The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 11th July 2024

Tavistock Clinic, 120 Belsize Lane, NW3 5BA and Virtual

Please refer to the agenda for timings.

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY 11th JULY 2024 AT 2.00PM – 5.00 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

24/05	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Service Presentation – Fitzrovia Youth Action CAMHS	Discussion	Rachel James, Clinical Services Director	V	2.05 (20)	
005	Minutes of the Previous Meeting held on 9th May 2024	Approval	Chair	E	2.25 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.30 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.35 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.45 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	V	2.55 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
010	Our Future Direction – Update & Next Steps	Discussion	Chief Executive Officer	E	3.05 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
011	Self-Declaration on Trust Compliance with the NHS Provider License	Approval	Director of Corporate Governance	E	3.15 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Comfort Break (10 minutes) 3.15pm – 3.25pm						

PROVIDING OUTSTANDING PATIENT CARE						
012	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
013	Quality Priorities 2024-2025	Assurance	Chief Nursing Officer	E	3.30 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
WELL-LED & EFFECTIVELY GOVERNED						
014	Annual Self-Assessment of Committees' Effectiveness and Committee Annual Reports	Approval	Director of Corporate Governance	E	3.35 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
GREAT & SAFE PLACE TO WORK, TRAIN & LEARN						
015	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	Discussion	Associate Director of Equality, Diversity & Inclusion	E	3.45 (15)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
016	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
017	Education and Training Committee (ETC) Assurance Report	Assurance	E&T Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
018	Performance, Finance and Resources Committee (PRFC) Assurance Report	Assurance	PFR Committee Chair	E	4.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
019	Finance Report – Month 02	Information	Chief Finance Officer	E	4.15 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSING ITEMS						
020	Board Schedule of Business 2024/2025	Information	Director of Corporate Governance	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
021	Questions from the Governors	Discussion	Chair	V	4.30 (5)	
022	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
023	Questions from the Public	Discussion	Chair	V		

024	Reflections and Feedback from the meeting	Discussion	Chair	V	4.35 (5)	
DATE AND TIME OF NEXT MEETING						
025	Thursday 12th September 2024 at 2.00pm – 5.00pm					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 05/07/2024)

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
NON-EXECUTIVE DIRECTORS						
ARUNA MEHTA	Non-Executive Director	01 November 2021 (1st Term)	Director, Dr A Mehta Limited (1)	01/04/2012	Present	Personal company – no conflict
			Chair Surrey and Borders Partnership FT	01/04/2024	Present	No perceived conflict as its an acute trust in a different area
			Associate, The Value Circle	01/04/2020	Present	Consultancy work for organisations outside of London- no conflict
			Closed Interests			
			Non-Executive Director, Clarion Housing (1)	01/11/2013	19/11/2022	No conflict
			Member, Kemnal Academy Trust	01/01/2020	01/12/2021	No conflict
			Non-Executive Director, Epsom St Helier NHS Trust (1)	01/02/2016	31/01/2024	No perceived conflict as its an acute trust in a different area
			Governor, University of Greenwich (4)	01/09/2020	31/08/2023	No conflict
CLAIRE JOHNSTON	Non-Executive Director	01 November 2022 (1st Term)	Registrant Council Member, Nursing and Midwifery Council	01/09/2018	Present	
			Chair, Our Time (3)	01/05/2018	Present	Charity supporting families with serious mental illness
			Member IFR panel NCL Intergrated Care Board (3)	05/04/2020	Present	
			Spouse is a journalist specialising in health and social care			
			Nurse member, Liverpool Community health Independent Investigation, NHSE	08/05/2024	Present	
DAVID LEVENSON	Senior Independent Director and Non-Executive Director	01 September 2019 (2nd Term)	Non-Executive Director, Industrial Dwelling Society (1)	01/01/2022	Present	Registered social housing provider – no conflict
			Director, The Executive Service Limited t/a Coaching Futures (1)	01/04/2016	Present	Personal Service Company – provides coaching and training services – no conflict
			Academy member, Institute of Chartered Accountants of England and Wales	01/10/2020	Present	Design and teach ICAEW Academy's courses on Corporate Governance, paid consultancy – no conflict
			Closed Interests			
			Non-Executive Director, Qualitas Housing CBS (1)	01/01/2022	06/12/2023	Housing provider for people with long term disabilities – no conflict
JANUSZ JANKOWSKI	Non-Executive Director	01 November 2022 (1st Term)	Non-Executive Director RDASH NHS Doncaster (1)	01/11/2022	Present	No conflict
			Consultant Advisor and Provost, Dubai Medical University, United Arab Emirates	13/12/2023	Present	No conflict
			Hon Professor University College of London	01/02/2020	Present	No conflict
			Chair EU Translational Cancer Panel (3)	01/08/2022	Present	No conflict
			Consultant Industry ad hoc	01/08/2021	Present	No conflict
			Healthnix (HealthTec Start up London)	01/12/2023	Present	No conflict
			Closed Interests			
			Clinical Consultant Placement Agency ad hoc (3)	01/10/2021	01/01/2024	No conflict
			Magistrate HMCTS (3)	01/11/2019	01/04/2024	No conflict
JOHN LAWLOR, OBE	Chair	06 June 2022 (2nd Term)	Trustee of the national charity, Think Ahead, under contract to DHSC to provide postgraduate education in mental health social work. (3)	01/09/2019	Present	No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by Think Ahead and vice versa
			Wife is an Associate Director at Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) (1)	07/04/2019	Present	No perceived conflict - Will withdraw from relevant business in relation to CNTW discussed by the Tavistock and Portman
			Wife is a Trustee of Carers' Resource serving parts of West and North Yorkshire	01/07/2023	Present	No perceived conflict - Will withdraw from relevant business in relation to Carers' Resource discussed by the Tavistock and Portman

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			Providing advice and guidance to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative	12/02/2024	Present	No perceived conflict - Will withdraw from relevant business in relation to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service discussed by the Tavistock and Portman
SABRINA PHILLIPS	Associate Non-Executive Director	01 November 2022 (1st Term)	Employed by the Lambeth Living Well Network Alliance as Service Director (The alliance is a partnership of 5 organisations SLaM, SEL ICS (Lambeth),Lambeth ASC,Certitude, Thamesreach) - I am seconded out to the Alliance from SLaM (4)	01/01/2020	Present	Full time employment - No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by the Alliance.
			Interim Deputy Chief Operating Officer at SLaM	20/09/2023	30/11/2023	
			Employed as a Managing Director, adult mental health and learning disability services at Central and North West London NHS FT	01/11/2024	Present	Will withdraw from business decisions in competition with CNWL
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	23/02/2023	Will withdraw from business decisions in competition with University of Westminster
			Governor, Londale PNI School, Brittan Way, Stevenage	18/09/2018	Present	No perceived conflict - Will withdraw from business decisions in relation to the school as discussed by The Tavistock and Portman
SHALINI SEQUEIRA	Non-Executive Director	01 November 2021 (1st Term)	Director, Sonnet Consulting Services Limited (1)	10/07/2018	Present	Personal company for consulting work - no conflict
KEN BATTY	Non-Executive Director	01 April 2024 (1st Term)	Council member QMUL, which included Barts and the London Medical School	01/01/2022	Present	No perceived conflict - Will withdraw from business decisions in competition with QMUL, Barts and London Medical School
			Chair, Mosaic LGBT+ Young Persons Trust based in Camden (3)	01/09/2019	Present	No perceived conflict - Will withdraw from business decisions in competition with MOSAIC LGBT+ Young Persons Trust
			Vice Chair, Inner Circle Educational Trust (provides support for Looked After Children in Canden)	01/10/2020	Present	No perceived conflict - Will withdraw from business decisions in competition with Inner Circle Educational Trust
			Independent Chair, Nominations Committee Royal College of Emergency Medicine which is a professional body. (3)	01/02/2021	Present	No perceived conflict - Will withdraw from business decisions in competition with Royal College of Emergency Medicine
EXECUTIVE DIRECTORS						
ELISA REYES-SIMPSON	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	16 June 2022	Company Secretary Simpson Practice Ltd (1)	19/11/2004	Present	No perceived conflict - Small psychotherapy private practice. As there are no direct referrals from the NHS and no lonk to Tavistock & Portman clinical services.
MARK FREESTONE	Chief Education and Training Officer and Dean of Postgraduate Studies	10 June 2024	Honorary position as Professor of Mental Health at Queen Mary University of London	05/06/2024	04/06/2027	Will withdraw from any business decisions relating to QMUL.
			Director, North Thames NIHR ARC (Applied Research Collaboration)	01/04/2021	31/08/2025	No conflict to declare as T&P is a member of the ARC
			Director, Mark Freestone Consulting	08/11/2012	Present	Forensic Mental Health Research Consultancy (Sole trader). No direct conflict of interest.
			Honorary Senior Researcher, East London NHS Foundation Trust	01/07/2013	31/07/2026	Will withdraw from any business decisions relating to ELFT

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
GEM DAVIES	Chief People Officer	1 February 2022	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	Present	No perceived conflict - This is unpaid.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12 November 2016	NIL RETURN			
PETER O'NEILL	Interim Chief Financial Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ADEWALE KADIRI	Director of Corporate Governance	7 August 2023	Partner is an NHS GP in Ipswich, Suffolk	01/10/2023	Present	No conflict - no connection to the Trust
ROD BOOTH	Director of Strategy, Transformation & Business Development	26 June 2023	NIL RETURN			
JANE MEGGITT	Director of Communications & Engagement	24 April 2023	NIL RETURN			

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 9th MAY 2024 AT 2 P.M.

LECTURE THEATRE,
THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
AND VIRTUALLY VIA ZOOM

PRESENT:

John Lawlor	Chair of the Board of Directors	JL
David Levenson	Non-Executive Director & Chair of the Integrated Audit & Governance Committee	DL
Aruna Mehta	Non-Executive Director & Chair of the Performance, Finance and Resources Committee	AM
Shalini Sequeira	Non-Executive Director and Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Claire Johnston	Non-Executive Director and Chair Quality & Safety Committee	CJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality & Safety Committee	JJ
Sal Jarvis	Non-Executive Director and Chair Education and Training Committee	SJ
Ken Batty	Non-Executive Director	KB
Michael Holland	Chief Executive Officer	MH
Sally Hodges	Deputy Chief Executive and Chief Clinical Operations Officer	SH
Chris Abbott	Chief Medical Officer	CA
Clare Scott	Chief Nursing Officer	CS
Rod Booth	Director of Strategy, Transformation & Business Development	RB
Elisa Reyes-Simpson	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	ER-S
Peter O'Neill	Interim Chief Finance Officer	PON

IN ATTENDANCE:

Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Gem Davis	Chief People Officer	GD
Jane Meggitt	Interim Director of Communications and Marketing	JM
Mark Freestone	Incoming Chief Education and Training Officer and Dean of Postgraduate Studies (observing)	MF
Kathy Elliott	Lead & Stakeholder Governor	KE
Michael Rustin	Public Governor	
Julian Lousada	Public Governor	
Paru Jeram	Staff Governor	
Emma Ni Chinneide	DET M4 Programme Director (item 4)	ENC
Helen Shaw	Head of Portfolio (item 4)	HS
Fiona Fernandes	Corporate Governance Business Manager	FF

APOLOGIES:
None received

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL welcomed all in attendance.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	No new declarations of interest were made.	
004	**SERVICE PRESENTATION**	
	Emma Ni Chinneide and Helen Shaw attended to speak about the M4 Professional Doctorate in Child, Community & Education Psychology course. They gave a presentation on what the course entailed which included a short video presentation from a student on her experiences of studying at the Tavistock. ENC noted that this highly regarded professional doctorate training course had been recently re-validated with commendations by the University of Essex and accredited by the British Psychological Society (BPS). SS thanked ENC and HS for their presentation and noted that it was good to see the commendation for EDI supervision. ENC noted that bursaries were set by the Department for Education (DfE) for every student, however international students were not eligible. DL noted that expanding the reach of educational psychology in areas like the police force, first responders, etc would be a way forward. JL added that connections to the local MPs could me made once the political arena settles. JL on behalf of the board, thanked ENC and HS for a very informative presentation.	
005	**MINUTES OF THE PREVIOUS MEETING HELD ON 21st February 2024**	
	The minutes of the previous meeting held on 21st February 2024 were agreed as an accurate record pending minor amendment of GD and KE's surnames.	

006	**MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW**

It was noted that there were no matters arising.

It was noted all actions proposed for closure were approved apart from the action on mandatory training.

007	**CHAIR AND CHIEF EXECUTIVE'S REPORT**

The CEO Report was taken as read.

MH advised that a consultation on the clinical services structures had commenced for a period of 30 days. Once the consultation closed, the outcome would be brought to the board.

MH noted that on the national issues at the last Chief Executive Officer meeting they mentioned that due to the financial pressures across the NHS and the primary cycles, and even though we are in the first quarter, the planning cycle was not completed, further meetings with all Chief Executive Officer's and Chief Financial Officers would be held.
PON added that the last submission made to NHSE was on 2nd May. The ICB called a meeting, and they are expecting a further submission.

008	**INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)**

The report was taken as read.

SH advised that the IQPR was discussed in full at the Performance, Finance and Resources Committee (PFRC) and was also discussed at the Quality Safety Committee which were both held on 18th April 2024.

SH highlighted that the A3's are linked to the Strategic Objectives and are discussed on a weekly basis at the Executive Leadership Team (ELT).

The key areas of focus were waiting lists and data reporting. The waiting lists are still growing and there is a targeted piece of work that is being done on the GIC, Autism Service and Adult Trauma wait lists, however it will require additional resources and funding. We secured some resources via the Elective Recovery Fund, which has enabled us to create new roles. We have recruited to all the vacant roles in Adult Trauma. With GIC the appointment process has been closed and interviews will be held on 20th May 2024. Recruitment continues in the Autism Service as the vacancies are filled in by bank staff..

The Quality Improvement meeting huddles take place weekly and the quality improvement prospects have moved forward. As of today 9th May 2024, Department of Education and Training quality improvement joined the huddle.

SH noted that with the impact of the GIC waiting lists continuing to grow, some of the practices have been changed and we are working closely with NHSE who continue to open up places for GIC patients and 280 patients are going to the Sussex service.

On data reporting, SH advised that the data is about 6 weeks in arrears by the time it goes from the internal IQPR meetings to the FPRC. It has been agreed that for accuracies sake, we need one version of the full data set across quality, performance and people, hence the need to review last months data properly.

CS presented the Quality section of the IQPR. With regards to the service user experience A3, the quality of the data has improved, a baseline benchmark has been set with each service to increase response rates by 200% over the year. The next step is to review all versions of the questionnaire and work with the services and service users to develop a meaningful and concise.

Quality and safety metrics presented – it was noted that the daily patient safety huddle reviews all patient safety incidents and decides where further review is needed; the new 72 template is in use. In relation to internal care plan incident an incident response group was established, the work is being finalised and is reported through clinical incident review group.

CS noted that there were four incidents of aggression at Gloucester House; one of the incidents occurred at Tavistock Centre and required additional support. A protocol for clinical escalation is being developed.

Responding to SJ query about restraints at Gloucester House, CS noted that the narrative was that it was a hold not restraint of the student. The policy is being reviewed and the patient safety team is working with the Gloucester House staff on how to record the type of physical intervention on the correct system.

CS noted that 5 formal complaints were received in the last reporting period; regarding the response timeframe, the Trust moved from the 25 day to 40 working day timeframe in January 2024; there is a new investigation template in place resulting in compassionate and high-quality responses. As the two processes and timeframes are working concurrently, it has not been easy to report compliance. It was noted that the backlog has reduced significantly.

The local IQPR and local Watch Metrics highlighted that one service GIC will require more support and additional support will be provided.

Responding to CJ, SH noted that a lot of the case on the watch metric were dormant cases and do not appear on the wait lists. These are mainly related to GIC. These are patients who have not been seen for a year and are referred to the next stage and, been dormant, which skews the data, we are exploring ways to remove this set of dormant cases.

CJ noted that it would be beneficial to add a footnote to explain the dormant cases.

Responding to SS on Mandatory and Statutory Training (MaST) not improving, SH noted that there was still a backlog however a new yearly cycle has been set up which is aligned to staff's start dates. We recognise that this is an issue and were putting in the support to address this.

ER-S added that there had been some technical glitches that the system was not recording the training. With the support from HR, fixes have been put in and we have been clear with all managers and have put in clear actions to support them and cannot get through to appraisal without having done MaST.

GD advised that staff who use a smartcard will receive notifications through the Electronic Staff Record (ESR). GD acknowledged that this was not the case for those that did not have the smartcard.

ACTION: to provide a list of what the MaST should be, and which are relevant for the next Board meeting. **GD**

Responding to JL, GD noted that compliance for MaST was set at 85%. All managers received reports prior to ESR self-service being rolled out. Managers can now see through self-service the compliance rates on their dashboards for appraisal and MaST.

JL noted that there is a lot of high-level work and that it would be beneficial to have an executive summary not only for the Board but also for the Governors.

ACTION: IQPR to be added to the agenda for the next Council of Governors Meeting. **AK/FF**

009 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) ASSURANCE REPORT**

DL noted that there was no new information to report since the last Board Meeting and as the next meeting of IAGC is taking place on 21st May 2024.

010 **QUALITY & SAFETY COMMITTEE (QSC) ASSURANCE REPORT**

The report was taken as read and CJ noted the key points discussed:

- Great work had been done on patient safety.
- A framework had been put in for After Action Reviews.
- There was compassionate engagement for patients.
- 3 new patient and safety partners were challenging us.
- Quality Safety report is going from strength to strength.
- Internal audit reviewed the safeguarding action plan.
- There is a new interim Childrens Safeguarding Lead.
- Revitalising clinical audit effectiveness on mortality and clinical incidents/safety.

011 **QUALITY PRIORITIES 2024-2025**

The report was taken as read and CS noted that progress to date against the Trust's Quality Priorities for 2023/24 was positive, however, in some areas, it had been difficult to identify leadership and accountability, with a perceived mismatch between some of the priorities and other programmes of work in the Trust. This had led to progress against some targets progressing more slowly than planned.

For the setting of 2024/25 quality priorities, a stakeholder event was held in Quarter 4 of 2023/24 to engage stakeholders in developing quality priority proposals for 2024/25. The plan this year is to align the new quality priorities to the strategic pillars and build on quality improvement work in these areas. The event provided patients and other key stakeholders with the opportunity to understand what some of the key areas of quality focus are for the Trust, why

they have been chosen and how it will benefit patient care. The event was engaging but was not well attended.

The themes from the stakeholder event were presented to the Council of Governors for comment.

The draft version of the Quality Accounts is progressing well and at present it out for comments and will be presented at the June Private Board for final comments.
RD added that the SOF3 process rated it green and have had good feedback from the regulators.

The board noted the progress made on the 2023/2024 priorities and closed them off and, also noted the Quality Priorities for 2024/2025.

012 **WINDING UP OF THE UCL HEALTH ALLIANCE**

JL informed that in November 2023, the UCL Health Alliance and UCL Partners established a partnership known as the UCL Health Alliance, with the UCL Health Alliance becoming a ring-fenced division of UCL Partners (UCLP).
The UCL Health Alliance has completed the process to remove UCL as a formal partner and the branding change to become NCL Health Alliance.

As a board, we need to have discussion on 'What part are we playing in the Provider Collaborative to include primary care and our service in the community'.

ACTION: Discussion on 'What part are we playing in the Provider Collaborative to include primary care and our service in the community' to be added to a Board Seminar/Board Development Session agenda. **AK/FF**

013 **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE (POD EDI) ASSURANCE REPORT**

The report was taken as read and SS highlighted the key points from the meeting:

- Ffyona Dawber, Public Governor attended the meeting and had met with her prior to the meeting.
- Had robust discussions on the Staff Survey and that there was still work to do. It was noted that the data will be taken and be reviewed with the Teams.
- EDI Governance Review – AK provided an overview of the EDI Governance Review Report and provided the plan, timeline and actions that will be amalgamated with the EDI plan. In addition, the EDI Programme Board will specifically receive updates on the staff survey action plan.
- Receive regular updates on the Management Development Programme and are keen that all managers sign up for the course and it is very important to have a consistent management culture.

  GD informed that there are another three cohorts planned for the autumn and this should address the current need. Sarah from HR is working on the

communications for this. All the Executives have signed up to promoting this and as part of the review, a refresher programme is being considered and are looking at what can be repeated and the regularity of them.

014 **STAFF SURVEY RESULTS AND ACTION PLAN**

GD noted that the service level data will be taken to each service lead by the people team to be discussed in depth and they will be supported to create bespoke and targeted staff survey action plans for their teams. Thanda Mhlanga will be supporting the service leads on the EDI aspect. There has been a lot of staff engagement and we asked a number of questions in the Future Option Sessions using mentimeter one of the questions asked was' How did it feel working at the Tavistock', there was a mixed response. We will continue asking staff questions for the rest of May and will incorporate the date into the final action plan.

015 **EDUCATION AND TRAINING COMMITTEE (ETC) ASSURANCE REPORT**

ER-S highlighted various points from the report.

- The committee focused on the BAF to identify specific risks.
- There are ongoing pressures surrounding the delivery of the three-year full-time doctorate (M4), necessitating strategic modelling and exploration of alternative delivery methods.
- Student debt is ongoing and there is real focus to identify the issues, and there is a need to secure additional resources to mitigate this.
- There is good progress being made on the action plant regarding student experiences and this will need to be triangulate the data, the student survey and outcome data/feedback.
- Workforce Innovations Unit is progressing, and a consultancy firm have been supporting Tavistock Consulting in a project focused on modelling and evaluating the Trust's commercial and biodiversity aspects.
- Tavistock Consulting are recruiting four new consultants, this will help with the growth of the service.
- Triangulation of data to get better outcomes for new recruitment.
- National Workforce Skills Development Unit (NWSDU) staff have been redeployed within Education and Training.
- A3 references to SITS have been mitigated.

016 **PERFORMANCE, FINANCE AND RESOURCES COMMITTEE (PFRC) ASSURANCE REPORT**

The report was taken as read and SH highlighted the key points:

- That the level of assurance on this work has moved from 'limited' to 'partial' which is an improvement.
- Finance – although there continues to be concerns about the team level budget data not being clear, there have been some improvements.

- The Health Education England (HEE) contract, we have received 25% of this and it is unlikely that we will receive anymore in light of NWDSU.
- The PCPCS value of contract was confirmed and therefore is no risk. We are working closely and in partnership with the Commissioners on the contract and the risk has been diminished.
- RB went through the new business planning process and the committee was assured of the robust processes in place.
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017 **FINANCE REPORT – MONTH 12**

PON noted that for month 12, the Trust:

- Had incurred a net deficit of £2517k against the planned deficit and was on track with the plan.
- The cash balance was below the planned amount of £3091k.
- Capital Expenditure had a small variance against the original plan of £28k which is offset by an agree month 12 distribution of unused capital in the ICS. The agreed capital spend for the year is £2.2m which was a reduction from the previous year.
- The reported position includes the costs and the agreed income associated with the decommissioning of the GIDS and, the estimated costs is £3.8m

Financial Plan Update 2024/25

The report was taken as read, and PON noted that the plan submitted to the ICB on 29th April 2024 had not changed from the plan that was submitted on 2nd May 2024. There was a deficit of £2.4million. The Plan still needs to be approved by NHSE and the Trust maybe asked to make another submission to the ICB.

018 **MEDIUM TERM FINANCIAL PLAN UPDATE**

The information for this item was addressed in item 017.

019 **BOARD SCHEDULE OF BUSINESS**

The Schedule of Business for 2024/2025 was noted.

020 **QUESTIONS FROM THE GOVERNORS**

There were no questions from the Governors, however Kathy Elliott noted that it was wonderful to see that the board were coming back to issues and looking at where they can do more.

Kathy Elliott noted that for those online it was difficult for them to hear clearly those in the room.

021	**ANY OTHER BUSINESS**	
	The board noted it thanks to ERS for stepping into the interim Chief Education & Training Officer role for the past 2 years and, for all her valuable input and knowledge. Mark Freestone will be officially starting as the new Chief Education & Training Officer on 10th June 2024. ERS thanked the board and NEDs for their support.	
022	**QUESTIONS FROM THE PUBLIC**	
	There were no questions from the public.	
023	**REFLECTIONS AND FEEDBACK FROM THE MEETING**	
	• Board Development sessions was excellent and thought provoking. • Training and Education M4 Presentation from Emma Ni-Chinneide and Helen Shaw was impressive, and it was suggested that there should be more from DET at future board meetings. • Have more service user presentations from Clinical/Education • Thanks to the Executives for their input for reports and to AK and Governance Team for reviewing minutes for consistency. • Used to seeing senior/junior staff attending the board meetings. It would be useful to promote the board meetings so that all staff have a better understanding of how the board functions and what the NEDs do. **ACTION:** Communications team to circulate and promote the dates of the board meetings. • Antonia Carding-Wright is leaving the Trust on 24th May 2024, the board noted its thanks for all the work she did and wished her well. • Management training to support leaders to shadow the Board members/Executives.	**JM**
	Close	
	The Chair closed the meeting at 5.30 p.m.	

Date of Next Meeting in public: Thursday 11TH JULY 2024 at 2pm (time and venue to be confirmed).

Signature _____ Date _____

Board of Directors Part 2 - Public
Action Log (Open Actions)

Actions are RAG rates as follows: ->	**Open - New action added**	**To Close - propose for closure**	**Overdue - Due date passed**	**Not yet due - Action still in date**

Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Action Due date	Action owner (Name and Job	Status (pick from drop-	Progress Note / Comments (to include the date of the meeting the action was
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	In progress	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified. **UPDATE 04/07/24:** NHSE are providing Teams to assist with the second part of the training which is going to rolled out shortly.
09.05.24	8	Integrated Quality & Performance Report (IQPR)	To provide a list of what Mandatory & Statutory should be, and which are relevant	July Board meeting on 11.07.24	GD	In progress	This is due to be discussed at Clinical Services Delivery and will then be brought to the next Board meeting
09.05.24	8	Integrated Quality & Performance Report (IQPR)	IQPR to be added to the agenda for the next Council of Governors meeting	30.05.24	AK/FF	To Close	This was added to the Council of Govenros agenda and was discussed at the meeting held on 30.05.24
09.05.24	12	Winding Up of the UCL Health Alliance	Discussion on 'What part are we playing in the Provider Collaborative to include primary care and our service in the community' to be added to a Board Seminar/Board Development Session agenda.	July Board meeting on 11.07.24	AK/FF	To Close	This is on the forward Board Development schedule
09.05.24	23	Reflections and Feedback from the meeting	Communications team to circulate and promote the dates of the Board meetings to encourage staff attendance.	for the July Board meeting on 11.07.24	JM	In progress	Communications team will be putting the dates on the intranet as well as in the CEO weekly update prior to the board meeting.

MEETING OF THE TRUST BOARD OF DIRECTORS PART II (PUBLIC) 11 July 2024			
Report Title: Chief Executive's Report			**Agenda No.: 7**
Report Author and Job Title:	Michael Holland, Chief Executive	**Lead Executive Director:**	Michael Holland, Chief Executive
Appendices:			
Executive Summary:			
Action Required:	**Approval** ☐ **Discussion** ☒ **Information** ☐ **Assurance** ☐		
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.		
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.		
Assessment:	This report covers the period since the meeting on 9 May 2024		
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against the leadership responsibilities within the CEO's portfolio.		
Implications:			
Strategic Ambitions:			

☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability

Relevant CQC Quality Statements (we statements) Domain:	**Safe** ☐	**Effective** ☐	**Caring** ☐	**Responsive** ☐	**Well-led** ☐

Link to the Risk Register:	**BAF** ☒	**CRR** ☐	**ORR** ☐
	All BAF risks		
Legal and Regulatory Implications:	Yes ☐	No ☒	
	There are no legal and/or regulatory implications associated with this report.		
Resource Implications:	Yes ☐	No ☒	
	There are no resource implications associated with this report		
Equality, Diversity and Inclusion (EDI) implications:	There are equality, diversity and inclusion implications associated with different aspects of this report.		

