The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 24th May 2022

Please refer to the agenda for timings.

NHS
The Tavistock and Portman
NHS Foundation Trust

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 24th May 2022 – 4.15pm-6.00pm

#	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Inform	Chair	Verbal	4.15
2.	Declarations of interest	Inform	Chair	Enclosure	
3.	Minutes of last meeting	Approve	Chair	Enclosure 1a	
4.	Matters arising and action log	Review	Chair	Enclosure 1b	4.25
5.	Chief Executive's Report	Inform	Chief Executive Officer	Enclosure 2	4.30
DELIVERING BETTER HEALTH OUTCOMES					
6.	Quality Priorities for 2022/23	Approve	Chief Clinical Operating Officer	Enclosure 3	4.35
7.	Freedom to Speak Up Guardian – Annual report	Inform	Freedom to Speak up Guardian	Enclosure 4	4.45
ENSURING WE ALWAYS USE OUR RESOURCES WISELY					
8.	Finance and Performance report	Inform	Director of Finance	Enclosure 5	5.05
9.	Budget 2022/23	Inform	Director of Finance	Enclosure 6	5.10
GOVERNANCE AND WELL LED					
10.	UCL Alliance Business plan	Approve	CEO	Enclosure 7	5.20
11.	Provider License Self-Assessment	Approve	CEO	Enclosure 8	5.35
REPORTS FOR NOTING					
12.	Education and Training Committee Highlight report	Inform	Chair of Education and Training Committee	Enclosure 9	
13.	People, Organisational Development, Equality, Diversity and Inclusion Committee Highlight Report	Inform	Chair of PODEDI	Enclosure 10	
CLOSING ITEMS					
14.	Any other business:			Verbal	5.45
15.	Reflections and Feedback from the meeting	Discuss	Chair	Verbal	5.50
16.	Questions from the Public	Discuss	Chair	Verbal	
DATE AND TIME OF NEXT MEETING					

Tuesday 26th July, 2.00 – 4.00 pm
EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC
Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

HELD ON TUESDAY 29TH MARCH 2022
VIA ZOOM

PRESENT

Members

Prof Paul Burstow	Trust Chair (Meeting chair)
Ms Helen Farrow	Non-Executive Director
Mr David Holt	Non-Executive Director and Senior Independent Director
Mrs Shalini Sequeira	Non-Executive Director
Mr David Levenson	Non-Executive Director
Ms Deborah Colson	Vice Chair and Non-Executive Director
Mr Paul Jenkins	Chief Executive
Mr Terry Noys	Deputy Chief Executive and Finance Director
Dr Dinesh Sinha	Medical and Quality Director
Ms Jenna Davies	Interim Director of Corporate Governance
Mr Ian Tegerdine	Interim Director of HR
Ms Helen Robinson	Interim Director of Corporate Governance
Mr Brian Rock	Director of Education and Training and Dean of Postgraduate Studies
Ms Sally Hodges	Clinical Chief Operating Officer
Mrs Chris Caldwell	Director of Nursing

In Attendance

Mr Hector Bayayi	Director Gender Services
Ms Laure Thomas	Director of Marketing & Communications
Ms Rachel James	Divisional Director, CYAF
Mr Tim Kent	Divisional Director, AFS
Ms Fiona Fernandes	Business Manager Corporate Governance
Mr Julian Lousada	Public Governor
Mr Michael Rustin	Public Governor
Ms Paru Jeram	Staff Governor
Ms Badri Houshidar	Staff Governor
Ms Kenyah Nyameche	Public Governor
Ms Kathy Elliott,	Lead Governor and Stakeholder Governor
Mr Alastair Dickins	Corporate Governance officer (Minutes)

APOLOGIES

Mrs Aruna Mehta	Non-Executive Director

The Tavistock and Portman
NHS Foundation Trust

1/22	**Welcome, Apologies and Confirmation of Quorum**
	Mrs Colson opened the meeting noting that Professor Burstow was delayed owing to technical issues. She opened the meeting at 14:03 and welcomed those attending. The meeting was noted to be quorate, and apologies were as given as above.
2/22	**Declarations of Interest**
	None.
3/22	**Draft Minutes of the previous meeting held on 25 January 2022**
	The Minutes of the Meeting held on the 25th January 2022, were approved subject to minor amendments and the following change; Under 4.13 there should be an action "NEDs should be invited to all Lessons Learned events." **Action** 1/22: Patient Safety Officer (Alina Bacioana) to include NEDs in the invitations for all Lessons Learned events.
4/22	**Action log and matters arising**
	Professor Burstow joined the meeting, and noted updates against the action log, there were no questions or comments. The updated log was noted.
5/22	**Chair and Non-Executives' Reports**
	Mrs Colson requested that the NEDs' visits to teams be logged and reported to the Board and the Council of Governors **Action**; Interim Director of Corporate Governance to put in place a schedule of visits which will be reported to Board
6/22	**Chief Executive's Report**
	The Board acknowledged the services of *The Lighthouse* and *Haringey Thinking Space services* which have closed. Mrs Colson added her thanks together with the entire Board Mrs Sequeira thanked Mr Jenkins for his report and asked about the return to face-to-face working. Mr Jenkins noted that a task and finish group was currently reviewing national guidance and best practice to enable people to return to face to face working and learning Challenges include providing spaces in the building, and supporting people. Mr Levenson asked about the timing for regional GIDS services and the commitment to fund them. In response Mr Jenkins said the Trust was working with partners within specialised commissioning and NHSEI. NHSI is considering the scope of services, and where to make the distinction between services assessing and managing cases locally versus referring them to a specialist provider. Ms Colson raised the strategic review, she explained that she and NED

