurred, not preventing them happening in the first. The race equality duty was designed to shift the onus from individuals to organisations, placing an obligation on public

Legislation	Overview
	authorities to positively promote equality, not merely avoid discrimination.
The Employment Equality (Religion or Belief) Regulations 2003	This legislation prohibits the discrimination of employees due to their religion or beliefs, including in the context of vocational training, employment agencies and careers advice.
The Employment Equality (Sexual Orientation) Regulations 2003	The unreasonable discrimination against employees based on their sexual orientation, or perceived sexual orientation, was prohibited.
The Employment Equality (Age) Regulations 2006	This prohibited the unreasonable discrimination against employees on the basis of their age. It included a default national retirement age and enabled employees to request to work beyond the retirement age.
The Equality Act 2006, Part 2	This placed a duty on public authorities to promote equality for men and women, and outlawed discrimination based on religion, beliefs or sexual orientation with regard to the provision of goods and services. This Act also established the Equality and Human Rights Commission. This is a statutory, non-departmental body that is Britain's national equality body. It works with organisations to challenge discrimination, promote equality of opportunity, and protect human rights.
The Equality Act (Sexual Orientation) Regulations 2007	This Act made it illegal to discriminate on the grounds of sexual orientation in the provision of goods, facilities, services, education and public functions.
Public Sector Equality Duty	On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was developed in order to harmonise the equality duties and to extend the Equality Act across nine protected

Legislation	Overview
	characteristics. It consists of a general equality duty, supported by specific duties which are imposed by secondary legislation, and replaces the race, disability, and gender equality duties.

Appendix B Board RS and RAP Terms of Reference

Board of Directors

The Board of Directors has ultimate responsibility for setting the Trust's strategy on equalities and overseeing delivery. As part of this it will:

- Consider and agree in January 2022 a refreshed Trust wide race equality strategy and action plan. It will agree updates to the plan as required.
- Review progress against delivery three times a year including reviewing performance against agreed key metrics and hearing from the lived experience of staff, patients and students.
- Publish an annual report on progress towards its ambition to be an anti-racist organisation.
- Building on the work of the Colour Brave Avengers the Board of Directors will commit in 2023/4 to commissioning external assurance on the progress the Trust is making as an anti-racist organisation.
- Commit to an ongoing programme of training and development on race equality.
- Agree and delivery a succession plan to strengthen diverse representation on the Board.

Appendix C Equality Diversity and Inclusion (EDI) Committee

Equalities Committee

The Board will look to the Equalities Committee to provide detailed assurance of progress against the strategy and action plan. As part of this the Committee will:

- review progress at each meeting against key milestones and metrics and agree a rating of performance to be submitted to the Board of Directors.
- consider a "deep dive" once a year on the performance of Clinical Services, DET and Corporate Services.
- escalate to the Board and the Chief Executive any areas of concern.

1. The NED Chair of the Equalities Committee will act as the Board Champion for race equality and will provide the Board with their assessment of the progress the Trust is making towards its ambition to be an antiracist organisation.

Appendix D Race Equality Accountability Group Terms of Reference

The Race Equality Accountability Group will be a new group building on the work of the Race Equality Strategy Group.

The Group will be chaired by the Associate Director for Equalities and will include representatives from each Directorate, the Race Equality Network and the REN White Allies Group. It will be meet quarterly and provide feedback on performance against the delivery of the Strategy including any areas of concern to the Equalities Committee.

Appendix E Staff Network Champions

Race Equality Network Champion

The Trust's Race Equality Champion will be responsible for championing the needs of BAME staff, patients and students within the Trust. They will chair the Race Equality Network. They will be a member of the Equalities Committee and the Race Equality Accountability Group and should be consulted on all significant developments around the Race Equality Strategy and its implementation.

Appendix F Executive responsibilities for delivery

1. The Chief Executive has overall accountability for the delivery of the Trust's Race Equality Strategy and Action Plan and its ambition to become a non-racist organisation. They will be responsible for holding the Executive Management Team to account for their performance in delivering the strategy and ensuring that the necessary resources are available to deliver the strategy.

2. The Interim Director of HR is the accountable Executive Director responsible for work on race equality. They will be responsible for:

    - Leading the production of the Trust's strategy and presenting to the Board of Directors for approval.
    - Presenting reports to the Board of Directors and Equalities Committee on progress.
    - Co-ordinating actions across the Executive Team to meet the Trust's objectives on race equality.
    - As Interim Director of HR delivering objectives in the strategy relating to HR policies, practice and procedures.
    - Supporting the work of the Associate Director for Equalities and ensuring they have access to the necessary resources to support implementation of the strategy.