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Chief Executive's Report

Providing outstanding patient care

1. Clinical Structure review

During June, we responded to the significant number of responses to the consultation on re-shaping the structure of our clinical teams. Overall, the feedback has been reasonably positive, with staff feeling that they were listened to, and that the structures made sense to them. We are already beginning to implement the new structure, while trying to minimise as much as possible any disruption to clinical work.

Staff did express during the process a general sense of anxiety about change as the merger process moves forward. As such, the Executive Team are ensuring a high level of visibility and an increased number of team visits now and in the coming weeks.

2. Invited GIC review

The Trust received an initial proposal on the structure and proposed content of this review. The Chief Medical Officer is leading on a review of the terms of reference to ensure that the review focuses on the critical aspects of the work of the GIC.

3. Mental Health Awareness Week

The week of 13 May was Mental Health Awareness Week, and as in previous years, it was once again an opportunity for the NHS to celebrate its achievements in this vitally important area, while also acknowledging areas for improvement. Notable achievements include the recent roll out across England of mental health support via NHS 111, as well as delivery of mental health support for children and young people through the Mental Health Support Teams in schools and colleges, with 44% coverage of the country achieved thus far. As in other areas of healthcare delivery, long waits for patients as well as financial and workforce challenges continue to be an issue.

4. Radar

On 3 June, the Trust went live with Radar, the new risk management and incident reporting system which has been procured to replace the current Quality Portal, making us PSIRF-compliant in terms of how we report and record incidents. Radar offers a comprehensive suite of tools to manage all aspects of compliance seamlessly. It also streamlines workflows, automates repetitive tasks, and promotes collaboration across directorates. Its user-friendly interface and intuitive features ensure that multiple users can contribute to our compliance efforts seamlessly.

The system includes a number of optional modules, including for risk management, that could significantly enhance the way the operational and corporate teams record, manage and present their risks.

5. New service specification for community forensic child and young people mental health service

Early May saw the publication by NHS England of a service specification for a community based forensic child and young people's mental health service, including service overview, aims and outcomes and care pathways. This service will be delivered for a geographical area as defined by local commissioners, but will generally cover one or more ICS, as determined by local arrangements.

The specification highlights the importance of links between adverse childhood experiences and the development of anti-social behaviour, as well as the complications caused by co-morbidities with other mental and physical health needs, substance misuse and neurodiversity. Its aims emphasise the need to focus on the key aims of the Mental Health Act including maximising independence, respect and dignity for patients and collaboration with community services.

Enhance our Reputation and Grow as a Leading Local, Regional, National & International Provider of Training & Education

6. Student recruitment

As the end of the student recruitment cycle nears, the Department of Education and Training has received 706 applications for the 2024/25 academic year, an increase of 10.5% on 2023/24 (639). Of these, 168 are firmly accepted or unconditional offers, an increase of 130% on 2023/24 (73). These figures do not include the 367 applications received via a separate portal for our M4 training in educational psychology, or the 5 applications submitted to our Executive Coaching Programme via our website.

On Saturday 15 June, we welcomed over 130 prospective postgraduate students to The Tavistock Centre for an in-person open day. With opportunities to meet our course teams, hear from current students, get application advice and learn about enrolment, the event allowed potential applicants to get a taste of our approach and of student life at the Tavistock and Portman. Our Chief Education and Training Officer, Professor Mark Freestone reflected: "A highlight for me was our student panel, who took questions from prospective applicants – they were so enthusiastic and articulate. It's great to get that energy and knowledge from our student body, and [prospective students] as well". Thank you to all colleagues who worked so hard to make the event a success.

Developing Partnerships to Improve Population Health and Building on our Reputation for Innovation and Research in this area

7. Patient and carer race equality framework (PCREF)

Ms Jaqui Dyer, an independent health and social care consultant with a background in adult mental health, community and family social work, visited our Race Equality Network during June to talk about why and how she developed the PCREF. This was a popular session, with over 30 Network members in attendance, and Jacqui's experiences provided clear evidence of the urgent need to implement PCREF across all services. There was considerable enthusiasm among those present to support its implementation in our Trust.

Developing a culture where everyone thrives with a focus on equality, diversity and inclusion

8. Pride Month and Refugee Week

June was Pride Month, a time to honour the LGBTQ+ community, celebrate diversity, and reflect on the progress made towards equality, while acknowledging the work that still lies ahead. The Pride Picnic in the Portman Garden was a lovely event giving time for community members and allies to meet, eat, and discuss. We were also proud to attend the London Pride March as a Tavistock and Portman LGBTQI+ and allies walking float.

We now have a newly nominated LGBTQ+ Network Co-Chair, Jonathan Stubbs, who will be working closely with Nell Nicholson to grow the network and allyship.

Refugee Week also took place in June, and we partnered with the University of Essex Centre for Trauma, Asylum, and Refugees (CTAR) to host an open conference on the topic.

9. Black Inclusion Week

The week of 13 May was Black Inclusion Week, giving organisations an opportunity to show their commitment to Black Inclusion and work towards creating an anti-racist culture. To mark the week, our EDI Team organised an online event in partnership with Inclusive Employers to help address some of the issues around equality and inclusion around the Trust.

10. NHS national industrial action

Junior doctor members of the British Medical Association (BMA) took further strike action, calling a five-day strike from 27 June until 2 July. The BMA asked its members not to begin any shift from 06:59 on Thursday 27 June until 06.59 hours on Tuesday 2 July. So far, the impact of this latest round of industrial action on the Trust's services has been relatively limited.

11. Pay reform

NHS Employers' newly formed pay, pensions and reward working group has successfully launched and has allowed further collaborative working, enabling them to seek the advice of subject experts to better understand the concerns and

challenges employers face in the service. Their future work will be underpinned by this joint approach.

We have yet to receive confirmation of Government acceptance of any Pay Review Body recommendations for the 2024/25 financial year.

12. International Nurses' Day

12 May marked International Nurses Day, an annual celebration of nurses and the contribution that they make to society. The International Council of Nurses released their annual report which focused on 'the economic power of care', and the ways in which nursing can be used to boost economic growth around the world.

13. Staff engagement

The latest People Pulse survey is underway. The new Pulse Wave started on Monday 1 July, for people to share their views about their working experience within the organisation. The survey takes no longer than 5 minutes to complete and is fully anonymous; answers are really important to help shape improvements in staff experience.

Teams across the Trust are already working to develop local plans in response to the Staff Survey and in addition we wanted to hear from our people to get a broader understanding of staff experience and the things that we need to improve. So far there have been 9 facilitated online sessions including sessions at all staff networks, an online survey which ran for 6 weeks with 52 responses from staff, and a feedback box located in Toza Café. We asked staff what they value most about working at the Trust, what would make their experience even better, and what immediate improvements can be made.

We have collated a number of recommendations and agreed as an Executive Team those that we now want to open up for people to vote on as priorities.

Improving Value, Productivity, Financial and Environmental Sustainability

14. Merger update

The merger process is continuing, with executive level engagement taking place between the Trust and its proposed partners. As part of these ongoing discussions a finance working group has been established, with its initial focus being on the development of a joint plan to achieve a balanced financial plan in future periods and the consequences of the proposed merger on the Trust current asset base and the locally commissioned services.

15. **Development and delivery of the Trust's strategy and financial Plan**

The final agreed financial plan for 2024/25 was submitted to the ICB/NHSE 12th June 24. The final planned deficit was reduced to £2.2m, from the previously advised £2.4m, as part of the ICS wide revision of plans to close the gap of £31m. In addition, the increased capita; spend limit of £2.2m, an increase from the previously

advised £1.95m, was agreed as part of this plan. The Trust is still therefore planning to achieve a balanced financial plan in 2025/26.

Regional and National Context

16. NHS ConfedExpo conference

I attended the NHS ConfedExpo conference on 12 June, along with the Director of Strategy and Transformation. One of the key takeaways from the event was the speech delivered by Amanda Pritchard, the Chief Executive of NHS England, in which she acknowledged that the NHS is “struggling” but “not destroyed”. She urged whichever party forming the next government to prioritise securing additional funding for the service, fixing the social care system and tackling threats to public health such as poor diets.

Specifically on mental health, Ms Pritchard referred to Aneurin Bevan’s statement on its importance and how it is foundational to the service’s mission, and she highlighted the significant progress that had been made, including the fact that psychological therapies are now available to 1.2 million people. Ms Pritchard stressed the importance of mental health in integrated care, making mention of initiatives to improve coordination with other health and care services. Crucially, she emphasised the importance of supporting the mental health and wellbeing of NHS staff, acknowledging the pressures that they faced, and the need for a supportive work environment.

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 11 July 2024			
Report Title: Integrated Quality and Performance Report (IQPR)			**Agenda No.: 8**
Report Author and Job Title:	Amy LeGood, Hector Bayayi	**Lead Executive Director:**	Sally Hodges Peter O'Neil
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This is the IQPR for month 12 data.		
Background:	This data has been through the local teams, the service line IQPR meetings and the PFRC on 21 May 24. Wait time data has not improved despite the recruitment of Elective Recovery Funded staff in most areas. Services are redrafting their trajectories to allow for induction and aim to increase the number of first appointments. These countermeasures may not make the desired impact if the enabling workstreams pathway mapping, job plan implementation, and recruitment of staff into substantive vacancies are not managed robustly, this will be a key task of the new leadership group. Data quality and fidelity remain variable after introducing a hard stop on reporting and recording deadlines. The IQPR working group aim to complete the logic to automate processes and reduce the data synthesis burden on operational staff. This will include statistical formulation of upper and lower control limits, as well as setting clear targets as well as enabling team and individual access to the data dashboards.		
Assessment:	A3s are now discussed weekly in ELT and in the weekly QI huddles driving a clear focus on improvement concerning the strategic ambitions. Services have made some progress however, this is not consistent due to multiple factors recruitment, adherence to job plans, record keeping and data synthesis, analysis, and data-informed action planning. We expect to see incremental improvement following recruitment into vacant posts and automation of the dashboards, which will improve prospective management of issues impacting strategic priority deliverables. Targeted support and oversight are being provided weekly to services challenged by the delivery of their plans and trajectories. against their delivery plan. PFRC has recommended that GIC risk is increased in the context of a growing waiting list, significant workforce, and cultural issues likely to impact patient safety, contractual targets, and clinical governance. Additional countermeasures are being implemented to address co-occurring workforce planning and cultural issues related to delivery, governance and assurance grounded in data.		
Key recommendation(s):	The Board is asked to: • Note the increased risk for gender services regarding the delivery of the strategic priorities. • Note additional mitigation in place and verify if it is adequate.		
Implications:			
Strategic Ambitions:			

(tick)					
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain: (tick)	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register: (tick)	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: **Risk 13 - Delivery of performance targets** Failure by the Trust to achieve contractual and national operational perform **Leading to:** 1) Unintended harm to patients due to longer waiting times, and delays in c 2) Increasing numbers and severity of incidents and claims. 3) Failure to deliver expected financial performance. 4) Contractual penalties and reputational damage. **Risk 9 - Delivering financial sustainability targets.** A failure to deliver a medium/long term financial plan that includes the deliv program bringing the Trust into a balanced position in future periods. This r ICB/NHSE scrutiny, additional control measures and restrictions on autono				
Legal and Regulatory Implications: (tick)	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications: (tick)	Yes ☐	No ☒			
	There are no resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☒	No ☐			
Freedom of Information (FOI) status: (tick)	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					

Assurance Route - Previously Considered by:	Local IQPRs on 27 May 2024 the performance, Resources and Finance committee on 21 June 2024			
Reports require an assurance rating to guide the discussion: (tick)	☒ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report for Board

June 2024

Our vision is to be a leader in mental health care and education, promoting talking therapies, to make a meaningful difference to people's lives

Tavistock and Portman – Our Values and Strategy

The Tavistock and Portman NHS Foundation Trust

Our 24/25 Objectives are in review and will be updated in due course.

Integrated Quality and Performance Report

Month 2 24/25

	Metric	Waiting List Management	SRO	Sally Hodges	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

In at least 3 areas of the Trust patients are waiting longer than the NHS standard of 18 weeks for a first appointment (Adult Trauma/psychotherapy, Adult GIC and ASD).
The Adult GIC pathway currently has significant demand/capacity constraints, with the waiting list currently holding ~14500 patients (for wait for first appointment) as of Nov 23. We currently receive 350 referrals per month, and we are only seeing 50 new patient appointments per month, which is resulting in the waiting list growing exponentially and the gap increasing month on month.
The Adult Trauma pathway currently has significant demand/capacity constraints, with the waiting list currently holding ~650 patients (for wait for first appointment) as of Nov 23. Patients in this service are often seen weekly for a year and may also have group therapy for a further year. The trauma service average annual referrals has increased by 350% between 2019 and 2023.
The Autism Assessment (ASC) waits have been growing exponentially with a 285% increase in referrals for assessment since 2019. Due to the nature of the way we triaged patients, the waiting time for the actual assessment could be non-transparent. There are approximately 240 patients waiting with an average of 30 assessments completed each year.

Vision & Goals

Vision: No user services waiting longer than 18 weeks for treatment

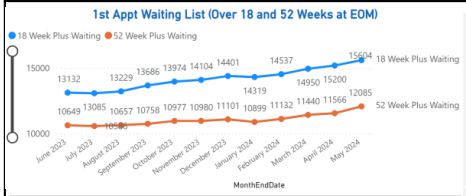
G1. Clearly defined pathways for patients within next 4 months

G2. Clear demand and capacity modelling identifying gaps so that they can be addressed by March 2024

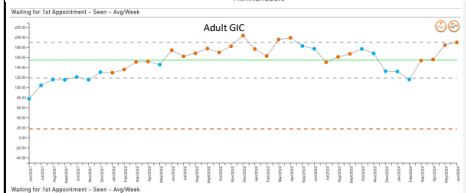
G3. Increase in patients in treatment vs on a waiting list

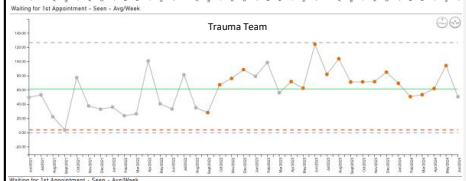
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

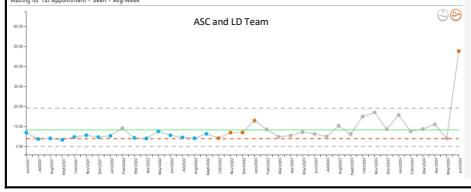
Historical Performance



This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

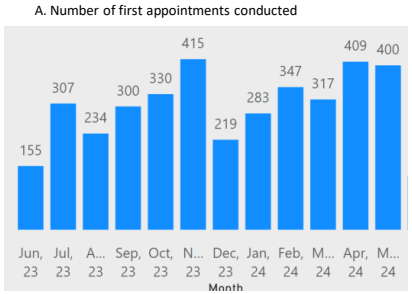


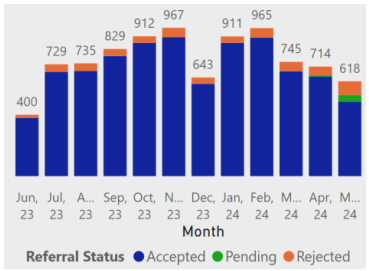


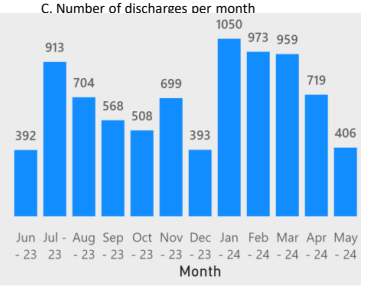


These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data







Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
There are patients that are dormant for more than 12 months that need review and/or discharge	Focus has been on active cases. PLT not in place to pick up dormant cases previously	Review and discharge dormant cases from PTL	Variable, in Gender expectation is that resource will be freed up for active case load management	Hector and GM/s
In some areas there is not enough resource for the numbers of patients being referred	Funding doesn't match demand	Negotiations with NHSE, we have received ERF funding that has doubled size of trauma and asd teams as well as increasing resources to GIC	Reduction in wait times due to taking more people from the waiting list	Hector and GM/s
Pathway Mapping has been developing or variable across the trust	Personalised or individualised care has driven care to patients already open	The mapping of 'as is' and 'to be' pathways is taking place across teams with a prioritisation of where there are longer waits	Having greater standardisation will prevent treatment drift, and with this create capacity which will enable waitlist reduction work	Sally Hector and ops teams

3

Integrated Quality and Performance Report — Month 2 24/25

Metric	User Experience	SRO	Clare Scott	Target	90%

	People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Problem Statement

Across the Trust, over the last year we have achieved an average of 84% of positive performance in service user satisfaction (ESQ/FFT) which is less than our target of 90%. This is relative to the amount of feedback that we receive which is low and this may impact the score significantly when the number of responses is increased. The lack of feedback is impacting on services ability to respond to people's experiences and make improvements where needed.

Vision & Goals

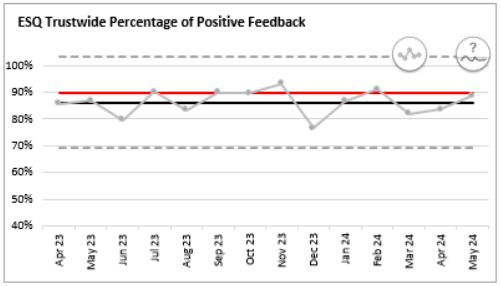
Vision: For all users to have a positive experience across the trust.

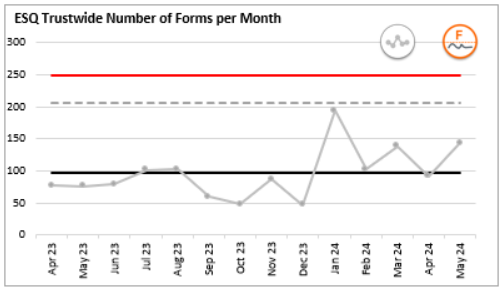
G1: Number of ESQ form rates to be monitored against benchmarks set in March 2024 every 3 months for the next 12mnths action plans put in place per service line to support progress

G2: To consistently meet 90% positive user satisfaction score in the next 12 months

Historical Performance

- SPC charts available for all service lines: C&I, CMH and GIC - these are designed to identify normal data variation in data, marked in grey. When significant improvement occurs data points are marked in blue and significant deterioration in amber.
- The number of forms completed includes Trust Internal ESQ and GIC PEQ forms





Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Ensure newly set benchmarks for service lines for ESQ responses are monitored and services supported to develop action plans to meet targets	• Benchmark baseline rates of 200% now established for each service line and will be monitored every 3 months via the monthly A3 meetings. • Complete deep dives with each service line to give the opportunity to look at team level data, exploring what is working well and what are some of the barrier/challenges to ESQ distribution • Develop a bank of ideas to test out in different teams and report back using PDSA cycles • Highlight service lines (and teams within this) who are doing well to share learnings with other clinical areas who are struggling to increase their response levels.	Ensure benchmarking data is incorporated in IQPR quality slides. Deep dive invites with service lines have been set, PDSA cycles to be used to explore successes and challenges to understand why numbers are increasing/decreasing	Sonia, Marcy, Ravneet & Service Leads
There is a wide range of ESQ's being used and varying ways to collect feedback	• Review what versions of ESQ are being used • Ensure SU preferences for development of a standardised ESQ are incorporated • Ensure contractual reporting requirements are fulfilled (MHSDS)	Collate all ESQ version being used Trust wide Establish Task & Finish group to agree a standardised Trust ESQ	Marcy/GM

4

Integrated Quality and Performance Report — Month 11

Metric	Student Intake	SRO	Elisa Reyes-Simpson	Target		Measure	

Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

Without adequate market intelligence and financial viability modelling, it isn't possible to set meaningful and sustainable growth targets regionally, nationally or internationally.

The number of applications for long courses was broadly similar in 2023/24 (1096) to 2022/23 (1098). The number of offers made to applicants in 2023/24 (813) fell by 1.5% from 2022/23 (825). However, the number of offers accepted has increased by 1.35% in 2023/24. As of 19/10/2023, 555 students had enrolled for 2023/24, compared to X at the same time in 2022.

Income from short courses has increased year on year from the pandemic (£1.2m in 2020/21 to £1.6m in 2022/23), as we moved to online delivery. We are currently forecast to see a slight decrease in income in 2023/24.

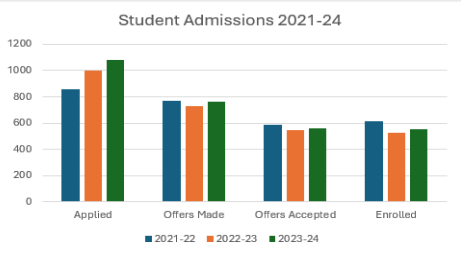
Vision & Goals

V1: Increase long course student population to 2000 students by 2023
G1: Increase student numbers by at least 40 additional students in 2024/25
G2: Scale growth to reach 5000 students by 2030, using a data-informed approach

V2: 60% increase in short course income by 2030
G1: Grow short course income by 15% for the 2024/25 cohort
G2: Implement a targeted marketing approach for 2025/26 recruitment cycle

Historical Performance

Year	Applied	Offers Made	Offers Accepted	Enrolled
2021-22	855	767	584	614
2022-23	998	727	546	528
2023-24	1080	764	561	551



The fee status differential has altered considerably between 2019 – 2023 (noting the effect of the pandemic on student recruitment in those years).

We experienced growth in certain international markets (China, India, Nigeria, Turkey) in 2023/24 compared to 2022/23, evidencing potential for growth in the coming years in the international student market – in traditional recruiting markets as well as new markets.

Notes on tables:

- *Perinatal has been excluded from all years to streamline data.*
- *This does not include enrolments done outside of the Trust (e.g. M23).*
- *Withdrawn and swapped applicants have been excluded.*
- *Deferrals are included in the enrolment stats, which explains the high-seeming conversion rate from offers accepted.*
- *ECP has been included in the 2023-24 figures.*

Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Inability to provide modular/flexible delivery (long course)	Current implementation of SITS does not allow for flexible student management	Comprehensive external discovery/review of SITS approved and due to commence in late-Feb/early-Mar.	Resigned SITS system (and corresponding processes) to allow for flexible student management (i.e., modular delivery).	ERS (RSD)
Lack of agility in relation to long course development	Restriction on validation from university partner, professional accrediting bodies	Ongoing discussions with existing partner/professional accrediting bodies, as well as scoping new additional partnership(s). *(Note: we are hampered by unwieldy nature of university validation processes).*	More agile approach to course development to enable responsiveness to market demand	ERS (PD)
Systems not suitable for short course management	Inadequate design and implementation of SITS; lack of Moodle-SITS integration; no dedicated booking system; no CRM and inability to communicate with customers; lack of dedicated space and systems for video recording.	Comprehensive external discovery/review of SITS approved and due to commence in late-Feb/early-Mar. Proposal being prepared for Moodle-SITS integration.	Flexibility of provision and increased number of students including those accessing LLE and competing with wider sector	ERS (PD)
Lack of capacity and skills-mix in workforce	Reliance on visiting lecturers and absence of substantive staff.	A review of course viability, market demand, and staffing need to determine recruitment of substantive staff (faculty and operations) to develop and deliver new courses. Recruitment of new staff and redeployment of existing staff as required.	An agile, diverse, and skilled workforce able to meet evolving market demand and meet our growth target.	ERS (RSD)
Lack of bespoke course commissions for high-revenue private entities	Lack of dedicated substantive staff in short-course portfolio	Explore alternative models similar to 'Department of Continuing Education' in HE settings Move from student marketing to student marketing, recruitment and admissions team based on marketing intelligence, data and conversion from enquiry to application	Increased student applications and new markets and reduce number of incomplete applications and increase number of complete applications	ERS
Lack of staffing resource across Professional Services teams	No investment in staffing in recent years – to match student growth	Approved FIRM proposal to be discussed at ELT, outlining substantial staffing increase (taking consideration of two ongoing consultations)	Increased resource to improve the student experience, minimise revenue loss and support student growth (= revenue growth).	ERS (RSD)
Lack of capacity for horizon-scanning in workforce planning	No dedicated resource for this activity	Recruitment of Associate Director of Business Development Redeployment of NWSDU staff to DET Operations team to apply market intelligence of NHS workforce	Develop programmes in line with the NHS Long-term Workforce Plan	ERS

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Integrated Quality and Performance Report — Month 11

Metric	Sustainable Partnerships	SRO	Elisa Reyes-Simpson	Target		Measure	

Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

We do not have a sustainable and diverse portfolio of incoming generating partnerships to help achieve significant contribution to the DET income. Such partnerships will provide access to global markets, enabling wider reach of our influence and reputation as a key MH education and training organisation.

Vision & Goals

Vision: We have sustainable and mutually beneficial partnerships in place that generate consistent income for the trust
G1: Produce prospectus for international markets
G2: Produce an international strategy including detailed market intelligence and identification of key markets; a decision making matrix to assess viability, relevance and value of prospective partners
G3: Identify X number of national and international partners (segregated into tiers by revenue value) per annum until 2030
G4: Generate income of £200k X in 2024-5FY and minimum of £1m p.a.by 2030

Historical Performance

Income and Contribution					
Contribution after direct costs only (e.g., teaching, travel expenses etc.) OSCP staff costs not included					
Year	Sum of INCOME	Sum of TOTAL DIRECT COST	Sum of CONTRIBUTION	Sum of OVERHEADS	%
2018-19	£148,547	£76,566	£71,981	£22,282	48%
2019-20	£94,910	£44,329	£50,581	£14,237	53%
2020-21	£88,065	£1,648	£86,417	£18,210	98%
2021-22	£116,586	£10,785	£105,801	£17,489	91%
2022-23	£76,186	£12,552	£63,634	£11,428	84%
Grand Total	£559,554	£151,887	£407,666	£78,646	
Type of activity					
Group training in Dubai	1				
Group training in Geneva	1				
Group training in Poland	1				
Group visit to Tavistock	15				
Individual visitor	2				
Online video content	42				
Online, live, in person	10				
Grand Total	72				

Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Lack of market intelligence to identify new markets for sustainable student growth Lack of data to identify key applicant audience on a regional and national level	Marketing function is not driven by longitudinal data in order to make evidence-led decisions for growth in student recruitment	Refocus the Marketing function to be data-led, utilising a more commercially focused approach alongside new CRM To take a transnational educational (TNE) approach to deliver in country T&P branded education and training: Identified countries: China, Philippines, Thailand and Vietnam, North Africa, Middle East, East Africa, South Asia. To adopt a pro-active approach using intelligence from existing interest to target specific countries and explore relationships with other HEIs. Meetings in place/being established with relevant organisations over next 4-6 weeks Digital delivery options to be developed	Marketing now moved into DET reporting to Director of Education: Operations Generation of new partnerships and student growth, increased revenue and promotion of T&P brand.	ERS
Lack of breadth in student recruitment markets	Student recruitment has historically not followed a market intelligence/data-led approach	Vietnam: discussions ongoing following trade mission in 2023 to offer CAMHS consultancy Brazil – exploration of potential partnership with Oswaldo Cruz German Hospital (Sao Paolo)	Increased potential for impactful revenue generating international partnerships for the medium/long-term	ERS (PD)
Lack of commercial focus on DET	No dedicated commercial/business development support for DET	Approval of an Associate Director of Business Development (DET) granted – advert going live in w/c 22 January.	Ability to develop ambitious and impactful revenue generating partnerships – with continual account management approach	ERS
No degree awarding powers, which limits the type/scope of TNE partnerships globally	Staffing resource, systems and processes not viable when last scoped	Explore additional University Partnerships Explore required resource for Degree Awarding Powers	Without Degree Awarding Powers (DAPs) – we are limited to international digital provision (through franchising/licensing). In the absence of DAPs, alternative University Partners *may* provide additional scope for partnerships	ERS

Integrated Quality and Performance Report — Month 11

Metric	Having a Voice	SRO	Chris Abbott	Target		Measure	

Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

As a Trust, we lack sufficient regional influence and representation in population health discussions. This constrains our capacity to drive change, foster collaboration with partners, and influence neighbouring healthcare providers to align with population health drivers

Vision & Goals

Empower our organization to build and nurture essential relationships while providing compelling evidence of our contributions to drive meaningful advancements in regional healthcare discussions, enabling us to play a pivotal role in shaping the future of population healthcare not only in the capital but also nationally.

