The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 29th March 2022

Please refer to the agenda for timings.

The meeting is being held online.

NHS
The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 29th March 2022 - 2.00-4.20pm

		Presenter	Timing	Paper No
1. Governance 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 25 January 2022	Chair		1
1.4	Action log and matters arising	Chair		
1.5	Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.15pm	Verbal
1.6	Chief Executive's Report	Chief Executive	2:20pm	2
2. Strategic Items				
2.1	Trust Objectives 2022/23	Chief Executive	2.30pm	3
2.2	Quality Update	Medical Director/Director of Quality	2.45pm	4
2.3	Board Assurance Framework	Chief Executive	2:55pm	5
3. Operational Items				
2.1	Finance and Performance Report	Director of Finance/ Deputy Chief Executive	3.05pm	6
2.2	Operational Risk Register	Medical Director/Director of Quality	3.20pm	7
3. People Items				
3.1	Trust Anti-Racist Statement	Interim Director of HR	3.35pm	8

		Presenter	Timing	Paper No
3.2	People and Equalities Report	Interim Director of HR	3.45pm	9
4. Board Committee Reports (for information)				
4.1	Audit Committee – verbal report Education & Training Committee Integrated Governance Committee	Chair	4.00pm	10
5. Any other matters				
5.1	Any other business	All	4.15pm	
6. Date, time and venue of Next Meeting				
6.1	Tuesday 24th May 2022, 2.00 – 4.45pm, venue to be confirmed			

Board of Directors Meeting Minutes (Part 1)

25th January 2022, 2.00pm-5.00pm,
Held via Zoom Webinar

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	David Levenson Non-Executive Director
Attendees:			
Fiona Fernandes Business Manager Corporate Governance	Kathy Elliott Lead Governor	Badri Houshidar Governor	Helen Robinson Interim Director of Corporate Governance
Amanda Hawke Business Manager Chair and Chief Executive	Ian Tegerdine Interim Director of HR	Laure Thomas Director of Marketing and Communications	Michelle Morais Governor
Michael Rustin Governor	Paru Jeram Governor		
Apologies:			
None			

Action Log

AP	Item	Action to be taken	Resp	By
27 July 2021				
1.	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	PJ / TN	Mar 22

		Board was comfortable with this gap.(27 July 2021)		
28 September 2021				
1.	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	Mar 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
25 January 2022				
1.	2.2.3			
2	2.4	A new set of quality priorities will be brought to the March Board	DS	March
3	2.4.6	Outcome measures to be discussed at the May Board	DS	May
4	3.1.10	The establishment of the new People and Equalities Committee is brought forward to March	SS	March
5	3.1.10	An oversight group should be established following the Governance Review. This will report back to the Board.	PJ	March

1. Administrative matters

1.1 Welcome and apologies

1.1.1 Prof. Burstow welcomed all of those present and noted that this was a meeting held in public, but not a public meeting. Members of the public are able to attend to observe the meeting but not to contribute. There were no apologies.

1.2 Declarations of interest

1.2.1 No declarations of interest were declared.

1.3 Minutes of the previous meeting

1.3.1 The draft minutes of the 20th November 2021 were approved as an accurate record, subject to amendments.

1.4 Matters arising and action points

1.4.1 Training on unconscious bias has been identified and will be offered to Executive Management Team. This will then be offered to Non-Executive Directors and Governors. An on-going programme of training will be captured in the Race Action Plan and Strategy.

1.4.2 A Complaints Flow Chart has now been circulated to the Board of Directors.

1.4.3 Prof. Burstow and Mr Jenkins will discuss the topic for a joint session for the Board and Council which may include input from the ICS

1.4.4 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 advised that he had tendered his resignation. His term of office was due to end in October this year, but due to pressure of his other roles, including Chair of another NHS organisation, made the decision to leave at the end of April. The process has started to identify a successor. Prof. Burstow was appointed in 2015 and said it has been a privilege to work at the Tavistock and Portman.

2.1.2 Dr Colson advised that at the NHS Provider meetings she attends there are discussions on quality improvement. Training on this has proved useful for Boards and we could perhaps consider this when arranging training for the Board. Prof. Burstow noted that the National Quality Board has issued further guidance on this type of training.

2.1.3 The board noted the verbal updates.

2.2 Chief Executive's report

2.2.1 Mr. Jenkins report was taken as read. He highlighted the salient points.

2.2.2 **Vaccination as a Condition of Deployment (VCOD)**

- As with other organisations we are in the process of implementing this process. All staff should have had two vaccinations. We have been working to get clarity on which staff are affected and communicating with them what is required and what the consequences are if this is not done. It will be necessary for staff who are as yet unvaccinated to have had the first vaccination by 3rd February 2022.
- There will be some exemptions. Staff who have a medical exemption and can provide evidence of this. We are working with the union representatives in reaching decisions about staff exemptions.
- An All Staff Meeting was held yesterday to discuss VCOD. This was attended by over 150 staff. It had highlighted strong feelings amongst some staff about the policy.
- Responding to a question from Dr Colson about the impact of the policy on Education and Training Mr Tegerdine advised that some of our teachers will be exempt. A panel will be set up to go through role by role to clarify the position..

2.2.3 **Education and Training – student letter about remote teaching**

- Responding to a question from Mr Holt about how this position might affect income for the year Mr Jenkins advised that this is not expected to have a substantial impact on income. We do expect, however, to see a change to the longer term 'shape' of our teaching.
- Mr Rock advised that he had held a constructive meeting with students on the issue of returning to face to face teaching. The students had made known the depth of their feeling on this issue and their concern about the quality of their experience particularly for clinical trainees. We have been working to get students back into the building, but have had to work within the constraints of COVID regulations. Mr Rock also noted that some students want to return to face to face and some do not so it is difficult to have a consistent approach.
- Mr Rock indicated that he would be establishing a Task and Finish group is established between DET, Scheduling, Estates and Students to look at blended learning. He noted that this had been discussed prior to the COVID pandemic as we had wanted to establish a range of teaching modes.
- Mr Levenson suggested that these issues be discussed at the next Education and Training Committee. Blended learning is expected to be how we work in the future. He noted that the Governance Review had highlighted the need for the student voice to be clearer in our governance.
- Mr Holt asked about how our Trust benchmarks with other smaller organisations. Mr Rock advised that he has been in contact with colleagues in higher education and also our partner Essex University to discuss blended learning.

1.3.4 The Board of Directors noted the report.

2.3 Finance and performance report

2.3.1 Mr. Noys presented the report and highlighted the salient points:-

- Up to the 8th month, November, the deficit is £3.7M
- The numbers for month 9 show an improvement, a deficit of £1.5M which is better than planned. This reflects staff vacancies.
- Income is as expected and some has been received earlier than expected
- Expected deficit at the end of the year of £7.5M which is better than expected

2.3.2 Prof Burstow noted that there have been discussions within the ICS and asked if there has been an indication as to what our starting position will be for the new year. Mr Noys advised that the position is not yet clear.

2.3.3 Mr Levenson asked about capital expenditure and if the forecast reflects what we can expect or if the money not spent will be lost. Mr Noys advised that we have identified projects associated with relocation on which to spend this money during the current year.

2.3.4 The Board of Directors noted the report.

2.4 Quality Report and Dashboard Q2

Dr Sinha presented the report which show the current position for the Trust. He highlighted the salient points:

- 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 do not 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.
- Mandatory training compliance has improved reaching 80.98%. This remains an area of focus, as appropriate for an NHS provider for numerous pathways.
- Outcome Measures – in Q3 rates for CORE improved: 73% of discharged patients, with a minimum of two forms completed. There has been an increase in the use of electronic methods, including qualtrix 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.

2.4.1 A full discussion was held and the following points were noted:

2.4.2 **Waiting times in Adult and Forensic Services** (AFS)

- These have been impacted by staff either leaving or retiring, recruitment to these posts has been challenging. Teams within AFS are small so losing key staff has a high impact.
- In addition trauma referrals have increased during the pandemic putting further pressure on the Trauma service. In other NHS organisations Trauma services have closed further increasing the number of referrals to our service.
- The Strategic Review is expected to create a fairer balance of management and governance of services and give more capacity to ensure that KPIs are being met.

2.4.3 **GIDS Waiting times**

- Dr Sinha advised that following the GIDS Transformation Programme we will be using Quality Improvement on monitoring of waiting times across Gender Services and that this learning will be shared across services.

2.4.4 **DBS Checks** for staff.

- There is some concern about rates of completion for DBS checks and if staff can be given a contract without a DBS check.
- Mr Tegerdine advised that there are very few exceptions to staff being given a contract without a DBS check. He advised that we check DBS every three years.
- There is some confusion over this as some staff are on auto-renew. Numbers will be checked as it is recognised that we need to provide assurances on the DBS status of all staff.
- It was noted that the position on DBS checks for Honorary Staff needs to be clearer.

2.4.5 **CAMHS Care Plans**

- We have become more aware of the processes for CAMHS Care Plans, but these need to be embedded.
- Dr Hodges advised that this is a problem across NCL Trusts, but we have been looking to develop this in partnership with them.

2.4.6 **Outcome** Measures continue to be a problem.

- Dr Colson suggested that this is discussed in more detail at a future meeting.
- Dr Sinha advised that we have been pursuing this over the past 18 months with some improvement when this issue is focussed on. The process and engagement of outcome measuring needs to be discussed.
- Moving to Qualtrix for outcome monitoring has been positive.
- Prof Burstow suggested that outcome measures are discussed at the May Board meeting focusing both on data collection but also the issues which the data is identifying.

2.4.7 **Mandatory Training.**

- It was noted that there has been good progress on mandatory training for staff.
- It was suggested that a discussion on lessons learnt on mandatory training compliance is held the next Integrated Governance Committee.

2.4.8 The board noted the report.

3. Items for discussion

3.1 Board Governance Review

3.1.1 A Board Governance Review was commissioned last year to look at the Board of Directors and our Committee structure. The Office of Modern Governance was appointed to carry out this work. Moosa Patel and Sarah Boulton from the Office of Modern Governance are attending the meeting for this item.

3.1.2 Mr Jenkins introduced the item. He advised that it is good practice for Boards to review their practices regularly. The Governance Review was carried out with the Strategic Review in mind. The

work included a review of Trust documents and interviews with members of the Board of Directors and also external stake holders.

3.1.3 The final report from the Office of Modern Governance has been circulated. This report highlights the important areas of development. Mr Jenkins is proposing that this Board accepts all the recommendations.

3.1.4 Key points of the Implementation Plan are:-

- A proposed re-setting of Board Committees. This will ensure stronger focus on workforce through a People and Equalities Committee and performance management through a Quality, Performance Management and Finance Committee
- A commit to invest in a programme of development for the Board of Directors, EMT and Council of Governors.
- Actions to address the cultural issues identified in the Review.
- The need to strengthen resourcing of corporate governance.

3.1.5 Mr Patel thanked the Board and external stakeholders for participating in the Governance Review.

3.1.6 Ms Boulton noted that the context of the Governance Review was that it was undertaken with external scrutiny and both an internal and national agenda were to be progressed. The Board has made progress and shown energy and positivity to take on the work required, which is the sign of a healthy Board.

3.1.7 Mr Patel advised that the Board will need to focus on the recommendations and the implementation plans. They should be vigilant that changes have taken place before they are outcomed as 'green'. This is so that progress is sustained and that within one year the Board should be moving on to being a high performing Board.

3.1.8 There was a full discussion on the Governance Report and the following points were noted:-

- Prof. Burstow felt that we have explored these issues and have a good understanding of this in order to ensure that changes take place. We need to have good governance to take the organisation forward over the next few years. This needs to be done in conjunction with other important pieces of work such as the Strategic Review and the Race Review. We may wish to look at the Patrick Lencioni model for the Board Development programme.
- Mr Holt advised that the Audit Committee will ensure that the Board of Directors hold people to account. The Board needs to lead and demonstrate the change of culture.
- Ms Sequeira suggested that following the Strategic Review and the emphasis on people and culture we may wish to bring forward the establishment of the new People and Equalities Committee to March.
- Thought will need to be given on how the Board committees are effective and are strategic and not operational in this focus.
- Across the implementation of the recommendations there will need to be a clear focus on Equality Diversity and Inclusion. It is expected that assurance on equality and especially race will be stronger through the lens of a People Committee as it will have the Board to reinforce actions we are taking around equalities.
- Dr Colson suggested that we should look at indicators for each recommendation to ensure that we are making progress and that we can identify success or otherwise. This will keep both the Board and the Executive involved and alerted to any issues.
- The proposed committee structure is good, but it is important to look at any gaps between the committees. It was agreed that work should be undertaken to ensure consistency in the Terms of Reference if different committees.

3.1.9 Ms Mehta asked for clarification on the Implementation dates for the Governance Action Plan. Mr Jenkins advised that the dates shown are completion dates. There is a desire to progress the implementation of the infrastructure and the change of culture in good time. It was noted that we need to ensure that actions are fully completed before they are designated 'green'

3.1.10 Prof. Burstow summarised:

- The new committee structure is agreed and the establishment of the People and Equalities Committee should e brought forward to March.
- An oversight group should be established to agree outcome measures, this group will report to the Board of Directors
- The proposed plan should be accepted as the basis for proceeding

3.1.11 The proposal was agreed

3.1.12 Mr Patel and Ms Boulton were thanked for their work on the proposal and it was suggested that they return to the Board of Directors in a year.

3.2 Race Equalities Strategy and Action Plan

3.2.1 Mr Jenkins introduced the report. The strategy has been informed by various pieces of work have been carried out including colleagues sharing their stories, reviewing of data and the independent review carried out by the Colour Brave Avengers on race issues.

3.2.2 We have an ambition to become an anti-racist organisation. We have had a strategy before which has had some success in the Department of Education and Training where it has influenced the

gaps in student groups. However this did not lead to an organsational shift so a new impetus was needed. A strategy and action plan has been developed and a Race Equality Steering Group was formed to work on this.

3.2.3 As part of developing the refreshed strategy we have looked closely at governance, delivery and assurance. The establishment of the People and Equalities Committee will give more significant lines of assurance to the Board of Directors. It will be supported by a Race Equality Assurance Group which will help provide challenge within the organisation on these issues.

3.2.4 While the Chief Executive will have strategic leadership of the equalities agenda, the Human Resources Director will lead the work on a day to day basis, but with all Directors also needing to be involved in leading work in their area. Mr Jenkins highlighted the work of Irene Henderson, our Associate Director of Equalities, Diversity and Inclusion who has made a huge contribution to this work and in particular in raising awareness of race inequality in the Trust..

3.2.5 Ms Henderson noted that there is now a good strategy that is more targeted and has been co-created with staff. One key point is that we have 'buy-in' from staff as well as assurances that all areas of the Trust are involved. Resources are needed to carry out the work and we must keep to the timetable in the action plan. The membership of the Race Equality Assurance Group must be representative of the staff

3.2.6 There is likely to be a cost to the Trust if we do not get this work right. The action plan is challenging, but achievable.

3.2.7 Thanks were extended to Ms Henderson, Mr Jenkins and Mr Tegerdine for bringing this issue to the Board. There was a full discussion which included the following points:-

- Energy, positivity and team work will be required to work on this.
- We will need to have clear metrics for how we will measure that we are becoming an anti-racist organisation. Feedback will be needed to reflect what staff are experiencing on a daily basis.
- It was agreed that it was important that the Board and the Executive committed to undertaking training to help them in their work to implement the strategy.

3.2.8 Prof. Burstow summarised.

- The report is a helpful document which clearly sets out what we need to do. As a Board we need to be seen to own this and to be energetic in the pursuit of the goals, the new People and Equalities Committee will hold the Board and Executive to account.
- Although the work on the Race review was carried out by an outside agency we need to clear that it is the Board who will be leading on this work. We will expect regular updates on the progress of the recommendations.

3.2.9 The Board noted the report.

4. Items for information

4.1 Serious Incident Quarterly Report

4.1.1 Ms Colson thanked Dr Sinha for the information on deaths and noted that the lessons learnt table was useful. She asked if there are mechanism in place to follow up this work.

4.1.2 Dr Sinha advised that all deaths of service users that occur within six months of discharge are reviewed. Some of these are from the

waiting list in our Adult Gender services and are of natural causes. Where other providers are involved we will co-ordinate with them on the review. The report on these deaths is anonymised and is available to the Board.

4.1.3 Responding to questions from a number of NEDS about what can be learned from incidents that would help prevent future issues Dr Sinha advised there was a process for doing this and that feedback could be reported to the Board.

4.1.4 The report was noted.

4.2 Guardian of Safe Working (Q3)

4.2.1 The report was noted

5. Board committee reports

5.1 Audit Committee

5.1.1 Responding to a question from Ms Sequeira Mr Jenkins advised that a framework for the use of Rag Rating will be undertaken as part of the new framework for performance management being developed following the Governance Review.

5.1.2 There was a discussion of the item which had been taken at Audit Committee on Freedom to Speak Up. This had been a one off deep dive and routinely reports would come to the People and Equalities Committee and to the Board.