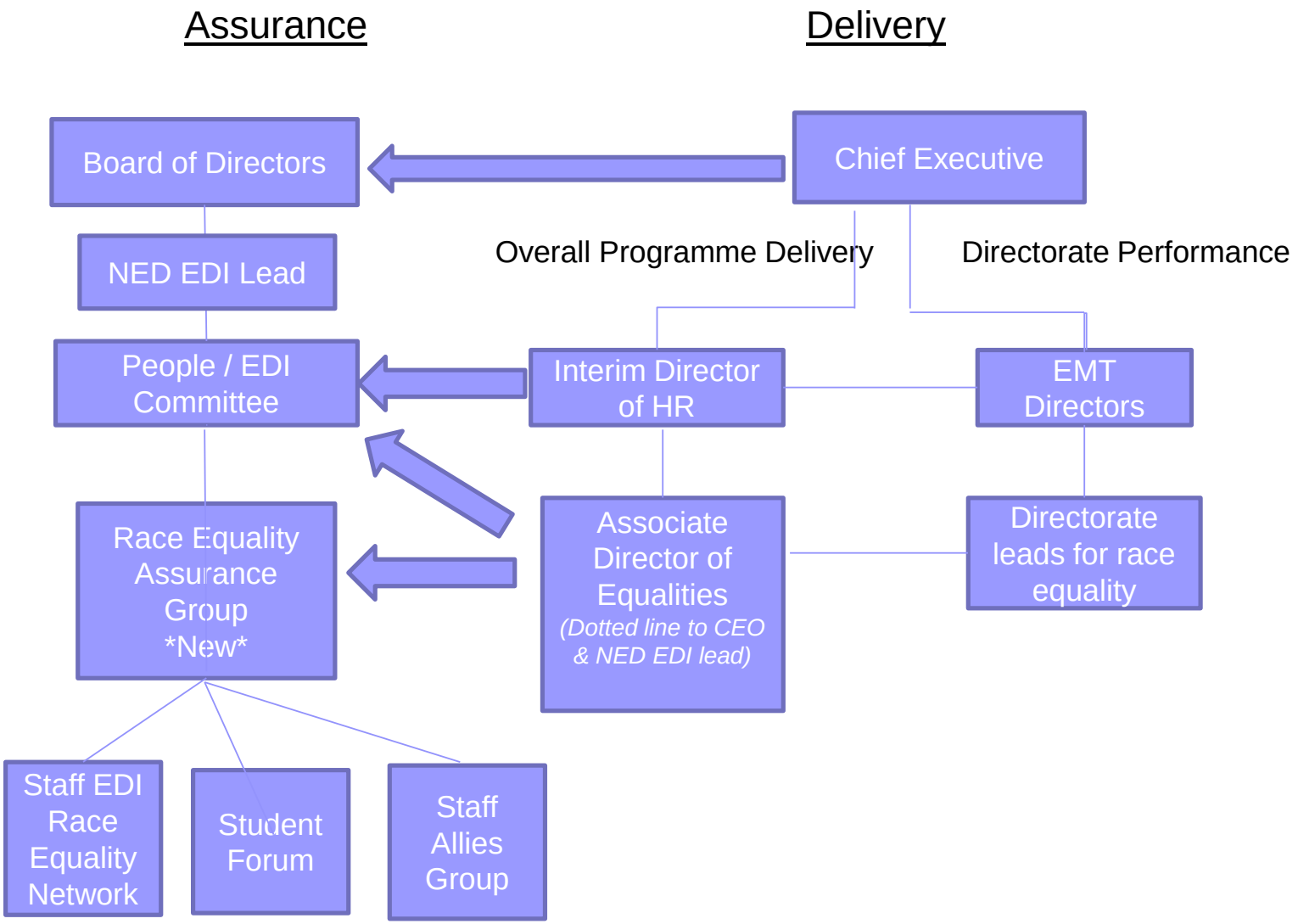
3. The Associate Director for Equalities has to day responsibility for progressing the strategy. This will include:

- Co-ordinating the development and updating of the Trust's strategy and action plan on race equality.
- Supporting other Executive Directors on developing action plans for their Directorates.
- Producing reports to the Board of Directors and Equalities Committee on progress in delivering the strategy and action plan.
- Co-ordinating the Trust data set for monitoring performance.
- Supporting the Chief Executive and Chair of the Equalities Committee in their assessment of Executive performance in delivering the strategy.
- Chairing the Race Equalities Accountability group.
- Working with representatives in other Directorates to take forward work on race equality.
- Engaging staff, student and patient and allies networks to seek their input on work on race equality and the progress being made by the Trust in becoming an anti-racist organisation.

Other Executive Directors

All Executive Directors will be responsible for producing strategies and action plans for progressing race equality in their Directorates including their contribution to the delivery of Trust wide objectives. They will be accountable for ensuring this work is adequately resourced in their areas of responsibility and there are representatives designated to lead this work.

Annex B - Race Equality, Governance and Management Arrangements



The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	25/01/2022

Serious Incidents – Quarterly Report – Q3 2021-22

Executive Summary

This quarterly serious incident summary report for the Board covers Q3 2021-22.

Clinical Incidents

During Q3 there were 35 clinical incidents logged:

- AFS - 3
- CYAF - 15
- Gender - 16
- Corporate - 1

(For comparison - 24 clinical incidents reported in Q2 2021/22).