Goals:

- Work with colleagues and partners to identify population health priorities for the next 2 years
- Agree on a framework for delivery and key partners to work with
- Develop a 2-year action plan linked to Trust values and strategy incl. areas of research and EDI priorities
- To have hosted an annual Regional Thought Leadership conference each year of the strategy to consider how best to meet the mental health and wellbeing needs of London

Historical Performance

Population Health Partner Type	Our Current Activity	Tier
Child and Adolescent Mental Health Services	Camden+/ i-THRIVE	1
Adult Mental Health Providers	Adult MH + Trauma	1
Integration of Mental Health into Primary Care	PCPCS	1
Leadership and Policy Development	DET + i-THRIVE	1
Community Support Services	NCL Waiting Room	1
Mental Health Research and Innovation	Research Team	1
Mental Health Promotion in the Workplace	TC (?)	1
Research and Data Collection	Research Team	1
Community Engagement and Support Networks	NCL Waiting Room	2
Policy and Advocacy		2
Cultural Competency and Equity		2
Mental Health Education and Awareness Campaigns		2
Telehealth and Digital Mental Health Resources		2
Mental Health Screening Programs		3
Homelessness and Mental Health		3
Disaster and Trauma Response		3
Elderly and Geriatric Mental Health Services		3

There are many potential partners who have a voice in the regional Population Health discussion and landscape of provision, and while we provide services in several of these categories of provision, we do not have connections to all elements of regional Pop Health, nor are we active in our Comms channels on the subject, and currently our National Media mentions are predominantly about GIDS.

Root Cause/ Gap Analysis

From: **Media mentions** weighted to Gender >>> To: Media mentioned re: Pop Health
:: Active campaign to garner positive; pop health related media attention

From: Not producing any media assets / trainings on topic >>> To: Producing quarterly videos
:: Programme of monthly media development; videos, trainings, infographics

From: Lack formal **connections to partners** >>> To: Build coalition with NCL-WR, Cavendish Sq. Grp.

From: Lacking marketing channel for events >>> To: Exploiting coalition for event

From: Barely currently presenting at conferences >>> To: Steppingstone presentations / webinars

From: Lacking clearly **defined 'pathways'** >>> To: Clarity of both our and others' interventions

From: Do we research in this space currently? >>> To: Now doing Pop Health specific research

From: Little coordinated voice on "Prevention" >>> To: Evidence of clear 'Prevention' work (See A3)

From: Little engagement from staff grass roots >>> To: Trained, mobilised + empowered staff group

Progress on Improvements

Concern	Cause	Countermeasure in progress
Media weighted to 'Gender'	GIDS transfer / GIC waiting lists	Programme of Pop. Health communications
Lack of formal connections to partners	Largely NHS focussed to date	Campaign of engagement (+ NCL-WR)
Where we fit in 'pop health' landscape	Lack of understanding of all interventions	Analysis of our pathways + partner's work

Integrated Quality and Performance Report — Month 11

Metric	Prevention & Partnerships	SRO	Chris Abbott	Target		Measure	

Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

At Tavistock & Portman, we lack strategic oversight of the prevention initiatives carried out by T&P and our local/regional partners. Currently, there are approximately 15 vital prevention programs in progress within the Camden Borough, with plans for expansion to the broader NCL area. This situation hinders our ability to assess the ongoing impact of these activities and identify areas where we may be falling short in meeting population health demands.

Vision & Goals

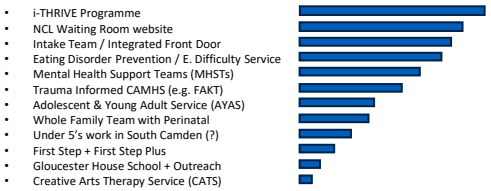
Vision: To be a regional leader in the delivery of preventative interventions for CYP which positively impacts population health outcomes

Goals:

1. Understand what provision / activity is happening currently (next 2-3 months)
2. Identified target populations to work on and the partners to work with to deliver (next 3 months)
3. Deliver first round of interventions/countermeasures in the next 6 months

Historical Performance

Our current initiatives (in order of relevance to 'Prevention')



The current process involves partners VCSE working on prevention initiatives which the Tavi is not fully versed on and therefore we are missing opportunities to efficiently help with delivery and to align our efforts for maximum impact.

- It is estimated that around 4,000 children and young people aged 5-16 years have a diagnosable mental health condition in Camden
- It is estimate that around 6,000 young people aged 16-24 years have a diagnosable common mental health condition in Camden
- More than 2,000 CYP (0-18 years) accessed support and treatment for mental health conditions, across the range of Child and Adolescent Mental Health Services (CAMHS) services offered in 2016/17

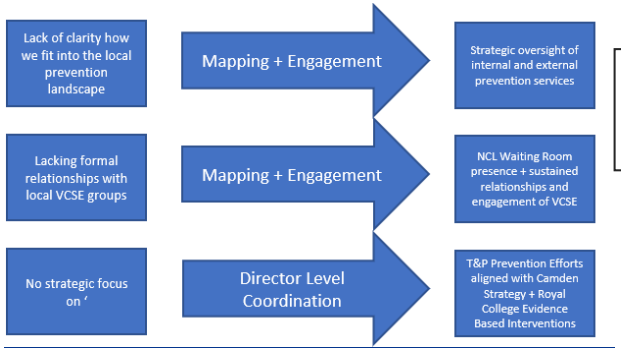
Current initiatives in Camden:

- Healing Together Camden School Offer
- Camden Council, Camden CCG and C&I
- Time to Change pledge
- Camden Early Help
- Healthy and ready for School
- The Health and Wellbeing Board

Camden partners:

- Camden Early Help
- The Camden Health and Wellbeing Board
- Camden council
- Camden and Islington NHS Foundation Trust
- The Brandon Centre
- The Hive
- Fitzrovia Youth Action (FYA)

Root Cause/ Gap Analysis



- Services are delivering this in isolation → no one service line/chain of accountability?
- Use focus groups/Camden Council to understand gaps if any

Progress on Improvements

Concern	Cause	Countermeasure in progress
Current Trust Prevention Initiatives are fragmented with no clear strategy and aim.	Trust does not have a prevention strategy in place and individual teams do not work together as no uniform leadership in area	Trust prevention strategy to be formulated and to consider operational and clinical leadership structures
No target population	Multiple areas of concern identified without agreement on where to focus work	Meeting with Camden to agree target of prevention work
No formal relationship with VCSE groups within the local area	The Trust has not reached out to work with these groups in the past so a relationship has not been formed	Start to identify VCSE groups and engage with groups that we want to create a formal relationship with

Integrated Quality and Performance Report

Month 11

Metric	Bullying and Harassment	SRO	Gem Davies	Target		Measure	

Outstanding Pt Care | Education & Training | Partnerships for Research & Innovation | **People Culture** | Sustainability

Problem Statement	WRES and WDES reflect that staff from minoritised ethnic backgrounds and staff with Disabilities and LTC experience more bullying, harassment and abuse compared to their counterparts. However, this is not reflected via other formal routes. This impacts culture, staff morale and the sense of inclusion.

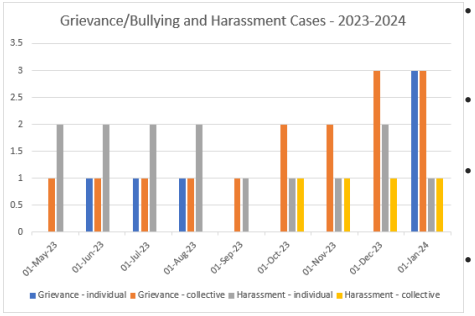
Historical Performance

Percentage of staff experiencing harassment, bullying or abuse from staff (2019-2023)					
	19/20	20/21	21/22	22/23	23/24
White (T&P)	20.5%	21.3%	19.9%	21.3%	20.7%
Other Ethnic Groups (T&P)	27.5%	23.4%	30.8%	30.1%	28.5%
Other Ethnic Groups (National Av)	24.9%	25.0%	22.9%	22.8%	21.0%

The WRES shows that harassment, bullying and abuse of staff from minoritised ethnic groups colleagues is decreasing. However, we are 7.5% worse than an average NHS Trust and have regressed from our position in 2019.

Percentage of staff experiencing harassment, bullying or abuse from staff (2019-2023)					
	19/20	20/21	21/22	22/23	23/24
LTC or Illness (T&P)	21.0%	24.7%	24.2%	23.0%	21.1%
No LTC or Illness	11.4%	11.2%	12.6%	13.4%	11.0%
LTC or Illness (Nat. Average)	22.9%	21.3%	20.2%	18.9%	18.9%

The WDES shows the proportion of staff with Disabilities and LTC compared to Non-disabled staff experiencing harassment, bullying or abuse from staff over the last 5 years. While we have made gradual improvement over the last three years our current position is not better than we were 5 years ago (2019) . Our position is 2.2% below average NHS Trust.



- Historically, we included interpersonal issues as "grievances", but have now moved to record these as "harassment" on ESR, so reporting will be more accurate going forwards. "Grievances" now relates to systems issues, such as pay, recruitment, etc and "harassment" relates to interpersonal issues.
- We currently have 9 people who have raised formal grievance cases (5 x white, 1 x mixed background, 1 x any other background, 1 x Asian – Indian, 1 x Black – African).
- We currently have 4 people who have raised formal harassment cases (1 x white, 1 x Black African, 1 x Black – Caribbean, 1 x mixed background). There are 2 individuals against whom harassment allegations have been made (1 x white, 1 x any other background).
- Currently most grievances/harassment cases relate to poor management practices (e.g. small issues not being tackled, which then blow up into formal issues)

Vision & Goals

Vision: for all reported incidents to match the WRES & WDES reported incidents

Goal for reported incidents to be more reflective of WDES/WRES incident levels

- Improvement based on reduction on difference between the reported incidents and WDES & WRES incidents:
- Year 1: 5% improvement/reduction in difference
- Year 2: 10% improvement/reduction in difference

Root Cause/ Gap Analysis

The 2023-24 WRES and WDES data highlights the following points:
WRES: (i) There has been a 1.6% reduction in the number of staff from minoritised ethnic groups experiencing BHA from colleagues. However, this is still above national average. (ii) Staff from a minortised ethnic background are x2 more likely to be discriminated by their manager/team leader than their peers.
WDES: Staff with LTC are citing a (i) significant reduction (nearly 15%) in BHA by managers. However, this is still 8.5% worse than national average, (ii) reduction of 1.9% in BHA from colleagues but they are still about 2x worse off than their counterparts without LTCs.

Progress on Improvements- Improvement Action Plan (WRES)

WRES & WDES Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Lead & Exec Owner	Timescale
Establish an Inclusive Recruitment Culture	• Debias Recruitment Process and have a more representative workforce	• All interviews have a trained manager and EDI Rep	Embed in Recruitment and Selection Policy	Associate Director of HR / EDI & CPO	Ongoing
Reduce number of staff experiencing Bullying, Harassment and Abuse	• Design posters to raise awareness about BHA	• Launch a poster campaign • Facilitate trust wide visibility	Deep dive workstream into BHA	Associate Director of EDI / HR & CPO	Deep Dive to be determined by EDI Progr. Board
Strengthen key EDI governance structures and staff networks	• Increase awareness of EDI governance • Develop relationship between Executive Sponsors and staff networks • Cascade EDI responsibility and accountability at all levels and facilitate local ownership	• Relaunch Staff Networks • Review Executive Sponsor role and responsibilities • Embed staff network maturity framework	Implement recommendations of EDI Review Set up functional staff network committees	Associate Director of EDI CPO	May 2024
Reciprocal Mentoring	• Implement Reciprocal Mentoring Programme	• Plan, select and pair mentors and mentees for pilot • Review pilot	Roll out pilot to whole organisation	Associate Director of EDI CPO	June 2024
Remove reporting barriers by completing root to branch review	• Create simplified version of grievance and disciplinary procedure • Embed Just Culture Approach • Develop and implement a Resolution Policy underpinned by Just Culture	• Facilitate collaborative approach between HR, EDI, FTSUG, staff side, DET, PPI • Policy development	Simplified version of grievance and disciplinary procedure Launch Resolution Policy underpinned by Just Culture	Associate Director of EDI / HR CPO	July 2024
Disseminate EDI data trust wide and facilitate local ownership	• Facilitate Service/Team level ownership of EDI data	• Launch A3 approach to EDI	Visit different Services / Teams and support with A3s	Associate Directors of HR & EDI	May 2024
Improve career progression opportunities for staff with Disabilities and LTC and for staff from minoritised ethnic backgrounds	• Develop fairer and transparent internal promotion process • Improve staff perception on equal opportunities for career progression and promotion	• Establish an Internal Promotion Panel	Develop Internal Promotion Panel Terms of Reference Agree membership of Promotion Panel	CPO Associate Directors of HR & EDI	August 2024
Improve representation in Agenda for Pay Bands 8a and above in the non-clinical cohort and Pay Bands 5 and above in clinical cohort	• Develop a career progression and talent management plan to improve the diversity of representation in workforce	• Implement career progression and talent management plan	Reviewing CPD process and Training Needs Analysis. Embed career conversations in appraisals	CPO Head of People (OD, Culture and Engagement)	September 2024

Integrated Quality and Performance Report — Month 12

Metric	EDI score	SRO	Gem Davies	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

The EDI score for the Trust is amongst the lowest scores compared to our benchmark peers nationally. The score is currently (2023) 7.36, with the median score being 8.33 nationally and the best performing trusts being 8.72. If we were to meet the median score, this would improve the experiences of staff and help the Trust become a more attractive employer going forward.

Vision & Goals

Vision: To consistently match or exceed the national average score

G1: Improvement in indicative factors on pulse survey by 0.4 every 3 months

G2: Improve EDI from 7.36 to national average 8.3 by March 2025

Historical Performance

	2021	2022	2023
Your org	7.21	7.32	7.36
Best result	8.75	8.73	8.72
Average result	8.30	8.34	8.33
Worst result	7.21	7.32	7.36
Responses	411	335	435

	Description
	Workforce Indicators Focus (Organisational Processes – Available 31st March)
1.	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (data from a two-year rolling average).
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey Indicators (Organisational Culture)
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage believing that Trust provides equal opportunities for career progression or promotion
8	Percentage of staff who have personally experienced discrimination at work from Manager/Team Leader or other Colleagues
	Board Representation Indicator (Available 31st March)
9	Percentage difference between the organization's Board voting membership and its overall workforce

Score overview:

Our diversity and inclusion score **increased by 0.11** from 21 to 22 (during a lower response rate period) and **increased a further .04 in 23 in a higher response rate period**. This is in the context of the best and average results in our benchmark group declining by 0.01 in 2022 to 2023.

Other comments:

- Disclosure of issues is currently misaligned to the survey results, which means we may have an initial deterioration in EDI indicators, However, we expect this to improve over time.
- Workforce composition is expected to improve over time as well – annual data will be downloaded from ESR on 31.03.24.

Root Cause/ Gap Analysis

We will be refreshing our WRES and WDES workforce composition actions for 2023 in line with the stipulated national data collection period (31st March 2023). This will assist in the review of the root cause / gap analysis.

However, early indications suggest that there is an increase in staff with LTC and staff in "other ethnic groups" indicating that we provide opportunities for progression. Also, there is a fantastic 14% increase in staff with LTC citing that reasonable adjustments have been carried out. In addition, there is a noticeable reduction in the number of staff from the same groups experiencing discrimination from managers and Bullying, Harassment and Abuse from colleagues.

WRES & WDES Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Lead & Exec Owner	Timescale
Establish an Inclusive Recruitment Culture	• Debias Recruitment Process and have a more representative workforce	• All interviews have a trained manager and EDI Rep	Embed in Recruitment and Selection Policy	Associate Director of HR / EDI & CPO	Ongoing
Reduce number of staff experiencing Bullying, Harassment and Abuse	• Design posters to raise awareness about BHA	• Launch a poster campaign • Facilitate trust wide visibility	Deep dive workstream into BHA	Associate Director of EDI / HR & CPO	Deep Dive to be determined by EDI Progr. Board
Strengthen key EDI governance structures and staff networks	• Increase awareness of EDI governance • Develop relationship between Executive Sponsors and staff networks • Cascade EDI responsibility and accountability at all levels and facilitate local ownership	• Relaunch Staff Networks • Review Executive Sponsor role and responsibilities • Embed staff network maturity framework	Implement recommendations of EDI Review Set up functional staff network committees	Associate Director of EDI CPO	May 2024
Reciprocal Mentoring	• Implement Reciprocal Mentoring Programme	• Plan, select and pair mentors and mentees for pilot • Review pilot	Roll out pilot to whole organisation	Associate Director of EDI CPO	June 2024
Remove reporting barriers by completing root to branch review	• Create simplified version of grievance and disciplinary procedure • Embed Just Culture Approach • Develop and implement a Resolution Policy underpinned by Just Culture	• Facilitate collaborative approach between HR, EDI, FTSUG, staff side, DET, PPI • Policy development	Simplified version of grievance and disciplinary procedure Launch Resolution Policy underpinned by Just Culture	Associate Director of EDI / HR CPO	July 2024
Disseminate EDI data trust wide and facilitate local ownership	• Facilitate Service/Team level ownership of EDI data	• Launch A3 approach to EDI	Visit different Services / Teams and support with A3s	Associate Directors of HR & EDI	May 2024
Improve career progression opportunities for staff with Disabilities and LTC and for staff from minoritised ethnic backgrounds	• Develop fairer and transparent internal promotion process • Improve staff perception on equal opportunities for career progression and promotion	• Establish an Internal Promotion Panel	Develop Internal Promotion Panel Terms of Reference Agree membership of Promotion Panel	CPO Associate Directors of HR & EDI	August 2024
Improve representation in Agenda for Pay Bands 8a and above in the non-clinical cohort and Pay Bands 5 and above in clinical cohort	• Develop a career progression and talent management plan to improve the diversity of representation in workforce	• Implement career progression and talent management plan	Reviewing CPD process and Training Needs Analysis. Embed career conversations in appraisals	CPO Head of People (OD, Culture and Engagement)	September 2024

Integrated Quality and Performance Report — Month 11

Metric	Team Level Budgets	SRO	Peter O'Neill	Target		Measure	

Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement	We don't have agreed team level budgets in place that are recognised to reflect the outcome of the strategic review across the Trust. We currently have 11 budgets updated and finalised out of a total of 123. The impact is the lack of team level accountability and an inability to produce service level monthly reporting. There is no established budget maintenance at team level.

Historical Performance

Current Situation - initial

- We have team level staff and non staff budgets identified that are consistent with the agreed financial plan for 23/24.
- We don't have any team level budgets signed off, as services don't recognise the outcome of the SR in some cases.
- We are working with individual teams to agree/update budgets as required.
- ESR reconciliation process identified with input from HR and budget holders.
- Budgets will be drafted based on known plans and queries/cleansing done at cost centre level but reflecting whole divisional position, i.e. functional groups of services
- Budget working papers produced and updated based on tracked movements each month
- Recurrent and non recurrent additions to resources, eg ERF funding added and reflected in budget reporting going forward
- Monthly process in place, including scheduled meetings to pick up queries and budget variance issues, and feed into existing IQPR process
- Actual spend to be reviewed against budget, as part of the update and cleansing process.

Update and Next Steps 14th March

- **Consistent set of budget reports produced for C&I, CMH & Corporate, from M10**
- **DET and Gender reports produced as previous months**
- **Assessment of scale of budget queries being produced**
- **M11 & M12 – budget queries continue to be updated**
- **Budgets at M12 to form basis of base budgets 24/25**
  - **Consistency check/update to reflect 24/25 trust level plan**
  - **Significant budget variances to be investigated, with individual budgets updated if required.**
- **Budget report summaries to be included in IQPR reporting from M11**
- **CIP plans and delivery to be incorporated into the financial reporting for 24/25**

Vision & Goals

1. Complete an initial set of team budgets by end of January 24
2. Ensure they are consistent with the agreed Trust Financial Plan, including updates for pay awards and assumed vacancy factors
3. Share with divisional managers and do initial cleanse for known movements of staff and/or posts
4. Provided actual spend to date and in month at same level/comparable format
5. Populate ledger with updated budgets
6. Updated base budget reports to be available and distributed to budget holders. To be consistent with the financial plan 24/25, April 24.

Root Cause/ Gap Analysis

- The outcome of the strategic review resulted in the trust not having agreed team level organograms that budgets could be based on
- We didn't have a controlled process in place that maintained a set of budget working papers
- Not BAU for HR and Finance to maintain budget working papers → **we don't have a process**

Forward looking:

- Capacity to do the exercise (HR, Finance, Budget Holders)
- Some budget holders may not agree with the outcome of the review – might require additional resource to complete
- Additional resource required for new posts → map against impact on overall problem
- Process in place for assurance that Budget working papers are aligned with ESR – isn't in place currently. To be developed between Finance and HR.
- Updated budgets form baseline for next years Financial Plan.
- Draft budgets shared with budget holders in advance of new financial year.

Progress on Improvements

Concern	Cause	Countermeasure in progress
Risk of not maintaining papers for future budgets	Not BAU for Finance and HR to maintain budget working papers	- Put process in place - Put assurance process in place
Reporting Process not adequate to generate team level accountability	No budget reporting done routinely	Budget reporting being developed with adequate monthly budget management

Integrated Quality and Performance Report

Month 11

Metric	MTFP	SRO	Peter O'Neill	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement	We haven't got a medium term (3-5 year) financial plan that delivers a financially balanced outcome for the future in the Trust. This is required to reach 100% by December 23. This is required as it will identify how we achieve financial balance and be consistent with ICS planning assumptions, which we need this to be seen as an attractive partner for merger opportunities. If we do not have a plan to deliver to, we risk a larger deficit with potential for regulatory scrutiny and limitation of operational autonomy.

Historical Performance

- Agreed set of assumptions to feed the MTFP that have been shared with the ICS
- ICS are aligned in approach
- There is a model internally to produce the plan and a first draft has been produced
- This draft does not deliver financial balance in 24/25, and this is being updated w/c 30/10 to identify the level of income and savings required to bring the plan back into balance.
- The cash flow element of the MTFP requires confirmation of the funding of the GIDS decommissioning before it can finalised. The current model assumes that they are funded so cash deficit will be Q1/2 next year as originally envisaged.

Vision & Goals

G1: To have a medium term (3-5 year) financial plan that delivers a financially balanced outcome for the future in the Trust by Dec 23

G2: For it to be a rolling 3-5 year plan moving forward

Root Cause/ Gap Analysis

Plan is not currently balanced in 24/25, balance to be achieved via income growth and additional CIP in future periods.

- GIDS decommissioning will impact on plan with revenue costs falling in 23/24 as a provision – working on assumption that redundancy payments and other cash outflows will be in early 24/25.
- We haven't got sufficient income or savings identified in 24/25 to mitigate the loss of GIDS income in full.
- Too many timing unknowns to predict cash position month on month next year, further work to finesse these are currently ongoing.
- Balance to be achieved 25/26. To be agreed with ICB colleagues.

Forward looking:

- *Internal process in place with finance to keep updating the medium term financial plan as assumptions change.*
- Impact of GIDS decommissioning and the lack of NHSE support to be raised directly, phased reduction in overhead contribution being sort.
- Merger work potentially has an impact on baseline assumptions – we may end up with different MTFP dependent on the scenarios from the merger discussions.

Progress on Improvements

Concern	Cause	Countermeasure in progress
We don't have a balanced plan in 24/25.	Additional income and savings not identified sufficient to mitigate GIDS overhead loss.	MTFP currently being drafted and reviewed
Destabilisation of plan	GIDS being decommissioned – no clarity on funding and decommissioning costs	Finalise decommissioning plan with NHSE and negotiate financial consequences

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

Business Rules

Our strategic objectives will drive us to achieve our strategic ambitions, and are our focus for this year. These metrics have a challenging improvement target and the scorecard will show as red until the final goal is achieved when it then turns green. Once achieved a further, more stretching target may be set to drive further improvement, turning the metric back to red, or a different metric is chosen. Metrics that are not included in the strategic objectives, but are critical to our service delivery are placed on a watch list, where a threshold is set by monitored. More of these metrics should appear green and remain so. Watch Metrics are metrics we are keeping an eye on to ensure they don't deteriorate. Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action. This approach allows us to take a measured response to natural variation and aims to avoid investigation into every metric every month. The IQPR will provide a summary view across all strategic objectives metrics as well as a RAG rating supporting metrics that have either ; • Been red for 4 + months (OR) • Breached the upper or lower SPC control limit.

Rules for Watch Metrics:	Action:
1. Metric is green for reporting period	Share success and move on
2. Metric is green for six reporting periods	Discussion: 1. remove from watch metrics 2. Increase target
3. Metric is red for 1 reporting period (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4. Metric is red for 2 reporting periods	Produce Countermeasure/action plan summary
5. Watch is red for 4 months	Discussion: 1. Switch to include metric in strategic objectives 2. Review threshold
6. Watch is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Watch Metrics Score Card

(The scorecard requires a change to Statistical Processing Charts (SPCs), which measure upper and lower limits as well as standard variation, which the digital team are working on)

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous month	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
	Patient safety incidents (actual or potential harm)	N/A	Meeting target within tolerance with no standard variation	↓	18	12	10	9	8	10	4
	Open SI / PSI investigations	N/A	Meeting target within tolerance with no standard variation	↔	3	3	3	3	3	2	3
	Violence & aggression incidents	<5	Variability within past 7 months but for the past 5 months, performance stabilising	↓	9	11	6	6	4	8	2
	Restraint incidents	0		↑	1	0	0	0	1	4	5
	Lower-level physical intervention	TBC	Variability within the last 7 months but performance stabilising.	↓	30	15	8	5	4	10	1
	52-week+ dormant cases	0	PTL meetings are live and the numbers are starting to reduce. Numbers impacted by GIC which currently has 18 months between appointments (1824 of the 2080).	↓	2380	2350	2366	2266	2185	2126	2080
	No of referrals (including rejections)	>919	Referrals in GIC have reduced due to a backlog, numbers likely to increase when data refreshed	↓	912	967	643	911	965	745	713
	No. of attendances	7046	Activity remains variable and below standard expected variability.	↓	5867	7162	4643	6406	6369	6144	5755
	No. of discharges	>827	Patient pathways are being reviewed as part of the waiting list strategic priority. Patient flow is an underlying issue.	↓	508	699	393	1051	974	959	719
	No. of rejections	<92	One team identified with high % rejection rates and audit of team underway.	↑	43	60	41	42	62	59	94
	% of Trust led cancellations	<5%	Meeting target within tolerance with no standard variation	↑	5.04%	3.22%	5.89%	4.57%	4.16%	3.39%	4.29%
	% of DNA	<10%	DNA policy standardisation being undertaken and review of teams with high DNA rates	↑	9.95%	9.38%	9.81%	9.76%	9.60%	9.49%	10.58%
	Number of formal Complaints received	<10	Meeting target within tolerance with no standard variation	↔	5	7	3	5	5	2	2
	Number of compliments received	TBC	Meeting target within tolerance with no standard variation							81	61

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Comments	Trend from previous month	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
	Number of informal (local resolution) complaints	<5		↑	4	1	1	0	0	4	7
	ESQ positive responses (%)	90%		↑	94%	94%	84%	87%	91%	82%	84%
	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS	0	Positive continuous improvement over 7 months	↓	58	51	54	53	38	20	18
	18-week RTT breaches ASC	0	Waiting list continues to grow, however first appointments are increasing, the referrals rates are still higher than the first appointments available to offer. See A3 page 3 for waiting list updates	↑	40	50	67	77	90	98	104
	18-week RTT breaches GIC	0		↑	13061	13174	13429	13298	13458	13814	13884
	18-week RTT breaches Trauma	0		↑	449	480	517	558	607	640	680
	18-week RTT breaches PCPCS	0		↑	48	46	70	71	80	114	134
	Mand and stat training	95%	Variability across the 7 months, however slight positive improvement last 3 months	↑	55.72%	75.78%	76.93%	77.97%	75.68%	76.21%	77.08%
	Appraisal completion	95%	Recent change in the appraisal reporting parameters see slide 28 for more information.	↓	78.86%	79.57%	81.47%	80.65%	80.36%	30.77%	28.67%
	Staff sickness	3.07%	Standard variation within the last 4 months	↑	2.23%	3.98%	3.17%	1.45%	1.61%	1.34%	1.84%
	Staff turnover	2.20%	Following closure of GIDS, staff turnover has returned to stabilised levels	↓	0.57%	1.07%	1.47%	2.46%	0.75%	8.32%	1.32%
	Vacancy rate (On Hold)	<15%	Standard variation over last 7 months	↓	12.35%	12.46%	12.90%	12.90%	12.60%	13.06%	11.98%
	YTD Reported Position	TBA	Trust deficit on target at M02, as per submitted plan 12th June 24								
	Efficiency Plan Update	TBA	No planned delivery at M02								

Are we safe?