5.1.3 The Board of Directors noted the report.

5.2 Education & Training Committee

5.2.1 The board noted the report.

5.3 Integrated Governance Committee (IGC)

5.3.1 The Board of Directors noted the report.

6. Any other matters

6.1.1 There was no other business raised.

6.1.2 The meeting closed at 4.30pm.

7. Date of next meeting

7.1 29th March 2022 at 2.00pm.

Report to	Date
Board of Directors	29th March 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. Strategic Review

1.1 The period for receiving responses on the consultation document on the Strategic Review proposals will close on Monday 28 March. This was extended from the original date of 17 March to give more time to complete meetings with staff directly affected and to provide the space for discussion with staff around alternative proposals.

1.2 There has been a significant programme of activity to engage with staff around the proposals with over 60 group meetings being held on top of formal 1:1 meetings. During the additional time provided for consultation responses we have been holding a series of 5 drop-in meetings with a specific aim to hear issues and concerns with the proposals and to explore alternative proposals.

1.3 We have been finalising a plan for carrying out a full analysis of responses to the consultation with the aim of making recommendations to the Board of Directors on final proposals.

2. ICS Support

2.1 We have had discussions with colleagues in our ICS and London Region about the support for the Trust to successfully enact the Strategic Review proposals and the independent well led review commissioned by the Board and support us to address our ongoing accommodation issue. The Region has commended the Trust for taking a proactive approach to the reviews and we have accepted the proposal for support. The support is being proposed in recognition of the Trust's financial challenge and our small size placing additional pressures on our capacity to deliver the changes the Board is seeking to make.

3. Covid19 Update

3.1 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.

3.2 While recognising changes in the incidence and impact of cases and in central Government regulations 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. We will be looking to work alongside colleagues in the ICS to take steps to increase our ability to accommodate face to face activities over the coming months. This has already included a move to increase the maximum group size which can be accommodated in our larger meeting rooms.

3.3 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.

4. Board Governance Review

4.1 Work is in hand to take forward the recommendations of the Board Governance Review.

4.2 A task and finish group has been established to oversee the work. The group, which met on 22 February, has a particular focus on ensuring that there is a robust framework for the work of Board Committees including the new People, Organisational Development and Equalities Committee and Quality, Performance Management and Finance Committee.

4.3 Work is progressing to establish the new committees and the People, Organisational development and Equalities Committee held its first meeting on 14 March.

5. GIDS

5.1 Dr Hilary Cass has published an interim report of her independent review of gender identity services for young people.

5.2 As expected, the report highlights the need, in light of the growth in the number of referrals and the long waiting times to access care, to move away in the longer term from reliance on a single national provider and to develop a new distributed service model. The hope is to create capacity to respond to the needs of young people more quickly and which is better able to link with other local services. This builds on and develops the proposals to create Regional Professional Support Services already announced by NHS England. While recognising the work still required to put these in place and define their operating model the Trust welcomes this direction of travel.

5.3 The Trust is engaging with Dr Cass and her team about the report and the next stages of her work and putting together a formal response. We are also awaiting a response from NHS England, as our commissioner, to the report.

5.4 We are preparing for a third Quality Summit with CQC and other stakeholders which is now likely to be held in May.

6. The Lighthouse and Haringey Thinking Space

6.1 I wanted to note sadly the ending of two important contracts for the Trust at the end of March.

6.2 This includes the Lighthouse, the NCL service based in Camden supporting young people in recovery from sexual abuse or exploitation and the Haringey Thinking Space service.

6.3 Both have been important activities for the Trust, and I would like to record my appreciation of the contribution of both services and the staff working in them.

Paul Jenkins
Chief Executive
24 March 2022

Report to	Date
Board of Directors	29th March 2022

Preliminary Board and Trust objectives for 2022/3

Executive Summary

This paper sets out a set of preliminary Board objectives for 2022/3.

Recommendation to the Board

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

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Paul Jenkins	Chief Executive

Preliminary Board Objectives – 2022/3

1. Introduction

1.1. This paper sets out at a preliminary set of Board and Trust Objectives for 2022/3.

2. Board objectives

2.1. The preliminary Board Objectives build on the key priorities we have discussed at November and January Board meetings.

2.2. We are proposing preliminary objectives at this stage to reflect the current uncertainty in the Trust's operating environment and the stage we have reached with the Strategic Review.

2.3. We would expect to revisit the objectives as we get further along in taking final decisions about the Strategic Review and are clearer about some of the key milestones which will need to meet as part of the programme of mandated support agreed with the ICS.

2.4. In the light of Board feedback on the headline objectives we will bring a more fully developed set of objectives to the May Board.

3. Trust objectives

3.1. A preliminary set of Trust objectives are proposed which reflect the 5 challenges which are driving the Strategic Review. It is intended that these would inform the appraisal cycle for 2022/3:

- Deliver high quality clinical and educational services which align with the needs of the wider health and care system.

- Strengthen our organisational effectiveness and provide assurance on ability to deliver regulatory and other requirements.

- Meet our ambitions to become a diverse, inclusive and anti-racist organisation

- Improve the quality of data available to drive better decision making and better demonstrate the impact of our work.

- Improve the efficiency of what we do and deliver value for money for our commissioners.

4. Conclusions and Recommendations

4.1. The Board of Directors are asked to agree the preliminary Board and Trust Objectives.

Paul Jenkins
March 2022

Annex A – Preliminary Board objectives

Objective	Milestones
Implement Strategic Review	Board considers consultation feedback and agrees final proposals Q12022 (April/May) Implement first phase of final proposals (September) Board statement on longer term strategy (September)
Progress GIDS Transformation Plan	3rd Quality Summit (May) Make changes in practice to respond to requirements following Cass interim Review (ongoing) Prepare for expected reinspection (ongoing)
Equalities	Implement Race Equality Strategy and Race Action Plan (ongoing) Agree overall Trust Equalities Strategy (May)

Governance	Establish new committee structures and integrated approach to governance (May)
Estates	Progress work within the ICS to identify longer term solution to the Trust's ongoing accommodation needs (ongoing) Progress the implementation of the Trust's Green Plan (ongoing)
Business as usual (Clinical and Education and Training)	Maintain provision of quality services (ongoing) Board agree refreshed People Strategy including review of FTSU and Raising Concerns policies (May) Agree and deliver 2022/3 budget (ongoing)

Report to	Date
Board of Directors	29 March 2022

Quality Update

Executive Summary

This report updates the Board of Directors on various aspects of quality and its reporting including

- The progress of the Quality Account 21/22
- Quality priorities for 22/23
- Trust quality improvement and OD wellbeing programme
- Renewal of QI structures

Recommendation to the [Board / Committee]

To note

Trust strategic objectives supported by this paper

Quality, Risk, Governance, Finance

Author	Responsible Executive Director
Dinesh Sinha, Medical Director and Director of Quality Emma Casey, Associate Director of Quality & Governance (interim)	Dinesh Sinha, Medical Director and Director of Quality

1.0 Quality Account 21/22

This section provides an update and assurance in respect of arrangements in place for completing the Trust's Quality Account for 2021/22. This is based on the timescales adopted for production in previous years.

Updated guidance for producing a Quality Account was provided by NHSEI in January 2022. Guidance issued this year for both the Quality Account and the Annual Report (NHS foundation trust annual reporting manual 2021/22) advises the following;

- There is no national mandated requirement for NHS trusts to obtain external auditor assurance on the quality account
- Quality reports are no longer a required part of an NHS foundation trust's annual report. Instead, the performance section of the annual report should be expanded to include performance against quality priorities and indicators

As with previous (pre-Covid) years, Quality Accounts must be published by 30 June 2022. One additional minor point to note is that the NHS.uk website no longer allows organisations to upload reports. Therefore providers are asked to upload to their external website only, followed by an assurance email to NHSEI to confirm that this has been done.

In preparedness for the Quality Account process next year (reporting on the financial year 22-23), the National Quality Board has been undertaking a review of Quality Accounts to determine how they could be improved and updated. This review does not affect the requirements for the report this year however it is anticipated that changes may come into effect for the 2022-23 requirements.

2.0 Update on Quality Account timelines

The broad content of the Quality Account remains the same as per previous years' guidance. Requests for return of information have been sent to the associated lead within the Trust. Dependent on whether or not the section data requires a confirmed year-end position a March or April deadline has been given. Reminders will be sent accordingly.

A final draft of the Quality Account is on track to be ready by mid-April to be sent to external stakeholders for review and comment via their statement. Following that, the Audit Committee and the Trust Governance Committee (new committee) in their May meetings before final Board approval on 24 May 2022.

3.0 Quality Priorities 22/23

The Trust will be looking again to highlight areas which have made quality improvements through the year, celebrating success stories and improvement projects.

The quality priorities for next year have been discussed with divisions via the monthly Quality Priorities Divisional Directors meeting and the Operations Board. It has been proposed and agreed that three of the four quality priorities from 21/22 will continue forward into 22/23. The

one remaining quality priority from 21/22, Job Planning, is now incorporated into business as usual and therefore will not need to continue into 22/23.

The three headline quality priorities for 22/23 will therefore be;

- Improving Waiting Times across the Trust
- Improving Equalities
- Embedding Meaningful Use of Outcome Measures across the Trust

As previously, all three are linked to at least one of the three core domains of quality – patient experience, patient safety and clinical effectiveness. The detailed targets underpinning each of the quality priorities is currently under discussion and will be finalised by the end of March.

4.0 Quality Improvement (QI) – Wellbeing Project

The Tavistock and Portman NHS Trust have commenced on a wellbeing programme using allocated charity funds to commission a robust external organisation (OD) intervention, underpinned by quality improvement projects.

QI methodology and QI groups are already established in The Trust. An additional, OD orientated intervention was incorporated to supplement these activities and positively impact the recovery from pandemic for the greatest number of staff. The external Quality Improvement and OD expertise are providing direct support for the Trust wide project on recovery of emotional wellbeing. Therefore, the wellbeing programme compromises of two workstreams as indicated in Fig 1.

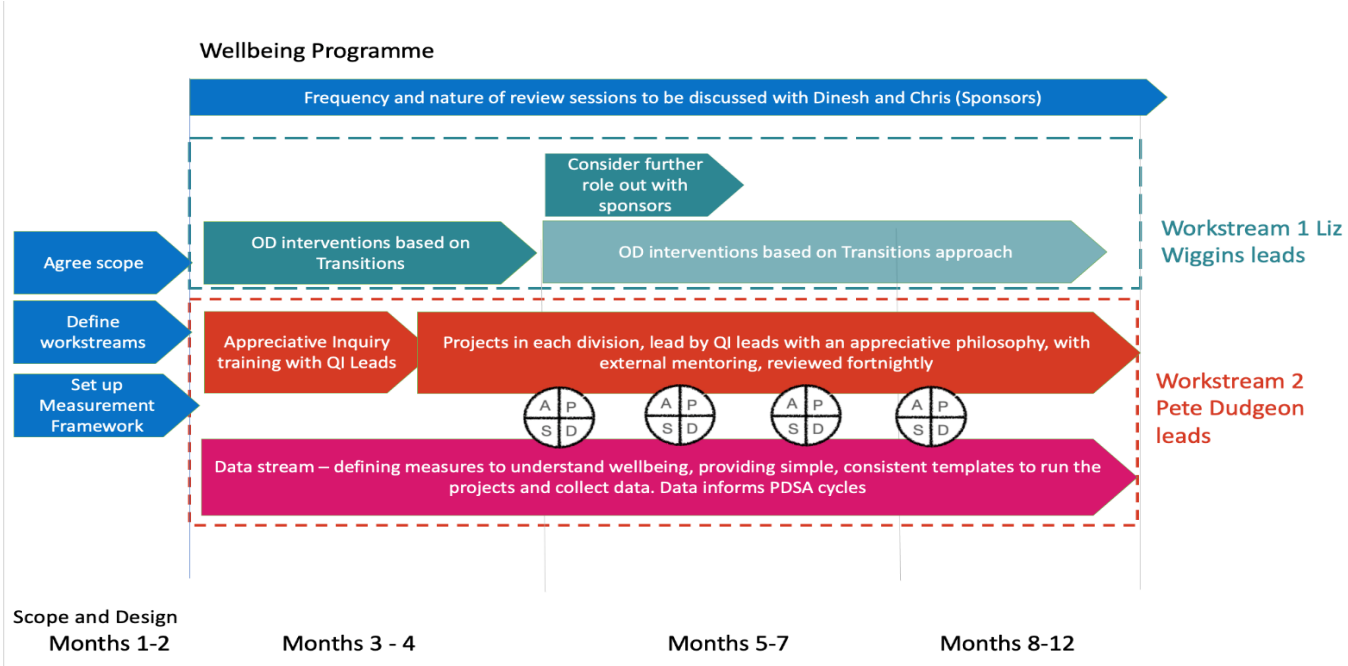
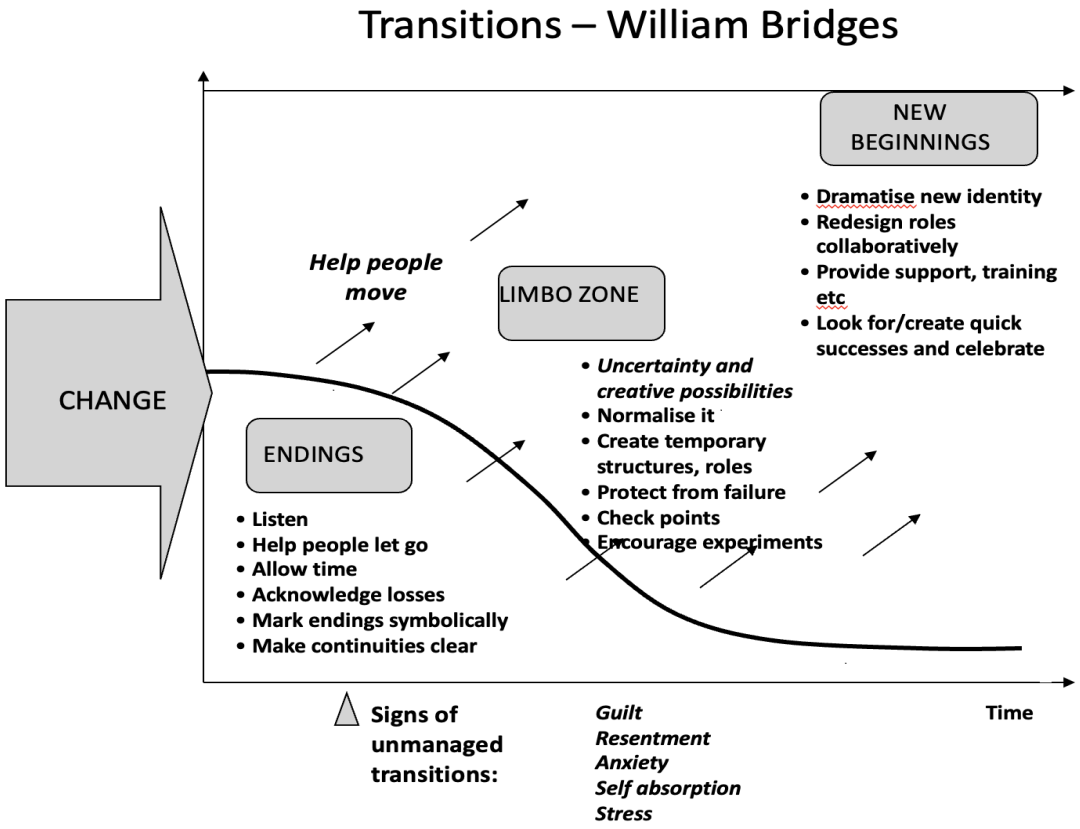


Fig 1

Workstream 1: OD workshops based on transitions

We have conducted 5 workshops with a variety of staff led by our external consultants and sponsored by executive directors leading the project. Attendance grew with every session as word spread about the value of these.



The workshops were based on the attached 'Transitions' model as defined by William Bridges. The most common reflection from attendees, is that they didn't feel they could properly define an ending, nor new beginnings, given where they were in relation the strategic review, but welcomed the opportunity to share their feelings of being in the "limbo zone" as they waited to understand the impact of the strategic review. The sessions were an intervention in themselves rather than necessarily leading to additional actions. They were places of ‘being’ rather than ‘doing’.

The sessions provided a welcome safe space for a whole range of clinical and admin staff from across The Trust to talk about the wide range of uncertainties they have been and continue to face. By introducing a framework (Bridges model of transitions) and using break out rooms, there was a structure for those conversations and a safety because it was just very small groups or pairs. Data suggests that - whilst not every aspect of wellbeing improved significantly - there was a significant improvement in the level of connection people felt with their colleagues.

There have been calls from many to organise fresh sessions once the output of the strategic review has been digested.