Of the 35 clinical incidents, 24 incidents reached the threshold for discussion at the incident panel, which is held monthly and chaired by the Medical Director. 12 incidents were related to patient deaths and in all cases, reviews of the appropriate level have been completed or planned, awaiting information from other sources including primary care etc, as required:

1. GIC. Suspected suicide of patient. Information of death collected from larger data source. Incident was discussed at the incident panel (IP), a mortality review completed and confirmed patient died of natural causes.
2. GIC. Patient died, death was discovered as part of a larger data collection. Mortality review discussed at the Nov 2021 IP. Unknown cause of death.
3. GIC. Patient died, death was discovered as part of a larger data collection. Mortality review discussed at the Dec 2021 IP. Unknown cause of death.
4. City and Hackney Primary Care Services. Cause of death was not known. Mortality review discussed at the Nov 2021 IP. Cause of death confirmed as cardiac arrhythmia and cardiomegaly.
5. GIC. The clinic was informed of the patient's death by the patient's mother. Mortality review discussed at the Dec 2021 IP. Service to arrange for a concise report to be completed. Unknown cause of death.
6. GIC. Patient died, death was discovered as part of a larger data collection. Concise report discussed at the Dec 2021 IP. Patient died by suspected suicide.
7. GIC. The clinic was informed of the patient's death by the informatics team. Mortality review discussed at the Dec 2021 IP. However because we do not know the patient's cause of death yet a concise report will be completed instead. Unknown cause of death.

8. GIC. Patient's death was picked by the NHS spine. Incident discussed at the Dec 2021 IP. The service will arrange for a report to be completed depending on the cause of death. Unknown cause of death.
9. GIC. The patient' death was picked up by the NHS spine. Mortality review discussed at the Dec 2021 IP. GP stated patient cause of death was Inherited Disease.
10. GIC. Patient died, death was discovered as part of a larger data collection. Incident discussed at the Dec 2021 IP. The service will arrange for a report to be completed depending on the cause of death. Unknown cause of death.
11. GIC. Patient died, death was discovered as part of a larger data collection. The mortality review will be discussed at the Jan 2022 IP. The cause of death was identified as Multiple Organ failure with Covid -19 pneumonitis as a disease /condition leading to the Multiple Organ failure.
12. Spine data collection identified the death of this patient. The incident will come for discussion at the Jan 2022 IP. Cause of death unknown.

Learning from incidents

There were no learning lessons events in Q3 2021-22.

However there have been events throughout the year. Topics for learning over the year have included:

- **National Confidential Inquiry into Suicide and Safety in Mental Health – during Q2**
- **Learning from youth services - during Q1**
- **The role of the Coroner, giving evidence at Coroner's Court and supporting those in such circumstances – delivered 4th February 2020**

Events in 2021

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

Identified learning via the Incident Panel

The following are learning lessons from incidents discussed at the incident panel in Q3 2020-21:

Incident Panel	Examples of Lessons Learned
Oct 2021 Incident Panel	Correspondence should be copied to all appropriate agencies. Risk needs to be explicitly recorded in contact with YP. GIDS have further developed protocols and training around risk management. Guidance for appropriate communication with the SG lead is needed Further thinking and action needed around management of potentially vexatious behaviour towards a Tavistock service

	Further thinking is needed regarding protection and support for a service working in a contentious area This incident needs to be considered in the context of other events that have occurred within a Trust where the GIDS service has experienced a sustained level of scrutiny, criticism and reduced support. A Trust wide review of prejudice and discrimination towards gender diverse identities and the services that work with this marginalised group may be indicated.
Dec 2021 Incident Panel	A specific focus on the children/young people and the need to hear the 'voice' (experiences) of the 'child'. Procedure to ensure private clinicians, who work in the Trust, carefully delineate their roles and do not compromise themselves by using Trust systems or facilities. Possible failure to understand the import of referrals, which might have been compounded by time and limited access to resources to enable thought via supervision and MDT processes. Where there is evidence of suicidality, there must be a risk management care plan irrespective of whether the patient attends any appointments. Strengthen clinical and skills capacity within Intake systems to improve decision-making and care management. Maintaining a focus on the child. Lack of information-sharing within and external to the Trust. Possible bias that could have facilitated limited information-sharing. Absence of following Trust procedures: clinical, safeguarding and complaints. Ensuring the Named Safeguarding Professionals are made aware of complex cases. Collegiate clinical analysis and recording to mitigate patient risks.

Finally, the continuing difficulties in recruitment for the clinical governance and quality manager have resulted in significant efforts needed by colleagues in delivering the responsibilities of the portfolio.

Recommendation to the Board
The Board of Directors is asked to note this paper
Trust strategic objectives supported by this paper
Clinical Services
Author **Responsible Executive Director**

Clinical Governance Team	Medical Director

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Trust Board	17/01/2022

Guardian of Safer Working Hours Q3 2021

Executive Summary

This is the report for Q3 period.
The report details the number of trainees on the rota at present. The issues reported by the trainees have been problems with logging on reports on the DRS system and delayed fine payments. I have spoken to HR and finance department regarding this.