Delivering our vision – How are we doing?

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 4 Patient Safety Incidents in April

A notably lower number of all incidents were reported in April (11 incidents reported in total). This was attributed to the Easter Holidays; Gloucester House being closed for school holidays for two weeks of the month and staff taking annual leave across the whole Trust. However, the Quality Portal was tested at the time to check that there wasn't a technology issue with reporting incidents. No issues were found.

Radar is live as of 3rd June 2024 for reporting incidents. This enables the automatic upload of all patient safety incidents to the Learning from Patient Safety Events (LFPSE) portal, a key objective in the implementation of PSIRF.

The Patient Safety team are in the process of trialling an approach to thematic reviews, in line with the implementation of PSIRF. These are planned for violence and aggression and information governance incidents in the first instance.

The Patient Safety Incident Investigation (PSII) which was commissioned in April is underway. The draft report is expected to be ready for the July Clinical Incident & Safety Group (CISG).

Patient Safety classification of actual or potential harm.

Patient safety Incidents

4

The Trust reported 2 Violence & Aggression incidents in April

Incidents of physical and/or verbal abuse are noted to be the highest reported category; the majority of which are reported by our Gloucester House team. The Patient Safety team are in the process of trialling an approach to thematic reviews, in line with the implementation of PSIRF. These are planned for violence and aggression and information governance incidents in the first instance.

In response to incidents taking place on external premises to Gloucester House, a joint After Action Review is being held. It is anticipated this report and learning will be ready by the middle of June. In the meantime, off site trips and teaching sessions have been paused.

Data as reported in the 'Physical & Verbal Abuse' category.

V&A Incidents

2

The Trust reported 5 physical restraint Incidents in April

Work is underway to make the restraint records electronic via the new Radar system, enabling ease of robust recording and reporting.

Restraint Incidents

5

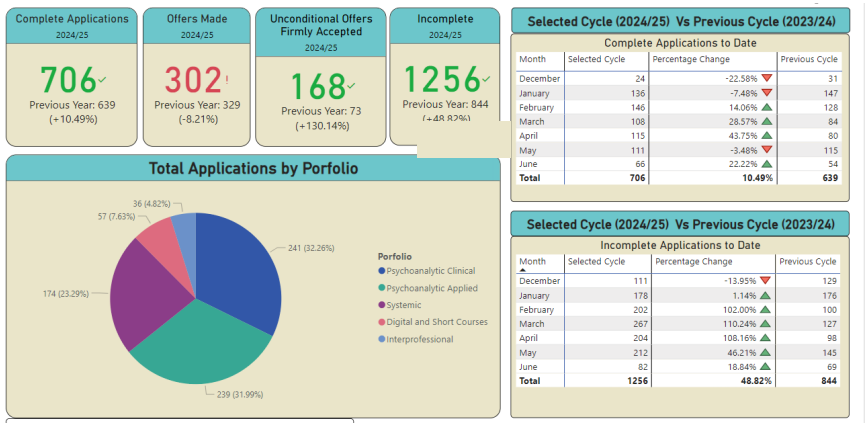
Are we effective?

Education & Training

The Tavistock and Portman NHS Foundation Trust

Successes	Challenges
• A more standardised approach to the student recruitment and admissions cycle, including firm application deadlines for the 2024/25 cycle and an earlier recruitment opening for 2025/26 in line with the sector and to increase the number of expected applications.	• Whilst we have seen an increase in the number of applications from international students, we are at a disadvantaged when compared with our competitors in converting applications to acceptances owing (e.g. unable to offer student accommodation).
• 10.49% increase applications compared to the same point last year in an increasingly challenging environment for HE student recruitment	• Lack of flexibility in SITS to support a more flexible/modular form of delivery as well as ensuring data integrity
• Introduction of a dedicated Project Management Officer within DET through the redeployment of experienced project management staff from NWSDU.	• To meet the increasing demands placed on the Trust – regulatory; statutory data returns; institutional conditions imposed by University partners; and the need to deliver a high student experience with increasing numbers – we require all posts in Professional Services approved at ELT and FIRM (January 2024) to be recruited well in advance of the start of the 2024/25 academic year.
• The Institutional Review Panel recommended that the Trust be re-approved as a partner institution of the University of Essex for a further five years, following the recent Institutional Review.	

Student Recruitment Activity Overview



Selected Cycle (2024/25) Vs Previous Cycle (2023/24)

Complete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle
December	24	-22.58%	31
January	136	-7.48%	147
February	146	14.06%	128
March	108	28.57%	84
April	115	43.75%	80
May	111	-3.48%	115
June	66	22.22%	54
Total	**706**	**10.49%**	**639**

Selected Cycle (2024/25) Vs Previous Cycle (2023/24)

Incomplete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle
December	111	-13.95%	129
January	178	1.14%	176
February	202	102.00%	100
March	267	110.24%	127
April	204	108.16%	98
May	212	46.21%	145
June	82	18.84%	69
Total	**1256**	**48.82%**	**844**

Analysis

Student recruitment: Postgraduate recruitment continues to look positive, with 706 complete applications received via MyTAP to date. This figure does not include the 367 applications received via a separate portal for our M4 training in educational psychology, or the 5 applications submitted to our Executive Coaching Programme via our website. A further 1,256 incomplete applications are in progress.

Courses which are recruiting particularly well compared to last year include the Introduction to counselling and psychotherapy (D12/ED12); the MA in Consulting and leading in organisations: psychodynamic and systemic approaches (D10); the consolidated Psychodynamic Psychotherapy (M58) training; and the professional doctorate in Advanced practice and research: social work and social care (D55). We are preparing to launch of a number of new short courses and have announced the imminent publication of a new online training in Child sexual abuse disclosure: how to support adult survivors - with 81 people registering their interest so far.

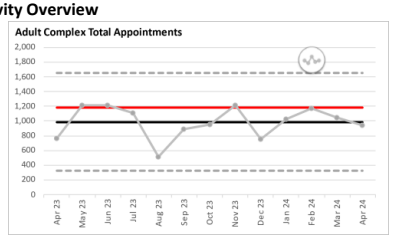
Staffing: Current Professional Services staffing, and structures fail to meet operational needs or support growth ambitions. Teams face single points of failure, posing risks to operations, finances, and Trust reputation. Academic Registry has approved 7.0 WTE new positions to meet statutory and university partner requirements. This includes additional staff for statutory compliance, academic governance, assessment, curriculum, and student credit control. The restructured management (Band 7s) will be supported by Band 6 and Band 5 staff, fostering internal growth and reducing reliance on external contractors. This ensures a stable and experienced workforce capable of stepping into senior roles.

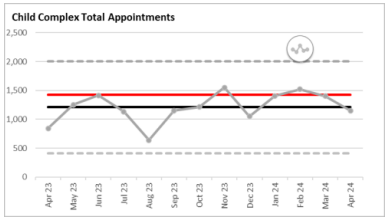
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move to a Senior Lecturer/Lecturer/Associate Lecturer model	CETO / Directors of Education	ASAP (tbc pending confirmation with HR)
Regulatory changes (OfS)	Office for Students' regulatory focus on franchise/partnership model	Identify stronger institutional partnership with university partner(s) including exploration of (T)DAPs	CETO / Directors of Education	Ongoing
SITS	Incomplete implementation of SITS in 2017 alongside inadequate processed and lack of staffing resource	Comprehensive review of SITS currently underway with implementation of recommendations to commence immediately upon completion of review	Director of Education (Operations)	21/07/2024

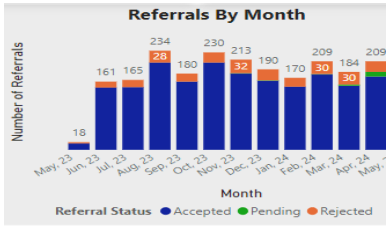
Complex Mental Health Overview

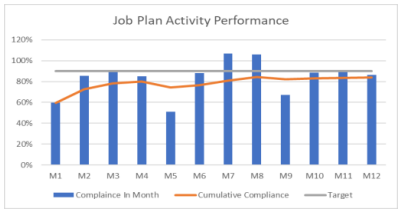
	Successes	Challenges
Safe	• 5% increase in MAST compliance over past 5 months. The service continues to prioritise these as we are still 13.5% short of the target.	• Appraisal rates at <30% for second month in a row. Line managers reporting significant numbers have been undertaken but documents still being finalized before being submitted. Services are reviewing their delivery plans and we are expecting to see significant improvement in June/July data.
Effective	• Autism Kaizen events in May were well attended and engaged with 3 A3s produced that address efficiency as well as patient & staff experience.	• Request from Haringey commissioners to provide less screening and more clinical interventions for looked after children. We are working with First Step and FAKCT to potentially update our service provision. This is likely to amplify the risk and the work relating to management of harm and prioritisation of patients waiting.
Caring	• User experience of the services remains high with an average 84% positive ESQ score over the past 12 months. Addressing waiting times and communication while waiting has been identified as areas we can further improve experience and have related actions in the A3s for Autism Assessment following the Kaizen event.	• Continue to have a backlog of complaints (17 open). Weekly meetings with complaints teams started in May, which have helped progress investigations. We are also increasing the pool of staff involved in responses.
Responsive	• 64% reduction in patients waiting over 18 weeks for 1st appt in Adult Psychotherapy over past 3 months due to implementing allocation and booking process QI	• Trauma backlog of 1st appointments increased by 46 in a month and 407 over the past 12 months (88% increase). Further investment maybe quired and this is currently being reviewed and supported by Director of Strategy to develop commissioner engagement plan. Level of risk of patient waiting is a growing concern.
Well Led	• CMH senior leadership group have focused on communicating and supporting staff through the leadership consultation via group, individual and team meetings.	• Teams have raised concerns about the potential loss of continuity and support following leadership consultation.

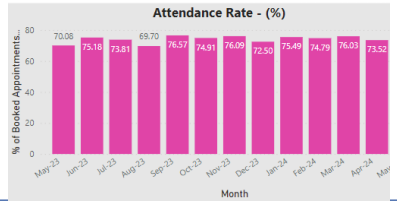
Activity Overview

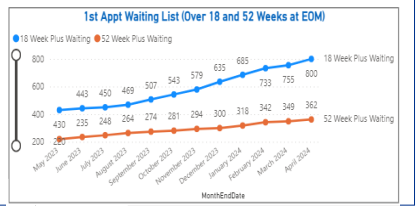












Analysis

Child Complex activity in April was 36% higher than last April 23 activity. Adult Complex activity was 23% higher than April last year. **Portman activity was 25% higher than last April.** April is a peak leave month and despite us still being short of targets in some areas, the improvement year on year is a very positive change. April job plan compliance data was not available at the time of this report. April and May will be reported together next month.

Referrals - for April continue to be high, with Trauma being the equal highest month on record.

Waiting times - across CMH remain low for most teams however there is a reduction in Adult Psychotherapy, following a QI initiative to improve assessment capacity and booking processes. However, waits for Trauma and Autism assessments continue to grow because of the significant increase in demand. Autism Kaizen event was undertaken in May and several key improvement initiatives agreed to improve the efficiency of the assessment process (detail in appendix).

The attendance rate of booked appointments was 76% for April and has remained stable through the year. The service will focus on reviewing the cancelation rate as it is quite high. The DNA rate was 8%, 4% trust cancellation, 12% patient cancellation.

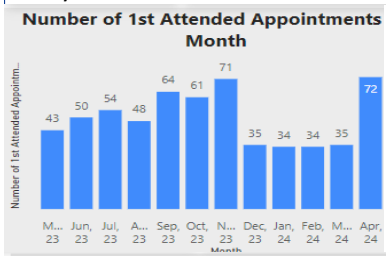
Next Steps

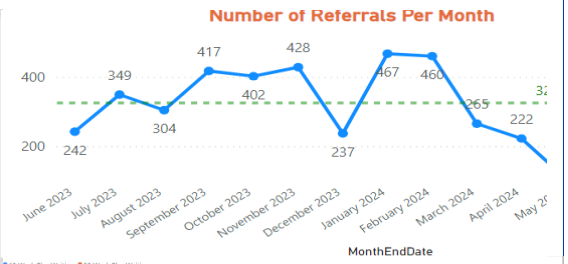
Concern	Cause	Countermeasure	Owner	Due Date
Job Plan / Activity Performance	Historic cultural issues, sickness, performance, recording issues	Monthly review and action plan process. Deep Dive into Portman activity over past 5 years	Clinical Managers / GMs	31st August 2024
Demand vs Capacity & Pathways in Trauma & Autism Assessment	Unclear pathways impacting on delivery	Mapping as-is and to-be pathways.	Clinical Managers / GMs	30th September 2024
Complaints backlog	Unclear scheme of delegation for respondents at service level	Weekly complaints meeting, increased pool of investigators and clear governance oversight and targeted support for specific outliers	Chief Nurse for oversight and Clinical AD for delivery	31st August 2024

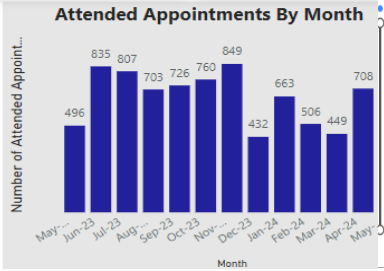
GIC

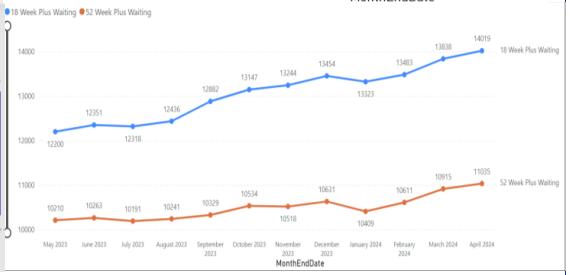
	Successes	Challenges
Safe	• The service have doubled the number of 1st assessments in April 2024.	• Staff morale is being impacted by the ongoing media attention on Gender. Staff well-being is a focus for this service with improvement and supportive measures being delivered through the kaizen workshops.
Effective	• Job planning for medics have been completed and going through the final round of governance checks.	• I.T continues to be an issue for the service and the IT team are working with the service to improve the functionality in a consistant way.
Caring	• The admin team continue to respond to red letters and HCP queries and have improved the response time significantly, thus improving patient safety.	• Recruitment challenges are ongoing and the service has a workforce plan to mitigate against further risks
Responsive	• Morbidity and mortality meeting has been launched in the service quarterly in response to a need to improve visibility and address recommendations from audit review.	• Equalities concerns have emerged due to current referral processes. The service and Trust has set up a task and finish group to address these concerns and mitigate.
Well Led	• SLT Group has received positive responses from users following the set up of their new voice group.	• Some elements of data capture remain manual and the Trust is working to develop improved digital dashboards.

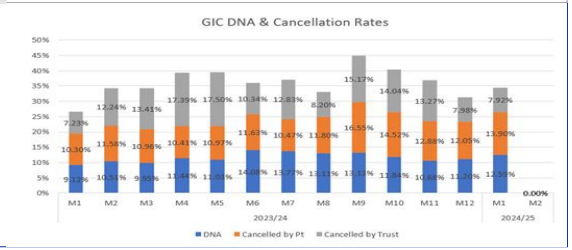
Activity Overview











Analysis

The service has increased activity the last month by approx. 62% this can be attributed to newly trained specialty doctors who have started clinics independently. We have 653 referrals to process on ERS and the service are actively working on improvement plans.

Referral to Treatment – the waiting list continues to grow due to capacity of the workforce to deliver 1st appointments versus the number of incoming referrals, even though the number of referrals has dropped the last few months. In addition, the impact of an open referral process into a tertiary service significantly increases referral rates and due to the size of the waiting list, continues to affect waiting times.

DNA and cancellation rates - the non attendance is high , however a review of the processes were undertaken during the kaizen events and improvement methodologies have been proposed and will be implemented aligned to the over-arching delivery and improvement plan.

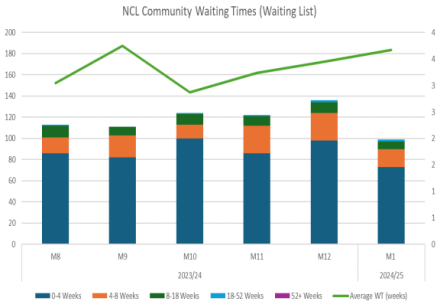
Next Steps

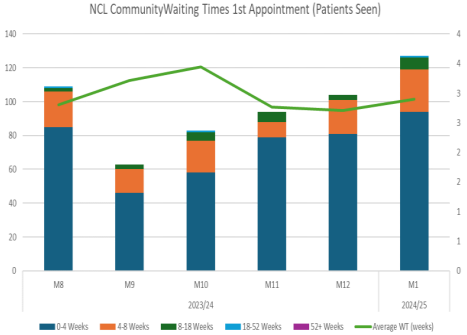
Concern	Cause	Countermeasure	Owner	Due Date
Capacity Vs Demand Review	Job plans not fully developed	Job plans have now been finalised for medics this will allow to complete analysis for 1st assessments	Chief Medical Officer / GM	30/06/2024
Increase in administrative workload	Increased admin in Endocrine service has had impact on admin service	The service is undergoing a workforce plan to look at current and forecasted staffing. Developing a Business case particularly looking at clinical risk associated in some specialties in the service Endocrine service appointments are booked differently due to medication monitoring	Clinical Lead / GM / Director of Operations	30/06/2024
Inaccurate referral data reported	Incomplete clinical referrals	Look into ERS functions and referral form to make fields mandatory	GM	30/06/2024
Levels of non-attendance is high	Patients not attending appointments for various reasons	Audit cancellation and dna reasons to propose strategy for improvement	GM and Clinical Director	31/08/2024

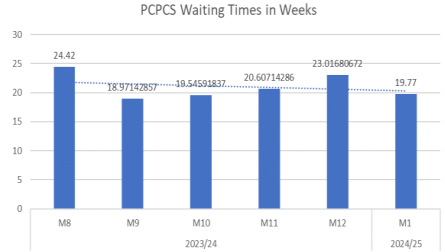
Community and Integrated Services

	Successes	Challenges
Safe	• Staff recruitment and induction completion has helped capacity recovery in SCCT.	• Ongoing challenges with recruitment to vacancies which is particular notable issue for the CAISS team.
Effective	• Following audit processes, learning from audit initiated QI development plan to address key improvement in CAISS Carenotes recording.	• Improving application of OMs (A3 underway)
Caring	• CWP service carrying out a comprehensive range of co-produced projects and service user involvement - increasing parent involvement in anxiety management, adapting interventions for neurodiverse patients.	• Feedback comes from multiple sources, causing delays in collation and sharing of learning. The QI team and GMs are working together to develop streamlined services
Responsive	• The service conducted Interviews with adolescent boys to identify barriers to using services. The results have been shared with the Waiting Room and schools to help remove those barriers.	• There are significant cultural challenges to enacting the job planning processes which largely stems from a lack of understanding in application.
Well Led	• Co-production and mentoring; partnership with FYA and Camden LA has produced a peer support group and also a film advertising the work.	• There are ongoing challenges regarding roles, responsibilities and accountability that impact on timely delivery. It is hoped that the post-consultation structures will mitigate this, however additional training and support is required to fully imbed the governance and operational frameworks.

Activity Overview







MAST 95%
3/18 teams at or above target
4/18 close 92% - over
11/18 range 62 -85%

Analysis

The service line on average is meeting the new 4-week standard for treatment for children's services.

PCPCS continues to show high levels of wait times across the spectrum resulting from wide ranging team issues including recruitment. However, ESQ data shows high levels of positive feedback which is supported by themed analysis of compliments received.

A range of EDI activity is taking place across the SL. CWP user involvement being shared with schools to help boys learn to talk about mental health issues. Work on the impact of racism on future generations is underway. A range of co-production with patients is taking place in Camden.

MAST data by team has been circulated for action to team managers with supportive measures in place, the service overall is on an improvement trajectory to the 95%. .

Next Steps

Concern	Cause	Countermeasure	Owner	Due Date
Job Planning is poorly understood and applied	Confusion on what JP data is meant for and how collected	GMs and Ops Director have reviewed the template, and a paper is being presented to ELT on 17 June 24	HB	30 Jul 24
CAISS recruitment urgent	High level of sickness and unsuccessful recruitment	The service are currently reviewing their workforce plan, supported by the People Team,	SB/TD	31 Aug 24

Are we Caring?

Delivering our vision – How are we doing?

Caring- service involves and treats people with compassion, kindness, dignity and respect

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 2 Formal Complaints in April 7 complaints were resolved informally in the same month. Despite the progress in reducing the backlog of complaints, the 40 working day response for formal complaints continues to not be met. As of the end of May, there were 27 complaints open; 20 of which were overdue. Capacity of services to undertake investigations, plus some increasing complexity of complaints, has meant that progress to close the number of overdue complaints had stalled during March and April. Services have been reminded to address and prioritise this with urgency. In addition, services are being reminded of the imminent closure of the Quality Portal system on 4th July and therefore that is the internal deadline for closure of the outstanding complaints currently registered on the system.	**Formal complaints 2**
The Trust has recorded 61 Compliments in April The number of compliments received from the beginning of the year has seen a steady increasing trend. Recording and reporting of compliments is currently under review for improvement and to ensure the logic used is accurate. This sits as part of the A3 quality improvement project focused on User Experience. The event module for Compliments in the new Radar system is currently being worked through with an anticipated go-live in the Phase 2 of the delivery project. This will enable a strengthened reporting framework as all compliments received will be categorised.	**Compliments 61**
The Trust has recorded 84% of ESQ Positive Responses in April There is an A3 QI plan in place to improve the process, recording and reporting of ESQ forms. The previous lack of feedback is impacting on services' ability to respond to peoples' experiences and make improvements where needed. Updates from the QI project include; • Benchmark baseline rates of 200% now established for each service line and will be monitored every 3 months via the monthly A3 meetings. • Complete deep dives with each service line to give the opportunity to look at team level data, exploring what is working well and what are some of the barrier/challenges to ESQ distribution • Develop a bank of ideas to test out in different teams and report back using PDSA cycles • Highlight service lines (and teams within this) who are doing well to share learnings with other clinical areas who are struggling to increase their response levels.	**Positive responses 84%**

The Tavistock and Portman
NHS Foundation Trust

Are we responsive?

Delivering our vision – How are we doing?

Responsive – services meet people's needs

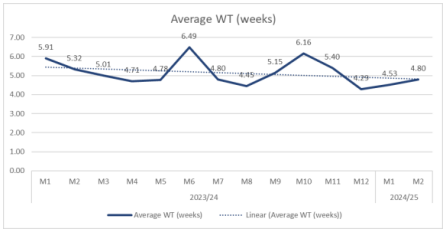
The Tavistock and Portman NHS Foundation Trust

The Trust has declared RTT 14,820 18-week breaches across our services

The trust has identified key teams where waiting times for patients are above optimal levels (GIC, ASC, Trauma, PCPCS). Waiting List management is a key priority area for us, focussing on the teams requiring the most support. Unprecedented increases in referrals in these area have led to further waiting list increases. Please see slide 3 for further detail on the work to date.

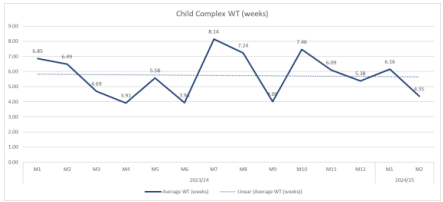
RTT breaches
14820

The Trust has declared an average wait of 4.8 weeks to treatment appointment in our Community and Integrated Service Line (excludes PCPCS as highlighted as an area of concern)



Average RTT Wait - Patients seen

The Trust has declared an average wait of 4.35 weeks to first appointment in our Childrens Complex Mental Health Service Line (excludes ASC and Trauma as highlighted as an area of concern)



Average Wait - Patients seen

Are we well-led?

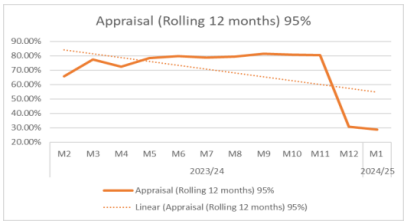
Delivering our vision – How are we doing?

Well-led – leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

The Tavistock and Portman NHS Foundation Trust

The Trust declared 28.67 % of Appraisal Completion

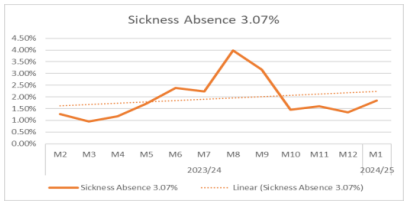
The significant reduction in appraisal compliance is due to the recent change in the appraisal reporting parameters. The Trust previously had a static appraisal cycle which ran from April - March. This changed following the introduction of the A4C pay progression, hence the need to move to a rolling appraisal cycle. We are working collaboratively with senior leaders across the organisation to improve this position within the next quarter.



% Appraisal completion
28.67

The Trust declared 1.84 % of Staff Sickness in February 2024

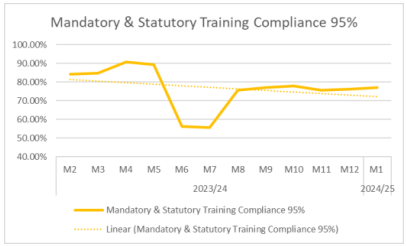
The number of reported health-related absence cases has fallen for the third month in a row. The business partnering team continues to support managers with support staff and expedite a return to work where feasible. The continues to deliver training session in line with the support health and well-being policy. These sessions will now be open to all staff shortly.



% Staff sickness
1.84

The Trust declared 77.08 % of MAST Completion

The people team continues to actively support managers with appraisal compliance across the board. Managers have been advised to book appraisal dates into diaries to ensure staff have the 'protected' time to complete their appraisals. The people team are also escalating non-compliance through the appropriate channels to action.