	colleagues had attended many staff sessions of the Strategic Review. She mentioned the strength of feeling among staff, and staff's constructive proposals. She referred to previous discussions on the evidence we need to show that the staff feedback has been properly considered. Mr Jenkins agreed, and stated that staff and the board will be provided with the responses to staff feedback and suggestions. The Board noted the report.
7/22	**Trust Objectives 2002/23**
	Mr Holt asked that the Board's objectives and people's personal objectives be linked to the five challenges of the Strategic Review. Mr Levenson welcomed the inclusion of quality of data, and making progress in data being entered, handled, and used for outcomes. The Board approved the preliminary Board objectives, with the following changes: 1. Mr Holt asked for the objectives to state which of the five challenges they support. 2. Mr Levenson asked for the Trust's work with the ICS to be included, and how we integrate our services with them. 3. Mrs S asked for Board training to be explicitly stated. 4. Mrs Caldwell asked for "Business as Usual (Clinical, Education and Training)" to include workforce development. 5. Mr Levenson asked for the objectives to state which committees have the main accountability for quality of data. 6. Professor Burstow asked for the objectives to recognise the support received from ICS on governance and other matters. **Action** 3/22: Mr Jenkins to add the items agreed in the meeting to the preliminary Board objectives. Professor Burstow said the first phase of implementation is scheduled for September. We want to put people's mind at rest at the earliest opportunity, so could we add a milestone to tell staff be told before then how the Strategic Review will affect them. Mr Jenkins replied that September was for completion of the first phase. **Action** 4/22: Mr Jenkins to add a milestone that staff, where possible, should be informed before September of how the Strategic Review will affect them. The Board noted the paper.

8/22	**Quality Update**
	Mr Sinha presented the Quality report and Members of the Board discussed the contents of the report. Professor Burstow suggested that there should be a stronger focus on equality, as well as putting a stronger focus on quality outcome measures so we can be assured that the Trust is delivering good patient care. Mr Sinha agreed with comments and said these would be taken on Board as part of the final priorities to be approved by the Board in June. Mrs Caldwell informed the Board that service-users would be better involved in the selection of Quality Priorities and delivering the action plan and that they had undertaken consultation at the Trust-wide forum. **Action 5/22:** Mrs Caldwell and Mr Sinha to discuss the timetable for co-production of the Quality Priorities. Mrs Sequeira noted that she has attended one of the wellbeing workshops. Mrs Sequeira informed the Board that the workshop gave staff to share their feelings, and gain peer support, she went to highlight the importance of staff been able to attend these workshops with data wellbeing suggesting that staff wellbeing can be improved by allowing people to feel that their work gives value add, having better-organised work-spaces, and better equipment for home working. Mrs Sequeira asked how is this being included in next year's work plan? In response Mrs Sinha explained that he plans to repeat the workshops and roll them out across the Trust. Professor Burstow requested that the cycle to complete the quality report we ensure we engage our Council of Governors. He wants to make sure that we're clear about where that will be in this cycle, so they feel properly involved in setting and shaping the objectives for the Quality Account. Mr Sinha replied that the Quality Accounts and Quality Priorities will go to a series of internal and external forums before they are signed off.
9/22	**Board Assurance Framework**

	Mr Jenkins presented the Board Assurance Framework, and noted that the Board Assurance Framework had bene updated and reviewed via Executive Team. Mr Jenkins informed the Board that a programme of improvement would commence on the Board Assurance framework to bring it in line with best practice After discussion, the Board agreed: • The usual process of elevating high-scoring operational risks to the BAF to Board for oversight and review would, at the moment, create an unmanageable workload for the Board, because of the large number of high-risk items. • As a temporary measure, the monitoring and mitigation of high-scoring operational risks will be devolved to the committee which owns the risk. Only if the relevant committee believes that mitigating actions are not sufficient to manage the risk will they escalate the matter to Board for possible inclusion on the BAF. • The Board views its existing risk appetite as applying in ordinary circumstances; however, it recognises that, in the short term, the Trust is carrying a heightened level of risk. • For some risks, the sole mitigation shown is the implementation of the Strategic Review. While the Board evaluates that this is an appropriate mitigation, it notes that the implementation is not due until September and therefore additional mitigations may need to be put in place for the interim for those risks. The following steps were agreed to implement this: **Action:** Mr Jenkins to inform risk owners of their new responsibilities for monitoring and mitigating risks which they would normally have raised as BAFs, and that they should only escalate the matter as a BAF if planned mitigating actions do not address the risk. Operational risks will continue to be reviewed regularly at ET meetings. **Action:** Mr Jenkins to inform risk owners that where the sole mitigation is the implementation of the Strategic Review, they may need extra mitigation to cover the interim period. This is to be completed by end May and the results circulated to the Board.
10/22	**Finance and Performance Report**
	The Board noted the paper.
11/22	**Operational Risk Register**
	This item was discussed with the Quality Update, item 08/22.
12/22	**Trust Anti-Racist Statement**
	Mr Tegerdine presented that the Trust Anti- Racist statement and welcomed Mrs Thomas to the meeting. Mrs Thomas informed the Board that the Race Action Plan included an action for the Trust to place a statement on the website on our ambition to be an anti-racist

	organisation. Mr Tegerdine informed the Board that the People Committee had reviewed the statement and were recommending it to the Board. Mr Holt asked that when the Statement was uploaded was to the website it included information about the purpose of the statement and the actions the Trust were taking to embed the statement. Professor Burstow agreed and went on to say that good work-force race quality standards correlated with delivering safe, high-quality services, and with better decision-making; and diversity in boards is correlated with being high-performing and challenging. Mrs Sequeira asked that the statement include how we will hold ourselves accountable to the pledges. **Action** 12/22: Mr Tegerdine and colleagues to add the suggested statements about purpose, urgency, and the benefits for decision-making, and accountability; also to seek approval from the Board (by email) of the final statement.
13/22	**People and Equalities Report**
	Mrs Colson said the report stated that the Freedom To Speak Up review was coming to this Board meeting, but was not on the agenda. Mr Tegerdine stated that the report would be coming to the Board in May Mr Levenson thanked Mrs Sequeira for the report especially its format with links to strategic objectives, recommendations to the Board, and reflections. **Action 13/22**; FTSU report to be presented to the Board in May
14/22	**Audit and Risk Committee Report**
	Mr Holt said we have discussed risk. The draft rating from the Head of Internal Audit is likely to be level 3, which is a deterioration from previous years. The Board noted verbal report
15/22	**Education and Training Committee**
	DL said a sub-group will meet to review the Committee's terms of reference and how to align the Committee with the others in the governance review.
16/22	**Integrated Governance Committee**
	No comments or questions. The Board noted the report.
17/22	**Any other business**
	None.