Recommendation to the [Board / Council]

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Gurleen Bhatia (GOSWH)	Dinesh Sinha

Guardian of Safe working hours Q3 2021 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q3 (October to December 2021)

2. Exception reports (with regard to working hours

Total exception reports:

Month	Total reports	Toil	Fine	NFA
October	1	-	1	--
November	1	-	1	-
December	2	1	1	-

2.2 Work schedule reviews

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

2.3 Vacancies

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

2.4 Locum

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

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

2.5 Fines

Due to DRS system not being able to be accessed by either HR staff or the GOSWH the exact amount will be reflected in next report. The skills for health team have been informed and are trying to resolve this issue.

3. Junior Doctors Forum (JDF)

Delay in fine payments for 1 trainee, DRS logging on errors reported to HR

New Trainee representatives in post.

Last JDF was held on 18th October 2021 and attended remotely by the 2 new trainee representatives.

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sheva Habel for LNC on 17th January 2022.

Conclusions and Recommendations

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

Dr Gurleen Bhatia
Guardian of Safer Working Hours

Report to	Date
Board of Directors	25 January 2022

Report on Audit Committee Meeting – 13 January 2022

Executive Summary

This paper highlights the key matters arising at a meeting of the Audit Committee held on 13 January 2022.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Finance and Governance

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

HIGHLIGHTS OF A MEETING OF THE AUDIT COMMITTEE HELD ON 13 JANUARY 2022

1. INTRODUCTION

1.1 A meeting of the Audit Committee ("Committee") was held on 13 January 2022.

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

2. RAG RATINGS

2.1 The Committee sought clarification as to when work on the Trust's use of RAG ratings would be undertaken.

2.2 Paul Jenkins (Chief Executive) informed the Audit Committee that this would form part of the work arising out of the Governance Review and that an indication of the timetable for this aspect of the work would be provided to the January meeting of the Board of Directors.

3. INTERNAL AUDIT REPORTS

3.1 RSM (the Trust's internal auditors) indicated that their Head of Internal Audit opinion for the year could be level 3 (out of 4), a decline compared with the previous year. This possibility was driven by the three recent internal audits undertaken, two of which (Procurement and Health and Safety) had resulted in partial assurance ratings and one of which (Payroll) had resulted in a Minimal Assurance rating.

3.2 The Committee expressed a concern that these results, along with other indicators (such as outstanding internal audit actions and the amber rating for all sub-committees of the Integrated Governance Committee) was a reflection of the broader pressures the Trust was currently under.

3.3 Whilst it was noted that the Board of Directors (at its November meeting) had considered the Trust's priorities, the Committee believed it important for the Chief Executive and Board of Directors to keep this under constant review.

4. FREEDOM TO SPEAK-UP GUARDIAN / EQUALITY, DIVERSITY, INCLUSION ("EDI")

4.1 The Committee heard from the Freedom To Speak-Up Guardian and also reviewed the current status of the Trust's progress around EDI.

4.2 In both cases, whilst it was acknowledged that progress had been made, it was also clear that much more needs to be done and that, in both cases, the associated work would take time and require significant engagement from all staff.

4.3 The issue of resources was also raised, it being noted that, as for all of the Trust's non-client facing activities, resources were stretched.

5. VACCINATION AS A CONDITION OF DELOYMENT ("VACOD)

5.1 The Committee noted that the Trust was now in a critical period in terms of having its staff vaccinated in order that they could continue to be employed or, indeed, deployed elsewhere.

5.2 Ian Tegerdine (Acting Director of HR) assured the Committee that the Trust was working to national NHS guidelines and had in place the appropriate processes to deal with this issue.

Report to	Board of Directors
Report from	Education & Training Committee – 02 December 2021

Key items to note

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

Graduation 2022
The Committee received an update on the planning for the Trust's 2022 Graduation Ceremony. It is hoped that a slightly later timing (May 2022) may allow for this to be face-to-face, however the contingency of offering an online ceremony is also being planned. Options for a blended event are also being explored. A final decision will be taken in February, taking into account any restrictions at the venue, and any country-wide restrictions.

Return to the building
The Committee noted the ongoing work with faculty to establish a phased return to the building for specific educational activities this term with an aimed for increase in face-to-face provision for the second term. The Committee noted the clear appetite for students to return to in-person sessions, as well as students enjoying the benefits of remote learning.

Education & Training website development
The Committee was updated on the proposal for the development of a separate education and training website, to make better data driven decisions around marketing spend and activity, to allow for a better user experience for both applicants and current students (ultimately resulting in better conversion rates), and to position training as a unique associated brand of the Trust. The Committee received assurance around the funding of the development.

Recruitment & Enrolment 2021/2022
The Committee noted that student recruitment has matched that of last year, with around 600 new students. The Committee received an update on improvement measures following the recruitment wash-ups, including the development of standard operating procedures to manage deferrals, the development of the new prospectus, and the possibility of a customer relationship management system.

EDI Roadmap
The Committee received the comprehensive Equalities, Diversity and Inclusion Roadmap, and noted the objectives, and broad themes, setting out activity across the academic year. The Committee noted that the work has become embedded within DET, with a clear methodology for the work, being both data driven and staff driven.