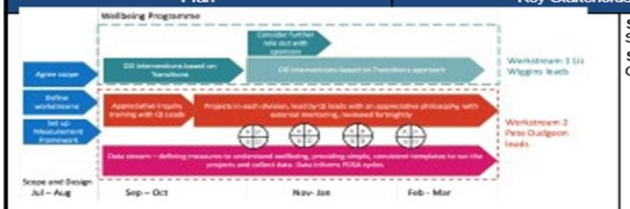
Workstream 2: Quality improvement projects run by QI leads, informed by appreciative philosophy, measured in a consistent way

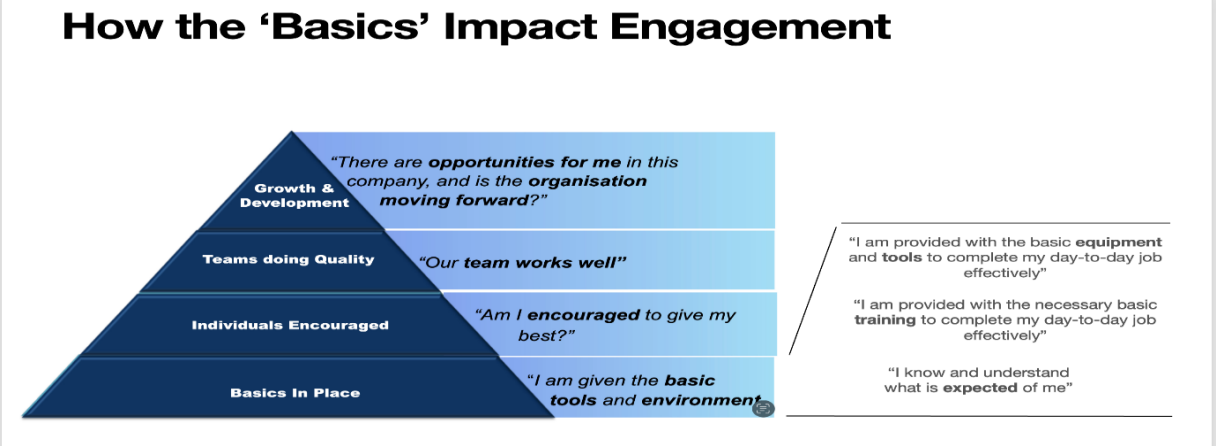
Wellbeing project

"How can we improve the wellbeing of ourselves and our colleagues?"

Aim/Objectives	Scope	Out of Scope
Aim : To improve the wellbeing of those Trust staff who are participating in the wellbeing projects, by x% by y end of March 22. **Objectives** : • Identify what interventions are most effective in improving wellbeing • Create an appreciative environment and a safe space for people to transition from what has happened during the pandemic, towards a brighter future	Selected teams within the following divisions AFS, DET, CYAF, Gender The impact of changes and how people cope with them Working with the Executive team and corporate to lead on wellbeing.	Broader structural changes

Deliverables	Benefits and Measurement		Critical Success Factors
• Measurement framework for wellbeing that can be used within the projects. • Design and delivery of training on the principles of Appreciative Inquiry • 6 'transition workshops' across the divisions • Cross-divisional driver diagram to explore and capture the factors which influence wellbeing • Monthly project reports on progress in each division • Cross divisional learning report	Improved sense of wellbeing	• 1-5 measurement scale (5 being positive) covering 8 different aspects of wellbeing. This data will be gathered as an initial baseline, and then following each designed intervention • (Recording and recognising structure changes in the narrative of the measurement timeline)	• Local buyin for the general approach and specific interventions. • Addressing fundamental barriers to wellbeing • Capacity of QI leads and Project Leads • Capacity of local teams to engage with interventions. • Clinical lead involvement and capacity • Well structure comms strategy (Pete to pick up with Dinesh)

Plan	Key Stakeholders	Resources
	**Sponsor**: Dinesh Sinha **Sponsor**: Chris Caldwell	**QI Leads/Project leads 1 hour per month for meetings, ½ day per week for project implementation:** **AFS:** Leticia Cestari, Sukhi Sidhu **DET**: Paul Dugmore, Will Fitzmaurice, Sabeha Hoque **CYAF**: Liz Searle, Neelam Solanki, Bethan Morris **Gender**: Sylvia Barcellona, Abraham Kuyateh. **Project leads AFS**: Leticia Cestari, Sukhjit Sidhu, Tim Kent, Reena Manghnani, Patricia McEvoy **DET**: Will Fitzmaurice. CYAF: Yoko Totsuka, Natalino Putzu **Gender**: Dr James Barret. **QI Lead and corporate oversight** Diane Halliley External support QI Peter Dudgeon 12 days. OD Support: Liz Wiggins 6.5 Days



This could be thought about based on Maslow's hierarchy of needs, where self-actualisation cannot be reached until physiological (housing, food and warmth) and safety needs are meet. There is a data trend in the project to suggest a similar principle can apply for mental wellbeing at work in the context of an organisation going through various structurally impactful changes, such as Strategic Review.

The qualitative data would suggest that whilst it's good to have better opportunities to connect with others and to have a mental break from work, the key factors effecting wellbeing are:

1. Feeling though the activity you are asked to complete is value added (e.g. reduce time spent on admin)
2. Have better/ better-organised working spaces
3. Have better equipment to enable effective home working.

We are not in a position to make a conclusion from the individual projects, as quantitative data from the different work streams is still coming in, and further activity is planned till Aug 2022. However, it looks so far that our interventions (such as workshops on managing risk) are having a moderate, but not yet statistically significant positive impact on wellbeing.

5.0 Renewal of Quality Improvement Structures

The Quality Improvement Group TOR is being renewed and the plan is for the various QI forums to follow the structure of new divisional/ service lines and DeT structures.

There is a plan for a modest increase in resources through the SR and if approved, posts will be recruited in the new financial year.

In particular, we will be linking up the new service line groupings with the QI infrastructure of appointed leads/ Associate Directors, along with QI forums. There is a need for an overall renewal, as the process of SR has resulted in a degree of disengagement and preoccupation amongst staff.

Additionally, the Trust quality strategy is undergoing renewal and is currently being drafted using commentary from various forums. We expect a final version to be ready in the next 4-6 weeks.

Report to	Date
Board of Directors	29th March 2022

Board Assurance Framework (BAF)

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives.

The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls.

The Strategic Risks contained within the 2021/22 BAF were agreed initially by the Executive Team and then endorsed by the Board. In line with governance best practice, each year the Board reviews and redefines its BAF risks based on its strategic objectives. As we near the conclusion of the strategic review the BAF risks will now be reviewed to ensure they reflect the risks to the strategic objectives moving forward.

In addition to reviewing the BAF risks, and aligned to the outcome of the governance review, and the outcome of the risk management internal audit we will be developing a process for reviewing the BAF and a revised reporting structure aligned to the revised Committee structure.

Recommendation to Board

The Board are asked to:

- discuss the board assurance framework and suggest further changes

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
Interim Director of Corporate Governance	Chief Executive

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

The term 'Board Assurance Framework' (BAF) is used to refer to a document that brings together in one place all of the relevant information on the risks relating to the Board's Strategic Objectives. This is one element of a suite of mechanisms which the Board uses to assure itself that it is delivering against its strategic objectives including the Integrated Performance Report, the outcomes of Board member visits, escalation reports from Committees and deep dives into specific areas of the business of the Trust.

The effective application of board assurance arrangements to produce and maintain a BAF, help management and the Board to jointly consider the process of securing assurance using a formal process that promotes good organisational governance and accountability.
The specific benefits include:

- Gaining a clear and complete understanding of the risks faced by the organisation in the pursuit of its strategic objectives, the types of assurance currently obtained, and consideration as to whether they are effective and efficient;
- Identifying areas where assurance activities are not present, or are insufficient for their needs (assurance gaps);
- Identifying areas where assurance is duplicated, or is disproportionate to the risk of the activity being undertaken (i.e. there is scope for efficiency gains, reduction of duplication of effort and/or a freeing up of resource);
- Identifying areas where existing controls are failing and as a consequence the risks that are more likely to occur;
- The ability to better focus existing assurance resources; and
- Providing an evidence base to assist the organisation in the preparation of its annual governance statement. Where the Board is of the view that there is strong assurance in place, the BAF allows the Board and its Committees to take a view on the controls in place to mitigate the risks, their appropriateness and effectiveness.

Over the coming months a key theme of the governance improvement plan will be improving the Board Assurance Framework and the reporting processes together with increasing triangulation including reinstating patient stories and a formal programme of Board visits. We are making these improvements with the aim of ensuring that the Trust is in line with best practice, and to ensure that the board receives greater assurance on the key risks impacting the Trust.

2. Key changes

The Board assurance framework has been reviewed by the executive management team; however, it should be noted that the BAF will be reviewed in line with the outcome of the strategic review and the approval of revised objectives.

The changes since the last version of the BAF was reviewed by the board, the BAF has been reviewed by the executive. All risks have been updated, with two risks increased in scoring;

- Risk ID185; If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work.

- Risk ID186; If we fail in our efforts to modernise our internal processes and advance initiatives which support and develop our staff, improve recruitment and retention, develop our substantive workforce and strengthen staff engagement, leadership and culture across the Trust

In terms of BAF risk 186, the wording has been simplified in order for the board to manage the risk and seek assurance.

1.1 **3. Recommendations**

The Board is invited to discuss the board assurance framework and suggest further changes.

Board Assurance Framework 2021/22 – Summary –

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

Risk ID	Risk	Risk Lead	Strategic Aim	Corporate Objective	May 2021	July 2021	Nov 2021	March 2022	Target Risk L=likelihood C=consequence Risk = L x C
185 (1)	If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	**CEO**	Finance & Governance	1	15 (3x5)	15 (3x5)	15 (3x5)	20 (4x5)	Amber (2x5)
186 (2)	If we fail in our efforts to modernise our internal processes and advance initiatives which support and develop our staff, improve recruitment and retention, develop our substantive workforce and strengthen staff engagement, leadership and culture across the Trust	**DoHR**	Finance & Governance	1	16 (4x4)	12 (4x3)	12 (3x4)	16 (4x4)	Amber (3x4)
90 (3)	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	**DoF**	Finance & Governance	2	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Amber (2x5)
187 (4)	Insufficient management and leadership capacity, along with a focus on internal structural/business process improvements may lead to the inability to meet regulatory requirements resulting in commissioner and regulator sanction and reputational impact.	**MD/COO/ DoE&T**	Finance & Governance	4	9 (3x3)	9 (3x3)	12 (4x3)	12 (4x3)	Green (2x2)

S

Risk ID	Risk	Risk Lead	Strategic Aim	Corporate Objective	May 2021	July 2021	Nov 2021	March 2022	Target Risk L=likelihood C=consequence Risk = L x C
188 (5)	If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts	**DoF&E**	Finance & Governance	5	9 (3x3)	9 (3x3)	9 (3x3)	9 (3x3)	Green (2x2)
108 (6)	The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and clinical and educational outcomes resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings. (updated 2020/21 risk)	**MD/COO/ DoE&T**	Services clinical	4	9 (3x3(	9 (3x3)	9 (3x3)	12 (3x4)	Green (2x2)
189 (7)	If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	**DoE&T**	Services education	6	9 (3x3)	9 (3x3)	9 (3x3)	9 (3x3)	Yellow (2x3)
190 (8)	If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will be at risk of becoming unsustainable and not be in a position to benefit from growth	**CEO**	Growth & Development	8	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	Yellow (2x3)
103 (9)	The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services. (updated commentary 2020/21 risk)	**CEO/DoHR**	People	9	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Green (2x3)
105 (10)	The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. (updated commentary 2020/21 risk)	**DoHR**	People	10	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	Yellow (2x3)

Strategic Aim: Finance and Governance

RISK ID 185 (1): If not managed well the strategic review may fail to deliver a sustainable financial and operational model impacting negatively on the safety and effectiveness of our current work	
Risk Owner: Chief Executive	Date reviewed: March 2022
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The Trust faces a number of challenges to ensure it is financially sustainable and that its work is relevant and aligned to the needs of the ICS. A Strategic Review has been launched to address this.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 4 x Consequence 5 = 20	TARGET risk rating 2 x 5 = 10
Rationale for current score: The Trust has an underlying deficit of £5-7m. This and other challenges will require a significant programme of change. The Strategic Review is a complex programme and crucial to the financial and wider sustainability of the Trust. Specific key risks have been identified in respect of the process of transition to new structures and HR support for the strategic review. Plans are in place to address the gaps identified however there is a need to increase the score until the implementation of improved processes and implementation of the strategic review	
Controls/Influences *(what are we currently doing about this risk?)*: Well-structured programme with focus on agreeing clear "compass points" for the direction of travel. Strong programme of staff engagement. Development of a phased plan, balancing operational and financial risk, to deliver a balanced position in the medium term.	Assurances received *(independent reports on processes; when; conclusions)*: Programme Board chaired by CEO (+) Board reports and monthly Board seminar on strategic review focusing on progress made (+) Strategic review programme risk registers in place and reviewed through programme governance (+)
Gaps in controls/influences: NCL MH Commissioning review Changes in wider NHS financial regime	Action plans in response to gaps identified: Action plan and support agreed with NHSEI and wider system

Unable to provide assurance on risks to quality arising from costs reduction and transformation schemes in the SR Lack of Investment in capacity and capability, particularly in relation to Human Resources (HR) and Organisational Development (OD)	Governance review action plan and delivery framework to be defined and implemented

RISK ID 186 (2): If we fail in our efforts to modernise our internal processes and advance initiatives which support and develop our staff, improve recruitment and retention, develop our substantive workforce and strengthen staff engagement, leadership and culture across the Trust

Risk Owner: Director of HR	Date reviewed: Match 2022
Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust	
Background / Context The implementation of the Strategic Review will have far reaching impact on the way we employ and communicate to staff. The process of the Strategic Review and subsequent staff consultation for change will require broad and deep communication and engagement with staff.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16	TARGET risk rating 3 x 4=12
CURRENT risk rating: **Likelihood 4 x Consequence 4= 16**	
Rationale for current score: A large number of staff engagement events with the Board have taken place. One to one and team level engagements events have also taken place. Staff are demoralised by the changes, and there has been an impact on retention and staff being at work as a result of the changes.	
Controls/Influences *(what are we currently doing about this risk?)*: Strategic Review Programme Board overseeing the impact on staff, and also the risks associated Clear programme structure with clearly defined work strands in the key areas Appointed external 'critical friend' to scrutinise the process Close engagement with staff side unions	Assurances received *(independent reports on processes; when; conclusions)*: Strategic Review Programme Board reports and minutes (+) Regular meetings with unions and clear engagement in strands of work (+)

Gaps in controls/influences: Understand impact of work on staff Whilst there is board oversight of the programme there is a lack of assurance of the actions taken to support staff	Action plans in response to gaps identified: Review communication plan and adjust as needed (ongoing)

RISK ID 90 (3): If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy.

Risk Owner: Director of Finance	Date reviewed: March 2022

Corporate objective 2: In line with Trust's service and financial requirements, progress the Trust's long-term plans for the Tavistock Centre site

Background / Context

The Tavistock Centre ("TC") is an old building with serious issues around its mechanical and electrical systems. The way the building is laid out is also old fashioned and does not meet current requirements for patients and students. Repairs to the TC would be disruptive to patient / student experience. Accordingly, the Trust is looking to relocate its main activities from TC to a new site – Jamestown Road ("JR") – to which end a contract for sale and purchase of the site has been exchanged with the owners of JTR.

INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 TARGET risk rating 2 x 5=10
CURRENT risk rating: Likelihood 4 x Consequence 3 = 12

Rationale for current score: The Trust has now got active engagement with NHSE/I and the NCL ICS. The Relocation project is also treated as a priority project within the NCL estates stream. However, NCL has not yet determined which projects will be formally supported and the bridging financing required for Relocation has not been identified. The Relocation project also assumes that a Registered Provider (yet to be identified) will provide some of the funding required. With regard to the TC itself, recent surveys have confirmed the potential fragility to the electrical systems in the building. Contract with Camden requires completion by end March 2022. Trust has sought extension to June 2022, however, this is still not long enough to enable completion. NHSEI together with the system providers have agreed a number of actions to support the relocation project and the identification of opinions for relocation.