18/22	Date, time and venue of next meetings
a)	Tuesday 24 May, 14:00 to 16:45, venue to be decided.

NHS
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Board of Directors: Action Log

Ref	Meeting Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
AP1	17.7.21	5.1.2	There is a significant gap between the current risk rating and the target risk rating in the Board Assurance Framework Requested a debate at a subsequent Board meeting to look at this issue and the extent to which the Board was comfortable with this gap.	CEO/Director of Finance	March 2022	Completed: to be discussed in this meeting.	Complete
AP1	28.9.21	6.2.4	A detailed report on FOIs to better understand the pressure and resourcing implications and how we mitigate the risks to be brought to a board meeting	Director of Finance	March 2022	Referred to the Audit and Risk Committee.	Overdue
AP1	30.11.21	2.1.2	Information briefing session to be arranged for the whole Board on the relationship with the ICS	CEO	None stated	To be scheduled in June.	Open
AP2	25.1.22	2.4	A new set of quality priorities will be brought to the March Board	Medical Director	March 2022	Completed	Completed
AP3	25.1.22	2.4.6	Outcome measures to be discussed at the May Board	Medical Director	May 2022		Open
AP4	25.1.22	3.1.10	The establishment of the new People and Equalities Committee is brought forward to March	CEO	March 2022	Completed. Its title is the POD EDI Committee.	Completed

Ref	Meeting Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
AP5	25.1.22	3.1.10	An oversight group should be established following the Governance Review. This will report back to the Board.	CEO	March 2022	Completed.	Completed.
1/22	29.3.22	3/22	The Patient Safety Officer (Alina Bacioana) to include NEDs in the invitations for all Lessons Learned events.	Chief Nurse	Ongoing	Completed. AD has informed her of this task and provided the NEDs' email addresses.	Completed
2/22	29.3.22	6/22	Interim Director of Corporate Governance to put in place a schedule of visits which will be reported to Board	DoG	April 2022	Patient story will re commence in July	Overdue
3/22	29.3.22	6/22	CEO to include items agreed in the meeting to the objectives.	CEO	April 2022	An updated document will be circulated to Board members in June	Overdue
4/22	29.3.22	6/22	Mr Jenkins to add a milestone that staff, where possible, should be informed before September of how the Strategic Review will affect them.	CEO	May 2022	On agenda for the meeting	Completed
5/22	29.3.22	7/22	Mrs Caldwell and Mr Sinha to discuss the timetable for co-production of the Quality Priorities Professor Burstow requested that the cycle to complete the quality report we ensure we engage our Council of Governors.	Medical Director and Chief Nurse	April 2022	Completed on agenda	Completed

NHS
The Tavistock and Portman
NHS Foundation Trust

Ref	Meeting Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
6/22	29.3.22	9/22	PJ to inform risk owners of their new responsibilities for monitoring and mitigating risks	CEO	April 2022	Members of the Exec have been informed about their responsibilities for Risks. The Risk Management strategy also includes roles and responsibilities. A BAF SOP is currently being developed ensure the BAF and the CRR are more closely linked.	Completed
7/22	29.3.22	9/22	PJ to inform risk owners that where the sole mitigation is the implementation of the Strategic Review, they may need extra mitigation to cover the interim period. This is to be completed by end May and the results circulated to the Board.	CEO	April 2022	On the agenda for the meeting	Completed
8/22	29.3.22	9/22	Mr Tegerdine and colleagues to add the suggested statements about purpose, urgency, and the benefits for decision-making, and accountability; also to seek approval from the Board (by email) of the final statement.	Director of People and Culture	April 2022	The statement has been amended and is attached as an appendix to this action log	Completed
9/22	29.3.22	9/22	FTSU report to be presented to the Board in May	Director of People and Culture	May 2022	On agenda	Completed

Appendix 1-Trust anti -racist statement

The murder of George Floyd two years ago, on 25 May 2020, affected us all deeply, particularly our black members of staff. In the wake of this heinous event, the whole world – whilst in the grip of a pandemic –faced up to the racism which is still endemic. Racism and racialisation is also present at the Trust. The outpouring of emotion and stories of everyday struggles with racism and discrimination was evident in our July 2020 event which gave a voice to colleagues and supported them to speak out about their experiences. It, and subsequent meetings and discussions, led the Trust to embark on a journey of reflection and change which has been very taxing on those contributing to it. We are at the start of this journey and have a much better understanding today of the experiences of our black and other minoritised ethnic groups colleagues and are taking step to address the challenges they, our patients and our students face.

We are committed to becoming an anti-racist organisation.

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

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

Becoming anti-racist is vital for us as a Trust: creating a supportive and empowering environment for our colleagues, patients, service users and students makes the services we deliver safer and of higher quality.

We recognise that making these changes is a matter of urgency. Differences in experiences of healthcare and the importance of fair and equal treatment of people from ethnic and minoritised groups in the UK must be a priority, and we need to start now to improve every future interaction between our colleagues and all those we support.

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

We have therefore begun a programme of practical actions to improve racial equality at our Trust. These actions are already underway, will be delivered at pace, and will support seven key objectives:

- Objective 1: Create an inclusive culture that promotes respect at all levels and fosters a sense of belonging among all staff
- Objective 2: Strengthen the key governance structures and networks for race equality to provide better leadership, buy -in, advocacy and support and to ensure ongoing external scrutiny of these arrangements
- Objective 3: Increase the diversity of the workforce and support the career progression of staff from Black, Asian and UK ethnic minority groups
- Objective 4: Remove barriers that discourage reporting and fast track the process of resolving incidents of racial discrimination
- Objective 5: Increase engagement and communicate progress on racial equality across all levels of the Trust, in particular to publicly acknowledge to staff the findings of racial inclusion barriers, racist behaviours, and lack of diversity
- Objective 6: Extend the use of EDI data to monitor and improve race equality in the Trust

- Objective 7: Embed responsibility for racial equality at all management and administrative levels of the Trust, and provide appropriate EDI support, training and guidance.

We commit to being transparent and holding ourselves to account as we work towards these objectives, and to sharing our learning with staff, patients, students and stakeholders and other health and care organisations.