HESA/HESES 2020/21 Return
The Committee received the annual HESA/HESES return, and noted progress against the metrics and any issues that arose. The Committee noted the planned changes to submissions, including through earlier deadlines, and also through any application for Degree Awarding Powers.

Proposal for Degree Awarding Powers

The Committee received an update on timelines for any application for DAPs, and what the self-assessment process would entail. The Committee noted the envisaged changes through the strategic review, and the impact of these on the timeline of an application. The Committee discussed what an application would entail, including the required changes to governance structures, and the Trust's category of registration. The Committee agreed to a further piece of work to look at what it means to change registration category, including what it entails, the obligations and benefits.

Actions required of the Board of Directors

The Board of Directors is asked to note this paper.

Report from	Debbie Colson
Report author	Brian Rock, Director of Education & Training/ Dean of Postgraduate Studies
Date of next meeting	03 February 2022

Integrated Governance Committee (IGC)

Minutes of the committee meeting on Wednesday, 17th November 2021

Members	Present?
Dinesh Sinha, Medical Director (& IGC Chair) (DS)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	N
George Wilkinson, Public Governor (GW)	N
Debbie Colson, Non-Executive Director (DC), Vice Chair	Y
David Levenson, Non-Executive Director (DL)	N
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	N
Sally Hodges, Chief Clinical Operating Officer (SH)	Y
Jon Rex, Interim IMT Consultant (JR)	Y
Caroline McKenna, Associate Medical Director (CMK)	Y
Chris Caldwell, Director of Nursing covering Quality and Patient Experience (CC)	Y
Tim Kent, Director of Adult and Forensic Services (TK)	Y
Ailsa Swarbrick, Gender Services Director (AS)	Y
Rachel James, CYAF Director (RJ)	Y
Elisa Reyes Simpson, Deputy Director of Education and Training / Associate Dean, Academic Governance & Quality Assurance for DET (ERS)	Y
Ian Tegerdine, Interim Director of HR (ITe)	Y
Leticia Cestari, Clinical Governance Lead for Adult Forensic Services (AFS) (LC)	Y
Benita Mehra, Estates Consultant (BM)	Y
Eilis Kennedy, Director of Research and Development (EK)	Y
Deirdre Malone, Associate Director for Quality, North Central London CCG (DM)	Y
Clinical Governance & Quality Manager	N
Liz Searle, Consultant C&A Psychiatrist, Associate Director for Quality Improvement (QI) and Clinical Governance)	N
Kathy Elliot, Lead Governor, Council of Governors	Y

DRAFT

SUMMARY OF ACTION POINTS				
AP	**Item**	**Action**	**By**	**Due**
4	**6**	ITe to circulate report and all to please email questions, comments or challenges directly to ITe or DS.	**ITe**	

1	1	**Chair's opening remarks** DS welcomed all members to the IGC meeting and introduced the new members. All reports were taken as read, and members were asked to highlight any areas of concern/issues and raise questions. Previous minutes action points were discussed and closed.	
1	2	**Attendance** Apologies noted as per above.	
3	3.1	**Standing Item Updates** **Covid-19 vaccine** DS provided the following summary: • Trust trying to stay as much in line with Government as much as possible but closer to our health and social colleagues • Government still following line of no significant social restrictions • Health & social care settings decision made not to follow that line and that we would keep our IPC measures as they were pre-17th July • In advance of winter, service level SOPS have been reviewed • Adherence to IPC measures being kept within our settings • Some gatherings are happening whilst respecting IPC measures • A discussion for offsite gatherings guidance to be taken to Clinical Managers Group and a decision to be made at EPRR • Formalised Silver Command set up • All working in clinical context aware of high activity which is not all driven by Covid. Lots of elective activity. • High morbidity in presentations due to delays in being seen at appropriate times • Business Continuity Planning within team settings (to be taken to Clinical Managers meeting) - to make sure services have plans to continue to operate in difficult circumstances due to combination of flu, Covid and demand • Vaccinations: Fairly well on front line vaccinations for the first two doses. Struggling with booster vaccinations information from staff. Ongoing flu campaign (including vouchers) to get as many staff to get vaccinated. DC: Comment: There doesn't seem to be full clarity about what the situation would be if the patient wanted to be seen face to face but patient refused to be vaccinated and/or refuse wear facemask. If the therapist was unhappy with that what would the situation be?	