Controls/Influences *(what are we currently doing about this risk?)*: Established Programme Board with NED and Governor representation Estates & Facilities Compliance and Risk sub-committee of the IGC Regular contact with NHSE/I, NCL ICS and Camden Council	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of the Programme Board (+/-) Minutes of the sub-committee (+/-) Stock condition survey on TC

Gaps in controls/influences:	Action plans in response to gaps identified:
Post COVID working arrangements in TC Formal NHSE/I approval of Relocation project Bridging finance unidentified Need for Camden to agree contract extension	Outline Business Case being prepared (February 22) Negotiate extension with Camden (February 22)

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

Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: March 2022

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

Background / Context

Analysis of clinical leadership provision through the strategic review process has highlighted a large variation in performance and capacity in leaders. This will need to be addressed through the strategic review process if we are to be fit for purpose going forward. Strategic review workshops continue to highlight the variation across the trust, which is being addressed where ever possible

INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 TARGET risk rating 2 x 2 = 4
CURRENT risk rating: Likelihood 4 x Consequence3 = 12

Rationale for current score:

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

The recent governance review found that;

- 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	
Controls/Influences *(what are we currently doing about this risk?)*: This will be reviewed through the SR process Interim capacity challenges are being mitigated through operational and other forums A GIDS governance flow has been set up to follow through and support ongoing transformation linking it with Trust level structures Strategic Review Programme Board & consultation process Gender Oversight Committee – chaired by CEO – to monitor GIDs service transformation	Assurances received *(independent reports on processes; when; conclusions)*: High level principles documents shared and agreed to guide restructure of teams and functions (+) Good feedback from recent Quality Summit from CQC and other stakeholders (+) Strategic Review Programme Board minutes / reports (+) GIDS CQC inspection report (+/–) Gender Oversight Committee minutes (+)
Gaps in controls/influences: There are continuing issues with staff engagement with SR There are continuing issues with staff attrition and engagement in GIDS transformation GIDS inadequate CQC rating Challenges in delivering mitigations on known gaps in assurance	Action plans in response to gaps identified: SR process improvements allow for a good engagement plan in the upcoming period for required changes Continuing engagement and involvement of GIDS team including recruitment of various external seniors to support delivery CQC action plan at Trust level and GIDS Further support has been offered by the system

RISK ID 188 (5): If the Trust fails to deliver its Green plan it will not be addressing the key health crisis facing the planet and our patients, students and staff and could impact on any new healthcare contracts	
Risk Owner: Director of Estates, Facilities and Capital Projects	Date reviewed: March 2022
Corporate objective 5: To develop a Green Plan for the Trust, with a clear action plan and measurable objectives	
Background / Context This follows on from the launch of the campaign *For a Greener NHS* January 2020 and from the requirement for all organisations to have a Green Plan by 2021. The NHS recognises that the climate emergency is also a health emergency. As the largest employer in Britain the NHS is responsible for around 4% of the nation's carbon. For the emissions we control directly (the NHS carbon footprint), net zero by 2040, with an ambition to reach an	

80% reduction by 2028 to 2032. For the emissions we can influence (the NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. This activity is a requirement for the relocation OBC.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 TARGET risk rating 2 x 2=4 CURRENT risk rating: Likelihood 3x Consequence 3 = 9	
Rationale for current score: The Trust does not have a Green Plan as yet and is due to complete a green plan by the end of July 2021. Green Plan was signed off at July Board and will form part of the Relocation Outline Business Case. Current score unchanged.	
Controls/Influences *(what are we currently doing about this risk?)*: Established regular meetings of Environment Group Attendance of the Greener NCL Board	Assurances received *(independent reports on processes; when; conclusions)*: Relocation programme board oversight of Green Plan outcome (+) Environment Group stakeholder engagement group in place (+) Member of the Greener NCL Board
Gaps in controls/influences: Green Plan has been set with actions over next 2-3 years.	Action plans in response to gaps identified: The Green Plan has been signed off by the Board and has been shared with staff and externally with NCL. Agreed set of actions developed for the coming 12 months including procurement of utilities by April 22

Strategic Aim: Services Clinical

RISK ID 108 (6): The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress against our strategic objectives resulting in poor delivery of regulatory demands, commissioning performance requirements and poor ~~CQC~~ regulatory ratings (updated 2020/21 risk)	
Risk Owner: Medical Director, Chief Clinical Operations Officer, DoE&T	Date reviewed: March 2022
Corporate objective 4: To deliver key regulatory and performance requirements within corporate, clinical and education services to deliver sustainability and relevance	
Background / Context The strategic review discovery work and staff feedback suggest that we have inadequate systems, structures and processes for managing data. We are aware that there continue to be issues at all points in the system; data entry, data tools and system outputs.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 2 = 6 TARGET risk rating 2x2=4 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	
Rationale for current score: We are making significant strategic decisions on data that we do not feel confident in unless we have completed a manual review. Data entry is a significant issue for us, and without being able to properly represent the work we do, we risk reputational and financial consequences. We have also found gaps in automated processes with some of our reporting that could affect decisions affecting patient care (spine reports) The governance review found that there is not a sufficiently well embedded performance management and accountability culture at multiple levels within the Trust. A number of compliance reports have not been submitted to the Board in line with national guidance and governance best practice	
Controls/Influences *(what are we currently doing about this risk?)*: The strategic review has provided a much clearer analysis of the issues and we will be using the change process to ensure that we are able improve confidence in data through improvements at all points in the data journey Quality Assurance Board oversight for data issues The automation processes are being actively addressed including in seeking input from suppliers	Assurances received *(independent reports on processes; when; conclusions)*: Notwithstanding identified issues there have been significant improvement in understanding of gaps in the input, use and understanding of data Data led discussions now inform various forums including Quality Assurance Board, Trust Board etc. Dashboards have been developed for CYAF and AFS clinical divisions. There is work across divisions to ensure that the CYAF, AFS and GIDS dashboards are all producing consistent data. Quality Assurance Board reports & minutes (+)
Gaps in controls/influences:	Action plans in response to gaps identified:

Cultural challenge such as evident challenges in timely data input onto Trust platforms which remains a challenge ex. care notes Technical capability in collecting and using data in certain domains Fragmented ownership of data leading to confusion and lack of confidence Governance review outlined areas of weakness within the trust's current governance and performance management framework	We will continue to improve structures and processes for easing input, use and understanding of data across our services The Strategic review is aiming for better working of services involved in the processing and analysis of data to reduce duplication and clearer ownership We will continue our efforts to engage and empower staff in using data to achieve better outcomes in their interventions Staff training in running mitigating manualised reports Detailed action plan to be developed to address the gaps in control highlighted as part of the governance review System and NHSEI to offer additional support to improve quality reporting

Strategic Aim: Services: Education

RISK IS 189 (7): If as a result of not sufficiently adapting our current provision to meet learner requirements and demand and not developing sufficient new programmes (themes and approach), we will not leverage potential for growth, reach and impact i.e. making sustainable and relevant educational services	
Risk Owner: Director Education & Training	Date reviewed: March 2022
Corporate objective 6: To develop and deliver high quality, outcome focused and financially sustainable educational services which are data informed and responsive to changing requirements.	
Background / Context We have increased our year 1 student enrolment figures consistently over time and have also adapted our provision to meet the challenges of the pandemic and have also established and completed development in the Digital Academy and delivery of online learning through the pandemic. As difficult as the pandemic has been, it has also enabled and accelerated different ways of learning and teaching. However, it has been difficult to adapt our existing provision in more fundamental ways to significantly increase reach. There remain cultural barriers to further development and delivery online exacerbated by fatigue of online learning. This should be mitigated when we return to include more face to face delivery in a more blended format.	
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood x Consequence = 3x3=9	TARGET risk rating 2 x 3=6
Rationale for current score: Although there is evidence of successfully developing and delivering new provision it is often not well co-ordinated and sufficiently responsive to market need or opportunity, especially in the domain of long course development. Related factors include timely and relevant market assessment and external engagement, capability and capacity of teaching staff, PSRB requirements, resourcing and culture that can limit pedagogical range.	
Controls/Influences *(what are we currently doing about this risk?)*: Established Development Forum in DET with governance links to BDG Strategic review; Positive exemplars	Assurances received *(independent reports on processes; when; conclusions)*: Adaptation and pivot through COVID-19 with online delivery (+) Pulse student surveys with high levels of satisfaction (+) Successful Digital Academy launch (+)

Education and Training Committee oversight	Education and Training Committee reports and minutes (+) More focused development in the areas identified by BDG incl. SMHL training, perinatal and leadership and management
Gaps in controls/influences: Scoping of broader strategic opportunities and resourcing for the nursing workforce	Action plans in response to gaps identified: External consultancy project commissioned to explore development opportunities for the nursing workforce (Dec 2021)

Strategic Aim: Growth & Development

RISK ID 190 (8): If we fail to adapt the delivery of our services and programmes sufficiently and respond more quickly to new opportunities then we will not be in a position to benefit from growth and will be at risk of becoming unsustainable	
Risk Owner: Chief Executive	Date reviewed: March 2022
Corporate objective 8: To maximise the potential of our historical relevance to current and emerging business pre-occupations for the purpose of business growth and organisation profile	
Background / Context The Trust has historically relied on new business development to support its financial sustainability. The move to new integrated care structures and the immediate impact of the pandemic has led to a reduction in opportunities. To address this a number of priority areas have been identified including new opportunities outside traditional markets.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16	TARGET risk rating 2 x 3 =6
Rationale for current score:	

The move to integrated care and the pandemic has had a significant impact on new opportunities. SR impacting on resources available to support longer term and more strategic business development. The governance review highlighted the need for further corporate support, this has been reflected within the SR with proposals in place to strengthen the business development team.	
Controls/Influences *(what are we currently doing about this risk?)*: Targeting of resources on core opportunities for business development including retenders. Workstream plans for new priorities. Exploration of partnership opportunities with GOSH	Assurances received *(independent reports on processes; when; conclusions)*: Tracking of core business development opportunities.
Gaps in controls/influences: Availability of external opportunities Diversion of resources due to the Strategic Review	Action plans in response to gaps identified: Targeting of resources on core opportunities Identification of business development needs in design of new structures. Objectives for 2022/23 to be presented to the board

RISK ID 103 (9): The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services	
Risk Owner: Chief Executive/Director of HR	Date reviewed: March 2022
Corporate objective 9 To set a clear direction for the Trust as an anti-racist organisation with key supporting actions	
Background / Context: The Trust faces a significant challenge on diversity. Unless addressed this will have a negative consequence on staff engagement and the quality of services.	
INITIAL risk rating (at identification): Likelihood 2 x Consequence 4= 8 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	TARGET risk rating 2 x3 =6

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

RISK ID 105 (10): The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services. . (updated 2020/21 risk)	
Risk Owner: Director of HR	Date reviewed: March 2022
Corporate objective 10 Develop a People Strategy for the Trust with a focus on future workforce needs and addressing staff engagement, welfare and morale.	
Background / Context	

With the well-researched link between staff engagement and service quality and delivery, the Trust has lower engagement indicators than it would aspire to as seen in the staff survey.	
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 TARGET risk rating 2 x3 =6 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12	
Rationale for current score: The trust is currently redefining the board and board committee structure and the proposals include a People and organisational development committee which will have delegated authority from the board for the oversight of the implementation of the race equality strategy and the soon to be approved trust people strategy and plan.	
Controls/Influences *(what are we currently doing about this risk?)*: Links to WRES actions Planned development of the Trust People Plan over Q 1 to 3 People and organisational development committee chaired by non-executive director	Assurances received *(independent reports on processes; when; conclusions)*: Board scrutiny of staff survey (+) Board approval of race equality strategy and plan
Gaps in controls/influences: Staff survey results WRES Indicators	Action plans in response to gaps identified: To develop OD and People subcommittee Terms of reference to be approved by the Board in May To develop People plan Race code to be adopted by the Trust

S

Report to	Date
Board of Directors	29 March 2022

Report on Finances

Executive Summary

This paper provides details of the Trust financial performance for the 11 month period ended February 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	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 11 months ending 28 February 2022.

2. SUMMARY

£m	Plan	Act	Var	
Income	54.9	55.3	0.4	-
Pay costs	(45.8)	(43.1)	2.7	6%
Non-pay costs	(14.6)	(14.8)	(0.2)	(1)%
Operating deficit	(5.5)	(2.6)	2.9	
Other costs	(2.0)	(2.0)	-	-
Net deficit	(7.5)	(4.6)	2.9	

2.1. The Trust continues to perform ahead of the latest Forecast / Plan, due primarily to staff costs being lower than intended. This reflects difficulty in recruiting into certain areas of the Trust.

2.2. Partly as a result of this operational out-performance but also reflecting the timing of commissioning payments, the Trust's cash position is ahead of Forecast / Plan.

2.3. For the full year the Trust is anticipating a deficit before 'exceptional' items of around £6m to £7m.

The Tavistock and Portman NHS
NHS Foundation Trust

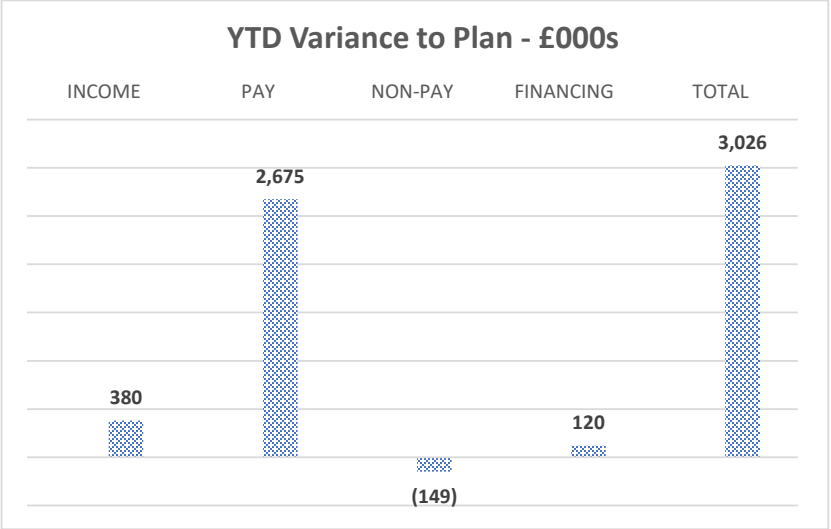
MONTHLY FINANCE AND PERFORMANCE REPORT

Period 11 **11** **Feb-22**

Section		Page
1	I & E Summary	2
5	Balance Sheet Trend	3
6	Funds - Cash Flow	4

KEY Positive Negative Variance

£000	Plan	Actual	Variance	Var %
INCOME	54,900	55,280	380	1%
PAY	(45,782)	(43,107)	2,675	(6%)
NON-PAY	(14,600)	(14,750)	(149)	1%
EBITA	**(5,482)**	**(2,577)**	**2,905**	**(53%)**
Interest receivable	0	2	2	
Interest payable	(20)	(28)	(8)	
Depreciation	(1,657)	(1,661)	(5)	
Dividend	(305)	(338)	(33)	
Net Surplus /(Deficit)	**(7,464)**	**(4,602)**	**2,861**	**(38%)**



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.
Exceptional items will nevertheless create a large deficit -£12 -£15m

Income **380** above plan

Coivd funding repaid in Nov, CYAF deferred income and MH & Wellbeing Hub partially offset by higher tuition fees

Pay costs **2,675** less than plan

Variances largely witiin Corporate, Gender and CYAF (Eating disorders and FDAC; MH hub accrual released in Jan22)

Non-pay costs **(149)** more than plan

Higher Rellocation expenditure

	Plan	Act	Var
Projected closing cash - Mar 22	**4,643**	**13,577**	**8,934**
YTD Cash in/(out) flow - £000s	**(8,617)**	**(1,350)**	**7,267**
due to :-			
Operating flows - reduced staff costs			***2,861***
Reduction in debtors			***818***
Deferred income - NHS England / Eating disorders			***2,321***
Captial slippage			***1,064***
Capital Expenditure - £000s	**3,267**	**2,203**	**(1,064)**

Debtors > 90 days	**Dec-21**	**Jan-22**	**Feb-22**
	£'000	£'000	£'000
NHS	100	56	32
Non-NHS	101	188	172
Student	323	344	385
Total	**456**	**523**	**589**

	Prior Year End £'000	Apr-21 £'000	May-21 £'000	Feb-22 £'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	24	23	21	
Land and buildings	24,045	24,031	24,039	24,046	24,079	24,026	24,072	24,267	24,191	24,467	24,555	24,607	
IT equipment	1,773	1,773	1,773	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	26,240	26,328	26,380	
Total non-current assets	25,868	25,850	25,855	25,858	25,887	25,832	25,875	26,067	25,989	26,264	26,351	26,401	
NHS Receivables	6,494	5,331	5,290	5,022	7,458	5,115	5,528	5,310	4,982	4,950	4,505	6,175	
Non-NHS Receivables	3,322	2,475	3,172	3,404	2,946	2,683	4,154	3,722	4,215	3,379	3,284	2,689	
Cash / equivalents	14,775	17,175	15,659	15,228	13,734	14,348	11,846	15,330	13,532	12,086	10,722	11,327	
Other cash balances		(123)	(111)	(167)	(60)	1,130	1,606	1,653	1,744	2,061	2,130	2,099	
Total current assets	24,591	24,858	24,009	23,488	24,078	23,276	23,134	26,015	24,473	22,476	20,641	22,290	
Trade and other payables	(2,660)	(2,936)	(2,247)	(2,496)	(2,586)	(2,653)	(2,591)	(2,353)	(2,738)	(2,675)	(2,816)	(2,655)	
Accruals	(8,090)	(8,406)	(8,471)	(8,114)	(9,172)	(8,852)	(9,211)	(12,278)	(12,021)	(10,539)	(9,739)	(11,468)	
Deferred income	(6,811)	(6,811)	(6,811)	(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)	(445)	(445)	(445)	
Provisions	(617)	(617)	(617)	(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)	(21,086)	(20,428)	(21,995)	
Total assets less current liabilities	31,837	31,493	31,274	30,864	30,335	29,732	29,334	29,578	27,831	27,653	26,564	26,696	
Non-current provisions	(70)	(65)	(65)	(24)	18	18	18	20	20	(53)	22	22	
Long term loans > 1 year	(2,666)	(2,666)	(2,666)	(2,666)	(2,666)	(2,443)	(2,443)	(2,443)	(2,443)	(2,443)	(2,443)	(2,221)	
Total assets employed	29,101	28,763	28,543	28,175	27,688	27,307	26,910	27,155	25,408	25,157	24,142	24,497	
Public dividend capital	(4,678)	(4,678)	(4,678)	(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)	(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)	(7,601)	(6,586)	(6,941)	
Total taxpayers equity	(29,101)	(28,763)	(28,543)	(28,175)	(27,688)	(27,307)	(26,910)	(27,155)	(25,408)	(25,157)	(24,142)	(24,497)	