We have established an Equality Diversity and Inclusion (EDI) Team, with an EDI Associate Director, EDI Manager, and EDI champions. These colleagues work with our staff networks, the unions and staffside teams to identify issues and ensure appropriate support, education and training are available to mitigate any occurrences of discriminatory behaviour that may arise.

We have also established a new committee which will provide oversight and ensure that we are meeting our commitments: the People, OD, and Equality Diversity and Inclusion (POD EDI) committee. The POD EDI Committee works closely with our EDI Team, Race Equality Champion and Race Equality Staff Network to ensure that the changes are making a real and meaningful difference to the lived experience of staff, patients, service users and students at the Trust. EDI also forms part of our Board meeting agenda, and our board papers will include regular updates on our progress in this regard, as we work to become an anti-racist organisation. We will also re-invite external race equality experts to assess our progress once we have delivered the programme of actions from the Workforce Race Equality Standard, the Race Action Plan and the objectives mentioned above to ensure we are appropriately monitoring our progress, with a robust line of accountability embedded into the process.

We look forward to receiving feedback from staff, patients, service users and students on their experiences, as we anticipate improvements in those experiences as well as our performance and service delivery outcomes.

The Tavistock and Portman NHS Foundation Trust

Report to	Date
Board of Directors	24th May 2022

Chief Executive's Report
Executive Summary
This report provides a summary of key issues affecting the Trust.
Recommendation to the Board
The Board of Directors are asked to note and discuss this paper.
Trust strategic objectives supported by this paper
All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Trust Chair

1.1 On May 6th the Council of Governors approved the appointment of John Lawlor as the Trust's new Chair. John will be taking up his role on 6th June. John was the former Chief Executive of the Cumbria, Northumberland and Tyne and Weir Trust.

1.2 I would like to put on record my appreciation of the very significant contribution which Paul Burstow has made as Chair of the Trust over the last six and half years.

2. Executive appointments

2.1 There have been a number of recent changes in the Executive Team.

2.2 Chris Caldwell has left to take up the role of the Chief Nurse Officer at the North Central London ICS. Jenny Goodridge, the Director of Nursing and Director of Quality at North Central London CCG will be joining the Trust on secondment as Chief Nursing Officer and Director of Quality.

2.3 Ian Tegerdine our Acting Director of HR will be reverting to his substantive role at the end of May. Helen Farrington, formerly Chief People Officer at Lancashire and South Cumbria NHS Trust will be joining the Trust as our interim Chief People Officer.

2.4 Dinesh Sinha has been appointed as Chief Medical Officer at Sussex ICS. We are currently undertaking a process to appoint an interim internal Chief Medical Officer.

2.5 I would like to put on record my appreciation of the contribution which Chris, Dinesh and Ian have made to the leadership of the Trust and very much look forward to working with Jenny, Helen and the new Chief Medical Officer.

3. Strategic Review

3.1 The Trust has consulted staff on the proposals for change stemming from the Strategic Review. The consultation was open for staff responses for a total of 56 days from 31 January to 28 March 2022. Since then, we have been focusing on reviewing staff responses and considering a range of alternative proposals.

3.2 The formal response from Staff Side and regional Union representatives was received on 28 March and discussed in detail during our meeting on 29 March. The Trust submitted a response to Staff Side colleagues on 6 April, for further discussion on 7 April. We are continuing close engagement with Staff Side colleagues during the next stages of the process.

3.3 The Board has had preliminary discussion of the responses to consultation including the presentation of alternative proposals to those which we originally consulted on. A final set of proposals are being presented for agreement by the Board in Part 2 of the agenda. Subject to the Board's agreement the intention is to publish these in the week commencing 13th June.

4. SOF 3

4.1 The Trust has now moved formally from segment 1 to segment 3 of the System Oversight Framework (SOF 3). The change reflects that, as relatively small organisation, the Trust is facing a number of challenges relating to:

- Our future strategy including the implementation of the Strategic Review and future options for our estates.
- Our financial performance
- Leadership and Governance including the implementation of the Well
- Quality improvement and performance, including the transformation agenda for GIDS.

4.2 With the move to SOF 3 the Trust is being provided with a package of mandated support to ensure that we have the capacity to address the challenges we are currently facing and are in the process of agreeing with the ICS and other stakeholders a set of exit criteria which, when achieved, will enable the Trust to move back to a higher rating.

5. Return of students to the building

5.1 Following the easing of the national picture in relation to the pandemic, we have been delighted to welcome many students back to our Trust building for in-person teaching this summer term. With the need to continue applying our infection prevention and control measures, we have needed to plan carefully to ensure we make suitable arrangements. We have received permission from the CQC to reduce our social distancing requirements from 2 metres to 1 metre, within teaching venues only. This has enabled us to bring more activities back to the building, while retaining the 2-metre distancing regulations for the rest of our building.

5.2 We have needed to make allowances for students and teaching staff who have clinical vulnerabilities and are therefore unable to travel to the building. This has meant 'hybrid' delivery on occasion, with a mix of in-person and online attendance. We have been closely monitoring feedback from our students and staff and have been providing extra support for our students to deal with enquiries and resolve teething issues. Initial student feedback shows a very positive response to sessions which are

conducted entirely face-to-face or entirely online. Feedback for our hybrid sessions have been more mixed to date, in particular indicating a preference for teachers to be in the room rather than online, when students are in the building.

5.3 We are also using the experience of this term's teaching to begin the process of planning for next academic year, to ensure we provide an excellent student experience. With the teaching rooms and their equipment being used regularly for the first time in two years, we have had a number of issues arise. DET is working closely with Estates and Informatics to ensure that we improve our facilities where possible.

6. Graduation

6.1 Saturday 7th May saw our Trust's annual graduation ceremony – the first held in-person since 2019, and the first one to be held at the People's Palace, Mile End.

6.2 Graduation is the best day of the academic year, but this year's celebration stood out for all sorts of reasons. We were able to confer awards for more graduands than ever before, including some of those who completed during the previous two years and who had opted to wait for a return to an in-person ceremony. With our normal venue of the Institute of Education being out of action because of refurbishment works, we needed to find a new venue at short notice. The People's Palace worked remarkably well, thanks in no small part to DET's graduations team who were able to ensure the event went very smoothly and was thoroughly enjoyed by all.