DRAFT

		What happens with staff who cannot be vaccinated in terms of them seeing patients face to face? Do we have a clear roadmap for staff who still need to be vaccinated (from here to April safely within the timings) DS Response: • We have been clear in our communications that we cannot refuse to see service users. We can request and try to educate on benefits of wearing masks. Contradictory information which is causes a challenge. • For exemptions - we are not allowed to request reasons for exemption. • Staff asked to use all IPC measures. If there is an individual vulnerability which places staff at additional risk then it has to be picked up in teams / HR. • Mandatory vaccinations as condition of employment and by 17th February for all to have second dose in order to comply with Government deadline. • Implementation of mandatory vaccination - waiting for implementation guidance from Government. • Inform and educate staff as much as possible SH: Comment: • Individual management conversation is required • Particular problem with Gloucester House with lower band staff none of whom have been vaccinated • Ethnically diverse population where a plan is needed to put support in place for those staff who have not been vaccinated	
	3.2	**CQC Update** • Last Trust level inspection in 2018 and GIDS inspection in 2020 • Timing is unclear at the moment • Engaged with CQC throughout the whole process including must dos and should dos GIDS action plan • Looking to actively and accurately represent the amount of work we have done with lots of positives coming from both action plans such as the transformation programme in GIDS and a number of significant and long reaching changes at Trust Level such as Quality review meetings and dashboards • On the other hand, internal context, significant challenges within GIDS and Trust Level with regard to Strategic Review and financial and sustainability challenges • Overall context at a time of great change within ICS and other parts • Significant number of risks from any inspection that comes forth • Trust Level action plan taken to EMT on monthly basis • Two weekly CQC prep meetings where key colleagues attend • GIDS level action plan signed off by GOC (Gender Oversight Committee) (two weekly meeting) • Complete must dos and should dos for the right reason to continue to build on quality of services and have a continuous cycle of improvement	

DRAFT

		DM: Question: What would the key risks be if CQC walked in tomorrow from a Trust point of view and how would you explain the mitigations you have taken? DS: Response: Three themes: 1. A number of risks have been pointed out in the brief paper. Risks are contextual. Gender services has led to a number of media headlines which has an effect on service users and staff. Twinned with process of change through SR across the organisation can mean staff feeling unsure about the future. One of the concerning risks is whether we can accurately and reasonably represent the uncertainties whilst holding onto the good work the teams are doing. 2. Linked with gaps in staffing issues. Small gaps can have a profound impact. 3. Interplay between assurance and performance management and delivery of mitigations. Not unaware of certain challenges but having sufficient traction on delivery of plans because that is where the biggest risk is. SH: Comment: Summed up very well. PJ: Comment: Agree with SH. Organisation as a whole is in a period of heightened uncertainty and with impact on morale and secondly the level of sensible preparation you do when something is imminent, and we are getting ourselves better prepared for that by making sure we have the narratives and information to support that.	
	3.3	**GIDS Update (AS)** • Overall transformation programme which covers response to the judicial review and the CQC inspection. • Transformation programme has set in place quite big pieces of service redesign. • Set out very broad framework piloting for a new initial consultation which will set out a care plan (whether endocrine pathway or other care in GIDS). • Intention to address must dos and should dos of record keeping. • Designing ongoing clinical pathways both endocrine and non-endocrine. • Also have developed view of basics if CQC came within the next few weeks. • Now working to accelerate big pieces of work such as record keeping (QI record keeping collaboratives due to start before Christmas) which needs to be structured, consistent and succinct across the service. Accelerated work on audits to ensure changes are embedded and sustainable. • Another focus is change and how to embed change. • Judicial review is positive news that the appeal was won and now in the process of simplifying processes to meet the needs of young people in a robust and transparent way.	
	3.4	**Clinical Services Operations Delivery Board Update** • Financial situation for the Trust remains the same with no clear allocation of funding	

		• Still trying to work out where monies have been allocated • How to prepare for any potential changes to staffing groups • Response to CQC covered already in this meeting • Covid – covered already in this meeting • FTSUP Guardian (Sarah Stenlake) at all staff meeting was very useful • Strategic Review looking to make sure things are equitable and consistent across the Trust. Detailed discussion at Operation Board to support staff such as away days. • Make a proposal to EMT as it affects Corporate Services and DET • Cover and cross-cover to make sure adequate cover in the building coming up to Christmas period DC: Question: Freedom to speak up is an issue that has come up in a number of different communities; are you aware of anything that will follow through that to come to the Board on what we can do and how we can set a better tone? PJ: Response: Sarah to come to January Board to cover both issues she has found and her experiences on dealing with issues. Dovetail with work that ITe has been dealing with. We are very conscious from a number of events on how issues get raised are not fit for purpose. Need to find ways to find it easier to escalate issues before formal disciplinary happens. IT: Response: The work goes on hand in hand with Sarah as FTSUP Guardian with deadline in place before Christmas **Surrey Updates**	
	3.5	Due to workforce challenges, there is significant underspend that will remain. Looking at ways to reduce that by "expressions of interest" for additional sessions and whether some of the funds could be moved to other opportunities. There is a potential challenge to that underspend being used by Surrey in other ways. Significant concern locally in NCL, in the past month there have been five child deaths three of which three are thought to be suicide. Concern across the system to manage the impact of the tragedies. How to manage the difficulties and challenges of those tragedies. Need to think about the impact on our own workforce. Surrey may come to us for support. There is work going on nationally to be thinking about those issues. **Education and Training Update**	
	3.6	• Term has had a good start. • Pleased to see the implementation of the clinical governance passport for student has gone well with close liaison by the Dean's office and clinical administrators. It is more consolidated and embedded. • Clinical inductions process went well for students seeing patients at Trust. • Pleasing to see the impact of introduction by AFS in relation to the governance and management of students seeing patients with thanks TK and the rest of the team. Continue to liaise closely with TK and Hiroshi in relation to governance and border issues for students placed in AFS.	