MAST training (%)
77.08

Do we use resources effectively?

The Trust declared £439k deficit YTD planned position for month 2	 **24/25 YTD planned position £439k deficit**
The Trust declared £439k deficit YTD actual position for month 2 **The final submission of the 2024/25 financial plan was agreed with NHSE on 12th June 2024. The revised profile of the plan reflected the actuals as of Month 2 24/25, hence no variance between plan and actual. However, the Month 2 actual expenditure is consistent with previous months and was in line the original versions of the plan.** .	 **24/25 YTD actual position £439k deficit**

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Thursday, 11th July 2024			
Report Title: Our Future Direction – Update and Next Steps			**Agenda No. 10**
Report Author and Job Title:	Rod Booth, Director of Strategy & Business Development	**Lead Executive Director:**	Michael Holland, Chief Executive Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This report provides an update on progress on the merger. Due to the pre-election period falling twice during the preceding months and the pre-election period guidance requiring the pausing of decisions on long term strategy, updates to the Public Board on progress with the merger have been reasonably minimal.		
Background:	**Progress timeline summary:** • The Board of Directors agreed on a two-stage approach to identify a merger partner. This involved an initial phase (Stage 1) to narrow the field to two preferred partners and a final phase (Stage 2) to agree the preferred merger partner. • On 8th January 2024, the Trust issued an invitation to five organisations who had expressed an interest in being merger partners. • The deadline for submission of Expressions of Interest (EoI) was 29 February 2024. On 29 February, the Trust received two expressions of interest. • Two organisations did not submit expressions of interest. They did, however, send letters advising the Trust of their interest in specific services if the Trust was to be broken up into 'lots'. • At the March 2024 Closed Board meeting, the Board agreed to take forward two expressions of interest (EoI) into the next stage of the process for further due diligence and to support bringing out the best in what they both offer the Trust as a potential merger partner. • At the May 2024 Closed Board meeting, the Board noted one of two potential partners did not wish to proceed to Stage Two of the merger process but remained interested in working with the Trust around the provision of children's and young people's mental health services in Camden. • At the June 2024 Closed Board meeting, the Board noted the remaining potential partner continued to be supportive of the strategic case and proposition as set out in its EoI. In summary, **to improve educational outcomes for students, and health and care outcomes for patients and their carers supported by the new organisation, whilst ensuring no partner is disadvantaged in the pursuit of those improved outcomes**. The Strategic Case sets out four key themes:		

	i. The development of more integrated health and care services ii. Education and training iii. Research and development iv. Our shared role in developing Camden as a Place • At the June 2024 Closed Board meeting, the Board approved continuing to the next stage in the due diligence process with the remaining potential partner (in collaboration with two organisations) as our preferred partner.
Assessment:	**Next steps:** We continue to work closely with the preferred partner to mitigate risk and develop a shared plan for taking forward our plan. This involves working through a hurdle criteria and **once mitigated**, progressing to the Strategic Case stage where we would submit a formal merger document to NHS England for consideration.
Key recommendation(s):	The Board of Directors is asked to **NOTE** the progress report on the merger which is subject to final due diligence, ICB & NHS England approval and any potential change in government policy which we will track closely as all progress.

Implications:				
Strategic Ambitions:				
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF Risk 5: Failure to attract a suitable merger partner.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	An independent legal review has been sought to review the process being followed.				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no EDI implications associated with this report.				

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.
Assurance:		
Assurance Route - Previously Considered by:	Merger Programme Board Meetings - January to June 2024 Part I (Closed) Board of Directors Meetings - March, May and June 2024	

Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) – 11th July 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	20th June 2024	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:			**Agenda Item: 12**		

Assurance ratings used in the report are set out below:				
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	X Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Patient Safety Incident Response Plan (PSIRP) Following approval of the first iteration of the Trust's PSIRP in September 2023, a significant amount of work has been undertaken to move the Trust to be compliant with the new framework. This includes staff engagement, training, review of systems and process, the introduction of new learning responses and the recruitment of three Patient Safety Partners who are now making a valuable contribution to strengthening and broadening our patient safety culture. Based on what was learnt through implementation, it is necessary to review the original PSIRP to ensure it is fit for purpose. The content and format have been reviewed to ensure it is accurate for the Trust's patient safety profile and that it is succinct and easy to follow for staff. This has been achieved in co-production with our staff. The Committee approved the refreshed PSIRP. The Trust's PSIRF Policy will now also be reviewed to ensure that it's in line with the PSIRP and that roles and responsibilities are correct as per current structures and processes. It is expected this will be ready for the Committee's approval at its August meeting.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Local Risk Management System (LRMS) replacement The Committee received updates in relation to the new Local Risk Management System (LRMS), Radar. The Committee were updated that the incidents and complaints forms, as well as the risk module, are now live and have been launched for all staff with minimal issues.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

The next stages of delivery for the remaining aspects of Radar (including compliments, excellence reporting and clinical audit etc) for are now being worked through. The Committee noted appreciation of the significant effort put in by the implementation working group to achieve such a smooth transition and in particularly for the project manager leading this work.	
3. FOI (freedom of information) requests The Committee recognised an increasing number of freedom of information (FOI) requests that have recently been received in relation to gender services (adult and children). It was acknowledged that the Trust must continue to fulfill its obligations under the Act both proactively and reactively, and where appropriate, make full use of the exemptions provided.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
4. BAF The Committee reviewed the updated version of the Board Assurance Framework (BAF) risks that have been allocated to the Committee for oversight. The Committee noted that the Radar system went live at the end of May, Training on the new portal is currently being rolled, and the existing risks are in the process of being transferred over to the new system. The corporate risk register is being reviewed and updated as part of the data transfer process, and it is expected that that will be received at this Committee's next meeting. The Committee also plans to do a further deep dive of the BAF risks reviewed to ensure the content is accurate.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the refreshed Patient Safety Incident Response Plan
- The Committee ENDORSED the Quality Account 23/24, previously approved by the Board on 13th June 2024.

Risks Identified by the Committee during the meeting:

There were no new risks identified by the Committee during this meeting.

Items to come back to the Committee outside its routine business cycle:

None.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
N/A		

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 11 July 2024			
Report Title: Quality Priorities 2024/25			**Agenda No. 13**
Report Author and Job Title:	Emma Casey, Associate Director of Quality	**Lead Executive Director:**	Clare Scott, CNO
Appendices:	N/A		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The following report includes the final version of the Trust's Quality Priorities agreed for 2024/25.		
Background:	Organisations are required under the Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. There is a core set of information, indicators and statements that must be included in every Quality Account, which are defined by regulations. This includes progress against quality priorities that the Trust had set for itself in the previous year, and areas of focus for the coming year. In March 2023, the Trust held a Quality Priorities stakeholder engagement event for the first time to engage stakeholders in developing quality priority proposals for 2024/25. The plan was to align the new quality priorities to the Trust's new values and strategic pillars and build on quality improvement work in these areas. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts. For 2024/25 priorities are arranged under the three core domains of quality – patient safety, patient experience and clinical effectiveness. Our Quality & Safety Committee endorsed these areas of focus at its April 2024 meeting.		
Assessment:	The draft of the Trust's Quality Account was sent to members of the Quality & Safety Committee, Board, Executive Leadership team, Council of Governors and other external stakeholders for review and with a request for feedback as required. Comments were welcomed on the quality priorities for 2024/25 and incorporated where appropriate. This is therefore the final set of quality priorities for 24/25, as approved by the Board as part of its approval of the full Quality Account on 20th June 2024. Leads are assigned to each objective and progress will be monitored via quarterly reporting to the Quality & Safety Committee.		
Key recommendation(s):	The Board of Directors is asked to: • Note the final version of the Trust's Quality Priorities agreed for 2024/25.		
Implications:			

Strategic Objectives:				
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☒ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☒ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.

Relevant CQC Quality Statements (we statements) Domain: (tick)	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒

Link to the Risk Register: (tick)	BAF ☒	CRR ☐	ORR ☐
	Risk Ref and Title: BAF Principal Risk 1 – Inequality of access for patients: **If** the Trust is unable to meet increasing demands for its services. **Then** the Trust will not be able to meet the needs of its patient population in a timely fashion, to the standard of care that is required. **Resulting** in increased waiting times for patients to access Trust services, and in turn leading to poor patient experience, including risk of harm to patients, and non-compliance with the Trust's contractual obligations, national standards, and regulatory requirements. BAF Principal Risk 2 – Failure to provide consistent: **If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.		

Legal and Regulatory Implications: (tick)	Yes ☒	No ☐
	Production of an annual Quality Account is a statutory requirement.	

Resource Implications: (tick)	Yes ☒	No ☐
	Resource implications to complete the Quality Priorities set for 24/25 and to address any areas for improvement identified in the Account.	

Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☐	No ☒

Freedom of Information (FOI) status: (tick)	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:

Assurance Route - Previously Considered by:	• Update on the Quality Account 23/24 and quality priorities for 24/25 presented to the Quality & Safety Committee meetings since January 2024 • Stakeholder event for Quality Priorities 24/25 held on 7th March 2024 • Board approval of Quality Account 23/24 and quality priorities for 24/25 on 20th June 2024			
Reports require an assurance rating to guide the discussion: (tick)	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☒ Not applicable: No assurance is required

Our Quality Priorities for 2024/25

For 2024/25 priorities are arranged under the three core domains of quality – patient safety, patient experience and clinical effectiveness, and aligned to the Trust's new values.

Strengthening our Patient Safety culture

- 85% of staff will be trained in the Level 1 Essentials of Patient Safety syllabus
- Training for staff in new PSIRF investigative techniques
- 100% of patients/families involved in Patient Safety Incident Investigations are included in the investigation process
- Investigation templates include reflection on Fair & Just Culture & Compassionate Engagement

Clinical Effectiveness

- Implementation of PCREF (Patient and carer race equality framework)
- Outcome Measures performance that meets the NHSE standards and includes matched pairs of outcome measures
- Reviewing the harm assessment process for services that have extended waiting times

Patient Experience

- Increase ESQ feedback received by 200% per service line (based on previous baseline rates)
- Reporting experience metrics by protected characteristics / demographics
- Developing a digital drop box for 'live feedback' innovative ways of collecting feedback from children & young people and where there may be language barriers (use of

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Thursday, 11 July 2024			
Report Title: Annual Self-assessment of Committee Effectiveness and Committee Annual Reports for 2023/24			**Agenda No.: 14**
Report Author and Job Title:	Dorothy Otite, Governance Consultant	**Lead Director:**	Adewale Kadiri, Director of Corporate Governance
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This report provides the Board with a summary outcome of the Annual Committee Effectiveness Reviews; and the Committee Annual Reports for 2023/24. The Committees (except one at the time of writing) received and discussed the full reports of the outcome of the effectiveness reviews and annual reports during the May / June 2024 cycle of meetings and recommended the reports to the Board. These reports have formed the basis of this summary report to the Board.		
Background:	The Terms of Reference (ToR) of the Committees requires an annual effectiveness evaluation against its Terms of Reference and membership to be undertaken and the outcome reported to the Board of Directors within the annual business cycle. A new process was introduced for the Committee Annual Effectiveness evaluation in 2022/23. This process was adopted for the 2023/24 evaluation. A timetable was agreed for the process and an agreement reached on survey respondents with the Committee Chairs and Lead Executives. The surveys were issued during Quarter 4 2023/24 for completion by early April 2024.		
Assessment:	**Annual Committee Effectiveness Survey 2023/24:** **Process** – a robust and comprehensive review was undertaken for each Committee and facilitated by the Governance Consultant in line with the agreed process. **Response rates** – survey response rates although varied by Committee, were adequate across all Committees. Overall, the survey responses received for all Committees were mostly positive. **Annual Report 2023/24:** An annual report was produced for each Committee in Consultation with the Committee Chairs and Lead Executives to demonstrate to the Board the extent to which each Committee had met its Terms of Reference during the financial year 2023/24 including recommendations for		

	improvement in 2024/25. **Attendance** – All Committees were quorate for all meetings during 2023/24 in line with the quorum set within the respective Terms of Reference. Overall, all Committees were assessed as being compliant with the key areas of their Terms of Reference. **Cross Committee analysis shows that key strengths include:** • Written Terms of Reference which clearly set out their roles and scope of responsibilities. • Frequency of meetings being regular and of appropriate duration. • Members have a good understanding of their roles with adequate skills and expertise to contribute and scrutinise the Committee business. • Effectively contributing to the effectiveness of the Board of Directors, including providing assurance reports to the Board following each meeting. • Effectively monitoring of action logs to ensure timely delivery against actions. • Meetings chaired effectively with clarity of purpose and outcome. • Good attendance at meetings with all meetings being quorate. **Cross Committee analysis shows that areas for development include:** • Strengthening of Committee administration including timeliness of circulation of minutes and actions following meetings; and of issuance of papers for meetings. This is currently being addressed with the recruitment of a dedicated Committee Secretary to ensure consistency in meeting arrangements across all Board sub-committees. • Ensuring sufficient time on the agenda for reflection at the end of each meeting. • Undertaking BAF risks deep-dives. • Strengthening of report writing skills for report authors. **Conclusion:** Based on the outcome of the Committee effectiveness self-assessment reviews and annual reports, some areas for further development have been identified and agreed to by the Committees. The areas are noted in Paragraph 5 (Pages 5 and 6) of this report.
Key recommendation(s):	The Board is asked to: - receive **assurance** from the process undertaken and the summary findings; and - **ratify** the areas for further development of the Committees.

Implications:				
Strategic Ambitions:				
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international	☒ Developing partnerships to improve population health and building on our reputation for innovation and	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability

	provider of training & education	research in this area			
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All BAF risks – as these are assigned to the Committees.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	NHS Foundation Trust Code of Governance requires that the Board of Directors should state in the annual report how performance evaluation of the Board and its Committees has been conducted.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no additional EDI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	• People, Organisational Development, Equality, Diversity and Inclusion Committee – 2 May 2024 • Education and Training Committee – 16 May 2024 • Quality & Safety Committee – 20 June 2024 • Integrated Audit and Governance Committee – 20 June 2024 • Performance Finance and Resources Committee – 21 June 2024 • Executive Appointments and Remuneration Committee – 11 July 2024 *(Committee had not met at the time of writing this report).*				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Report Title: Annual Self-assessment of Committee Effectiveness and Committee Annual Reports for 2023/24

1. Purpose of the report

1.1. This report provides the Board with a summary of the outcome of the Annual Committee Effectiveness Reviews; and the Annual Report of the Committees for 2023/24.

2. Background

Constitutional and Regulatory Requirements:

2.1. **Terms of Reference (ToR)** – The ToR of the Committees requires an annual effectiveness evaluation against its Terms of Reference and Membership to be undertaken and the outcome reported to the Board of Directors within the annual business cycle.

2.2. **NHS England Code of Governance** – requires that there should be a formal and rigorous annual evaluation of the performance of Board Committees.

3. Process and Timeline

3.1. A new process was introduced for Committee Annual Effectiveness self-assessment evaluation in 2022/23. This process was adopted for the 2023/24 evaluation.

3.2. The Governance Consultant developed an electronic survey on evalu8 based on best practice across the NHS. This was done in consultation with the Committee Chair and Lead Executive and as far as possible, these comments were incorporated into the final survey questions.

3.3. A timetable was agreed for the process with the Committee Chair in addition to an agreement reached on names of survey respondents.

3.4. The survey was issued during Quarter 4 2023/24 for completion by early April 2024.

4. Summary findings/ conclusions

Annual Committee Effectiveness Survey 2023/24:

4.1. **Process** – a robust and comprehensive review was undertaken for each Committee and facilitated by the Governance Consultant.

4.2. **Response rates** – response rates although varied, were adequate across all Committees.

4.3. Overall, the survey responses received for all Committees were mostly positive.

Annual Report 2023/24:

4.4. An annual report was produced for each Committee to demonstrate to the Board the extent to which each Committee had met its Terms of Reference

during the financial year 2023/24 including recommendations for improvement in 2024/25.

4.5. **Attendance** – All Committees were quorate for all meetings during 2023/24 in line with the quorum set within the respective Terms of Reference.

4.6. Overall, all Committees were assessed as being compliant with the key areas of their Terms of Reference.

5. Areas for further development

The Committees agreed the following areas for further development:

5.1. **Integrated Audit and Governance Committee:**

- Timeliness of issuance of papers for meetings.
- Timeliness of circulation of minutes and actions.
- Keeping to agreed timings on the meeting agenda to ensure sufficient time for each agenda item.
- Holding periodic private discussions with the external auditors.
- Review of the Committee's Freedom to Speak Up (FTSU) oversight role. The Committee agreed this should be within the POD EDI remit.
- Review of the scope/ remit of the Committee and any changes to this to be reflected in its Terms of Reference and Forward Planner i.e., Schedule of Business) 2024/25.

5.2. **Quality and Safety Committee:**

- Timeliness of circulation of minutes and actions.
- Review of NED membership to ensure quoracy.
- Strengthening of Committee administration.
- Ensuring sufficient time on the agenda for reflection at the end of each meeting.

5.3. **Education and Training Committee:**

- Timeliness of circulation of minutes and actions.
- Embedding of the Committee-to-Committee escalation process.
- Closing off of agenda items.
- Development of the BAF risks and undertaking BAF risks deep-dives.
- Assurance on strategic relationship with University Partners.
- Strengthening its oversight of issues regarding the integration of staff and students' community with the wider research community.

5.4. **Performance Finance and Resources Committee:**

- Timeliness of issuance of papers for meetings.
- Timeliness of circulation of minutes and actions.
- Strengthening of report writing skills for report authors.
- Strengthening of Committee administration.
- Ensuring sufficient time on the agenda for reflection at the end of each meeting.

5.5. **People Organisational Development Equality Diversity and Inclusion Committee:**

- Timeliness of issuance of papers for meetings.
- Timeliness of circulation of minutes and actions.
- Strengthening of report writing skills for report authors.
- Strengthening of Committee administration.
- Undertaking BAF risks deep-dives.
  Assurance on Trust workforce plans (including succession planning and talent management)

5.6. **Executive Appointments and Remuneration Committee** *(The Committee had not met at the time of writing this report – these were the proposed recommendations for discussion and agreement by the Committee):*

- *Scheduling of Committee meetings in advance for 2024/25.*
- *Approval of the Committee Forward Planner (Schedule of Business) for 2024/25 ensuring it reflects the full scope of its Terms of Reference. This is a separate agenda item for this meeting.*
- *Timeliness of issuance of papers for meetings.*
- *Timeliness of circulation of draft minutes and actions.*
- *Ensuring sufficient time on the agenda for reflection at the end of each meeting.*

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 11 July 2024			
Report Title: Workforce Race Equality Standard Report 2023-24			**Agenda No.: 15**
Report Author and Job Title:	Dr Thanda Mhlanga Associate Director of EDI	**Lead Executive Director:**	Gem Davies Chief People Officer
Appendices:	Insert title of the appendices (if any): Appendix 1: Improvement Action Plan		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This Workforce Race Equality Standard (WRES) report juxtaposes the experiences of staff from minoritised ethnic backgrounds and their White counterparts through nine WRES indicators that focus on workforce composition and people management, recruitment, bullying and harassment and discrimination as well as representation at Board level.		
Background:	The Workforce Race Equality Standard (WRES) was mandated through the NHS' standard contract in April 2015. All NHS organisations are required to publish their performance data and action plans against nine indicators of the WRES and make them public. According to the data presented in this report, staff from racially minoritised backgrounds have poorer experiences compared to White staff – this has been the case since the introduction of WRES.		
Assessment:	The findings from this year's WRES data are encouraging. Progress has been made in 7 of the 9 indicators, but there has been regression in two of them. One would note here that despite significant improvements made in the seven indicators this reporting year, the Trust remains positioned among weakest performing trusts nationally regarding differentials in experience and inequalities between employees from a Global Majority background and White staff. • The section of the workforce that comes from minoritised ethnic backgrounds has continued to increase gradually over the last five years, but they are overrepresented in low level non-clinical roles and are underrepresented in clinical roles. • Staff from minoritised backgrounds are more likely to be appointed from shortlisting than White staff. • Our low figures for Harassment, Bullying and Abuse of staff by patients and the public continue to be among the best nationally. • The representation of staff from minoritised backgrounds at Board continues to improve. • However, the figure for ethnic minority staff experiencing harassment, bullying, abuse and discrimination from their colleagues, managers of team leader has remained among the highest nationally. • The trust's score viz-a-viz the likelihood of entering a formal disciplinary process because of one's ethnic background is far above national average.		

	• Perceptions on equal opportunities for career progression or promotion remain in the inadequate category.
Key recommendation(s):	The Trust Board of Directors is asked to support the prioritisation of the following actions that have been identified for ameliorating the challenges emerging in the report: • A deep dive into Bullying, Harassment and Abuse to facilitate deep understanding trust wide. • Embedding of Just Culture approach to reduce likelihood of staff from minoritised ethnic backgrounds entering formal disciplinary process. • Develop a transparent and equitable internal promotion process. • Review and strengthen Inclusive Recruitment Process introduced last year. • Removing barriers to reporting.

Implications:

Strategic Ambitions:

☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☐ Improving value, productivity, financial and environmental sustainability

Relevant CQC Quality Statements (we statements) Domain: (tick)	Safe ☒	Effective ☒	Caring ☐	Responsive ☐	Well-led ☐

Link to the Risk Register: (tick)	BAF ☒	CRR ☐	ORR ☐
	Risk Ref and Title: **BAF 5:** Workforce development, retention, recruitment. **BAF 6:** Lack of inclusive and open culture		
Legal and Regulatory Implications: (tick)	Yes ☒	No ☐	
	• Standard NHS Contract • Equality Act (2010) • Public Sector Equality Duty (PSED).		
Resource Implications: (tick)	Yes ☒	No ☐	
	• Equalities Training Budget • Inclusive Recruitment Training • Just Culture Training		
Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☐	No ☐	
	• Equalisation of experience between staff from minoritised ethnic backgrounds and their white counterparts. • Eradication of inequality		
Freedom of Information (FOI) status: (tick)	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the	

			public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Board meeting (date)			
Reports require an assurance rating to guide the discussion: (tick)	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

WRES Report

Workforce Race Equality Standard

2023 - 2024

The EDI Team
Tavistock and Portman NHS Foundation Trust

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Tavistock and Portman WRES Report 2023-24

Workforce Race Equality Standard

Introduction

The Workforce Race Equality Standard (WRES) was mandated through the NHS' standard contract in April 2015: all NHS organisations are required to publish their performance data and action plans against nine indicators of the WRES and make them public.

Consequently, this report presents the Tavistock and Portman's 2023-24 WRES data and associated Action Plan. It provides an overview of the Trust's scores on workplace inequalities between staff from minoritised ethnic backgrounds and their White counterparts through nine WRES key indicators that focus on workforce composition and people management, recruitment, bullying and harassment and discrimination as well as representation of people from a global majority background at Board level – see full details of the WRES indicators in the summary of findings on page 4. The report identifies where improvements have been made, where data has stagnated or deteriorated and proposes an action plan / countermeasures for ameliorating the gaps.

Key Findings from the WRES 2023-24 Report

Table 1: WRES 2023-24, Summary of Key Findings

WRES Indicators	Workforce Indicators For each of these four workforce indicators, compare the data for White and staff from a global majority background.	Trend	Summary of Key Findings
Indicator 1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	**Improving**	Overall representation of ethnic minorities improved by 4.7% to 35.4%. Improvement was also made in Cluster 4 (AfC Bands 8C – VSM) for both Clinical and Non-Clinical Cohorts. However, there is overrepresentation in the non-clinical cohort (Bands 1-7) and underrepresentation at Bands 8a and above. Underrepresentation in the clinical cohort starts at Band 5.
Indicator 2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to minority ethnic applicants	**Improving**	Improvement made from 0.95 to 0.77. A figure below 1:00 indicates that applicants from racially minoritised groups are more likely than White staff to be appointed from shortlisting. This has been the trend for the past 5 years.
Indicator 3	Relative likelihood of minority ethnic staff entering the formal disciplinary process compared to white staff	**Regressing**	A figure above 1:00 indicates that minority ethnic staff are more likely than White staff to enter the formal disciplinary process. The Trust's figure is 1.76.
Indicator 4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to minority ethnic staff	**Improving**	The Trust has been within the non-adverse range of 0.80 to 1.25 for the past 5 years.
	National NHS Staff Survey indicators (or equivalent) **For each of the four staff survey indicators, compare the outcomes of the responses for White and staff from a global majority background**		
Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**Improving**	A significant reduction (improvement) of 7.3% was achieved this year. Our score (9.2%) is impressive – positions us 22.2% better than national average (31.4%).
Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**Improving**	A slight improvement of 1.6% was realised in 2023-24. However, 28.5% positions us as one of the lowest performers nationally for this indicator.
Indicator 7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	**Regressing**	There was a slight regression of 0.1%. The Trust's score (26%) is one of the lowest performers nationally.
Indicator 8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	**Improving**	A huge improvement of 4.7% was made this year. However, our score (20%) places the Trust among lowest performers nationally for this indicator.
	Board representation Indicator ***For this indicator, compare the difference for White staff and staff from racially minoritised groups**		
Indicator 9	Percentage difference between the organisations' Board voting membership and its overall workforce ***Note:** Only voting members of the Board should be included when considering this indicator	**Improving**	Staff from minoritised ethnic backgrounds are underrepresented at Board. However, the deficit continues to be addressed - it was slightly reduced by 0.4% in 2023-24.

Indicator 1: Workforce Representation

Workforce Representation by Ethnicity

Figure 1 below shows the workforce profile trends at Tavistock and Portman – there has been a gradual improvement in representation over the last 5 years. In 2023-24, 300 (35.4%) of our workforce came from a global majority background and 527 (62.2%) are White. Our workforce profile is not consistent with trends in NHS Trusts in the London region where the average for staff from minoritised ethnic backgrounds is 52.1% and 43% for White staff – see **Figures 1 and 2** below for details.