6.3 Jacqui Dyer, MBE, was awarded an honorary doctorate, and spoke with passion and inspiration about the influences of personal adversity. A posthumous honorary doctorate was awarded to our respected, admired and loved colleague Mike Solomon, with the award so graciously and movingly accepted by his widow, Hilary. It meant so much to see so many key guests and dignitaries, including John Macklin (UEL), Annecy Lax (Essex), Kenyah Nyameche and Freda McEwen (our governors).

Paul Jenkins
Chief Executive
17th May 2022

The Tavistock and Portman NHS
NHS Foundation Trust

Report to	Date
Board of Directors	24th May 2022

2021/22 Quality Report Update

Executive Summary

The following report provides an update in respect of activities for completing the Trust's Quality Account 2021/22.

Updated guidance for producing a Quality Account was provided by NHSEI in January 2022. Guidance issued this year for both the Quality Account and the Annual Report advises the following;

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

The broad content of the Quality Account remains the same as per previous years' guidance and in line with mandated requirements. The final draft has now been completed and shared with external stakeholders (NCL CCG, Camden Healthwatch and Camden's Health & Scrutiny Committee. It has also been shared with the Board of Governors for their feedback and comment.

Feedback received both internally and externally will be incorporated, where appropriate, and statements included in the appendices. The final draft will then be presented to the extraordinary Audit Committee on 15 June, pending the agreement of delegated approval responsibility.

Following discussions with the divisions, it has been agreed that three of the four headline quality priorities from 21/22 will continue forward into 22/23. The three headline quality priorities for 22/23 will therefore be;

- Waiting Times
- Equalities
- Outcome Measures

As previously, all three are linked to at least one of the three core domains of quality – patient experience, patient safety and clinical effectiveness. The detail underpinning each of these headlines can be found in section 4.0 of this report.

The Board of Directors is asked to note this update report and also approve delegated responsibility for the Extraordinary Audit Committee of 15 June to sign off the final draft of the Quality Account for 2021/22.	
Recommendation to the Board	
• To note this update. • To approve sign off of the Quality Account 21/22 via delegated responsibility to the extraordinary Audit Committee.	
Trust strategic objectives supported by this paper	
Quality, Risk, Governance, Finance	
Author	**Responsible Executive Director**
Emma Casey, Associate Director of Quality & Governance (interim)	Dinesh Sinha, Medical Director and Director of Quality

1.0 Introduction

This report provides an update and assurance in respect of arrangements in place for completing the Trust's Quality Account for 2021/22.

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

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

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

2.0 Update on final draft & sign off

The broad content of the Quality Account remains the same as per previous years' guidance and in line with mandated requirements. The final draft has now been completed and shared with external stakeholders (NCL CCG, Camden Healthwatch and Camden's Health & Scrutiny Committee). It has also been shared with the Board of Governors for their feedback and comment.

Feedback received both internally and externally will be incorporated, where appropriate, and statements included in the appendices. The final draft will then be presented to the extraordinary Audit Committee on 15 June, pending the agreement of delegated approval responsibility.

As with previous years, Quality Accounts must be published by 30 June 2022. This year, providers are asked to upload to their external website only followed by an assurance email to NHSEI to confirm that this has been done.

Due to the change in governance and committee structure at the Trust, it has not been possible for a review of the final draft though a committee. However the quality priorities, both performance against 21/22 objectives and proposed objectives for 22/23, have been discussed at a number of groups throughout the year including Operations Board, Quality Assurance Board

and PECQ. A discussion will be had with the new Chief Nurse around presenting the report to the newly established Quality Committee if timelines allow.

3.0 Achievement of Quality Priorities 21/22

The progress we have made in delivering our four quality priorities for last year are set out in the following tables.

Clinical Effectiveness

Our Quality Priority	What success will look like	How did we do?
Embed a revised job planning process within clinical services	Clarify parameters for job planning across the directorates (AFS, CYAF and Gender) and the processes for updating job plans when situations change	***We achieved this*** • Separate guides for the job planning process were established for each division and were used for the first round of job planning • A set of Trustwide job planning principles were agreed to ensure a consistent approach to Job Planning across the organisation moving forwards • These principles specify the amount of time needing to be focused on clinical work and guidance on how this should be adjusted based on management responsibilities. • The principles are being incorporated into a new trust wide policy and job plan template to support the implementation
	Ensure all clinical staff across the Trust have an initial job plan and review these at a divisional level to identify areas that reduce clinical capacity	***We partially achieved this*** • At the end of the year there were draft Job Plans on file for around 80% of staff in CYAF and AFS directorates and 100% of staff in the Gender directorate • We are waiting for the updated guidance to be finalised before completing the remaining Job plans in CYAF/AFS so they don't need to be repeated soon after completion • Once the new policy and guidance are confirmed for the trust, a round of job plan reviews will take place for the existing job plans
	Agree principles across the Trust on the identified areas to ensure staff have sufficient capacity for clinical work as expected for their banding and role	***We achieved this*** • As above, the new principles have been agreed and shared across the organisation
	Implement the agreed principles and review job plans accordingly	***We partially achieved this*** • This is due to take place in Q4 2021/22 and Q1 2022/23. This may need to be reviewed in line with the strategic review consultation outcome • Job planning will be re-launched in 22/23 Q1 with the aim of all staff having completed a plan and had it signed off by the end of Q2
	Agree standard timescales and mechanism for reviewing job plans and monitoring capacity on an ongoing basis	***We partially achieved this*** • The suggested timescales and mechanisms for review and monitoring are mentioned in the divisional guides and will be confirmed in the trust job planning procedure • Its likely job planning will be an annual process with individual and team performance against job plans being reviewed at regular interviews during the year. The timing will need to be confirmed but may align with the annual appraisal cycle