DRAFT

		• Education delivery continues to be delivered remotely with provisions for students to see patients face to face and attend team meetings and remote learning opportunities. • Pressure from some students to return to building with arguments of confusion. • Preparations in the future for remote access to education. • Planning for next term to try and arrange for all courses to have some degree of face to face activity within guidance from regulation which is being communicated to students. • In terms of regulatory point of view, all accreditations and periodic reviews have gone well in particular educational psychology review where trust has received commendations. • Preparing for the ACP accreditation for Child Psychotherapy training in the Spring and re-tendering of HEE child psychology training posts putting emphasis on blended forms of education delivery as well as innovation. • BPC also planning to look at our psychoanalytic training with a visit in the summer (currently being discussed). • Will be reviewing some of our policies including Fitness to Practice policy. DS requested to put these comments together in a brief report for members to read prior to next meeting.	
4		**SUB-COMMITTEE REPORTS**	
4	**1**	**Data Security & Protection Sub-Committee** Jon Rex, Interim IMT Consultant *(on behalf of Terry Noys, Director of Finance and Trust SIRO)*	
		JR introduced the report with a rating of amber and highlighted the following: • FOI starting to collectively produce data which will suffice in a lot of instances • One IT complaint around patient related to SAR which is being reviewed • No further serious incidents but still looking at one raised in last quarter regarding letters being put in envelopes. Will continue to monitor. • Archive paper record. We now know what the extent of issue around the number of paper records currently around 10,000. Liaising with Estates to scan or destroy records. • ICO complaint on GIC patient is to be investigated. Now agreed a process for that particular service. • One risk at 9+ which is being monitored • Most RAG ratings are similar or same as last time they were reported • SARS main issue is gathering information together with a long winded process to get the information ready. Reduced process in place which will enable more responsive way to respond. • FOI have a number of areas to benefit for significant improvement with controlled meeting which is underway. Key process changes which will start to see some areas with complex queries to be turned round within compliance rate. • Benchmarking with other areas; we get more requests pro rata than other Trusts. Complexity of request means more work to get them completed.	

		DM: Question: Can you give us a flavour of some of the processes you have put in place with regard to management of FOIs to make the process much easier? JR: Response: We have looked at the structure of the team which is being adjusted. We have added more timing to the function as part time function with IM&T; restructuring, flexibility and additional resources is the practicalities to get activity through. We have looked at very good case management software. Putting together a bid for that (£3k) which will help move the FOIs more efficiently through to avoid duplication of activity. DC: Question: Are there many parts of the IGC papers or other committee papers that need to be redacted before going to public domain and are you comfortable that we have good processes in place to do that? Given that information was published that should not have been, is there any need to look back at past papers? JR: Response: From what I can gather it was a one-off incident. We have gone back and adjusted the error. DS: Response: We have successfully blocked FOI request for IGC papers. Minutes get published as part of Part 1 Board Papers. Minutes must be scrutinised by all sub-committee chairs to avoid incidents happening.	JR
4	**2**	**Patient Safety and Clinical Risk Sub-Committee** *Caroline McKenna, Patient Safety and Clinical Risk Lead*	
		CMcK presented the report and highlighted the following: • Eight deaths reported in this quarter. Three are unknown cause, two natural and three others probably suicide. Not all deaths occurred in Q2. Of the eight deaths, seven in gender (). • Outcome of audit is to approach national confidential enquiry in relation to suicide and safety and ask for their support around an audit of suicides in this patient group (Trans group). • Series incident of death of young person in Children's service and two other serious investigations are outstanding. • Safeguarding supervision returns have improved. • Gaps in services due to not being able to recruit to posts along with sickness absence with significant and direct impact on work in risk and safety sub-committee. DM congratulated CMcK for Suicide for Young People event. Helpful discussions and workshops. Also thanked CMcK for all the hard work that has taken place to try and improve the amount of supervision staff receive for safeguarding. DM: Comment: Congratulations to CMcK for hosting "Suicide amongst young people" which was a fantastic, useful event. Thank you for all the hard work that has taken place to try and improve the amount of supervision for safeguarding.	