FINANCE AND PERFORMANCE REPORT **Section 6** **FUNDS FLOW** **Commercial: In Confidence** **Page 4**
Period 11
Feb-22

	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**	**YTD Plan £'000**	**YTD Var £'000**
Net Surplus/(Deficit)	**(338)**	**(220)**	**(368)**	**(487)**	**(381)**	**(397)**	**245**	**(1,747)**	**(251)**	**(1,015)**	**355**		**(4,605)**	**(7,633)**	**3,029**
Depreciation / amortisation	135	135	135	135	193	147	146	182	159	145	158		**1,670**	**1,614**	**57**
PDC dividend paid	41	23	32	76	43	41	82	0	0	0	0		**338**	**506**	**(168)**
Net Interest paid	2	2	2	2	5	0	5	2	2	2	2		**28**	**29**	**(0)**
(Increase) / Decrease in receivables	2,010	(656)	35	(1,978)	2,606	(1,885)	650	(164)	867	540	(1,075)		**952**	**134**	**818**
Increase / (Decrease) in liabilities	592	(625)	(108)	1,148	(254)	297	2,829	128	(1,545)	(659)	1,568		**3,372**	**1,051**	**2,321**
Increase / (Decrease) in provisions	(5)	0	(41)	(42)	0	0	(2)	0	73	(75)	(0)		**(92)**	**(70)**	**(22)**
Non operational accural movement	(44)	(25)	(34)	(78)	(33)	364	(87)	(2)	(2)	(2)	(2)		**54**	**(98)**	**152**
Net operating cash flow	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,180**	**(1,433)**	**3,869**	**(1,601)**	**(696)**	**(1,064)**	**1,006**	**0**	**1,718**	**(4,469)**	**6,187**
Interest received													**0**	**0**	**0**
Interest paid					(15)								**(15)**	**(29)**	**14**
PDC dividend paid						(405)							**(405)**	**(408)**	**3**
Restructuring															
Cash flow available for investment	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,165**	**(1,838)**	**3,869**	**(1,601)**	**(696)**	**(1,064)**	**1,006**	**0**	**1,298**	**(4,906)**	**6,203**
Purchase of property, plant & equipment	18	(4)	(4)	(29)	55	(42)	(192)	77	(275)	(87)	(50)		**(533)**	**(1,653)**	**1,121**
Depreciation	(135)	(135)	(135)	(135)	(193)	(147)	(146)	(182)	(159)	(145)	(158)		**(1,670)**	**(1,614)**	**(57)**
Capital purchases - cash	**(117)**	**(139)**	**(139)**	**(164)**	**(138)**	**(189)**	**(338)**	**(105)**	**(434)**	**(231)**	**(209)**	**0**	**(2,203)**	**(3,267)**	**1,064**
Net cash flow before financing	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**2,027**	**(2,027)**	**3,531**	**(1,706)**	**(1,130)**	**(1,295)**	**797**	**0**	**(905)**	**(8,172)**	**7,267**
Repayment of debt facilities	0	0	0	0	(222)	0	0	0	0	0	(222)		**(445)**	**(444)**	**(0)**
Net increase / (decrease) in cash	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**1,805**	**(2,027)**	**3,531**	**(1,706)**	**(1,130)**	**(1,295)**	**575**	**0**	**(1,350)**	**(8,617)**	**7,267**
Opening Cash	14,775	17,052	15,547	15,061	13,674	15,478	13,451	16,982	15,276	14,146	12,851		14,775	14,775	0
Closing cash	**17,052**	**15,547**	**15,061**	**13,674**	**15,478**	**13,451**	**16,982**	**15,276**	**14,146**	**12,851**	**13,426**	**0**	**13,426**	**6,158**	**7,267**

Report to	Date
Board of Directors	29 March 2022

Operational Risk Report 9+

Executive Summary

This is a summary of open operational risks graded 9+

There are currently 40 operational risks open with a score of 9 or above. Numbers per division, noting that some risks overlap divisions, are; AFS – 4, CYAF – 6, Corporate & Trust-wide – 20, Gender - 8 and DET 7.

One new risk has been recorded this quarter, detailed below;

- Risk ID 222; risk score 9

If there is an increase in referrals to the GDRSS and the admin team for Arden & GEM does not have enough capacity to process all of the referrals and run the reports (staffing issues at Arden & GEM causing capacity problems with processing the referrals and reports), then NHSE, Arden & GEM and GIDS will not have an accurate picture of the number of referrals and YP waiting in the GDRSS. GIDS cannot update or assure the CQC of the number of YP being held by the NHSE GDRSS, resulting in GIDS being unable to update the CQC and provide assurance on the change in referrals numbers, rejections and total waiting list at the service. This has a reputational impact for all parties including GIDS. Please note the responsibility for patient safety sits with NHSE and Arden & GEM for any referral and YP held with the GDRSS.

No other risks have significantly increased this quarter.

Risks 9+ have continued to be reviewed via the relevant Integrated Governance Committee sub-committees on a quarterly basis. The governance of how live risks will be reviewed in the new committee structure from April 2022 is currently under discussion.

Please note that there is a recognised issue with some of the risk reports generated via the Quality Portal, in that it does always display the correct date of when the risk was last updated or the detail of the updates made. Actions are underway to rectify this issue and also, more broadly, to improve the functionality and operability of the Risk Module overall. A risk learning group has recently been established to share best practice of risk reporting and reviewing across each of the divisions.

Recommendation to the [Board / Committee]	
To note	
Trust strategic objectives supported by this paper	
Quality, Risk, Governance, Finance	
Author	**Responsible Executive Director**
Emma Casey, Associate Director of Quality & Governance (interim)	Dinesh Sinha, Medical Director and Director of Quality

Risk ID	Date Identified	Risk Statement	Initial Risk Score	Current Risk Score	Risk Appetite	Target Risk Score	All risk categories	Scope (Directorate)	Scope (Service)	Risk owner name(s)	Operational Lead name	Monitoring group name	Latest monitoring group update date	Latest monitoring group comments	Latest operational lead update date	Latest operational lead update comments
120	01/04/2015	If staff do not keep patient case records up to date , we will be unable to provide appropriate clinical treatment, resulting in potentially poorer patient outcome	2x3=6	4x3=12	Medium	1x3=3	Delivery (Primary) ,	Adult & Forensic Services (AFS),Children, Young Adults and Families (CYAF),Gender	AFS service wide, CYAF service wide, Gender service wide	Hodges, Sally	McKenna, Caroline	Executive Management Team (EMT)	25/03/2021	Risk level increased, will move to EMT for review	29/03/2021	Risk level increased following review and CQC inspection, will escalate to EMT
152	01/04/2015	Poor management and delivery processes may lead to statutory and mandatory training requirements not being met, impacting on the quality of services delivered, and resulting in a risk of non-compliance in a range of regulatory measures, patient harm and possible litigation.	3x3=9	3x3=9	Medium	1x3=3	Compliance/ Regulation (Primary) ,Financial ,Reputation ,	Trust Wide		Tegerdine, Ian	Merchant, Karen					

140	02/04/2015	If we don't take actions to implement contract, KPI and CQUIN requirements or input accurate and timely data into Carenotes, we may fail to meet our contract requirements, with resulting impact on finances and reputation	3x3=9	4x3=12	Medium	3x3=9	Financial (Primary) ,Reputation ,Compliance/ Regulation ,	Trust Wide		Noys, Terry	LeGood, Amy	Strategic and Commercial Committee			04/03/2021	Updated as part of migration to electronic system. Close review and monitoring of data is taking place due Covid-19 to ensure continuity of care and to highlight risks to senior management, this has highlighted both areas of concern and areas where remote working has been positive for patients.
119	01/09/2016	If we do not have sufficient workforce capacity and systems in place to meet referral demand in the Adult Trauma Unit there will be increased delays in offering appointments , resulting in possible increases in patient safety incidents, non compliance with contract requirements and impact on Trust reputation.	3x3=9	3x3=9	Low	2x2=4	Safety (Primary) ,Compliance/ Regulation ,	Adult & Forensic Services (AFS)	Complex Needs (AFS)	Hodges, Sally	Amino, Hiroshi	AFS Senior Management Team				

148	07/08/2017	If internal operational delivery and management processes are not robust in order to meet CQC KLOE requirements, then services will not be delivered that meet patient and service needs, impacting on the quality of care provided and resulting in loss of 'good' CQC rating at inspection	3x4=12	3x4=12	Low	1x4=4	Compliance/ Regulation (Primary) ,Safety ,Reputation ,	Trust Wide		Sinha, Dinesh	Shipman, Marion	Executive Management Team (EMT)				
127	13/04/2018	Because of a lack of documented and approved E&F Policies clearly associated to both the E&F Strategy and applicable regulations, the E&F department may not be able to assure itself that all work is undertaken in a manner that delivers the E&F Strategy and performs the services in a statutorily compliant manner, resulting in,	4x3=12	4x3=12	Low	1x4=4	Safety (Primary) ,Delivery ,Reputation ,Financial ,	Corporate	Estates & Facilities (E&F)	Mehra, Benita	Ruggeri, Alessandro	Estates and Facilities Risk Action Group				

		possible personal injury to the individual, staff, patients or students, property damage or disruption to provision of Trust services or litigation and reputational damage.													
128	13/04/2018	Because of a lack of either lease or licence to occupy for all sites where Trust services operate, Trust services may not be safely or continually provided from those sites, Detrimental impact to patient appointment and extension of waiting time.	3x3=9	3x3=9	Low	2x2=4	Safety (Primary) ,Delivery ,Reputation ,Financial ,	Trust Wide		Mehra, Benita	Ruggeri, Alessandro	Estates and Facilities Risk Action Group			
132	13/04/2018	Limited controls in place to maintain control of means of access to the building and within the building, may lead to inappropriate access being gained by third parties	3x3=9	3x3=9	Low	3x3=9	Safety (Primary) ,	Trust Wide		Mehra, Benita	Ruggeri, Alessandro	Estates and Facilities Risk Action Group			

		to the building or individual rooms within the building, resulting in theft or risk to safety of patients, students, staff or other members of the public													
133	13/04/2018	If the distribution of Estates On Call rests with a limited number of staff, in order to respond to out of hours incidents, then may be delays in responding to out of hours incidents and major incidents with an estates component, resulting in delays in remediation of the Estates component which may impact on available facilities and impact on delivery of services.	3x2=6	3x3=9	High	1x2=2	Delivery (Primary) ,	Trust Wide		Mehra, Benita	Stubbs, Jonathan	Estates and Facilities Risk Action Group			
144	13/04/2018	If inadequate procedural controls monitoring the performance of compliance	3x5=15	3x4=12	Low	3x4=12	Safety (Primary) ,Compliance/ Regulation ,	Trust Wide		Mehra, Benita	Ruggeri, Alessandro	Estates and Facilities Risk Action Group	10/02/2022	Frequency of review updated	

		checks related to Electricity safety, The Trust may not successfully identify gaps in compliance or poor process. Resulting in potential lapses or elevated risk of electrical safety related incident and / or poor response in the event of an incident including increased likelihood of personal injury.													
44	26/02/2019	If the comms team do not approve draft FOI responses within twenty working days responses will be delayed beyond statutory deadline and / or overall compliance rate drops, resulting in a possible fine or other action by the regulator (ICO).	5x2=10	5x2=10	Medium	1x1=1	Compliance/ Regulation (Primary) ,Financial ,Reputation ,	Corporate,Trust Wide	IM&T,Trust Wide	Noys, Terry	Endres, Frances	Gender Executive				

90	19/06/2019	If the Trust fails to deliver affordable and appropriate Estates solutions , there may be a significant negative impact on patient, staff and student experience , resulting in the possible need to reduce Trust activities and potentially resulting loss of organisational autonomy.	3x5=15	4x3=12	High	2x5=10	Delivery (Primary) ,Compliance/ Regulation ,Financial ,Safety ,	Trust Wide		Noys, Terry	Noys, Terry	Executive Management Team (EMT)	04/05/2021	Reviewed current risk and updated post meeting.	03/07/2021	The Trust has now got active engagement with NHSE/I and the NCL ICS. The Relocation project is also treated as a priority project within the NCL estates stream. However, NCL has not yet determined which projects will be formally supported and the bridging financing required for Relocation has not been identified. The Relocation project also assumes that a Registered Provider (yet to be identified) will provide some of the funding required. With regard to the TC itself, recent surveys have confirmed the potential fragility to the electrical systems in the building.

108	28/06/2019	If our data systems and processes do not provide reliable information in a consistent way, , it will be difficult to track progress and clinical and educational outcomes , resulting in poor delivery of regulatory demands, commissioning performance requirements and regulatory ratings.	4x2=8	3x3=9	Medium	2x2=4	Compliance/ Regulation (Primary) ,Reputation ,	Adult & Forensic Services (AFS),Children, Young Adults and Families (CYAF),Gender		Sinha, Dinesh	Hodges, Sally	Executive Management Team (EMT)	05/05/2021	The strategic review has provided a much clearer analysis of the issues and we will be using the change process to ensure that we are able improve confidence in data through improvements at all points in the data journey. Notwithstanding identified issues there have been significant improvement in understanding of gaps in the input, use and understanding of data. Data led discussions now inform various forums. There are cultural challenges as evident in timely data input onto Trust platforms, technical capability in collecting and using data in certain domains and fragmented ownership of data leading to	03/07/2021	Score increased to 9. We are making significant strategic decisions on data that we do not feel confident in unless we have completed a manual review. Data entry is a significant issue for us, and without being able to properly represent the work we do, we risk reputational and financial consequences .

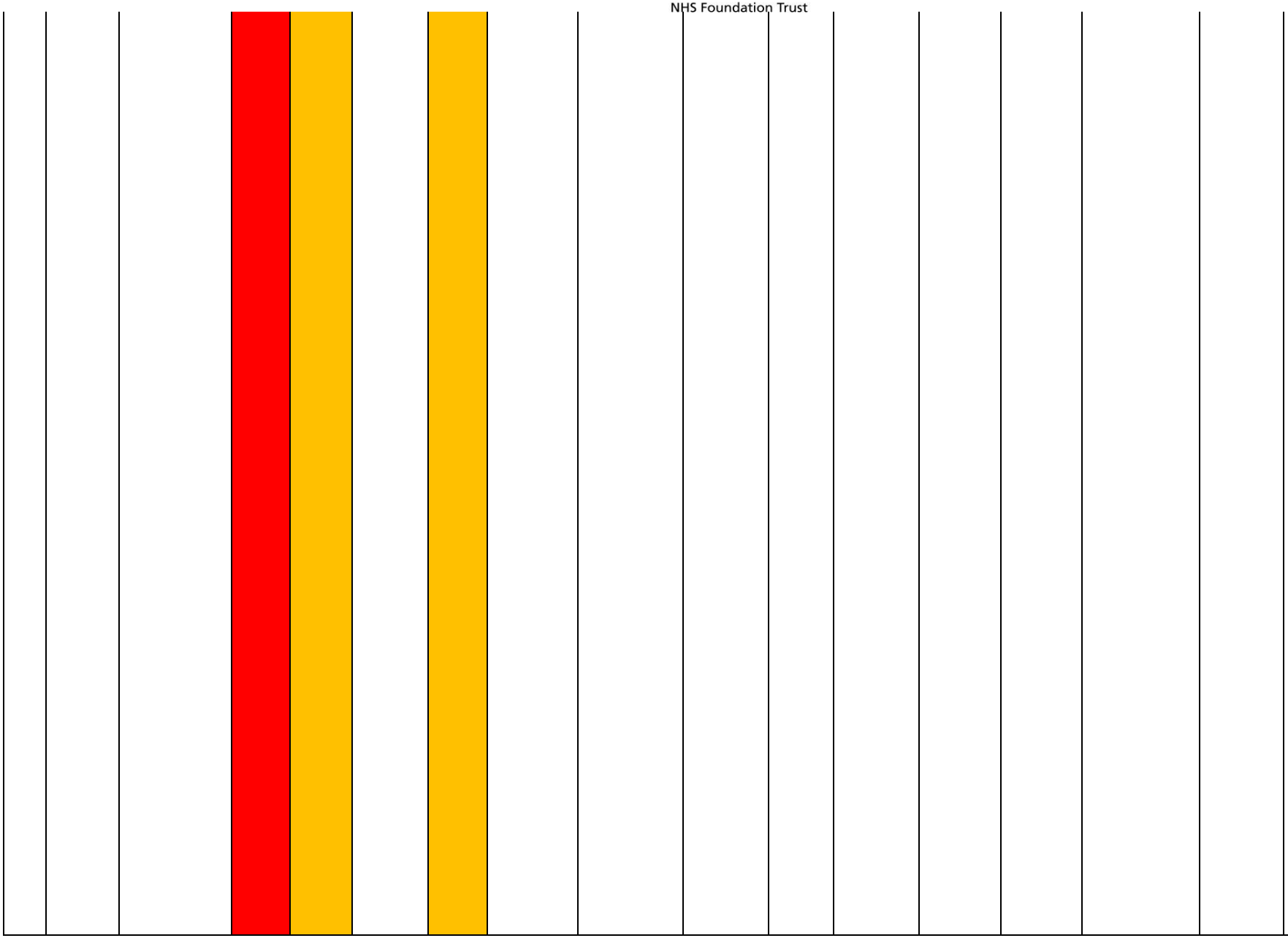
															confusion and lack of confidence. Work continues to improve structures and processes for easing input, use and understanding of data across our services. The Strategic review has already indicated possible interventions to reduce duplication and clearer ownership of data. We will continue our efforts to engage and empower staff in using data to achieve better outcomes in their interventions. SH update.		