Figure 1: Global Majority Representation at the T&P

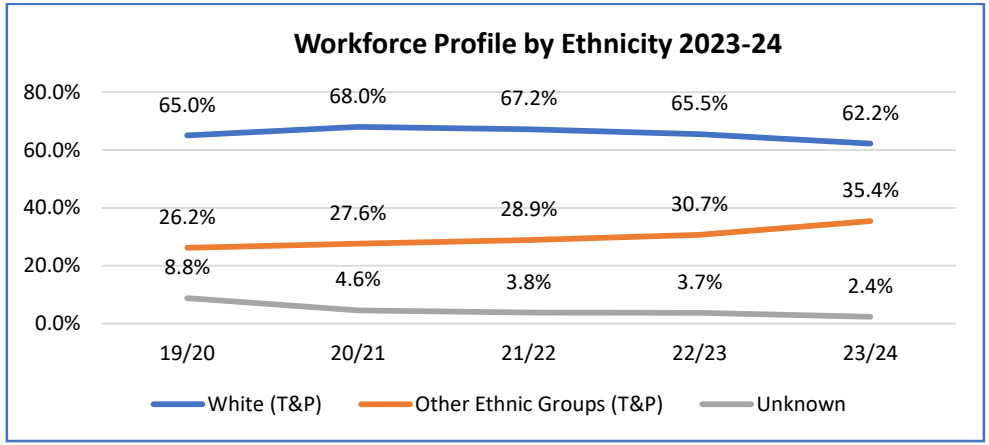
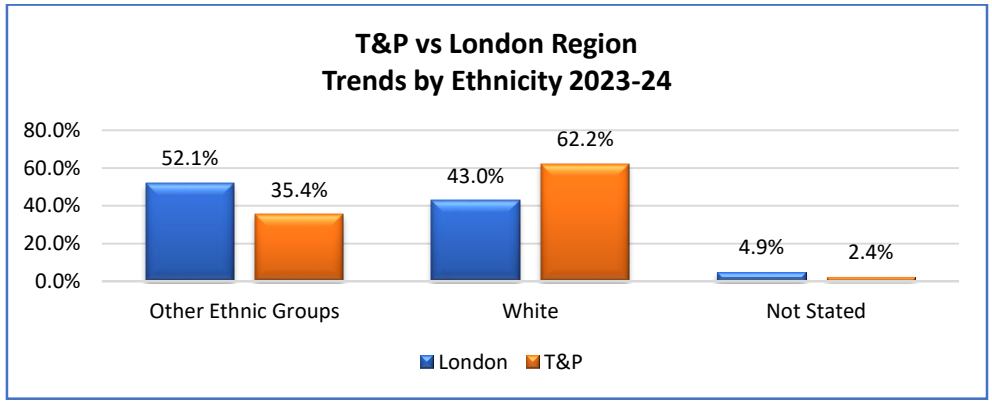


Figure 2: T&P vs London Region Workforce Profile by Ethnicity



Workforce Profile: Non-Clinical Cohort

Table 2: Workforce Profile (Non-clinical Cohort 2019-2024)

Workforce Profile: Non-clinical Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown
Cluster 1: AfC Bands < 1 *to* 4	28 (32.2%)	50 (57.5%)	9 (10.3%)	31 (36.5%)	50 (58.8%)	4 (4.7%)	30 (38.5%)	45 (57.7%)	3 (3.9%)	26 (38.8%)	37 (55.2%)	4 (6.0%)	19 (25.0%)	55 (72.4%)	2 2.6%
Cluster 2: AfC Bands 5-7	81 (54.4%)	51 (34.2%)	17 (11.4%)	87 (55.8%)	62 (39.7%)	7 (4.5%)	91 (56.2%)	68 (42.0%)	3 (1.9%)	84 (51.2%)	75 (45.7%)	5 (2.8%)	90 (52.0%)	78 (45.1%)	5 (2.9%)
Cluster 3: AfC Bands 8a-8b	25 (71.4%)	9 (25.7%)	1 (4.0%)	37 (69.8%)	12 (22.6%)	4 (7.5%)	36 (69.2%)	13 (25.0%)	3 (5.8%)	39 (70.9%)	13 (23.6%)	3 (5.5%)	43 (68.3%)	19 (30.2)	1 (1.6%)
Cluster 4: AfC Bands 8c-VSM	25 (89.3%)	3 (10.7%)	0 (0%)	39 (90.7%)	2 (4.7%)	2 (4.7%)	26 (96.3%)	0 (0%)	1 (3.7%)	26 (76.5%)	8 (23.5%)	0 (0%)	24 (68.6%)	11 (31.4%)	0 (0%)
Total Non-Clinical	**159 (53.2%)**	**113 (37.8%)**	**27 (9%)**	**194 (57.6%)**	**126 (37.4%)**	**17 (5%)**	**183 (57.4%)**	**126 (39.5%)**	**10 (3.1%)**	**175 (54.8%)**	**133 (41.6%)**	**12 (3.4%)**	**176 (50.7%)**	**163 (47.0%)**	**8 (2.3%)**

Workforce Profile: Clinical Cohort

Table 3: Workforce Profile (Clinical Cohort 2019-2024)

Workforce profile: Clinical Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown	White	Other Ethnic Groups	Ethnicity unknown
Cluster 1: AfC Bands < 1 *to* 4	19 (67.9%)	9 (32.1%)	0 (0%)	7 (41.2%)	10 (58.8%)	0 (0%)	5 (22.7%)	16 (72.7%)	1 (4.5%)	9 (37.5%)	15 (62.5%)	0 (0%)	5 (29.4%)	12 (70.6%)	0 (0%)
Cluster 2: AfC Bands 5-7	155 (72.4%)	40 (18.7%)	19 (8.9%)	165 (75.0%)	46 (20.9%)	9 (4.1%)	169 (76.5%)	45 (20.4%)	7 (3.2%)	157 (74.8%)	50 (23.0%)	11 (5.0%)	147 (68.7%)	62 (29.0%)	5 (2.3%)
Cluster 3: AfC Bands 8a-8b	129 (82.2%)	20 (12.7%)	8 (5.1%)	142 (84.0%)	20 (11.8%)	7 (4.1%)	134 (81.2%)	25 (15.1%)	6 (3.9%)	133 (79.2)	29 (17.3%)	6 (3.8%)	131 (75.7%	38 (22.0%)	4 (2.3%)
Cluster 4: AfC Bands 8c-VSM	36 (70.6%)	11 (21.6%)	4 (7.8%)	35 (71.4%)	13 (26.5%)	1 (2.0%)	31 (72.1%)	10 (23.3%)	2 (4.7%)	27 (79.4%)	6 (17.6%)	1 (2.9%)	23 (76.7%)	6 (20%)	1 (3.3%)
Total Non-Clinical	**339 (75.3%)**	**80 (17.8%)**	**31 (6.9%)**	**347 (76.6%)**	**89 (19.6%)**	**17 (3.8%)**	**339 (75.1%)**	**96 (21.3%)**	**16 (3.5%)**	**324 (71.7%)**	**110 (24.3%)**	18 (4%)	**306 (70.5%)**	**118 (27.2%)**	**10 (2.3%)**

Table 2 is an overview of the non–clinical workforce cohort over five reporting years 2019-24. According to Figure 1, the workforce population consists of 35.4.% of staff from minoritised ethnic backgrounds. This suggests that the at 47% (as shown in Figure 2) they are overrepresented in the non-clinical cohort. However, over- representation is in lower bands (2-7) - there is underrepresentation in senior roles (Band 8a and above).

Table 3 shows an improvement of 9.4% in the representation of staff from a global majority background in the clinical cohort over the last 5 years. Bands 1- 4 are the lowest AfC pay bands: 12 (70.6%) of that cluster come from minoritised ethnic backgrounds. However, there is underrepresentation at Bands 5 and above.

Table 4: Workforce Profile (Medical / Dental Cohort 2019-2024)

Workforce Profile: Medical / Dental Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	White	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**	**White**	**Other Ethnic Groups**	**Ethnicity unknown**
Consultants	25 (59.2%)	10 (23.8%)	7 (16.7%)	23 (60.5%)	11 (28.9%)	4 (10.5%)	24 (63.2%)	13 (34.2%)	1 (2.6%)	24 (64.9%)	12 (32.4%)	1 (2.7%)	24 (66%)	10 (27.8%)	2 (5.6%)
Snr Medical Manager	5 (83.3%)	1 (16.7%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Non-Consultant Career Grade	3 (27.3%)	7 (63.6%)	1 (9.1%)	4 (80%)	1 (20%)	0 (0%)	4 (80%)	1 (20%)	0 (0%)	4 (80%)	1 (20%)	0 (0%)	6 (85.7%)	1 (14.3%)	0 (0%)
Trainee Grade	7 (38.9%)	6 (33.3%)	5 (27.8%)	12 (57.1%)	8 (38.1%)	1 (4.8%)	10 (47.6%)	6 (28.6%)	5 (23.8%)	10 (62.5%)	5 (31.3%)	1 (6.25%)	9 (60%)	6 (40.0%)	0 (0%)
Other	8 (61.5%)	3 (23.1%)	2 (15.4%)	2 (100%)	0 (0%)	0 (0%)	2 (100%)	0 (0%)	0 (0%)	5 (55.6%)	4 (44.4%)	0	6 (75%)	2 (25%)	0 (0%)
Total	**48 (53.3%)**	**27 (30%)**	**15 (16.7%)**	**41 (61.2%)**	**21 (31.3%)**	**5 (7.5%)**	**40 (60.6%)**	**20 (30.3%)**	**6 (9.1%)**	**47 (66%)**	**22 (30.9%)**	**2 (2.8%)**	**45 (68.2%)**	**19 (28.8%)**	**2 (3%)**

According to **Table 4**, the Medical / Dental Cohort was representative of the overall workforce profile from 2019 - 22.

However, the global majority section of the workforce shrunk by 3 members of staff (2.1%) in 2023-24, leading to overall under - representation of 6.6%.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

Table 5: Relative likelihood of appointment from shortlisting

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22	2022/23	2023/24
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants **A figure below 1:00 indicates that applicants from a Global Majority background are more likely than White staff to be appointed from shortlisting.*	Tavistock & Portman	0.41	0.73	0.85	0.95	0.77
		NHS Trusts	1.46	1.61	1.61	1.54	1.59

Table 5 above shows that in most NHS trusts, White applicants are more likely than applicants from minoritised ethnic backgrounds to be appointed from shortlisting. However, at Tavistock and Portman the relative likelihood of White staff being appointed from shortlisting compared to staff from a global majority background is 0.77 which indicates that applicants from racially minoritised groups are more likely than White staff to be appointed from shortlisting. The average in the London region is 1.47 and the national average is 1.59. It's encouraging to note that after a continuous regression for three consecutive years (2020-23) we have made progress from 0.95 to 0.77 this year. Increasingly, there is awareness that to achieve the desired changes in the workforce profile, the Trust should ensure that the increase in the recruitment of applicants from minoritised ethnic backgrounds is not only limited to lower banded roles.

Indicator 3: Relative likelihood staff entering the formal disciplinary process

Table 6: Relative likelihood of entering formal capability process

WRES Indicator	Metric Descriptor		2019-20	2020-21	2021-22	2022-23	2023-24
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff **A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process.*	Tavistock & Portman	0.82	0.00	0.00	1.60	1.76
		NHS Trusts	1.22	1.16	1.14	1.14	1.03

The data in Table 6 indicates that there has been a regression in this indicator for two consecutive years. In 46% of NHS trusts, staff from minoritised ethnic backgrounds are over 1.25 times more likely than White staff to enter the formal disciplinary process in the NHS. The national average is 1.03 and the London average is 1.41. However, this disparity is larger at the Tavistock and Portman – the figure has regressed from 1.60 to 1.76.

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

Table 7: Relative likelihood of staff accessing non-mandatory training and CPD

WRES Indicator	Metric Descriptor		2019-20	2020-21	2021-22	2022-23	2023-24
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff **A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD .*	Tavistock & Portman	1.25	1.49	1.00	1.05	1.02
		NHS Trusts	1.15	1.14	1.14	1.12	1.12

The data in Table 7 illustrates three key points:

- Nationally, White staff are no longer more likely to access non mandatory training and continued professional development than staff from ethnically diverse backgrounds. All regions now fall within the non-adverse range of 0.80 to 1.25. The London average is 0.92 and the national average is 1.12.
- Incremental progress has been made at the Tavistock and Portman: we improved from 1.05 to 1.02 in 2023-24 and have been in the non-adverse range for 5 consecutive years.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse by patients and public

Figure 3: Harassment, Bullying or Abuse in the last 12 months (patients, relatives & public)

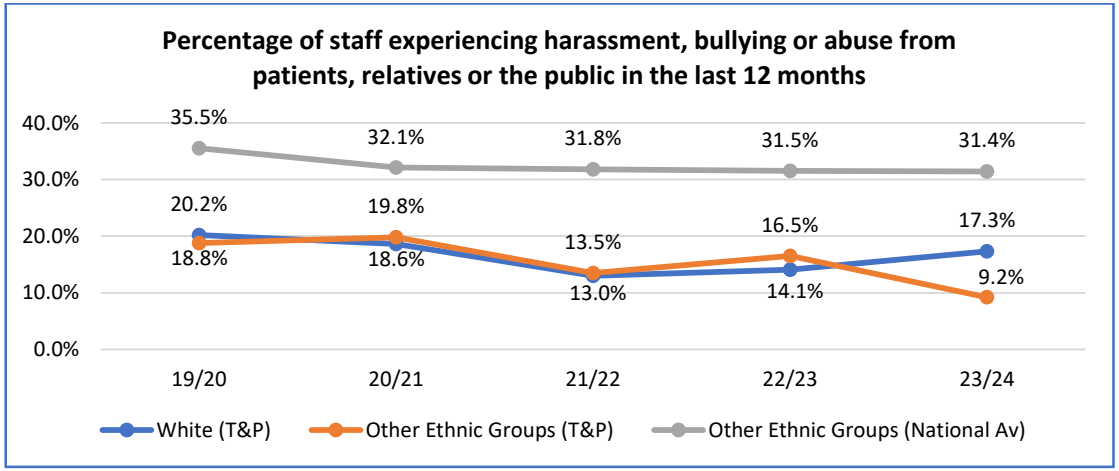


Figure 3 shows that the number of staff from a global majority background experiencing harassment, bullying or abuse from patients, relatives or the public has fallen by 9.6% in the last 5 years. Notably, after a 3% regression in 2021-22 the harassment, bullying and abuse plummeted from 16.5% to 9.2% in 2023-24 – an improvement of 7.3%. Our figure (9.2%) is 22.2% better than the national average (31.4%). The London average is 32.1%. Inversely, the harassment, bullying and abuse of White staff by patients, relatives or the public at the Trust has increased for two consecutive years.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff

Figure 4: Harassment, Bullying or Abuse in the last 12 months (staff)

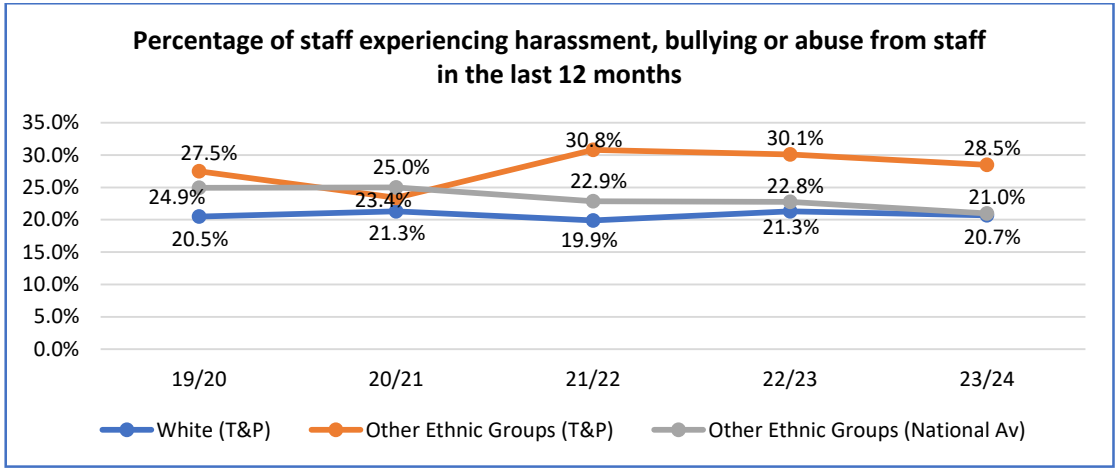
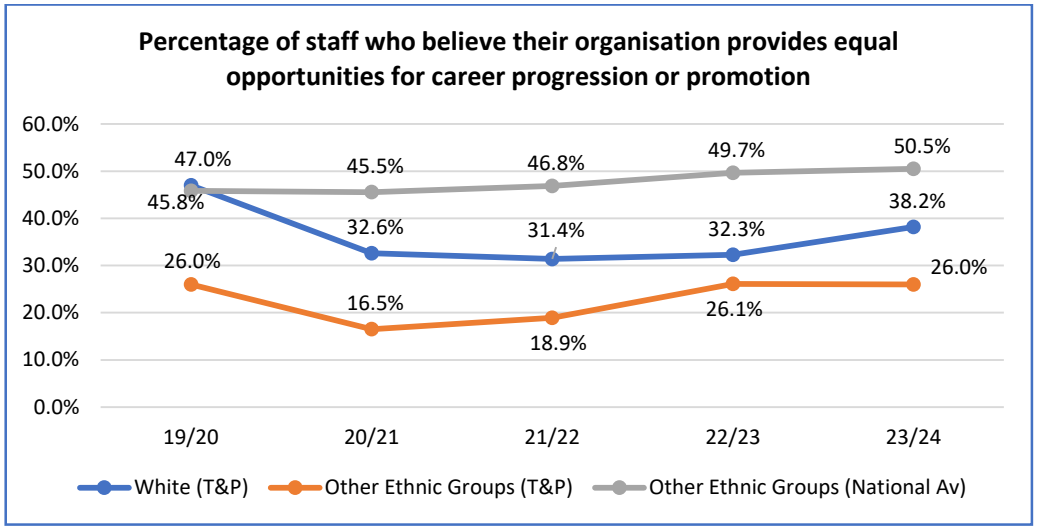


Figure 4 shows that while the harassment, bullying and abuse of staff from minoritised ethnic backgrounds by their colleagues has decreased by 2.3% to 28.5% over the last 2 years (by 1.6% this year), our position is 1% worse than it was 5 years ago and 7.5% below national average.

When one juxtapositions data in **Figures 3** and **4**, it is regrettable to note that the harassment, bullying or abuse that ethnic minority staff receive from their own colleagues at Tavistock and Portman is three times the amount that they receive from patients and the public (patients 9.2% and staff 28.5%).

Indicator 7: Perceptions on equal opportunities for career progression or promotion

Figure 5: Perceptions on opportunities for career progression or promotion

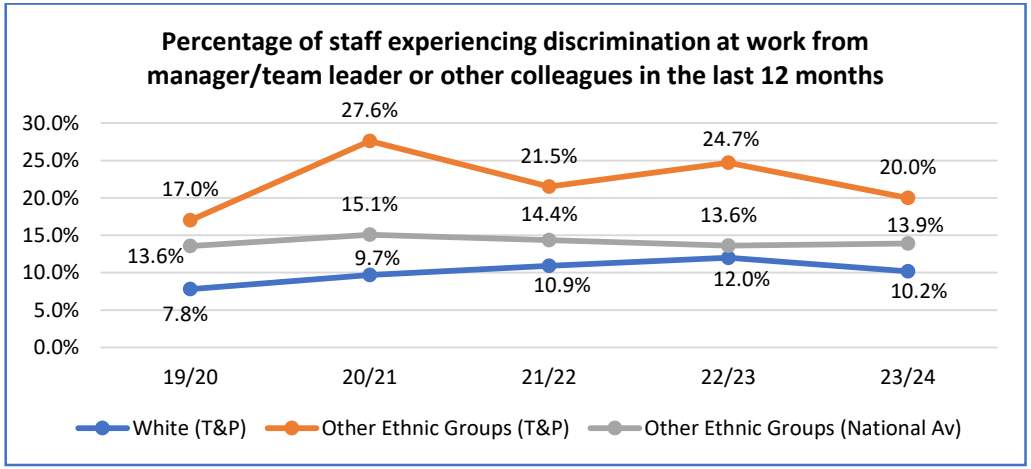


According to **Figure 5**:

- There was a slight dip from 26.1% to 26.0% in the number of staff from minoritised ethnic backgrounds at the Trust who believe that there is fairness in opportunities for career progression and promotion.
- Nationally there was slight improvement from 49.7% to 50.5%.
- The Trust's score of 26% for staff from a global majority background in this indicator was the same 5 years ago.
- This means that most staff from ethnic minority backgrounds (74%) feel there is lack of equity. This is a daunting picture – the score of 26.0% positions the Trust 24.5% below the national average of 50.5% for this indicator.

Indicator 8: Discrimination at work from manager/colleagues or team leader

Figure 6: Experience of discrimination at work from manager/team leader or colleagues



The data in **Figure 6** demonstrates that:

- The number of staff who report to having personally experienced discrimination at work from either their manager, team leader or colleagues fell from 24.7% to 20.0% this year – an improvement of 4.7%.
- The figure for White staff is 10.2%, suggesting that staff from racially minoritised backgrounds are twice more likely to experience discrimination at work from manager/team leader or colleague than their White peers – data suggest that this has been the trend since the introduction of WRES.
- The national average in this indicator is 13.9% and thus our score positions us among lowest performers for this indicator.

Indicator 9: Board Representation

Indicator 9 examines the percentage difference by ethnicity between the organisation's Board voting membership and the overall workforce.

Table 8: Board Representation

Indicator 9: Board Representation and the difference between Board voting membership and its overall workforce															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
Board Representation	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**	**Other Ethnic Groups**	**White**	**Ethnicity unknown**
Total Board Members by ethnicity	14.3% (2)	85.7% (12)	0% (0)	21.4% (3)	78.6% (11)	0.0% (0)	16.7% (2)	75% (9)	8.3% (1)	26.32% (5)	73.68% (14)	0% (0)	31.58% (6)	68.42 (13)	0% (0)
Voting Board Members by ethnicity	16.7% (2)	83.3% (10)	0% (0)	16.7% (2)	83.3% (10)	0% (0)	18.2% (2)	72.7% (8)	9.1% (1)	44.44% (4)	55.56% (5)	0 (0%)	26.67% (4)	73.33 (11)	0% (0)
Overall Workforce by ethnicity	24.1% (191)	63.2% (502)	12.7% (101)	26.3% (219)	64.9% (541)	8.8% (73)	27.5% (235)	68% (582)	4.6% (39)	30.7% (255)	65.5% (544)	3.7% (31)	35.42% (300)	62.22% (527)	2.36% (20)
Difference (Total Board – Overall Workforce)	-9.8%	22.5%	-12.7%	-4.9%	13.6%	-8.8%	-4.70%	10.8%	-3.8%	-4.4%	8.1%	-3.7%	-4%	6%	-2%

Table 8 shows that there has been a gradual increase in the number of Board members from minoritised ethnic backgrounds over the last 5 years. Currently, (4) 26.67% of voting Board members are from racially minoritised groups, compared to 300 (35.4%) of the Trust's workforce that comes from that background. This means that staff from minoritised ethnic backgrounds are underrepresented, but the deficit has been slightly reduced from -4.4% in 2022-23 to -4% in 2023-24.

Conclusion and Next Steps

This WRES report shows that the Trust has made improvements in seven of the nine indicators. However, while some of these improvements are major their impact is minimal because the challenges associated with the Workforce Race Equality Standard remain in situ due to the low starting base – the Trust remains positioned among the lowest performing trusts:

- The size of the global majority workforce in the Trust has increased for five consecutive years – in this reporting year it improved by 4.7% to 35.4%. The Trust remains focused on improving the diversity of its workforce by 5% each year towards the London average of 52.1%.
- The representation of staff from ethnically diverse backgrounds has continued to increase in more senior roles, however underrepresentation starts at Band 5 for clinical roles and at Band 8a for non-clinical roles.
- Applicants from minoritised ethnic backgrounds continue to be more likely than White staff to be appointed from shortlisting. The Trust is committed to ensuring that this trend is not exclusive to lower banded roles and non-clinical roles.

- The relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to staff from a global majority background has remained in the non-adverse range of 0.80 to 1.25 for five consecutive years.
- The number of staff from racially minoritised groups experiencing harassment, bullying or abuse from patients, relatives or the public has fallen by a further 7.3% this year to 9.2% - this excellent score is 22.2% better than the national average score of 31.4%.
- The bullying, harassment or abuse that staff from a global majority background receive from their colleagues at Tavistock and Portman has decreased by 1.6% to 28.5% this year. However, this is three times the amount that they receive from patients and the public and positions the Trust among the lowest performers nationally.
- There was a significant improvement of 4.7% in the number of staff from racially minoritised groups experiencing discrimination from their manager, team leader or colleague. However, with a score of 20%, the Trust remains among lowest performers nationally for this indicator.
- There has been an improvement in the underrepresentation of ethnic minorities at Board - the deficit has been reduced from -4.4% to -4%.

There was regression in the following areas:

- Staff from minoritised ethnic backgrounds are 1.76 times more likely than White staff to enter the formal disciplinary process. This disparity has worsened for two consecutive years.
- There was a negligible regression from 26.1% to 26.0% in the number of staff from racially minoritised backgrounds at the Trust who believe that there is fairness in opportunities for career progression and promotion. This score places the Trust in the lowest performing category.

In response to the data presented in this WRES report, the following areas have been prioritised:

- Embedding Just and Learning Culture principles in our systems.
- Reviewing and strengthening the inclusive recruitment ethos launched last year to ensure that the Trust's workforce continues to journey towards a position where it mirrors the communities it serves in the London region. This includes tackling the disparities in representation in higher bands and clinical roles.
- Creating an internal promotion panel to facilitate transparency around promotions and career progression opportunities.
- Reducing the numbers of ethnic minority staff from experiencing discrimination at work from manager / team leader or other colleagues.
- Reducing the numbers of ethnic minority staff from experiencing bullying, harassment or abuse at work from colleagues.
- Continuing to improve the demographic composition of the Board.

Next Steps

- The WRES data and its analysis will be disseminated trust-wide to facilitate better understanding of challenges associated with colourism.
- Local understanding and ownership of WRES data will be facilitated in each service.
- The EDI Programme Board and POD EDI Committee will monitor progress against outcomes and actions.
- Each service to discuss the bullying, harassment and abuse of staff by colleagues and come up with an service plan for ameliorating the challenges.
- Accelerate efforts to remove barriers to reporting discrimination of global majority staff at work by manager/team leader or colleagues.

- Review Reciprocal Mentoring scheme launched for Execs last year and roll it out trust wide to facilitate better understanding of difference and staff with protected characteristics.
- Ensure inclusive recruitment ethos is embedded across the Trust.
- Embed Just and Learning Culture principles within the Trust.
- Ensure there is a committee that looks at all internal promotions.

Appendix 1

Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Executive Lead(s)	Timescale
Review and strengthen Inclusive Recruitment Process introduced last year	Develop a representative workforce Equip all recruiting managers and EDI representatives with inclusive recruitment principles, tools and ethos **WRES indicators 1, 2 & 7**	All interviews have a trained manager and inclusion representative Improvement in representativeness of the workforce	Comprehensive review of Inclusive Recruitment Process Design and launch an inclusive recruitment toolkit Embed Inclusive Recruitment training in current Leadership and Management training.	Chief People Officer	
Carry out a deep dive into Bullying, Harassment and Abuse	Raise awareness about BHA Reduce BHA experienced by staff from minoritised ethnic backgrounds **WRES indicators 5, 6, 7 & 8**	Better understanding of BHA by staff Reduction in BHA	Carry out a deep dive and share findings with all staff to build trust	Director of Corporate Governance	
Remove reporting barriers by completing root to branch review	Create simplified version of grievance and disciplinary procedure and support it by policy Embed Just Culture Approach **WRES indicators 5, 6, 7 & 8**	Collaboration between People Team, FTSUG, EDI and staff side	Expand / diversify FTSUG role Simplified version of grievance and disciplinary procedure Review previous cases and share themes of outcomes to develop trust and confidence	Director of Corporate Governance	
Address concerns on lack of Equal Opportunities for career progression or promotion	Develop a transparent and equitable internal promotion process **WRES indicators 7 and 8**	Transparency and scrutiny of all internal promotions	Create an internal promotions panel with clear Terms of Reference	Chief People Officer	
Reduce relative likelihood of global majority staff entering the formal disciplinary process	Address overrepresentation of staff from minoritised ethnic backgrounds in the formal disciplinary process **WRES indicators 3 and 8**	Embed Just Culture Approach Implementation of new early resolutions policy	Carry out a deep dive into previous cases, share lessons learnt and facilitate just and learning culture training.	Chief People Officer Chief Nursing Officer	

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 11 July 2024			
Report Title: Workforce Disability Equality Standard Report 2023-24			**Agenda No.: 15**
Report Author and Job Title:	Dr Thanda Mhlanga Associate Director of EDI	**Lead Executive Director:**	Gem Davies Chief People Officer
Appendices:	Insert title of the appendices (if any): Appendix 1: WDES Improvement Action Plan		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	This report uses 10 Workforce Disability Equality Standard (WDES) metrics on the Trust's workforce composition, recruitment, relative likelihood of entering the formal capability process, bullying and harassment, opportunities for career progression or promotion, feeling valued by the organisation, presenteeism, reasonable adjustments, staff engagement, and Board composition to help the Trust to visualize and address the differentials in experience between Disabled and Non-Disabled staff.		
Background:	The Workforce Disability Equality Standard (WDES) was mandated via the Standard NHS Contract in April 2018. All NHS organisations are required to publish their performance data and action plans against the 10 metrics that measure the experiences of staff with Disabilities and long-term health conditions compared to the experiences of Non-Disabled staff.		
Assessment:	This WDES report paints a very mixed picture: • Enormous progress was made in 8 of the 10 WDES metrics this year: two of them were over 14 percentage points. • However, despite these impressive improvements the Trust remains in the weakest performing category nationally. Briefly: • Workforce representation / declaration rates have increased over the last 5 years. • The percentage of the Board's membership who have declared a disability has increased. • The number of Disabled staff harassed, bullied and abused by patients and the public is among the lowest/best nationally. • Disabled applicants are more likely to be appointed from shortlisting short listing compared to Non-Disabled applicants. However, despite scores improving in the following themes they remain in the inadequate category: • Harassment, Bullying and Abuse by managers. • Harassment, Bullying and Abuse by colleagues. • Reporting of Harassment, Bullying and Abuse. • Perceptions on Equal Opportunities for career progression or promotion. • Presenteeism • Percentage of Disabled staff who feel the Trust values their work. • Percentage of Disabled staff satisfied with workplace adjustments.		