DRAFT

		Question to DS: There are delays in gaps around the service and challenges in recruiting interims. CQC will definitely ask, in terms of delays in completing the investigation reports, for assurance on the terms of your 72 hour reviews, what are the immediate actions that needed to be taken if necessary and were those actions and mitigations put in place? Also, Dinesh, where are you at with the recruitment of the 8c Assistant Director Quality and Governance post? DS: Response: We are very aware of the gaps in both in Central and Services. For the 8c role interviews are planned for next week. Pursuing secondment lines. Whilst Strategic Review is underway the majority of appointments will be interim which places a degree of stress. DC: Question: Can you say anything more about the NRLS Patient safety incident? You mentioned nine incidents. With regard to staff shortages and absences, is there anything that can be done to mitigate the risk? CMcK: Response: Things like abuse to staff, violence, self-harm where NRLS platform have ongoing technical issues which has prevented us from logging incidents. All working very hard by committed staff who see the gaps with patient safety at forefront which involves extra hours or extra work and doing things which you might not normally do which is not sustainable in the long run. Trying to recruit the best they can. Not dissimilar to other trusts. PJ: Comment: Appreciate the improved performance around safeguarding and supervision. Acknowledge concern CMcK has raised which PJ shares. One commitment to share, we have to prioritise and treat differently those posts which impact directly on patient safety. PJ: Question: Regarding Spine, can we have a definitive statement on how to mitigate significant number of additional deaths. How close are we to getting an easier fix? JR: Reviewed towards the end of last week with design meeting this week. With some external work with Care Notes, we can take the reports from Spine and provide an automated update into the system with an external report which can be reviewed by relevant department. Timeframe early to say but it is in timeframe of months. PJ: Make sure keep this under review when we are clearer with the timeframe to bring to this Committee. TK: Example: Helpful to have a peer which makes a difference to outcomes. CMcK: Acknowledged TK's comment in the chat box regarding National Confidential Enquiry which will be pursued.	
4	**3**	**Patient Experience & Quality Care Sub-Committee** *Chris Caldwell, Director of Nursing covering Quality and Patient Experience*	
		CC assumed report had been read.	

		• Good conversations in the group about service user involvement and engagement in Strategic Review and work around EDI which has led to a number of conversations on how to engage executive and non-executive directors in the patient experience either by bringing patients to the Board or the Board to patients. Conversations planned with PB and PJ. • Very positive engaged patient group. PJ and Emily from Strategic Review attended Trust wide Forum. • Less positively still struggling with backlog with regard to responding to complaints. Making progress but backlog is significant, and pressure is on in both central team and clinicians. DC: We deal with complaints quite well but discussions about the need to pick up compliments and positive stories as well as areas that could do better. DS: Positive that commentary in the report is speaking of service users in the language of service users which is what IGC requested last year.	
4	**4**	**Estates, Facilities Sub-Committee** *Benita Mehra, Estates Consultant*	
		BM assumed report has been read and highlighted the following: • Making significant headway • Evidencing and reporting assurance model • Details around previously assumed and relied upon actions is now being evidenced • Success in large electrical work and upgrading buildings and now focussing on water to fill compliance obligations • Slowed down but now will be tougher with marginal improvements • Success in not spending enormous amounts in catering needs as equipment is in good shape DC: What should I make of the figures on the charts? For example Gloucester House, the Munroe Centre and the Tavistock Centre. BM: Response: We are moving in the right direction, investing in items such as fire doors, and compartmentation investment. We have capital plans in play which we need to work through. We do have old buildings and we aim to deliver but could take 3, 4, 5 or 6 years depending on the amount of funds we have. We are delivering to the plan and fulfilling our obligations around compliance and prioritising on a risk based model. DS: It will be helpful in future reports to have a focus on analysis of risks particularly from a service user safety perspective.	
4	**5**	**Research and Development Sub-Committee** *Eilis Kennedy, Director of Research and Development*	
		EK presented the report and noted the following: • Key challenge is vacant posts which is having an impact.	

		• Context in which we are undertaking research (CAMHS, Logic Study, Gender Services) with obvious pressures • Specific issues with cohort turning 18 and transferred to adult GIC. Looking at clinical risk management with reports of very high rates of self-harm. • Robust risk management protocol in place but a few challenges with that for a range of reasons. Looking to address. • Positive – three papers published on the Logic Study with BMJ Open with a couple more in preparation including a health economics paper • Two grant applications that are close to a decision being made. • Recruitment to NHR portfolio studies is good. Compare favourably to mental health trusts nationally in relation to recruitment to portfolio studies • Trust awarded significant funding from the Economic Social Research Council in partnership with the University of Kent (the Lead Organisation) st DS: Comment: Helpful trajectory of challenging period with lots positive outputs. DC: Question: I am so impressed with the way the recruitment is up so high in such challenging times. Congratulations to the team. Delighted to hear about the ESRC funding. Is the Trust the PI? EK: Response: No, we are very much in partnership with the University of Kent which is the lead organisation. DC: Question: There is a lot of information that is beginning to come from the Logic Study. How are you disseminating the information more widely? EK Response: Agreement to speak to Comms regarding the dissemination strategy. .	
4	**6**	**Organisational Development & People Sub-committee** *Ian Tegerdine, Interim Director of HR*	
		No written report was received which will be circulated by ITe. • Still haven't established sub-committee to IGC which will depend upon governance review. • Reporting needs more work. • Appraisal rate is below the level they would want. • CPD activity is green. We are spending CPD money although work is going on in that area. • Statutory and mandatory training not at the level we would wish. Currently red – deadline for 10 December • Sickness low but concern that we may be under reporting • Staff Survey – above average for a mental health trust but below the normal level for this Trust. • Staff turnover remains high with high levels in Gender Services DS: Once the report has been circulated by ITe, please email questions, comments or challenges directly to ITe or DS.	**ITe**
5		**Any other business** None	

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6		**Future Meeting Dates:** Wednesdays, 11am – 1pm in the Tavistock Board Room or via Zoom Dates tbc and circulated	

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