87	01/07/2019	If we give inappropriate advice and there is a lack of on hand and up to date expertise on disability matters, then this could lead to Student complaints and possible legal action, financial loss, quality of care, safety reputation and regulator penalties and poor delivery.	3x3=9	3x3=9	Medium	2x3=6	Reputation (Primary) ,Delivery ,Financial ,Compliance/ Regulation ,	Department of Education & Training (DET)	Professional Services	Rock, Brian	Florish, Kara	DET Operational Managers Meeting	13/01/2022	Risk Rating remains the same. Having more accessible data would be helpful, and we are monitoring this. No update on phase 2 of the BI reporting platform. Essex PMB in February, and WF will include an agenda item to relay concerns to Essex. Systems and Processes work stream includes Disabilities as a process to focus on through a workshop.	04/05/2021	Risk levels need to remain as they are until Strategic review as unable to recruit additional resource and so cannot change current structure within the team around support. Student disability stakeholder meeting group has been created and will start to meet in May ahead of the 2021-22 academic year. MyTAP process has now been reviewed and amended to allow student to upload evidence earlier in the process- which should make response times quicker. This is now in use from May 2021. MyTAP report created to allow better oversite of data which

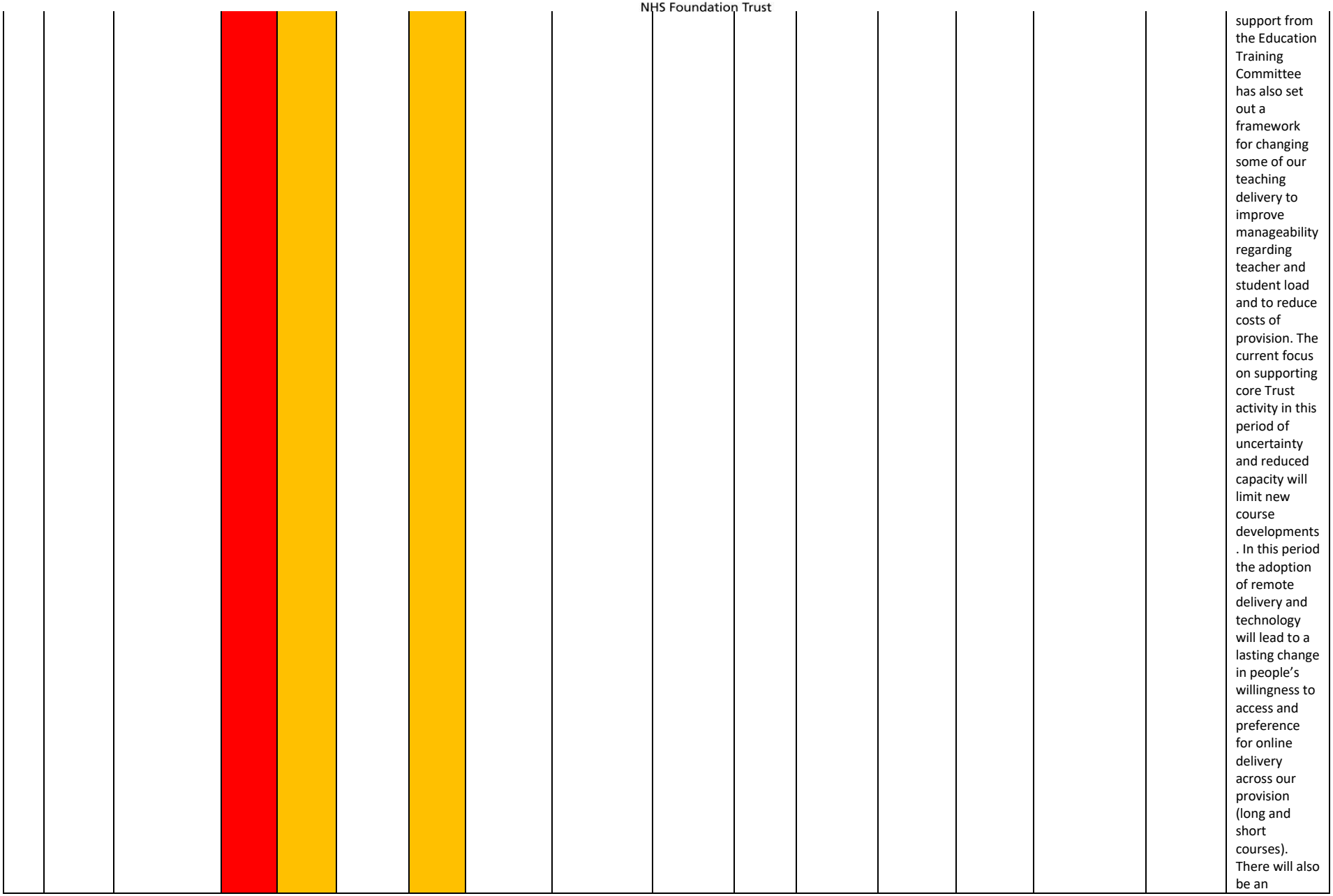
															will improve record keeping and ensuring all students supported. KF holding CPD sessions for faculty and DET staff for training and to address knowledge gaps. KF reviewed and updated disability SOP, including support for the DA, NCs and at interview stage. Disability timetable and documentation to new students form 2021-22 not yet started- will be the function of the new disability group to work on this.
103	01/07/2019	If the Trust fails to deliver the commitments of its risk equality strategy (RES) and the ambition to become an anti-racist organisation, there could be a negative	2x4=8	4x3=12	Medium	2x3=6	Reputation (Primary) ,Compliance/ Regulation ,Delivery ,	Trust Wide		Tegerdine, Ian	Tegerdine, Ian	Executive Management Team (EMT)	04/05/2021	Operational review update reviewed at EMT. Score remains 4.3=12	03/07/2021	The target score has increased from 4 (1x4) to 6 (2x3).

		impact on staff engagement , and as a consequence impact on the quality of services.													
105	01/07/2019	The risk that failure to develop a comprehensive and ambitious people strategy, will have a negative impact on staff morale and engagement , with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	3x4=12	3x4=12	High	2x3=6	Delivery (Primary) ,Safety ,Compliance/ Regulation ,	Trust Wide		Tegerdine, Ian	Tegerdine, Ian	Executive Management Team (EMT)	04/05/2021	Update by Operational Lead reviewed	03/07/2021	The current score remains at 12 owing to the lack of an in date comprehensive People and Organisational Development strategy and plan 'People Plan'.
109	01/07/2019	If wider financial pressures in North Central London in relation to the pandemic or finance are not appropriately addressed, there will be negative consequences for the delivery of the mental health programme in	3x4=12	4x4=16	Medium	3x3=9	Delivery (Primary) ,Reputation ,Financial ,	Trust Wide		Jenkins, Paul	Jenkins, Paul	Executive Management Team (EMT)	04/05/2021	Risks reviewed for 2021/22. Risk 109 closed.	28/01/2021	Risk was 3x4(12) until March 2020 when it increased to 4x4(16). November 2020 risk update: Wider financial pressure across the STP with increased disruption owing to COVID-19. A

		the ICS and on the delivery of the Trust's wider objectives, resulting in a reduction in mental health service provision and associated patient and staff impact.													significant amount of uncertainty remains. Trust Strategic Review focusing on financial and operational sustainability.
113	01/07/2019	If we are unable to develop and modernise the Trust's Education offering , it will have a negative impact on the sustainability of our education provision, and impact on the ability to deliver comprehensive clinical services	4x4=16	3x4=12	Medium	3x3=9	Financial (Primary) ,Delivery ,Reputation ,	Department of Education & Training (DET)		Rock, Brian	Rock, Brian	Executive Management Team (EMT)	04/05/2021	Risks reviewed for 2021/22. Risk 113 closed.	26/01/2021	Current risk score 3x4 = 12 for 2020. Risk migrated to electronic risk system 26 January 2021. Current commentary from November 2020 review. Progress is being made in the establishment of the Digital Academy following Board sign off and is on course to launch as planned. International development is being adversely impacted by COVID-19 though we continue to focus on communicating our offer and



developing potential partnerships, including the delivery of an international conference. We expect a dip in activity and income through FY20/21 but believe this position will be mitigated following a resolution to the spread of coronavirus. Delivery of term 3 has been successfully delivered with high rates of student satisfaction. Further work is underway to determine the delivery of AY20/21 building on the experience gained in this last period. Staff have worked very hard and the fatigue might contribute to difficulties considering changes for the year ahead. DET senior leadership team with



support from the Education Training Committee has also set out a framework for changing some of our teaching delivery to improve manageability regarding teacher and student load and to reduce costs of provision. The current focus on supporting core Trust activity in this period of uncertainty and reduced capacity will limit new course developments . In this period the adoption of remote delivery and technology will lead to a lasting change in people's willingness to access and preference for online delivery across our provision (long and short courses). There will also be an

																increase in our capability to deliver through remote means. The market will also become more crowded and competitive and therefore more sustainable development will require a longer period for more fundamental change. There is an opportunity to increase our reach beyond current geographical constraints. This has a longer time horizon aimed at AY21/22.
149	24/07/2019	If we cannot recruit appropriate staff we risk underperforming and not future-proofing our services, This can also then lead to unsupported patients and the inability to grow the service.	3x3=9	3x3=9	Medium	2x2=4	Delivery (Primary) ,	Gender	GIC	Endres, Frances	Cavalli, Carlo	Gender Executive				

146	25/07/2019	If, following the judicial review and CQC inspection, there is a sustained significant impact on workload, staff morale and retention, then it will be difficult to deliver required improvement and change needs, resulting in a negative impact on service delivery, reduced ability to meet patient needs and non-compliance with regulatory, legal and contractual requirements.	4x4=16	4x4=16	Medium	3x3=9	Delivery (Primary) ,Compliance/ Regulation ,Reputation ,	Gender		Swarbrick, Ailsa	Hughes, Kathleen	Gender Oversight Committee			08/07/2021	Risk level has increased from 16 to 20 following the Judicial Review and CQC inspection, and the impact of these on staff capacity and morale to deliver a challenging agenda.
147	25/07/2019	If delivery against the CQC waitlist action plan is not achieved , there may be an increased chance of a serious incident or increased anxiety and stress for young people on the waiting list, less	4x4=16	4x4=16	Low	2x4=8	Safety (Primary) ,Reputation ,Compliance/ Regulation ,	Gender	GIDS	Swarbrick, Ailsa	Hughes, Kathleen	Gender Oversight Committee			08/07/2021	There remain considerable capacity constraints in this service and until the CQC waitlist action plan work is embedded this risk will remain high.

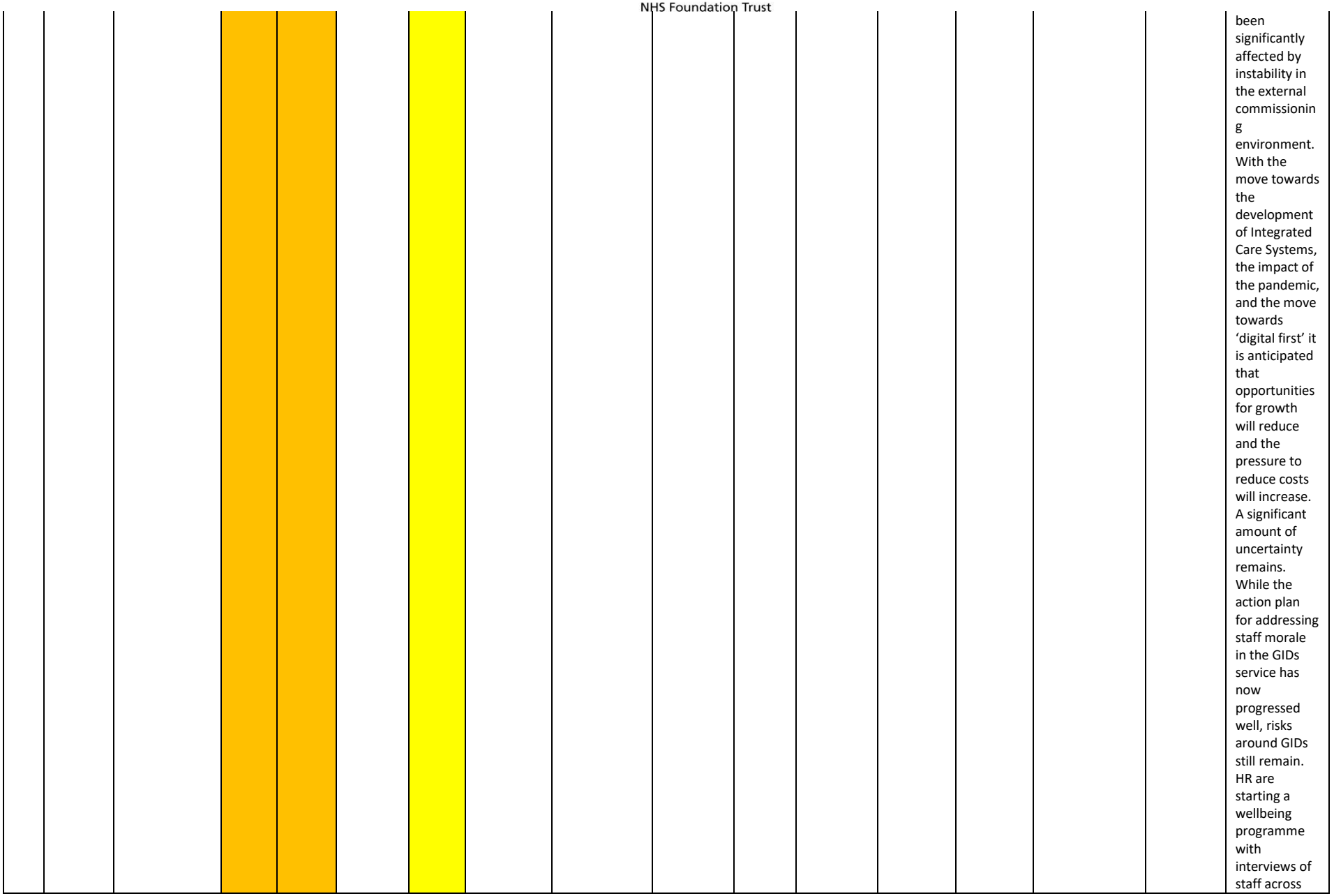
		available staff time to deliver and develop well managed services resulting in loss of service reputation and non-compliance with regulatory and contract requirements.													
82	14/10/2019	If personal data is accidentally or maliciously released outside terms of the Trust privacy policy or if personal data is not recorded or maintained accurately and this is challenged through a subject access request (SAR), or prevents effective delivery of a programme, then a reportable data breach may occur. A complaint may be lodged regarding the Trust's data handling processes, a course may not be delivered effectively, for	3x3=9	3x3=9	Low	2x3=6	Compliance/ Regulation (Primary) ,Delivery ,Financial ,Reputation ,	Department of Education & Training (DET)	Professional Services	Fitzmaurice, Will	Mills, Tim	DET Operational Managers Meeting	09/12/2021	Information Governance risk - should be owned by them - as trust wide risk.	09/12/2021	Information Governance risk - should be owned by them - as trust wide risk.

		example if a booking is lost and financial errors may occur, Resulting in a potential fine from the ICO, reputational damage and potential loss of business													
112	08/11/2019	If as a result of changes in the commissioning environment, and impact of the pandemic on funding and delivery models the Trust is unable to establish sustainable new income streams and adapt the current Trust service configuration, the Trust's service provision will be unsustainable in the long term, impacting on the viability of the services offered by the Trust.	3x3=9	4x4=16	Significant	2x4=8	Financial (Primary) ,Delivery ,	Trust Wide		Jenkins, Paul	Jenkins, Paul	Executive Management Team (EMT)	04/05/2021	Risks reviewed for 2021/22. Risk 112 closed.	25/01/2021	Current risk score moved to 4x4 in May 2020. November 2020 update information migrated from BAF.