Clinical Effectiveness and Patient Safety

Our Quality Priority	What success will look like	How did we do?
Improve Waiting Times across the Trust	**Review waiting times across Trust services and identify range, variation and areas of good practice in waitlist management, based on Trust data**	***This Quality Priority has been re-designed for next year*** During the year, a decision was taken to better refine the overall aim of the Quality Priority and to organise the individual workstreams in a way that would allow for a consistent approach to be taken to a wide variety of clinical services that experience different issues when it comes to managing their waiting lists. As such, this Quality Priority will be re-launched during the 2022/23 financial year with a renewed focus on the following areas: • The development of a waiting list management framework to ensure that reports and actions are consistently delivered and monitored • Review waiting list initiatives currently being implemented across different service lines to ensure that best-practice is adhered to and embedded across the Trust • Develop and implement a Trust-wide access policy to formalise waiting list management including patient tracker lists (PTL), DNAs, cancellations and non-responders • Building on the clinical harm SOP, to develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions • Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support
	Agree key areas of focus and hold workshops to develop plans and QI projects to address wait times, ensuring that work aligns with strategic review changes	
	Implement, monitor & review these plans, based on agreed measures for waitlist reduction	

Clinical Effectiveness

Our Quality Priority	What success will look like	How did we do?
Embed meaningful use of outcome measures across the Trust	**To complete a pilot of an appropriate software solution for OM data e-mail out and return that is compatible with Carenotes data. To reduce administrative time in manual data input**	***We achieved this*** • Qualtrics was trailed in Adult Complex Needs, PCPCS and AYAS to distribute and collect CORE and ESQ Outcome Measures (OMs) over Q3 & 4. The process saves considerable admin and clinical time and has improved OM returns. However, it still requires manual input of data onto Carenotes • A Carenotes upgrade scheduled in early Q1 2022/23 will facilitate automated data entry and we anticipate the software will be in place by the end of Q2
	To increase OM returns across all services by 25% above baseline by year end	***We partially achieved this*** • Overall return rates for OMs have increased by 22% compared to the last financial year (see table below). Whilst this is just shy of the 25% target, it still represents significant improvement which can be built on over the next year • The continued expansion of Qualtrics across more services and measures should facilitate this for CORE, ESQ and RCADS. Improved Carenotes logic, as well as increased access to data and reminders for clinicians should also help continue to improve CGAS and CORE OM completion
	To pilot brief and STP wide OM feedback (e.g. dialogue) OR for specific clinical services (e.g. Trauma) nationally benchmarked OM	***We partially achieved this*** • Following engagement with other trauma providers The Adult Trauma Unit started trialling 3 new outcome measures more relevant to their patient group in Q3/4. Going forward this should provide more accurate data on trauma treatment impact as well as providing data that can be benchmarked against other relevant services

Patient Experience

Our Quality Priority	What success will look like	How did we do?
Improve the collection of race and equality data	**Complete report of ethnicity data completion rates within each of the clinical divisions (AFS, CYAF and Gender)**	***We achieved this*** • An updated report has been created and is run monthly to monitor compliance across the Trust • Performance has improved in three of the four clinical divisions, although monthly compliance does vary significantly within and across divisions
	Provide a baseline of Experience of Service Questionnaire (ESQ) completion by ethnicity (Q1) and provide comparitive data analysis during 2021/22	***We achieved this*** • The new ESQ and its associated report allow for experiential data to be assessed for the various ethnic groups that make up our patient cohort • An audit carried out in Q4 looked at both completion rates of ESQ forms for the various ethnic groups and also looked at the reported experience of patients • There was no clear indication that experience differed by ethnicity. However, the volume of returns the trust received means this couldn't be seen as conclusive. The exercise will be repeated when the volume of returns has increased
	Clarify the current initial data collection methods and processes for updating based on changed situation	***We achieved this*** • All services have shared their current practices and a summary document was circulated in July so learning could be shared. Some new practices based on the learning as well as a QI project were implemented in Q2 resulting in improved collection rates in most services • Qualtrics was trailed to distribute the ESQ 12+ in 3 services (Adult Complex Needs, AYAS and PCPCS) in Q4, which significantly increased returns. The use of Qualtrics for ESQ will be expanded over the next quarter
	Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review	***We partially achieved this*** • Existing processes were mapped, evaluated, and developed over the course of the year • Once the remaining gaps in processes are identified and resolved, updated guidance will be issued
	Implement guidance and report again across the directorates to monitor adherence and make adjustments where needed	***We partially achieved this*** • Some initial learning has been implemented in advance of the final guidance being drafted • Monitoring has been ongoing via the report each month and any specific QI projects will measure their direct impact separately •

4.0 Quality Priorities 22/23

The quality priorities for the coming year have been discussed with divisions via the monthly Quality Priorities Divisional Directors meeting and the Operations Board. It has been proposed and agreed that three of the four quality priorities from 21/22 will continue forward into 22/23, and broadened out to better capture more roundly what we want to achieve. As previously, all three are linked to at least one of the three core domains of quality – patient experience, patient safety and clinical effectiveness.

Each of the three quality priorities is assigned to one of the Trust Divisional Directors to ensure senior leadership, accountability and embedding throughout each of the clinical services. Progress against the priorities is monitored though various forums including the Quality Assurance Board.

Quality Priority 1: Equalities
Targets for 2022/23
1. Improve Accessible Information Standards (AIS) data recording by 25% compared to 21/22 data
2. Use data collected via Experience of Service Questionnaire (ESQ) by protected characteristics *(list to be defined in line with what is collected)* to understand how experiences of services differ, and devise a plan to address areas identified for improvement
3. In collaboration with Quality Improvement, seek to understand barriers within the local community to accessing treatment and develop a quality improvement project that will seek to address these barriers
4. Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review. (Q3/4)
5. Implement guidance and report again across the directorates to monitor adherance and make adjustments where needed. (Q3/4)

Quality Priority 2: Waiting Times
Targets for 2022/23
• Review waiting list initiatives currently being implemented across different service lines to ensure that best-practice is adhered to and embedded across the Trust
• Develop and implement a Trust-wide framework for managing waiting time performance across the Trust and agree an access policy to formalise waiting list management including use of patient tracking lists & meetings (PTLs), DNAs, cancellations and non-responder

- Building on the clinical harm SOP, develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions
- Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support

Quality Priority 3: Outcome Measures

Targets for 2022/23

1. To increase OM returns across all services by 25% above baseline by year end
2. Develop an agreed logic to sending and counting outcome measure and ESQ forms (which may differ by individual clinical and service lines) to enable a true reflection of the patient voice (to be able to get an agreed denominator of how many forms were required to be sent out per month vs. a numerator of how many were received back)
3. Roll-out of Qualtrics to other service user completed Outcome Measures across the Trust including all ESQ (12+, Parent/Carer & 9-11), RCADs & SDQ

The priority topics for 2022/23, and 2021/22 before that, were developed following discussions with a number of service users, non-executive directors, staff, management and commissioners. In addition we considered current Trust Quality Priorities, service challenges, key performance issues and quality data reviewed and presented to Board over the past year.