Key recommendation(s):	The Board of Directors is asked to: • Support the training of Leaders and Managers so that they are equipped with inclusive behaviours to facilitate the desired culture change. • Support initiatives to create an environment where staff are comfortable to bring their authentic selves to work – this will make staff feel comfortable to share their Disabilities or long-term health conditions. • Support the adoption of a zero-tolerance approach to harassment, bullying or abuse from patients/service users, relatives or the public. • Support the adoption of a zero-tolerance approach to harassment, bullying or abuse of staff by managers. • Support initiatives that aim to remove barriers to reporting experiences of harassment, bullying or abuse. • Facilitate the creation of more transparent approaches to career progression or promotion. • Ensure systems are put in place to educate staff and managers to facilitate better understanding of disability and presenteeism. • Ensure Trust adopts employer recognition schemes. • Ensure there is standardisation of the reasonable adjustments process and that it is backed by a clear and comprehensive policy.

Implications:

Strategic Objectives:

☐ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☒ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.

Relevant CQC Domain:	Safe ☐	Effective ☒	Caring ☐	Responsive ☐	Well-led ☒

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	Risk Ref and Title: BAF 5: Workforce development, retention, recruitment and BAF 6: Lack of inclusive and open culture		

Legal and Regulatory Implications:	Yes ☒	No ☐
	• Standard NHS Contract • Equality Act (2010) • Public Sector Equality Duty (PSED)	
Resource Implications:	Yes ☒	No ☐
	• Equalities Training Budget • Reasonable Adjustment Budget • Events to support staff networks	
	Yes ☒	No ☐

Diversity, Equality and Inclusion (DEI) implications:	• Amelioration of the challenges faced by staff with Disabilities and Long-Term Medical Conditions. • Equalisation of experience between staff with Disabilities and Long-Term Medical Conditions and their counterparts who do not have disabilities.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.		
Assurance:				
Assurance Route - Previously Considered by:	Board Meeting (Date)			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

WDES Report

Workforce Disability Equality Standard

2023 - 2024

The Tavistock and Portman NHS Foundation Trust
EDI Team

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Tavistock and Portman WDES Report 2022-23

Workforce Disability Equality Standard

Introduction

The Workforce Disability Equality Standard (WDES) was mandated via the Standard NHS Contract in April 2018: all NHS organisations are required to publish their performance data and action plans against 10 metrics of the Workforce Disability Equality Standard and make them public.

Correspondingly, this report presents the Tavistock and Portman's 2023-24 WDES data and associated Action Plan. The 10 WDES metrics focus on workforce composition, recruitment, relative likelihood of entering the formal capability process, bullying and harassment, opportunities for career progression or promotion, feeling valued by the organisation, presenteeism, reasonable adjustments, staff engagement, and Board composition. Nationally, the WDES consistently shows that staff with Disabilities and Long-Term Health Conditions have poorer experiences at work compared to the experiences of Non-Disabled staff - see full details of the WDES indicators in the summary of findings on page 4. This report identifies where improvements have been made, where data has stagnated or deteriorated and proposes an action plan / countermeasures for ameliorating the gaps.

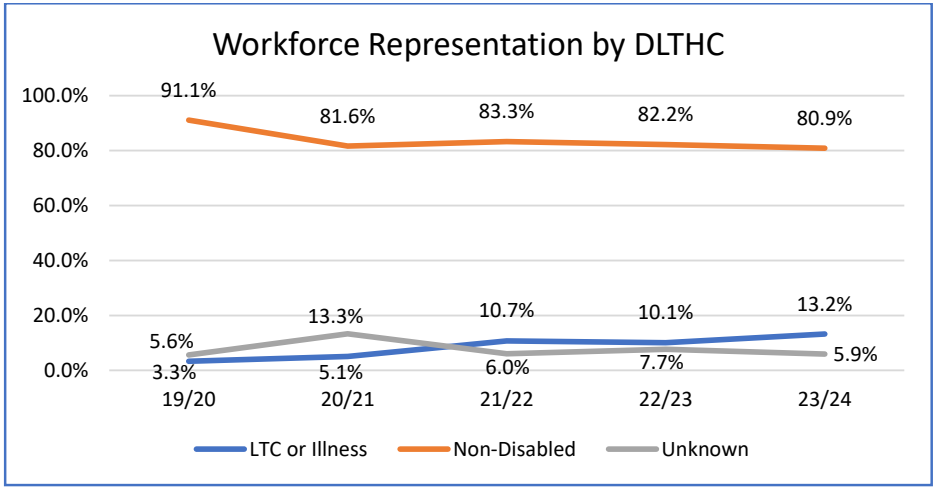
Key findings from the WDES 2023-24 Report

Table 1: WDES 2023-24 Summary of Key Findings

WDES Metrics	Workforce Disability Equality Standard Metrics based on 2023 Electronic Staff Record and HR recruitment database	Trend	Summary of Key Findings
Metric 1	Workforce representation (Declaration rates)	**Improving**	The number of staff who have shared their Disability or Long-Term Health Condition has increased by 3.1%. Non-clinical cohort is representative and clinical cohort has improved by 4.2% (underrepresentation now reduced to 1%).
Metric 2	Recruitment: Relative likelihood of disabled applicants being appointed from shortlisting compared to non-disabled applicants	**Regressing**	Regressed by 0.3 but disabled applicants still more likely to be appointed from shortlisting.
Metric 3	Capability: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance	**Regressing**	Disabled staff 1.5X more likely to enter formal capability process than non-disabled staff.
Metric 10	Board representation: percentage of the board's membership who have declared a disability.	**Improving**	There has been gradual improvement over the last 2 years.
	WDES metrics based on 2022 NHS Staff Survey data		
Metric 4a	Harassment, bullying or abuse from patients, service users, their relatives or other members of the public	**Improving**	One of the Trust's strongest scores – we are 13.3 percentage points above national average score.
Metric 4b	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from managers	**Improving**	Improved by nearly 15%, but still among lowest performers in this indicator nationally.
Metric 4c	Harassment, bullying or abuse by colleagues	**Improving**	Improved by 1.9%, but still among lowest performers in this indicator nationally.
Metric 4d	Reporting of harassment, bullying or abuse	**Improving**	Improved by 4.5%, but still among lowest performers in this indicator nationally.
Metric 5	Percentage of disabled staff compared to non-disabled staff believing their trust provides equal opportunities for career progression or promotion	**Improving**	Improved by 2.8%, but with a score of 27.5% we are still among lowest performers in this metric nationally.
Metric 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Improving**	Improved by 4%, but still among lowest performers in this indicator nationally.
Metric 7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	**Improving**	Improved for the first time in 4 years, but still among lowest performers in this indicator nationally.
Metric 8	Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	**Improving**	Made enormous improvement (14.2%) but the Trust score (67.7%) is still 11.6% below national average (79.3%).
Metric 9a & b	The staff engagement score for disabled staff from the NHS Staff Survey, compared to non-disabled staff / Voices of disabled staff	**Improving**	Trust has made first improvement in 4 years in this metric.

Metric 1: Workforce Representation

Table 2: Overall Workforce Profile (Disability & Long-Term Health Conditions) 2019-2024



The data presented in **Table 2** indicates that the proportion of the workforce that has declared a Disability on the Trust's ESR has increased by 9.9% over the last 5 years. As part of this gradual increase, the number of staff who have shared their Disability or Long-Term Health Condition increased from 10.1% in the previous year to 13.2% – an improvement of 3.1%.

However, it is important to note that the number of staff at Tavistock and Portman who reported a long-term illness or condition through the 2023 NHS Staff Survey is 25.8%: this figure is nearly 2X the internal declaration rate. Reporting on the NHS Staff Survey is more reflective of the UK population working-age population, where 23% have identified as having a disability through HM Government.

Table 3: (Metric 1a) Non-Clinical Workforce Profile 2019-2024

Workforce Profile: Non-clinical Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown	Disabled	Non-Disabled	Missing / Unknown
Cluster 1: AfC Bands < 1 *to* 4	5.7% (5)	65.5% (57)	28.7% (25)	8.2% (7)	83.5% (71)	8.2% (7)	20.5% (16)	71.8% (56)	7.7% (6)	18.2% (12)	69.7% (46)	12.1% (8)	13.2% (10)	78.9% (60)	6 (7.9%)
Cluster 2: AfC Bands 5-7	3.4% (5)	68.9% (102)	27.7% (41)	6.4% (10)	85.9% (134)	7.7% (12)	14.8% (24)	80.2% (130)	4.9% (8)	14.8% (24)	76.2% (125)	9.15% (15)	13.9% (24)	79.8% (138)	6.4% (11)
Cluster 3: AfC Bands 8a-8b	5.9% (2)	61.8% (21)	32.4% (11)	8.2% (4)	77.6% (38)	14.3% (7)	21.2% (11)	73.1% (38)	5.3% (3)	16.4% (9)	78.2% (43)	5.5% (3)	22.2% (14)	77.8% (49)	0% (0)
Cluster 4: AfC Bands 8c-VSM	4.8% (1)	42.9% (9)	52.4% (11)	8.0% (2)	80.0% (20)	12.0% (3)	7.4% (2)	92.6% (25)	0% (0)	17.9% (5)	78.6% (22)	3.6% (1)	17.1% (6)	80.0% (28)	2.9% (1)
Total Non-Clinical	**11 (3.8%)**	**189 (65.6%)**	**88 (30.6%)**	**23 (7.3%)**	**263 (83.5%)**	**29 (9.2%)**	**53 (16.6%)**	**249 (78.1%)**	**17 (5.3%)**	**50 (16.0%)**	**236 (75.4%)**	**27 (8.6%)**	**15.6% (54)**	**79.3% (275)**	**5.2% (18)**

Table 3 presents the number of Disabled and Non-Disabled staff employed at the Trust across the non-clinical Agenda for Change (AfC) pay-bands over the last 5 reporting years. It is encouraging to note that the non-declaration rate in this cohort has shrunk across all AfC Bands. In addition, the non-clinical cohort is representative of the workforce profile presented in Table 2 above.

Table 4: (Metric 1b) Clinical Workforce Profile 2019-2024

Workforce Profile: Clinical Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	Disabled	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**
Cluster 1: AfC Bands < 1 *to* 4	3.7% (1)	85.1% (23)	11.1% (3)	0.0% (0)	94.1% (16)	5.9% (1)	9.1% (2)	86.4% (19)	4.5% (1)	8.7% (2)	91.3% (21)	0.0% (0)	17.6% (3)	82.4% (14)	0.0% (0)
Cluster 2: AfC Bands 5-7	3.3% (7)	76.6% (161)	20.0% (42)	5.5% (12)	86.8% (190)	7.8% (17)	5% (11)	90.5% (200)	4.5% (10)	7.8 % (17)	86.2% (188)	5.9% (13)	12.1% (26)	82..7% (177)	5.1% (11)
Cluster 3: AfC Bands 8a-8b	3.2% (5)	76.1% (118)	20.6% (32)	5.0% (8)	88.1% (141)	6.9% (11)	9.7% (16)	85.5% (141)	4.8% (8)	10.1% (17)	82.1% (138)	7.7% (13)	11.6% (20)	83.2% (144)	5.2% (9)
Cluster 4: AfC Bands 8c-VSM	0.0% (0)	47.8% (22)	52.1% (24)	0.0% (0)	75.6% (34)	24.4% (11)	4.7% (2)	88.4% (38)	7.0% (3)	9.5% (4)	85.7% (36)	4.8% (2)	13.3% (4)	83.3% (25%)	3.3% (1)
Total Clinical Cohort	**13 (3.0%)**	**324 (74.0%)**	**101 (23.1%)**	**20 (4.5%)**	**381 (86.4%)**	**40 (9.1%)**	**31 (6.9%)**	**398 (88.2%)**	**22 (4.9%)**	**40 (8.2%)**	**421 (86.1%)**	**28 (5.7%)**	**12.2% (54)**	**82.8% (366)**	**5% (22)**

Table 4 highlights that:

- The overall representativeness of the clinical cohort has improved by 9.2% over the last 5 reporting years.
- The underrepresentation of Disabled staff in the clinical cohort has shrunk to 1%.
- The highest cluster (AfC Bands 8c-VSM is now representative (13.3%).

Table 5: (Metric 1c) Medical / Dental Cohort 2019-2024

Workforce Profile: Medical / Dental Cohort 2019-2024															
Pay Band	**2019-20**			**2020-21**			**2021-22**			**2022-23**			**2023-24**		
	Disabled	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**	**Disabled**	**Non-Disabled**	**Missing / Unknown**
Consultants	2.3% (1)	40.4% (17)	57.1% (24)	2.6% (1)	84.2% (32)	13.2% (5)	7.9% (3)	89.5 (34)	26% (1)	8.1 % (3)	89.2% (33)	2.7% (1)	8.33% (3)	86.11% (31)	5.56% (2)
Non-Consultant Career Grade	0.0% (0)	60.0% (3)	40.0% (2)	0.0% (0)	100.0% (6)	0.0% (0)	4.3% (1)	87% (20)	8.7% (2)	20% (1)	60% (3)	20% (1)	14.29% (1)	71.43% (5)	14.29% (1)
Trainee Grade	0.0% (0)	33.3% (6)	66.6% (12)	0.0% (0)	61.9% (13)	38.1% (8)	14.3% (3)	42.9% (9)	42.9% (9)	5.9% (1)	76.5% (13)	17.6 (3)	0% (0)	53.33% (8)	46.67% (7)
Total Medical & Dental	**1 (1.5%)**	**26 (40.0%)**	**38 (58.5%)**	**1 (1.51%)**	**51 (78.5%)**	**13 (20.0%)**	**7 (8.5%)**	**63 (76.9%)**	**12 (14.7%)**	**5 (8.5%)**	**49 (83.1%)**	**5 (8.5%)**	**6.90% (4)**	**75.86% (44)**	**17.24% (10)**

Table 5 suggests two key points for the Dental / Medical cohort:

- The numbers are relatively small but there has been under-representation of Disabled staff for the last 5 years.
- Non-declaration rates are high, particularly 46.6% for the Trainee Grade.

Metric 2: Recruitment - Relative likelihood of Disabled applicants being appointed from shortlisting

Table 6: Relative likelihood of being appointed from shortlisting

Metric	Descriptor	2019-20	2020-21	2021-22	2022-23	2023-24
2	Relative likelihood of Disabled applicants being appointed from shortlisting compared to Non-Disabled applicants across all posts. *****A figure below 1:00 indicates that Disabled applicants are more likely than Non-Disabled applicants to be appointed from shortlisting.	**1.03**	**0.82**	**1.33**	**0.95**	**0.98**

The data in **Table 6** indicates that there has been no consistency in recruitment trends over the last 5 reporting years. While there has been a negligible regression of 0.03 in the likelihood of Disabled applicants being appointed from shortlisting, Disabled applicants at the Trust are more likely to be appointed from shortlisting than Non-Disabled applicants. This has been the trend for two consecutive years. The picture is similar nationally – the average in NHS trusts is 0.99: this suggests that Disabled applicants are slightly favoured over Non-Disabled applicants on average. A figure of 1.0 would represent equity of opportunity.

Metric 3: Relative likelihood of Disabled staff entering the formal capability procedure

Table 7: Relative likelihood of entering the formal capability procedure

Metric	Descriptor	2019-20	2020-21	2021-22	2022-23	2023-24
3	Relative likelihood of Disabled staff compared to Non-Disabled staff entering the formal capability process on the grounds of performance. *****This metric will be based on data from a two-year rolling average of the current year and the previous year. * A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.	**0.00**	**0.00**	**0.00**	**0.00**	**1.52**

The data in Table 7 shows a regression in this metric: from 2019-2022 no Disabled staff entered the formal capability process. However, the 2023 figure suggests that Disabled staff at Tavistock and Portman are 1.5 times more likely than Non-Disabled staff to enter the formal capability process. The national average 2.17 suggests that Disabled staff are twice as likely as Non-Disabled staff to enter the formal capability process on the grounds of performance.

Metric 4a: Harassment, Bullying or Abuse by Patients/Public

Figure 1: Harassment, Bullying or Abuse from patients/service users, relatives or the public

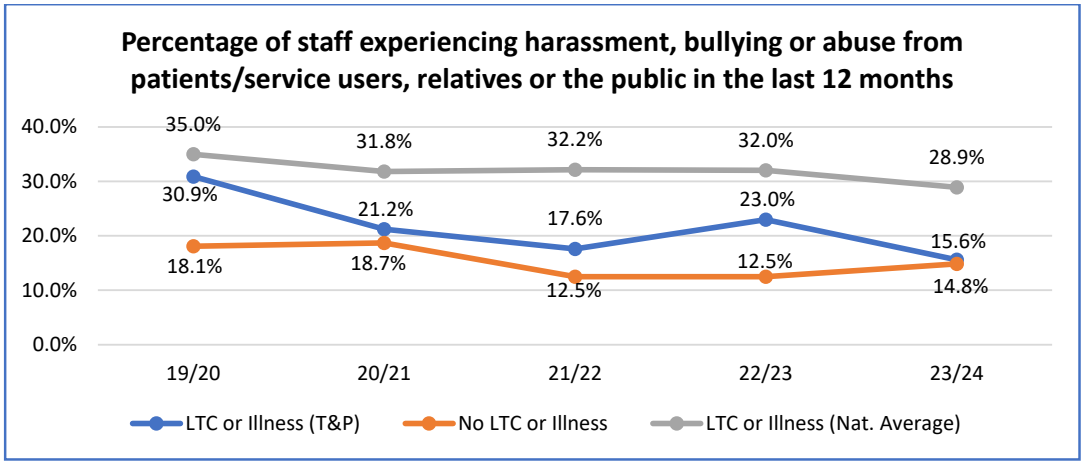


Figure 1 shows the proportion of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives or the public in the last 5 years:

- The number of Disabled staff experiencing HBA from patients, public and relatives over the past 5 years has been halved from 30.9% to 15.6%.
- There was an improvement of 7.4% this year.
- The disparity in experience between Disabled and Non-disabled staff has been reduced to 0.8%.
- Nationally (28.9%), about 1 in 3 disabled staff experience HBA from patients, service users or the public. Our score (15.6%) is significantly better than national average score.

Metric 4b: Harassment, Bullying or Abuse by Manager

Figure 2: Percentage of staff experiencing Harassment, Bullying or Abuse from managers

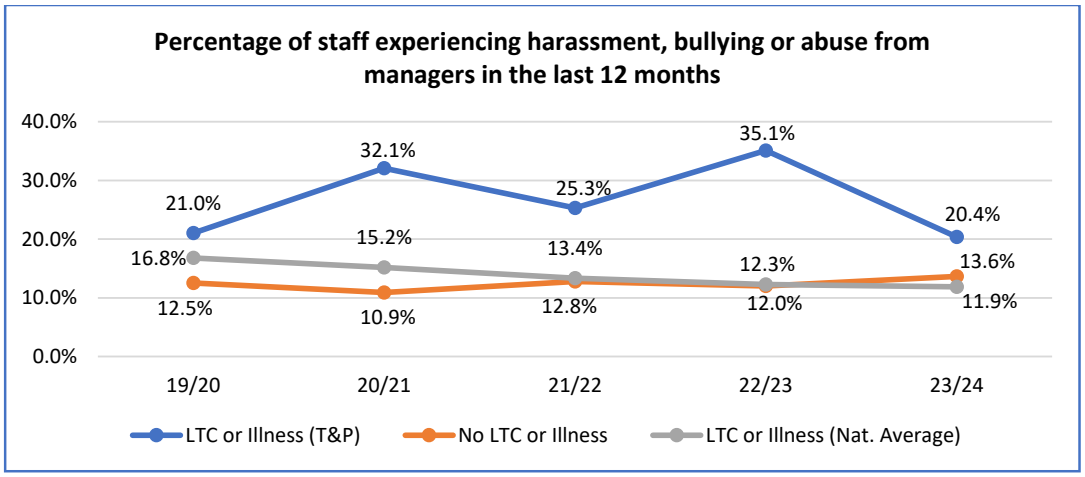


Figure 2 presents the percentage of staff experiencing HBA from managers over the last 5 years.

- The figure shrunk by nearly 15% from 35.1% to 20.45 this year. However, despite this huge improvement we are still positioned among the weakest performers in this metric as the national average is 11.9%.
- There is a higher proportion of Disabled Staff, compared to Non-Disabled staff, experiencing HBA from managers – the disparity is 6.8% at the Trust.
- Overall, the Trust's performance in this indicator has been weak – we have improved by 0.6% over the last 5 reporting years – the national average has improved by 4.9% over the same period.

Metric 4c: Harassment, Bullying or Abuse by Colleagues

Figure 3: Percentage of staff experiencing Harassment, Bullying or Abuse from other colleagues

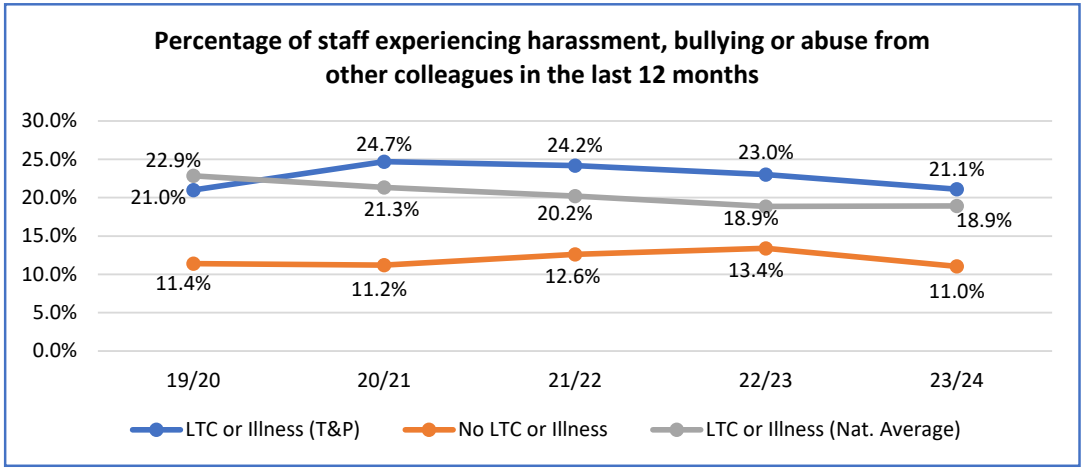
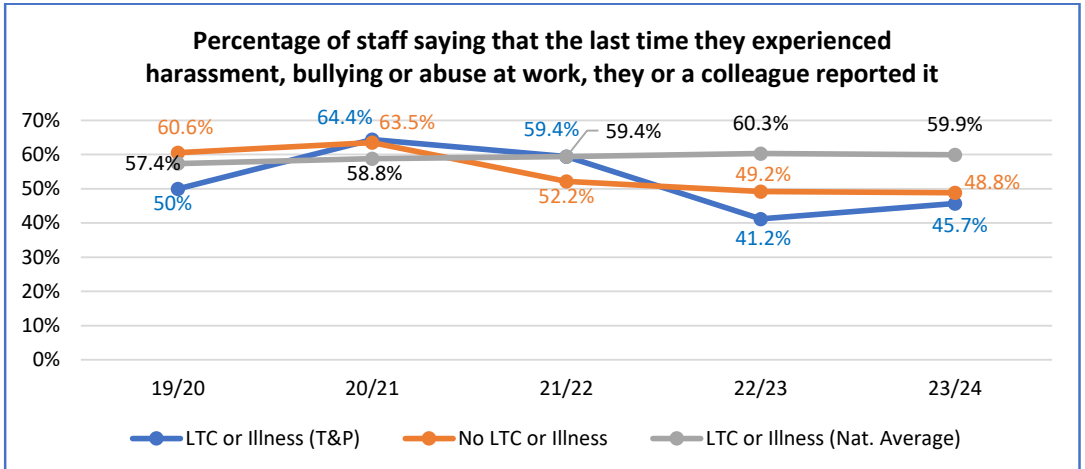


Figure 3 shows that the percentage of staff experiencing harassment, bullying or abuse from other colleagues fell by 1.9% this year – we have sustained this improvement for 4 consecutive years. However, looking at the 5-year trend, we are now at the same position we were 5 years ago (2019) and are 2.4 percentage points weaker than the national average score for this indicator.

1 in 5 Disabled staff at the Tavistock and Portman experience harassment, bullying or abuse from colleagues. This is 10.1 percentage points higher than for Non-Disabled staff – this disparity has remained in situ for the last 5 reporting years.

Metric 4d: Reporting Harassment, Bullying or Abuse

Figure 4: Percentage of staff who reported Harassment, Bullying or Abuse they experienced



The data in **Figure 4** shows the percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. This figure has improved by 4.5% from 41.2% to 45.7% this year.

While data in Figure 3 suggests that staff with disabilities are 2X more likely to be harassed, bullied or abused by their colleagues, Figure 4 shows that they are less likely to report compared to their Non-Disabled colleagues.

Also, the national average in this indicator is 59.9%: this is 14.2 percentage points better than the Trust's score. We are in the weakest performing category for this indicator.

Metric 5: Equal Opportunities for Career Progression or Promotion

Figure 5: Opportunities for career progression or promotion

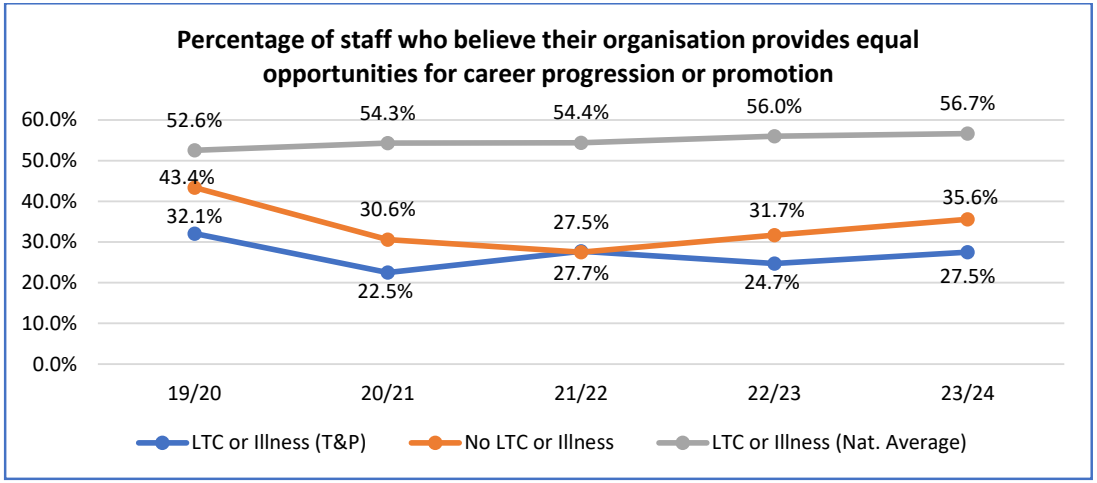


Figure 5 shows that there was an increase of 2.8% to 27.5% in 2023-24 in the number of Disabled staff believing the Trust provides equal opportunities for career progression or promotion. The disparity between Disabled and Non-Disabled staff is 8.1%.