159	04/02/2020	If there is not an alarm system installed at FDAC for staff to use in session, then staff cannot get support to manage clients in sessions if it is needed , resulting in staff and clients being unsafe while being seen in the service	3x3=9	3x3=9	Low	1x3=3	Safety (Primary) ,	Children, Young Adults and Families (CYAF)	Vulnerable Children	James, Rachel	Williams, Pauline	Executive Management Team (EMT)	16/11/2021	FDAC have confirmed that the Green button is operational in the service. it has been agreed for a regular operational system test. SB to liaise with FDAC management team to ensure quarterly review and test processes are in place and ensure appropriate record keeping is in place and accessible register for Exec Team. PW to ask LT for a standard form for monitoring equipment with regular frequency.	16/11/2021	FDAC have confirmed that the Green button is operational in the service. it has been agreed for a regular operational system test. SB to liaise with FDAC management team to ensure quarterly review and test processes are in place and ensure appropriate record keeping is in place and accessible register for Exec Team. PW to ask LT for a standard form for monitoring equipment with regular frequency.
151	17/03/2020	If COVID-19 pandemic is not appropriately managed, exposure to the virus through contact may also result in staff and patients becoming ill, resulting in disruption to	5x4=20	3x3=9	High	2x2=4	Delivery (Primary) ,Compliance/ Regulation ,Safety ,	Trust Wide		Sinha, Dinesh	Tucker, Lisa	Executive Management Team (EMT)	23/03/2021	Reviewed in advance of risk going to March Board as part of the Operational Risks paper. Noted risk level has reduced from 20 to 16 as a result of actions being in place, but remains high.	08/07/2021	The Trust has ensured a number of continuing changes in practice in the delivery of face to face services and to manage the risk form the ongoing pandemic. This includes a full set of

		service delivery, non-compliance with contract requirements and possible serious health impacts.													SOPs across our services, which have been adjusted in response to waves of the pandemic and IPC guidance. These include details of applicable measures including PPE, social distancing etc. A number of measures to manage our estates, governance and welfare have been implemented across all Trust sites
110	05/05/2020	If ongoing pressure on the GIDS service affects staff morale , it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of covid-19, resulting in poor service delivery and non compliance with contract requirements	3x4=12	3x4=12	Medium	2x4=8	Delivery (Primary) ,Compliance/ Regulation ,Reputation ,Financial ,	Gender	GIDS	Hodges, Sally	Swarbrick, Ailsa	Executive Management Team (EMT)	04/05/2021	Risks reviewed for 2021/22. Risk 110 closed.	28/01/2021	Risk score 3x4 (12) - unchanged from first identification May 2020. Transferred to electronic register 28 Jan 2021. November 2020 update follows: The Trust has a strong record of good financial performance which has allowed it to maintain the quality and safety of our patient and education

																services. This has been achieved each year through a combination of modest cost improvement programmes; new income generation through the development of new courses and services; and annual contract activity uplifts. However whilst the organisation's overall financial position has been balanced, there is significant variation between services which has been exacerbated by a number of contract losses. In addition, costs have been incurred to support development and infrastructure work, and contribution from new business has



																been significantly affected by instability in the external commissioning environment. With the move towards the development of Integrated Care Systems, the impact of the pandemic, and the move towards 'digital first' it is anticipated that opportunities for growth will reduce and the pressure to reduce costs will increase. A significant amount of uncertainty remains. While the action plan for addressing staff morale in the GIDs service has now progressed well, risks around GIDs still remain. HR are starting a wellbeing programme with interviews of staff across

															the service, in order to develop appropriate wellbeing improvement plans.
88	15/10/2020	If student placements are not adequately recorded in the department as a result of poor administrative practices, then this could impact on the safety of trainees and patients and quality of training, resulting in trainee or patient harm and reputational damage	3x3=9	3x3=9	Medium	2x4=8	Reputation (Primary) ,Safety ,	Department of Education & Training (DET)	Professional Services	Fitzmaurice, Will	Bratt, Isabelle	DET Operational Managers Meeting	13/01/2022	SITS developments pushed back to next financial year. In the meantime, course administration are prioritising updating current records in relation the placements.		

158	12/11/2020	If teams do not manage their waiting times in a clear and consistent way, patients are not allocated promptly for treatment, resulting in longer waits for treatment in some teams. We cannot accurately report on waiting times for specific treatments, Inequalities of access. Damage to reputation by being unable to provide data.	3x3=9	3x3=9	Medium	1x3=3	Delivery (Primary) ,Financial ,	Adult & Forensic Services (AFS),Children, Young Adults and Families (CYAF)	AFS service wide,CYAF service wide	Kent, Tim	Horner, Aaron	Executive Management Team (EMT)	16/11/2021	There is a Trust wide draft SOP for referrals with a wait longer that 52 weeks requiring a Harm Review this needs to be signed off by the board with consideration locally and Trust wide. Internal waits - work is underway to enable treatment waiting lists to be managed using Carenotes reporting rather than excel spreadsheets. This will increase visibility of waiting times and enable greater levels of decision making across clinical teams to reduce inequalities of access.	16/11/2021	There is a Trust wide draft SOP for referrals with a wait longer that 52 weeks requiring a Harm Review this needs to be signed off by the board with consideration locally and Trust wide. Internal waits - work is underway to enable treatment waiting lists to be managed using Carenotes reporting rather than excel spreadsheets. This will increase visibility of waiting times and enable greater levels of decision making across clinical teams to reduce inequalities of access.

155	22/03/2021	If GIC waitlists continue to grow, there may be an increased chance of a serious incident or increased anxiety and stress for patients on the waiting list and less available staff time to deliver and develop well managed services, resulting in loss of service reputation and non-compliance with regulatory and contract requirements.	4x4=16	4x4=16	Low	2x4=8	Safety (Primary) ,Compliance/ Regulation ,	Gender	GIC	Swarbrick, Ailsa	Endres, Frances	Gender Executive	25/03/2021	Discussed in Gender Executive meeting, continue to monitor inline with other GIC's also awaiting outcome of waiting list consultants recommendations	08/07/2021	The risk is very real and sadly, we have lost a patient on the waiting list in this past quarter to suicide. We continue to develop our new screening process and are working with Comms to develop a programme of communications that will come from the clinic to the waiting list at regular intervals. The Gender services have also started conversation with voluntary organisations in order to explore further WL support.
156	########	Inability to resolve the staffing and workflow can result in jeopardising the contract and patient safety risks.	3x4=12	3x4=12			Safety (Primary) ,	Children, Young Adults and Families (CYAF)	Vulnerable Children		James, Rachel				

187	01/04/2021	Insufficient management and leadership capacity, along with a focus on internal structural / business process improvements , may lead to the inability to meet regulatory requirements , resulting in commissioner and regulator sanction and reputational impact.	3x3=9	3x3=9	Medium	2x2=4	Compliance/ Regulation (Primary) ,Reputation ,	Trust Wide		Sinha, Dinesh	Shipman, Marion	Executive Management Team (EMT)			
189	01/04/2021	Is, as a result of not sufficiently adapting our current provision to meet learner requirements and demand, and not developing sufficient new programmes (themes and approach), we will not leverage potential growth, reach and impact, impacting on the sustainability and relevance of our educational services.	3x3=9	3x3=9		2x3=6	Financial (Primary) ,Delivery ,	Department of Education & Training (DET)		Rock, Brian	Fitzmaurice, Will	Executive Management Team (EMT)			

190	01/04/2021	If we fail to adapt the delivery of our services and programmes sufficiently, and respond more quickly to new opportunities, then we will not be a position to benefit from growth, and will be at risk of becoming unsustainable.	4x4=16	4x4=16	Significant	2x3=6	Financial (Primary) ,Reputation ,	Trust Wide		Jenkins, Paul	Hawke, Amanda	Executive Management Team (EMT)	08/06/2021	Reviewed at EMT. No change to commentary or risk score.	03/07/2021	No update to commentary or change in risk score
166	23/04/2021	If no approach is agreed on requirements for mandatory training for Visiting Lecturers (VLs), We will be unable to confirm to our VLs the training they are required to complete in order to fulfil their role; therefore training will not be undertaken. The impact would be non-compliance with training on statutory areas such as information and data governance and safeguarding. Without	3x4=12	3x4=12	Low	1x4=4	Compliance/ Regulation (Primary) ,Safety ,	Department of Education & Training (DET)	Professional Services	Rock, Brian	Fitzmaurice, Will					

		completing the required training, VL's would also risk being unable to carry out their full range of duties effectively.													
185	04/05/2021	If the strategic review is not managed well, it may fail to deliver a sustainable financial and operational model , impacting negatively on the safety and effectiveness of our current work.	3x5=15	3x5=15	High	2x5=10	Delivery (Primary) ,Safety ,Financial ,Reputation ,Compliance/ Regulation ,	Trust Wide		Jenkins, Paul	Stacey, Julia	Executive Management Team (EMT)	08/06/2021	Reviewed EMT - no change to commentary or score	03/07/2021	No change to score or commentary
186	04/05/2021	If, in our efforts to modernise our internal processes and address the required change we are not able to prioritise attention to the staff who are our key to our future success, we risk losing them from the organisation, and jeopardising our future strategy.	4x4=16	4x4=16	High	3x4=12	Delivery (Primary) ,Reputation ,Compliance/ Regulation ,	Trust Wide		Tegerdine, Ian	Dean, Lisa	Executive Management Team (EMT)	08/06/2021	Reviewed at EMT - no change to score or commentary	03/07/2021	No change to score or commentary

179	06/05/2021	If as a result of low staff morale there is an increase in the number of staff leaving the service , then the staffing level could become too low to manage the school safely, resulting in a failure to achieve 'Good' in the upcoming Ofsted inspection, which is necessary for the continued operation of the school.	4x3=12	4x3=12	Low	2x2=4	Compliance/ Regulation (Primary) ,Reputation ,Safety ,Delivery ,	Children, Young Adults and Families (CYAF)	Gloucester House Day Unit	Nicholson, Nell	Kidd, Louise					
170	13/05/2021	In-building audio-visual support requirements from the Trust disrupt the complex preparations for lift and shift, which means students will not receive the training they have paid for , resulting in an increase in student complaints, an impact on the Trust's ability to provide training and punitive measures	4x4=16	4x4=16			Reputation (Primary) ,Compliance/ Regulation ,Financial ,	Department of Education & Training (DET)	Professional Services		Fitzmaurice, Will					

		instituted by the OfS.													
183	25/06/2021	If the critical & high risks identified in the assessment are not addressed in a timely way, The trust may not meet the robust level of cyber security required , would impact the trusts cyber security	3x3=9	3x3=9		1x3=3	Compliance/ Regulation (Primary) ,	Corporate	IM&T	Akram, Muhammad	Williamson, Linda	IM&T Risk Action Group				
222	07/03/2022	If there is an increase in referrals to the GDRSS and the admin team for Arden & GEM does not having enough capacity to process all of the referral and run the reports (staffing issues at Arden & GEM causing capacity problems with processing the referrals and reports), then NHSE, Arden & GEM and GIDS will not have an	3x3=9	3x3=9			Delivery (Primary) ,Reputation ,	Gender	GIDS		Harvey, Edward					

		accurate picture of the number of referrals and YP waiting in the GDRSS-GIDS cannot update or assure the CQC of the number of YP being held by the NHSE GDRSS- , resulting in GIDS being unable to update the CQC and provide assurance on the change in referrals numbers, rejections and total waiting list at the service. This has a reputational impact for all parties including GIDS. Please note the responsibility for patient safety sits with NHSE and Arden & GEM for any referral and YP held with the GDRSS.														

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	29 March 2022

Trust anti-racist statement

Executive Summary

From the Race Action Plan, approved by the Board in January:

Objective 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

- **2.1.2**: The statement to be approved by the Board in March 2022.

Recommendation to the Board

The Board of Directors approve the following anti-racist statement.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Head of Communications	Ian Tegerdine, Acting HR Director

Trust anti-racist statement

We commit to becoming an anti-racist organisation.

We aspire to provide an inclusive, equitable and welcoming environment to all people who work, study and receive care with us.

We want our staff group to reflect the diverse mix of ethnic minority backgrounds of the people we support, and to create and sustain a culture that creates pathways to leadership and encourages career progression among staff from ethnic groups minoritised in the UK.

We acknowledge that our Trust has a long way to go to become a fully diverse and inclusive organisation, and that there are systemic and cultural barriers that stand in the way of providing equitable healthcare and working and learning environments.

We therefore commit to undertake a programme of practical actions to improve racial equality at our Trust. These actions will support seven key objectives:

- **Objective 1:** Create an inclusive culture that promotes respect at all levels and fosters a sense of belonging among all staff
- **Objective 2:** 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
- **Objective 3:** Increase the diversity of the workforce and support the career progression of staff from Black, Asian and UK ethnic minority groups
- **Objective 4:** Remove barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination
- **Objective 5:** Increase engagement and communicate progress on racial equality across all levels of the Trust, in particular to publicly acknowledge to staff the findings of racial inclusion barriers, racist behaviours, and lack of diversity
- **Objective 6:** Extend the use of EDI data to monitor and improve race equality in the Trust
- **Objective 7:** Embed responsibility for racial equality at all management and administrative levels of the Trust, and provide appropriate EDI support, training and guidance

We commit to being transparent and holding ourselves to account as we work towards these objectives, and to sharing our learning with others.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	29th March 2022

Committee Chair Report:
People, Organisational Development, Equality, Diversity, and Inclusion Committee (POD EDI)

Executive Summary

The POD EDI Committee met for the first time on 14th March 2022. It is subject to formal authorisation by the Board as part of the Governance task and finish group work.

The Trust EDI committee has been formally disbanded and its work and responsibilities have become part of the POD EDI Committee. The agenda of the POD EDI Committee has a standing EDI section.

- **Terms of Reference**: The committee discussed its draft Terms of Reference. These will now be reworked for formal Board sign off in May.

  Key issues:
  - The involvement, or not, of **service user representatives** in this committee. It was agreed to request the Governance task and finish group be asked to consider the appropriate place for development and scrutiny of the wider educational and clinical service EDI strategy and plan;
  - The **diversity of the committee**: is it diverse enough and if not, how can we bring in diverse voices? IJT will research how other Trusts have done this for discussion at the next meeting.

- **Staff Survey:** The Committee received a presentation on the 2020 staff survey and agreed (a) the seven themes for action proposed and (b) the actions would be incorporated into the Trust People Plan (due to be presented to May Board).

- **Freedom to Speak Up report**: The Freedom to Speak up Guardian did not give the scheduled report to the POD EDI committee, as this was

due at the March Board. The schedule for future FTSUG reports and their presentation to Board remains to be agreed (with the Board NED FTSU sponsor and the Governance task and finish group).

- **Race Equality Strategy (RES) and Race Action plan (RAP):** these have been signed off by the Board and oversight has now been taken on by the POD EDI committee.
    - The narrative report from the outgoing EDI lead summarised the seven RES objectives and gave them a RAG rating: one was graded Red, three Amber and three Green.
    - The Committee noted the eight-week gap in EDI leadership and resourcing of the RES and RAP work due to the retirement of the EDI lead and start date and induction time of the new EDI lead
    - **The Board should note that this may result in a delay in the three year RES and RAP implementation plan of up to three months.**

- **EDI Strategy**: The committee requested that the draft EDI strategy and Plan (which is currently with the Staff Diversity networks for feedback) be brought to the next POD EDI committee meeting in May.

- **Network reports**: The LGBTQI+ network champion and the Trans staff associate Champion had sent in a report but neither was able to attend the meeting. It was agreed to hold the report over to the next POD EDI meeting to enable their attendance and have full discussion of their proposals, with them.

- **Reflection:** The committee reflected on its first meeting and reviewed its structure, papers and effectiveness for future working. It articulated what had gone well and what to improve next time. It was agreed that papers should be consistently prepared across all committees and the means to achieve this should be raised at the Governance task and finish group.

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

- *Disability Champion Report*
- *HR Recruitment processes & checks*
- *'Speaking up' / 'Dispute resolution' /'Retributive Justice' approaches.*
- *Employee Relations activity*
- *Workforce metrics dashboard*
- *EDI/ RES strategy and plan regular report*
- *People strategy and plan*
- *EDI Strategy and Plan*
- *BAF Risks remitted to this committee*

Recommendation to the Board

The Board of Directors are asked to:

- **Note the following:**
  - the progress on establishment of this committee
  - progress on the RES and RAP; delay to the implementation timeline
  - development work underway on the EDI strategy and Plan
  - the approach to the LGBTQI+ champion report
  - the planned agenda for the May meeting of the POD EDI committee
- **Remit:**
  - the issue of service user engagement and wider Educational and Service EDI strategy and plan to the Governance task and finish group
  - the standardisation of papers to the Governance task and finish group
  - the treatment of FTSUG reports to the Board the FTSU sponsor and POD EDI committee Chair to agree
- **Confirm:**

- The Committee's agreement on the staff survey seven actions/action plan for inclusion in the People Plan
- The POD EDI Committee ToR
- The process for formal adoption of the POD EDI Committee.

Trust strategic objectives supported by this paper
(2021/ 2022) Corporate Objectives /Associated BAF risks: ObJ 1,/ Risk ref 186(2) Obj 4, / Risk ref 187(4) / Obj 9, / Risk ref 103(9) Obj 10 / Risk ref 105 9 (10) (See below in full for ref)
Author Shalini Sequeira — Chair POD EDI Committee Ian Tegerdine — Acting Director of Human Resources

Relevant Corp Objectives and BAF risks

Corporate objective 1: To identify and implement a set of changes through the Strategic Review which support the financial and operational sustainability of the Trust

BAF risk ref: 186(2) If, in our efforts to modernise our internal processes and address the required culture change we are not able to prioritise attention to the staff who are key to our future success we risk losing them from the organisation and jeopardising our future strategy.