The quality priorities are to be presented to the Trust wide Forum in June to receive service user feedback and approval. As these are extensions of Quality Priorities agreed with service users last year there is not a huge amount of challenge anticipated

The process for receiving feedback from our external stakeholders will also incorporate any feedback on our proposed quality priorities for the coming year.

5.0 Summary

The Board of Directors is asked to note this update and to approve sign off of the Quality Account 21/22 via delegated responsibility to the extraordinary Audit Committee.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24th May 2022

Report from the Trust's Freedom to Speak up Guardian

Executive Summary

This report is an update from the Trust's Freedom To Speak Up Guardian (FTSUG) since the last report presented in November 2020 and focuses on the work she has been involved in since taking over the role in December 2020, and feedback from staff and the 2021 NHS staff survey the relates to speaking up in the Trust.

The first part is an overview of the FTSUG role within the Trust.

The second and third parts are a summary of concerns raised with the FTSUG since December 2020, and formal complaints/investigations logged since December 2020.

The fourth part highlights key information from the Freedom to Speak Up Index published in May 2021, and the 2021 NHS Staff Survey Benchmark Report for the Trust.

The fifth part focuses on speaking up initiatives that have been completed or are ongoing within the Trust.

The sixth part raises ongoing concerns, and the seventh part raises recommendations for the Board to consider and discuss.

Recommendation the Board

The Board is asked to:

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

Trust strategic objectives supported by this paper

People: supporting and developing our staff now and in the future.

Author	Responsible Executive Director
Sarah Stenlake	Paul Jenkins

1. Overview of Freedom to Speak Up role in the Trust

1.1. The 2015 Francis Review recommended that all NHS Trusts should appoint Freedom to Speak up Guardians (FTSUG) as an additional, confidential person available for staff to turn to if they wanted to raise concerns about anything that gets in the way of providing high-quality effective care, or that affects their working life. The current Freedom to Speak Up Guardian (FTSUG) has allocated time of 2 paid sessions per week (7.5 hours) at 8C equivalent.

1.2. The Trust has made an ongoing commitment to speaking up, with the goal that all staff feel free to speak up and raise their concerns, and that in turn these concerns will be listened to with care, and followed-up on promptly. As part of this commitment to speaking up, the Trust has had a Freedom to Speak Up Guardian (FTSUG) in post since October 2015. Previous FTSUGs have been Gill Rusbridger and Dan Sumpton; I was appointed to this role in December 2020. Meetings can be held in person, on Zoom or Teams, or over the phone. Since starting in the role in December 2020, most people have contacted me by email and most meetings have been on Zoom. I feel this has been a successful approach during a period of frequent change due to the COVID-19 pandemic, and has also allowed me to easily meet with people who work across the wide geographic range that the Trust covers.

1.3. During my time in the role, I have met and been in regular contact with Paul Jenkins as CEO, Director of HR and Executive Director for Raising Concerns Ian Tegerdine, and Helen Farrow as Non-Executive Director for Raising Concerns. I have also met regularly with Angela Haselton as Staff Side Chair and Irene Henderson in her role as Equality, Diversity and Inclusion (EDI) Associate Director (and more recently I have met with Thanda Mhlanga in this role), working closely together on shared objectives for and concerns raised by staff. I have met with the medical director, the chief clinical operating officer, directors, service managers, and attended the Operations Board Meeting in November 2021, the Audit Committee in January 2022, and the POD EDI committee in May 2022.

1.4. I have also attended the Race Equality Network meeting, the LGBTQI+ network meeting, and joined various other team and staff meetings in order to discuss and promote the role of FTSUG, as well as gathering feedback on speaking up in the Trust. I am connected to and gain valuable information and resources from the National Guardian's office, and the London FTSUG network.

1.5. I have consistently found that senior leadership are invested in speaking up, supportive of me and the FTSUG role, and are keen to learn from staff members through concerns and feedback they offer. However, there continue to be barriers to the timely implementation of change and offering of

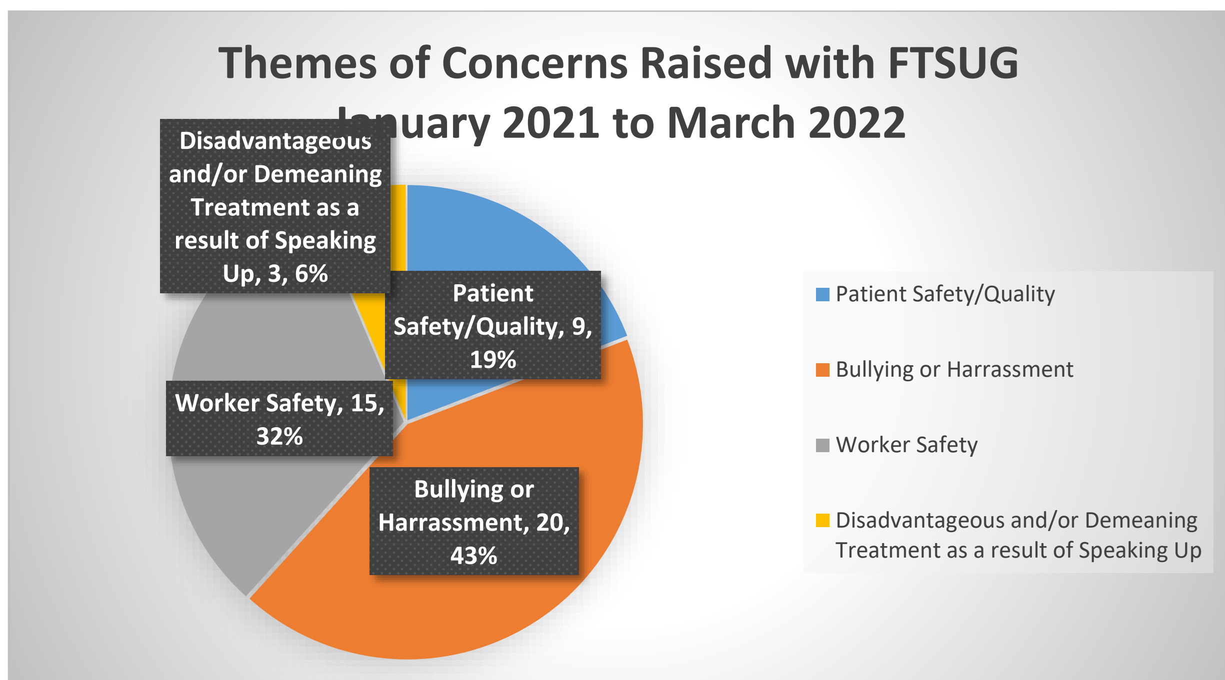
feedback when concerns and/or suggestions for improvement are raised by staff, which will be addressed below in the initiatives and recommendations section of the report.