One would note here that across NHS trusts, there has been a gradual increase over the last 5 years in the average percentage of Disabled staff believing they have equal opportunities for career progression or promotion – the national average is now 56.7%. The Tavistock and Portman score is 29.2 percentage points below – there has been a regression of 4.6% over the last 5 years.

Metric 6: Presenteeism

Figure 6: Presenteeism

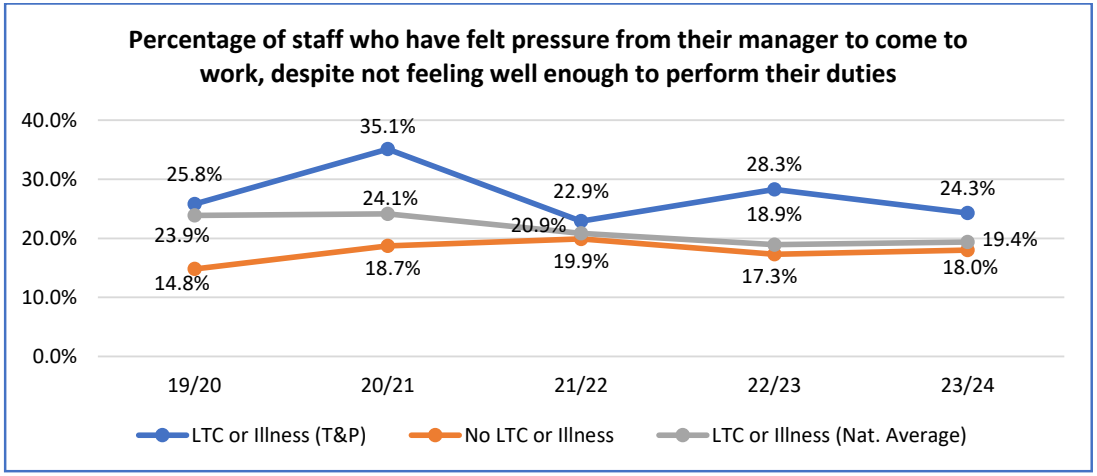


Figure 6 demonstrates several key issues:

- There has been an improvement of only 1.5% in this metric over the last 5 years – this represents an improvement rate of 0.3% each year.
- There is an improvement of 4% in the percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough over the last 12 months.
- Our score, 24.3% for this metric is 4.9% behind the national average score for Disabled staff.
- Also, there is a disparity of 6.3% between Disabled and Non-disabled staff.

Metric 7: Feeling valued by the organisation

Figure 7: Perceptions of staff on how their organisation values their work

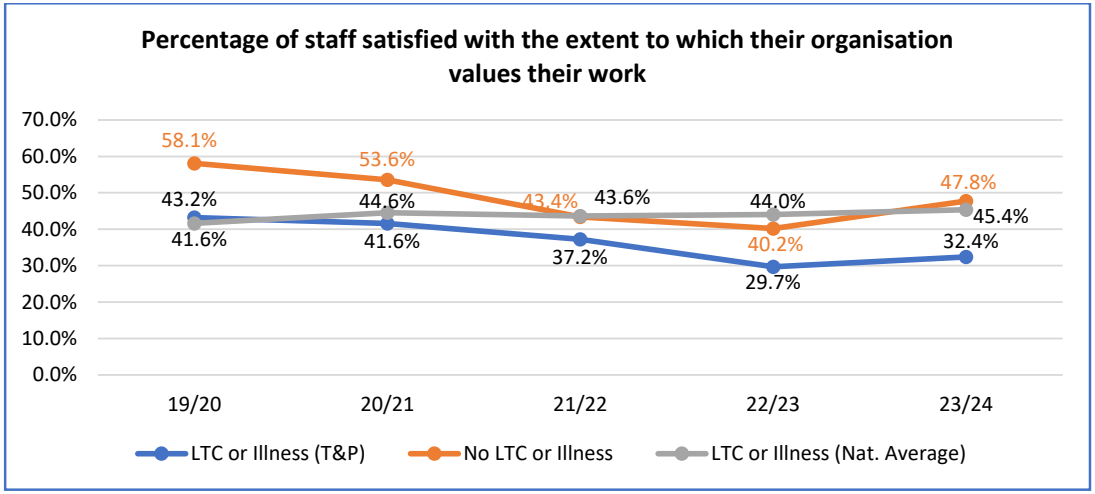


Figure 7 shows that there was a consistent decline in the number of Disabled staff who felt satisfied with the extent to which the organisation valued their work in the reporting years 2019-22. In 2019 the Trust's score was 43.2%, 4 years later it had shrunk considerably (by 13.5%) to 29.7%.

In this reporting year, the proportion of Disabled staff who feel valued by the Trust improved for the first time in 4 years by 2.7% to 32.4%. However, this score is 15.1 percentage points lower than that of staff without disabilities or long-term health conditions at the Trust and 13 percentage points lower than the national average score (45.4%).

Metric 8: Workplace Adjustments for Disabled Staff

Figure 8: Reasonable Adjustments for Disabled Staff

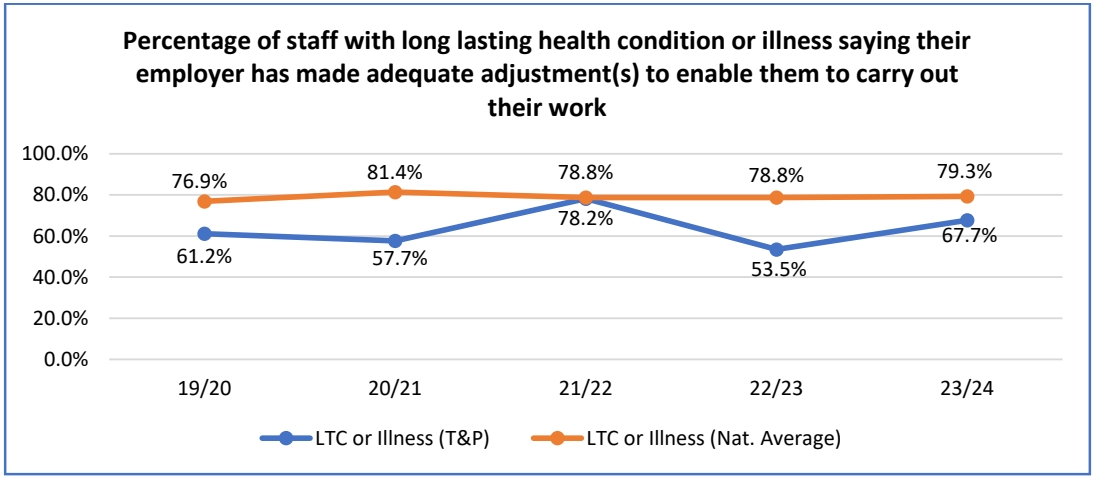


Figure 8 shows that the proportion of disabled staff who obtained the workplace adjustments they need to perform their work effectively increased by 14.2 percentage points to 67.7% this reporting year. This is an enormous improvement; however, it stills positions the Trust 11.6 percentage points behind the national average score for this indicator (79.3%).

Metric 9: Staff Engagement Score

Table 8: Staff Engagement Score

Metric	NHS Staff Survey and the engagement of Disabled staff	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22	Disabled 2022/23	Non-Disabled 2022/23	Disabled 2023/24	Non-Disabled 2023/24
9 National Survey Staff Engagement Score (0-10)	(a) The staff engagement scores for Disabled and Non-Disabled staff	6.5	7.3	6.4	7.1	6.3	6.7	5.4	6.5	6.1	6.7
	(b) Has Tavistock and Portman taken action to facilitate the voices of Disabled staff in your organisation to be heard?	**No**		**Yes**		**Yes**		**Yes**		**Yes**	

Table 8 shows that after a 4-year downward trend (2019-22) the staff engagement score for Disabled staff at the Trust has improved from 5.4 to 6.1. The national average score for staff with Disabilities or Long-Term Conditions is 6.8. Our score (6.1) places the Trust among the lowest performing trusts in this category nationally and is 0.6 points lower than that for Non-Disabled staff.

Metric 10: Board Representation

Table 9: Board Representation

Metric 10: Board Representation and the difference for Disabled and Non-Disabled staff															
Board Representation	**2019-2020**			**2020-2021**			**2021-2022**			**2022-23**			**2023-24**		
	Disabled	**Non-Disabled**	**Unknown**	**Disabled**	**Non-Disabled**	**Unknown**	**Disabled**	**Non-Disabled**	**Unknown**	**Disabled**	**Non-Disabled**	**Unknown**	**Disabled**	**Non-Disabled**	**Unknown**
Total Board Members	7%	57%	36%	0.0%	0.0%	0.0%	0.0%	89.5%	10.5%	(1) 5.26%	(14) 73.68%	(4) 21.05%	(3) 15.79%	15 (78.95%)	(1) 5.26%
Overall Workforce by Disability	3%	67%	30%	5.11%	81.61%	13.28%	10.7%	83.3%	6.0%	10.1%	82.1%	8.%	13.2%	80.9%	5.9%
10.b) Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:															
(a) By voting membership of the Board	-3%	33%	-30%	-5.11%	81.61%	86.72%	0%	0%	0%	-0.35%	-3.37%	3.71%	7%	-8%	1%
(b) By Executive membership of the Board	9%	20%	-30%	-5.11%	81.61%	86.72%	0%	83.3%	-6.2%	-11.46%	-11.15%	22.6%	-3%	-1%%	4%

This return shows that the Board membership of disabled staff is (3) 15.79% and the voting membership is 7%. 1 member of the Board is marked as unknown.

Conclusion and Next Steps

This WDES report has painted a mixed picture: it is encouraging to note that enormous progress has been made in ameliorating the challenges faced by staff with disabilities and long-term conditions at the Tavistock and Portman. Progress was made in 8 of the 10 indicators and in 2 of them there was an improvement of over 14 percentage points, yet the Trust is still positioned in the lowest performing category for those indicators.

- The declaration rate on the Trust's ESR has increased by 9.9% over the last 5 years.
- There has been a gradual increase in the percentage of the Board's membership.
- The percentage of Disabled staff experiencing Harassment, Bullying and Abuse from patients, public and relatives has shrunk from 30.9% to 15.6% over the last 5 years.
- The staff engagement score for Disabled staff improved for the first time in this reporting year after deteriorating for 4-years.

There was regression in the following areas:

- The relative likelihood of Disabled applicants being appointed from shortlisting compared to Non-Disabled applicants across all posts regressed by 0.3 points, however Disabled applicants are still more likely than Non-Disabled applicants to be appointed from shortlisting.
- Disabled staff are now 1.5 times more likely to enter formal capability process than Non-Disabled staff.

The following areas need to be prioritised – significant improvements were made in this reporting year, some well over 14 percentage points yet the Trust remains anchored in the lowest performing category for the following themes:

- Harassment, bullying or abuse by managers.
- Harassment, bullying or abuse by colleagues.
- Reporting of harassment, bullying or abuse.
- Perceptions on equal opposition for career progression or promotion.
- Presenteeism.
- Perceptions on work of Disabled staff being valued.
- Reasonable adjustments to enable Disabled staff to carry out their work.

Next Steps:

- Adopting a zero-tolerance approach to harassment, bullying or abuse of staff by managers.
- Removing barriers to reporting experiences of harassment, bullying or abuse.
- Creating transparency around equal opportunities for career progression or promotion.
- Educating staff and managers about presenteeism.
- Development of employer recognition schemes and initiatives.
- Reviewing and standardising the Reasonable Adjustments process introduced last year and backing it back up by a clear and comprehensive policy.

Appendix 1

Improvement Action Plan

Action	EDI Strategy Objective	Target	Next steps	Executive Lead(s)	Timescale
Review, standardise and accelerate reasonable adjustments process	Improve satisfaction rate on workplace adjustments and feeling valued **WDES Metric 7 & 8**	Train managers in Reasonable Adjustments / Access to work Facilitate a common or standard understanding of reasonable adjustments	Launch a Reasonable Adjustments Policy Trust wide communication of RAs	Chief People Officer	
Carry out a deep dive into Bullying, Harassment and Abuse	Raise awareness about BHA Reduce BHA experienced by Disabled staff **WDES Metric 4b, c, d**	Better understanding of BHA by staff Reduction in BHA	Carry out a deep dive and share findings with all staff to build trust	Director of Corporate Governance	
Remove reporting barriers by completing root to branch review	Facilitate clear understanding of grievance and disciplinary procedure and relevant policy Embed Just Culture Approach **WDES Metric 3, 4b, c, d & 9**	Collaboration between People Team, FTSUG, EDI and staff side	Expand / diversify FTSUG role Re-launch of grievance and disciplinary procedure Review previous cases and share themes / outcomes to develop trust and confidence trust wide	Director of Corporate Governance	
Address concerns on lack of Equal Opportunities for career progression or promotion	Develop a transparent and equitable internal promotion process **WDES Metric 5**	Transparency and scrutiny of all internal promotions	Create an internal promotions panel with clear Terms of Reference Communicate and make panel visible trust wide	Chief People Officer	
Reduce the number of Disabled staff who come to work even when they are unwell (Presenteeism)	Eliminate the differential between Disabled and Non-Disabled staff **WDES Metric 4b & 6**	Embed Just and Learning Culture approach	Embed understanding of presenteeism in Leadership and Management training	Chief People Officer	
Reduce relative likelihood of Disabled staff compared to Non-Disabled staff entering the formal capability process on the grounds of performance	Address overrepresentation of staff with Disabilities and LTHC in the formal capability process **WDES Metric 3, 7 & 8**	Embed Just Culture Approach	Carry out a deep dive into previous cases, share lessons learnt and facilitate just and learning culture training.	Chief People Officer Chief Nursing Officer	

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) 11 JULY 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	June 2024	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 16**		

Assurance ratings used in the report are set out below:				
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. EDI considerations • BAF Risk 7 - Lack of a fair and inclusive culture. This risk was chosen as the focus for the June meeting and subsequently we spent time both discussing the risk and using it to inform our examination of items during the meeting • Bullying and harassment – as an organisation we believe this is under reported; as such we discussed the reasons underpinning this and steps that could be taken to achieve a more accurate and realistic picture of the extent of incidents. • Race Equality Network – a great amount of work was presented to the committee; 14 events held in three months, and all led by Pauline as the network has no co-chair at present. This is in process of being rectified. • WRES/ DES action plans - robust high-level actions identified which the committee are assured will make a difference. Whilst there will not be much time to make an impact before the next staff survey in October, it is important that they are implemented. In addition, it was noted the recommendations are being triaged by the EDI Programme Board for prioritisation. Both the Board Seminar and the Board meeting proper will receive a presentation from TM today on WRES and WDES.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Other staff experience considerations • MLDP – it was noted that we are making good progress towards getting all managers on the MLDP and the committee was assured of the 'wash up' approach to secure places for those who have not yet attended a cohort. The organisation will also disseminate the learning to groups at lower levels than those attending the MLDP; further info to come on what this looks like. Some gaps in provision	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

were identified e.g. freedom to speak up, dealing with bullying behaviours; these should be covered by back-to-basics training, and/or bespoke offerings. • Appraisal compliance - we are aware of the technical and timing issues and can see where the omissions are; we now need to actively address them. • Yoga room – concerns were shared that we will lose the charity funding for this intervention soon unless we can set up the room swiftly. Estates colleagues to provide an update and/or alternative solution. • Rooms – it is apparent that were do not have enough information about how rooms are being used but we are in the process of actively collecting data, to inform agreed principles for the new room usage system.	

Summary of Decisions made by the Committee:

There were no specific items for approval.

Risks Identified by the Committee during the meeting:

There was no new risk identified by the Committee during this meeting.

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – 11 July 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	n/a, next meeting 18 July 2024	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training officer	☒ **Yes**	☐ **No**
Appendices:	Previous Assurance Report, 11 March		**Agenda Item: 17**		

Assurance ratings used in the report are set out below:

Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The key discussion items including assurances received are highlighted to the Board below:

Key headline	**Assurance rating**
1. Development of Education & Training related BAF risks • The next ET committee (on 18/7) will be asked to discuss revised BAF risks around the merger and OfS accreditation.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Finance and Performance • A new lecturer role has been approved to support delivery of the M4 three-year doctorate programme. All 14 potential 23/24 graduates from the course passed their associated vivas. • The Trust expenditure on Visiting Lectures is disproportionate relative to other HE institutions and remains a concern as VLs lack accountability and can contribute to a poor student experience. Work to move to a more substantive teaching workforce and reduce the use of VLs continues but will need to be part of a DET staff consultation process. • There are ongoing concerns about the Trust's ability to manage student debt effectively, with risks associated with historical issues and the need to secure additional resource to mitigate future challenges.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. CETO Update • The DET Merger Board has been re-instated with a clear set of objectives and associated risk factors relating to various options to secure a sustainable HE partner and ensure DET's long-term viability. • Student recruitment has shown a year-on-year increase of 10.8% from 2023-24, with 799 applications for 24-25, up from 721 at this time in 23/24. We have also received 10 applications for the executive coaching programme, parity with last year.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Workforce Innovation Unit • Tavistock Consulting is moving from DET to the Strategy Office (Rod Booth).	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
5. Development	Limited ☐

• On 2/7/24, members of DET SLT with Clinical and Commercial colleagues attended a workshop convened by Premal Kamdar (Associate Director of Business Development) and facilitated by colleagues from Healthcare UK (part of the Department of Business and Trade). The need for a Trust International Strategy, together with associated business decision matrix, was identified for follow-up by end of August 2024.	Partial ☐ Adequate ☒ N/A ☐
6. SITS Review • The comprehensive review of our student record system (SITS) is nearing completion, with an expected completion date of 24th July. The outcome report is due soon after with recommendations to technical and process changes required.	
7. Student experience and the Annual Student Survey • The current student survey commenced on 16/04/24 and will complete on 12/07/24. Our current response rate is 20% (above the 2023 national average of 12%) and our overall satisfaction is 79% (slightly below the average of 83% in 2023).	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- Next committee is 18/07/2024

Risks Identified by the Committee during the meeting:

- n/a, next committee is 18/07

Items to come back to the Committee outside its routine business cycle:

n/a, next cycle is 18th July

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – 11th July 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	21st June 2024	Aruna Mehta, Non-Executive Director	Sally Hodges, CCOO and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 18**		

Assurance ratings used in the report are set out below:				
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Integrated Quality and Performance report: • It was highlighted that the existing A3s need to be amended to reflect the updated strategic objectives. • Concern was raised about the lack of progress on some waiting times but recognised that the ERF investment was close to starting in some services, e.g. Trauma, and regular support meeting were being put in place for those areas with waiting list issues to agree recovery plans. • GIC waiting list volume and times were highlighted as an area of concern, with the chair asking for this to be escalated to Board for consideration. • It was recognised that the Watch Metrics in the report were a positive step in highlighting areas of concern. • ASD Kaizen event has identified areas for performance improvement to do with the current pathway. The team are making adaptations which will be tracked through the ERF trajectories • Performance issues flagged in PCPCS and First Steps primarily to do with the service and staffing models. Commissioners working with us to review service model. • DET reported an increase in applications of c10%, with the issue of losing international students due to a lack of an accommodation offer being highlighted. DET are looking at options to mitigate this risk.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
2. Finance report: • Finance Report for M02 was presented to the Committee, based on the final version of the Trust Financial Plan for 2/25 submitted 12th June 24. • The final plan reflected M02 actuals as target, so no variance to plan. The report highlighted that M02 reported position was very close to the previous versions of the plan, so no delivery risks identified. • Committee were updated on final accounts progress, with the deadline expected to be achieved at the time of the meeting, with a	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

deficit more than the control total (£2,517K) by £156k. This has since reduced to be within the control total. A risk of £800k relating to deferred income was highlighted to committee for information also. The impact would have been detrimental to the 24/25 plan. The issue has since been resolved so not highlighted to Board of Directors. • The cash support included in the plan was explained to committee, with the interest payable on this support specifically highlighted by the chair.	
3. BAF Risks • AK went through the updated BAF Risks one by one for the committee to comment on and suggest changes to initial Executive scoring. • Specific focus was given to the Finance, Estates, IT and Performance risks. • Performance risk 13, was recommended to come back to committee for further scrutiny of controls. • Finance risks (9&11) – it was agreed that some narrative to control environment section reflecting the work on team level budgeting. • Estates risk was agreed as ok, with slight amendment to the risk scoring. • IT risk didn't at the time of writing reflect the lapse in Cyber Essentials accreditation, which had only come to the attention of the Contracting Team that week. This will be resolved asap and the risk narrative updated, plus committee agreed a minor adjustment to the risk score also.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Over/Under Payments • The management actions highlighted in the report had not impacted on the over payments as expected. It was agreed that additional measures were needed with the monthly reporting by team/manager to be part of the IQPR report going forward. • This was referred to the IAGC.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Escalation • Waiting list risk in GIC to be escalated to Board.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- The Committee was not required to make any decisions.

Risks Identified by the Committee during the meeting:

Cyber Essentials accreditation is a risk to income generation activities.
Annual accounts audit risk, since resolved.

Items to come back to the Committee outside its routine business cycle:

There was no specific item over those planned within its cycle that it asked to return.

Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
Over and under salary payments	Action	

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 11 July 2024			
Report Title: Finance Report - As at 31st May 24 (Reporting Month 02)			**Agenda No. 19**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	Appendix 1 - Finance Report 24/25 Month 02 – May 24		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation: Private)	The report provides the Month 02 (cumulative position to 31st May 24) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £439k in the period, that is consistent with the revised final plan submitted to NHSE 12th June 24. The Trust is anticipating achieving its year-end deficit plan of £2,200k, with no significant risk to plan known at the time of writing. Note, this is consistent with the originally agreed expected deficit pre the final agreed plan being submitted. **Capital Expenditure** To date capital spend is limited, totaling only £66k, slightly behind the planned spend to date of £107k. Anticipated expenditure at the year-end is expected to be on plan at £2,200k. **Cash** The cash balance at the end of M02 was £1,468k consistent with the revised final plan. The year cash position is planned to be £1,950k, after accessing planned cash support of £7,500k in year.		
Background:	The Trust has an agreed deficit revenue plan for 2024/25 of £2.2m, with a Capital Expenditure limit of £2.2m and an associated year-end cash position of £1.9m.		
Assessment:	**Income and Expenditure** The Trusts agreed deficit plan of £2,200k is contingent on the delivery of recurrent efficiency targets of £2,500k and the release of non-recurrent balance sheet opportunities of £2,656k, a total of £5,156k. The Trust will in addition continue to identify and pursue additional income opportunities, not currently part of the 24/25 plan, as part of its development of the medium-term financial plans designed to achieve a balanced financial position in future periods. This being a key part of the merger development and delivery work. **Capital Expenditure** The agreed capital spend limit for the year is £2,200k, being broadly similar to that in 23/24. Initial planning was based on an expected allocation of c.£1,950k, thus a limited degree of replanning of the capital program will be required in the early part of 24/25 to reflect the additional available capital. **Cash** The agreed plan included a reduction in cash over the year to an outturn of £1,950k, which is driven by the deficit, non-cash income sources in the financial plan for 24/25 and the planned capital spend. This cash flow forecast in the 24/25 plan is reliant on cash support of £7,500k being		

	agreed throughout the year by NHSE. The cash support comes into the Trust via a monthly application for additional non repayable PDC.
Key recommendation(s):	The Board is asked to **NOTE** the position outlined in the report.

Implications:

Strategic Objectives:

☐ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☒ Develop & deliver a strategy & financial plan that supports medium & long-term organizational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.

Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 9: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.		

Legal and Regulatory Implications:	Yes ☒	No ☐
	It is a requirement that the Trust submits an annual Plan to the ICS and monitors and manages progress against it.	
Resource Implications:	Yes ☐	No ☒
	There are no resource implications associated with this report.	
Diversity, Equality and Inclusion (DEI) implications:	Yes ☐	No ☒
	There are no DEI implications associated with this report.	
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Schedule of Business 2024/2025 draft v8

MEETINGS	AGM/ Board Extraordinary (ARA)	Board Meeting	Board Seminar	Council of Governors	Integrated Audit & Governance Committee	Quality & Safety Committee	Performance Finance and Resource Committee	Education and Training Committee	POD & Equality, Diversity and Inclusion	Remuneration Committee	Joint BoD and CoG	CoG Nom Committee
CHAIR/LEAD		Chair: John Lawlor	John Lawlor	Chair: John Lawlor Vice-Chair: David Levenson	Chair: David Levenson Exec Lead: Peter O'Neill	Chair: Claire Johnston Exec Lead: Clare Scott	Chair: Aruna Mehta Exec Lead: Peter O'Neill/ Sally Hodges	Chair: Sal Jarvis Exec Lead: Elisa Reyes-Simpson	Chair: Shalini Sequeira Exec Lead: Gem Davies	Chair: John Lawlor	Chair: John Lawlor	Chair: John Lawlor
APRIL			11 April 10.00 – 4.00			18 April 1.30. – 4.00	18 April 10.00 – 12.30			11 April 4:00 – 5:00	11 April 12.30-4.00pm	
MAY		9 May 10:00-5.30			21 May 10:00 – 1:00			16 May 1:30 – 4:00	2 May 10:00 – 12:00			
JUNE			13 June 10.00 – 4.00	30 May 1.00 – 5.30	18 June (Ex-Ord for ARA) 10:00 – 1:00	20 June 10.00 – 12.30	Friday 21 June 10.00 – 12.30		27 June 10:00 – 12.30	13 June 4:00 – 5:00		
JULY		11 July 10:00-5.30						18 July 1:30 – 4:00				
AUGUST	**NO MEETING**	**NO MEETING**	**NO MEETING**	**NO MEETING**	**NO MEETING**	22 August 1.30 – 4.00	22 August 10:00 – 12.30	**NO MEETING**	**NO MEETING**	**NO MEETING**	**NO MEETING**	**NO MEETING**
SEPTEMBER	AGM: 19 September TBC	12 September 10:00-5.30			3 September 10:00 – 1:00			19 September 1:30 – 4:00	5 September 10:00 – 12:00			
OCTOBER			10 October 10.00 – 4.00	17 October 1.00 – 5.30		24 October 1.30 – 4.00	24 October 10:00 – 12.30			10 October 4:00 – 5:00		
NOVEMBER		14 November 10:00-5.30			26 November 10:00 – 1:00			21 November 1:30 – 4:00	7 November 10:00 – 12:00		28 November 1.00-4.00pm	
DECEMBER			12 December 10.00 – 4.00	5 December 1.00 – 5.30		19 December 1.30 – 4.00	19 December 10:00 – 12.30			12 December 4:00 – 5:00		
JANUARY		16 January 10:00-5.30						23 January 1:30 – 4:00	9 January 10:00 – 12:00			
FEBRUARY			13 February 10.00 – 4.00		25 February 10.00 – 1.00	27 February 1.30 – 4.00	27 February 10:00 – 12.30			13 February 4:00 – 5:00	20 Feb 1.00-4.00pm	
MARCH		13 March 10:00-5.30		27 March 1.00 – 5.30				20 March 1:30 – 4:00	6 March 10:00 – 12:00			