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

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

Corporate objective 9 To set a clear direction for the Trust as an anti-racist organisation with key supporting actions

BAF risk ref 103 (9). The risk that the Trust fails to deliver the commitments of its race equality strategy (RES) and the ambition to become an anti-racist organisation with a negative impact on staff engagement and the quality of its services.

Corporate objective 10 Develop a People Strategy for the Trust with a focus on future workforce needs and addressing staff engagement, welfare and morale.

BAF risk ref 105 (10) The risk that failure to develop a comprehensive and ambitious people strategy will have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Board of Directors
Report from	Education & Training Committee – 03 March 2022

Key items to note

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

The situation in Ukraine
The Committee received an update on the response to the troubling situation in Ukraine, including the communications sent to the Trust's student body, which have been well-received. The Committee noted that the Trust has identified 4 Russian nationals, and 2 Ukrainian nationals, within our long course provision, who are all UK domiciled.

Recruitment for Academic Year 2022-23
The Committee noted the high-level number around application and interest in our programmes, but a slowing of applications in the pipeline. There have been delays in processing applications, in part due to the strategic review and changes/potential changes in staffing within course teams. The recruitment group continue to have oversight of this and are managing delays with input from portfolio managers and associate deans.

To further update, the Trust held it's second Open Day of the cycle on 5th March. There were over 420 visitors across all the sessions and an increase in the number of applications started or submitted after the event. The Committee will continue to receive regular updates from the Recruitment Group as the recruitment cycle continues.

Strategic Review
The Committee discussed the considerable engagement and feedback from within the directorate with the strategic review consultation. The Committee received assurances in relation to the processing of responding to queries and responses. The committee noted the concerns of staff around the process and timescales, and the anxiety created by the uncertainty, and the need to be transparent around decision making when presenting the final proposals.

Return to the building
The Committee noted the ongoing work to return to fuller face to face delivery in the summer term, within the limitations of the Trust estate (room size, social distancing, and ongoing IPC). The Committee received on update on the work of the working group and noted the involvement of student representatives. This group is considering all aspects of face-to-face delivery, and involves colleagues from IMT and Estates, to ensure a joined-up approach. The Committee noted the variability of feedback from different cohorts of students to the current hybrid approach, which poses challenges in finding an approach to meet the needs of all cohorts.

Media Incident
The Committee received assurance in relation to the media incident.

Partnership with the University of Essex
The Committee received an update on the development of a course by the university that potentially constitutes a breach of intellectual property. The Committee was assured that this issue had been escalated to the Registrar/Vice Chancellor at the university, and that we will be seeking assurance that the Trust understands how this has happened, and the implications of the development. The Committee discussed the risks associated with partnerships and the need for these to be reflected within the Risk Register.

HESA returns from 2019/20
The Committee received assurances that the errors highlighted in the Trust's HESA returns from 2019/20 had been investigated, and an action plan put in place to prevent these occurring again.

Annual Student Survey Overview Report
The Committee received the full overview report of the Annual Student Survey from annual year 2020-21 and considered the recommendations. The Committee reflected on those recommendations that had been raised before, in particular around engagement with students and responsiveness to feedback, and the need to consider wider initiatives in relation to the student voice. There was a discussion about the difference in satisfaction level between Trust courses and validated provision and the difference in governance arrangements and a quality assurance framework for these courses, which needs to be addressed. There was a clear steer to reduce the number of questions in the survey and to consider other sources of student feedback across the academic cycle. This will include consideration of a key recommendation from the recent governance review for a forum for students in relation to ETC.

Governance: Quality Report and next steps
The Committee noted the development of an annual Quality Report, which would provide assurance to this Committee and the Board of Directors. The Committee will be receiving a fuller draft in May, and will update the Board thereafter. The Committee noted the link to the governance task and finish group, particularly in terms of agreeing frequency of reporting on quality to ensure assurance.

Digital Academy Performance
The Committee received an update on the performance of the Digital Academy over the past 17 months and noted that it had met or exceeded the majority of it's Key Performance Indicators, generating £295k in revenue and having delivered over 500 courses. The Committee noted the need to review the relationship with Pearson, as the contract will be coming to an end in November 2022, and considered three options for the partnership, including revenue share, which is Pearson's traditional model.

Risk Management in DET
The Committee was updated on a Trust wide working group which is exploring how reports are generated from the Quality Portal and looking to share learning across directorates. The Committee noted the work being undertaken to consider and identify risks within portfolios, and strategic risks, including partnerships.

The Tavistock and Portman
NHS Foundation Trust

Actions required of the Board of Directors	
The Board of Directors is asked to note this paper.	
Report from	David Levenson
Report author	Brian Rock, Director of Education & Training/ Dean of Postgraduate Studies
Date of next meeting	05 May 2022

Integrated Governance Committee (IGC)

Minutes of the committee meeting on Wednesday, 16th February 2022

Members	Present?
Dinesh Sinha, Medical Director (Chair) (DS)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	N
Aruna Mehta, Non-Executive Director (AM)	Y
Debbie Colson, Non-Executive Director (DC)	Y
David Levenson, Non-Executive Director (DL)	N
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
Sally Hodges, Chief Clinical Operating Officer (SH)	N
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
Rachel James, CYAF Director (RJ)	N
Elisa Reyes Simpson, Deputy Director of Education and Training / Associate Dean, Academic Governance & Quality Assurance for DET (ERS)	N
Ian Tegerdine, Interim Director of HR (ITe)	Y
Leticia Cestari, Clinical Governance Lead for Adult Forensic Services (AFS) (LC)	N
Benita Mehra, Estates Consultant (BM)	N
Eilis Kennedy, Director of Research and Development (EK)	N
Kathy Elliott, Lead Governor in the Council of Governors (KE)	Y
Hector Bayayi, Gender Services Director (HB)	N
Steve Bambrough, Associate Clinical Director Children, Young Adult & Families Department (SB)	Y
Emma Casey, Interim Associate Director Quality & Governance (EC)	Y
Deirdre Malone, Associate Director for Quality, North Central London CCG (DM)	Y
Clinical Governance and Quality Manager (vacant role)	N

SUMMARY OF ACTION POINTS				
AP	**Item**	**Action**	**By**	**Due**
3	2	It was agreed that the updates to the latest CQC action plan will be circulated to the board seminar.	DS	25 Feb 2022
4	5	EK to ensure the report also contains a copy of the lay summary of the research undertaken.	EK	No date set

1	1.1	**Chair's opening remarks** DS welcomed all members to the IGC meeting. DC noted there were no papers for Gender services and DET service, and no update available from the Ops Board. It was noted that this would be the last meeting of the IGC due to the Trust's committee restructure from April 2022.	
	1.2	**Attendance** Apologies noted as per above.	
2	2.1	**Minutes and actions from November IGC meeting**	
		4.6. ITe to circulate report and all to please email questions, comments or challenges directly to ITe or DS.	
		No robust dashboard in place yet. Following the governance review there will be a new board for the people's committee which will also hold responsibility for the existing role of the board EDI committee and there will be at least another NED on the committee. The ToR is in draft and the first meeting will be in March. The committee that replaces the IGC from April 2022 will receive a copy of the meeting notes from the new committee, as a reference.	
1	1.3	**Changes in Committee Structures**	
		Governance review paper circulated. As part of the review there were a set of recommendations. This committee will change its structure and name and this is the final meeting in the current format. AM would like to see patients safety in the new title, as part of the new structure. PJ – in respect to this committee the new structure will be bringing quality, performance and finance together in service of patients and also the requirement for a shift in the level of discussions in committee and building on the work from QRM. AM- since this committee won't exist anymore in its current format the people's committee minutes will more likely not come to this forum anymore and maybe to the board meeting instead. TK would like each of the new service lines to have a similar clinical governance committee structure that has ToRs and SOPs more or less identical. Members are in agreement, this is an opportunity to ensure the governance is set up correctly throughout the Trust. It is important to work out how the communications will function within the new structure to ensure people in teams feel more connected to what is going on without having to attend so many meetings. The governance structure paper mentions the importance of having discussion about risk at every meeting, we need to make sure this is done in a streamlined way and also to try to have a bit of time at the end of each meeting to reflect on best practice. DM agreed, this is a good opportunity to try to have a cohesive way on how we review and utilise the information from reports to achieve desired outcomes.	

3		**Standing Item Updates**	
	3.1	**Covid-19 vaccine** DS provided an update on the current situation: the IPC plan is looked at regularly as we try to respond to internal pressures, not just clinical but also education. Students are pushing for more face to face activities and increasingly the service users seem unwilling to keep to our IPC restrictions. This is still very much ongoing while at the same time we try to keep aligned with the rest of the NCL.	
	3.2	**CQC Update** We are facing a degree of risk in terms of overall context, exacerbated by recent events, such as the Governance review in HSJ, the strategic review and the ICO fine noted in documents circulated. The Trust is still preparing for an imminent CQC inspection. The Trust has set up a CQC preparation group which seems to be working as intended and in the next couple of weeks there will be a cycle of mock inspection for a service in each division. Divisions are encouraged to do their own internal reviews as well. We provide monthly updates on the GIDS actions and two weekly updates to EMT for the trust level action plan. The third quality summit for the GIDS service will take place in March and this is hosted by the CQC and attended by various stakeholders. CMK specified that as part of the mock inspections there are three planned and EC put together a guidance document which has been shared with divisional directors who can used it to undertake their own service mock inspections. The key thing is the learning that comes out of this and how we share it. Another important thing is to make sure that the issues that came up in previous CQC inspections are not replicated. There is an external consultant who works with the CQC and who is helping the Trust prepare for the inspection. DC – really important to look at the last CQC inspections of the whole Trust and also GIDS service to make sure all the actions have been addressed. AM – where do we get assurance around the GIDS actions re: CQC inadequate rating. DS stated that one of the plans in the committee restructure is that the gender oversight committee where the action plan reports and is reviewed every two weeks gets linked up with the resetting of the committee structure. It was agreed that the updates to the latest CQC action plan will be circulated to the board seminar. ITe left the meeting.	DS
	3.3	**Clinical Services Operations Delivery Board Update** No updates and no summary submitted to this meeting.	
	3.4	**Gender Services** No gender services representative in attendance and no report submitted. DS noted some updates: • The mock session for the third quality summit is taking place next month and the challenge from NHSEI is to say we talked about framework structures and principles of doing the work and what results did we get from this in terms of data. The challenge for us has been that the condition on our licence is the waiting times and this has been very	

		difficult to resolve. The current pathway for GIDS is still very challenging with long waiting lists. The trust is working very closely with NHSEI who have been responsive and have set up a referral management service, and there will also be a professional support hub which has been delayed • The NHSEI is undertaking a review of the entire gender service led by Hilary Cass. The trust is expected to match the proposed recommendations. • There are issues with the current referrals for endocrine treatment for gender patients under 16 years because of complications as a result of requirements set up by the Multi Professional Review Group (MPRG) who look at the referrals and agree if patient is to go for endocrine treatment or not. The main issue has been that we were asked by NHSEI to do a full check on each case in terms of safeguarding, regardless of whether there have been concerns or not. The NHSEI confirmed that they want these before MPRG accept patient for endocrine treatment. PJ noted that we will have to set some expectations that we will make meaningful progress against some of the basics that we flagged up and that we have a recovery plan that is sufficiently robust in terms of how we are going to improve the service and make some impact in terms of waiting lists. DC – there is more demand on the individual patient than it was before, an increased referral rate as well as the external pressures on gender issues. AM – do we plan to have an integrated performance report coming to this committee going forward? DS confirmed that this is a gap.	
	3.5	**Surrey Updates** No updates submitted.	
	3.6	**Education and Training Update** No updates submitted.	
4		**SUB-COMMITTEE REPORTS**	
4	**3**	**Patient Experience & Quality Care Sub-Committee** *Chris Caldwell, Director of Nursing covering Quality and Patient Experience*	
		CC presented the report: • At the last two meetings there was much focus on patient complaints backlog. Amanda Hawke, the complaints manager created an action plan and also a chart as per circulated report. The team feel more confident they can address the backlog and think differently about how to manage complaints. The rag rating for this remains amber. • The other item with much focus was 21/22 Quality Priorities. There hasn't been a clinical governance and quality manager for some time and no report submitted either but Emma and Alina shared progress. Things are on track. • The final item highlighted is the issue of communication with patients as per PALS notifications and discussions at trust forums. There is some work being done to think about how we standardise the way we code complaints and PALS and presentations so we can compare across the organisation. • We had a dip in responses on the experience of service questionnaires, this will be monitored across Q4	

		• The overall assurance rating is amber. CC confirmed that the action plan is based on the data received quarterly which is then discussed at various meetings where an action plan is being decided. Some of the members of the IGC are in the sub-committee where the data is discussed. AM noted that it is important for this meeting to have oversight over the data as well. CC left the meeting.	
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: • High level of incoming FOI • ICO Notice of Intent – a response has been sent on Monday and we are awaiting a reply • As a result of this particular ICO we are in the process of implementing new secure controls around how we pass information around the Trust • The new NHSX Records Management Code of Practice introduces additional requirements for records management that will require changes in practice and additional resources, including in the protection of transgender patient records. There are outstanding actions being implemented in this respect that followed an ICO complaint regarding processing of deadnames. DM – in relation to the FOI and SARs – how does the Trust plan to manage this risk and what resource it takes to safely manage it? JR – in the last report there were some plans highlighted, new software for example, some changes implemented to how we process the information. Under the strategic review the proposed way forward regarding FOIs and SARs is to consolidate the team responsible for information governance under a new directorate. This will allow for more resource and more senior input and a quicker resolution. TN noted that a report will go to the board of directors for the March meeting. At the beginning of the year there were 12 FOIs all in one go and the Trust did seek legal advice as they were considered to be vexatious. Some were requested by people who were not using their real names and this is not part of the FOI standard procedure. TK- from experience most of the time it doesn't seem to improve patient experience. It is very important to only write what is necessary and to be brief and objective. It was noted that we are increasingly being asked to share data within our records and as a result we need to ensure the notes are clear and appropriate.	
4	**2**	**Patient Safety and Clinical Risk Sub-Committee** *Caroline McKenna, Patient Safety and Clinical Risk Lead*	
		CMcK introduced the report with rating of amber and highlighted the following: • In Q3 we reported many patient deaths but they did not take place in Q3. They were picked up via spine report; this has been rectified and should not occur in Q4 • Non clinical incidents are down compared to previous quarter • Serious incidents reports- 2 outstanding reports	

		• Safeguarding metrics – supervision in relation to child protection plan is down by quite a lot • Report on the National Child Mortality Database – very important document and is something we have to think about as a Trust There was discussion around the two incidents involving medicine prescribing. It was confirmed that both cases were picked up by pharmacists. We do not have electronic prescribing which presents as a risk. As an action following the incidents there is a plan in place. Discussion around safeguarding supervision for child protection plan cases. Some reasons as to why figures have gone down so much might be stress, not interacting one to one with the patient, resources, chasing and maybe to do with our models of supervision. We have organised a learning lessons event on safeguarding supervision in March and will use this opportunity to have a discussion with our colleagues about supervision. TK noted that having medium to large clinical group discussion about complex cases is part of our main strategies for managing risk. This needs to be taken into consideration post strategic review in relation to the structures that we may have so that we don't lose an implicit element of risk prevention.	
4	**4**	**Estates, Facilities Sub-Committee** *Benita Mehra, Estates Consultant*	
		TN introduced the report with a rating of amber and highlighted the following: • Structural risk has moved from green to amber because we are undertaking a number of surveys. It will remain amber until reports are completed • Some of the fire doors need replacing, particularly in the Portman clinic • In terms of reporting – the need to report on estates and facilities is increasingly a burden. We now have to report to NHSE and the ICS is taking quite an active interest in the green plan which further increases the burden around administration • Overall we are making a good steady progress. JR - on the 5th of March we will be doing relevant work to switch to the new electrical system. It was confirmed that all the red ratings are reported to the board. It was acknowledged the report has improved significantly compared to previous years, easy to read and comprehensive.	
4	**5**	**Research and Development Sub-Committee** *Eilis Kennedy, Director of Research and Development*	
		DS presented the report and noted the following: • Proposed rating is green • The report contains various studies and highlights challenges and recruitment • NIHR LOGIC study is very key for the Trust because is one of the first properly planned studies with this group of service users. We recruited very well into the Quant study; logic 2 has been analysed, papers have been prepared and additional funding has been awarded for a sub study	

		• Report highlights information on recently awarded grants. DC suggested that it would be useful for the report to have a lay summary on what these studies comprise and this is particularly important with the gender population. EK to ensure the report also contains a copy of the lay summary of the research undertaken. Giving that our financial position is deteriorating there is a possibility that, going forward, we will get less grants for research as there are some conditions such as to declare any changes to our financial accounts in the last period.	EK
5		**Any other business** Surrey updates: RJ sent updates via SB noting that there are no significant updates apart from concerns due to recruitment difficulties. It was noted that across the CYAF recruitment difficulties have been the worst in a long time. In the past there have been applications from overseas but the challenge has been that the paperwork takes a very long time to be approved, up to 8 months. There are worries that this has to do with reputation and this is felt across the Trust. CMK left the meeting.	
6		**Future Meeting Dates:** No further meetings noted under the current format.	