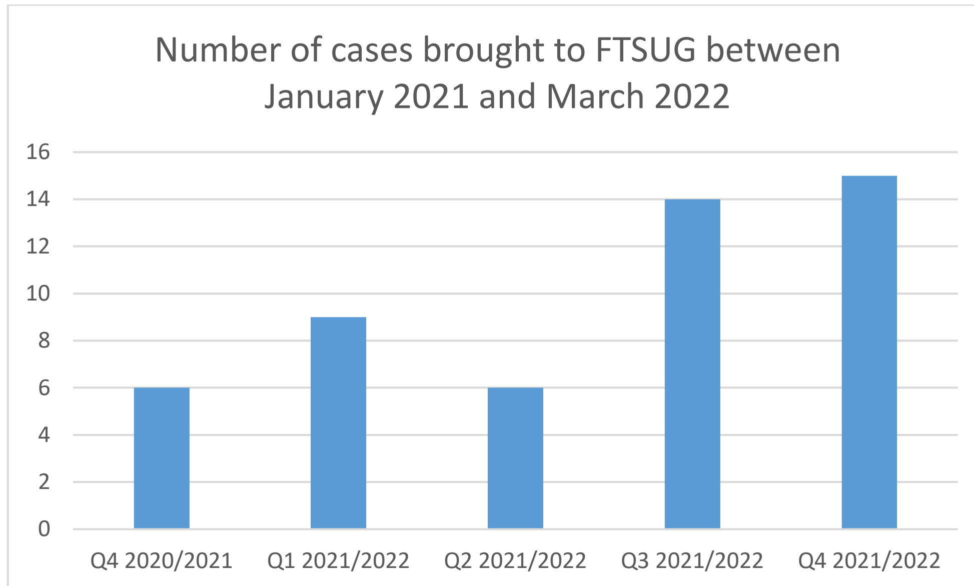
2. Concerns raised with FTSUG between January 2021 and March 2022

2.1 There has been a gradual increase in speaking up cases since the last report in November 2020 when 40 cases were reported; over a similar period of time (from January 2021 to March 2022), there have been 50 cases raised with the Freedom to Speak Up Guardian, 58% of which occurred in the last two quarters. This dates from start of Quarter 4 of 2020/2021 to end of Quarter 4 of 2022/22 and full records can be seen on the National Guardian's office website. No anonymous concerns have been raised with the FTSUG since December 2020.

2.2 Although it is important not to overly individuate the data in order to protect the confidentiality of those who have had contact with the FTSUG, speaking up cases have occurred from staff members across the Trust and from each directorate. This has included the gender directorate, which is relevant in the context of the CQC action plan for GIDS that aims to increase the effectiveness of speaking up within the service.

2.3 A breakdown by themes and numbers of cases brought to FTSUG between January 2021 and March 2022 is shown in the two charts below.





2.4 Additional themes:

2.4.1.1 Racism - 3 cases raised during this period of time included explicit mention of racial discrimination as a relevant factor within the concerns raised. Examples of persistent micro-aggressions and differential treatment were described, which were noted as either having affected initial experiences of trying to speak up to managers, and/or being part of the concerns themselves with regards to mistreatment. Each staff member described challenges and/or concerns with regards to naming the racial discrimination element of their experiences, in part due to previous experiences of having had this dismissed by others as not relevant, not real, or not related to racism. This highlights the ongoing necessity of the implementation of the race action plan, given ongoing issues with the understanding and validation of experiences related to racial discrimination within the Trust, compounding the impact of the experiences of mistreatment also described. Additionally, dismissive and discriminatory experiences such as these have been shown to affect the ability for staff members to speak up about other concerns in the workplace due to feeling invalidated and/or unsafe to speak up.

2.4.1.2 Equality, Diversity and Inclusion (EDI) initiatives - Concerns were also raised with the FTSUG during this period about tokenism with regards to Equality, Diversity and Inclusion (EDI) initiatives, with a call for the Trust to consider meaningful intersectionality-focused interventions. It was raised that previous initiatives have often been implemented without sufficient planning, resource, training, or monitoring mechanisms to evaluate how effective they actually are.

2.4.1.3 Communication – Concerns were raised with the FTSUG during this period about lack of communication and regular updates about the race action plan implementation.

2.4.1.4 Issues with listening up / following up of concerns – a frequent theme of concerns raised was that people had already tried to speak with a manager, supervisor, or senior person within the Trust, but that no further action had been taken and no further communication had occurred. This also includes people leaving the Trust - a common situation is that people come to the FTSUG at the point of departing the Trust or considering departing the Trust, and feedback is often that they are leaving due to lack of change when feeding back concerns. In many cases these staff members have reached the "point of no return" due to cumulative negative experiences, but are raising concerns with the FTSUG for the benefit of others still working in the Trust.

2.4.1.5 Investigations – concerns have been raised about investigations into formal complaints raised under a range of Trust policies, with concerns about the length of time and lack of communication during investigations, along with concerns about some of the processes themselves.

2.4.1.6 Clinical administration staff – there were concerns raised during this period by a large number of administrative staff members (38% of cases) with similar concerns. Persistent themes from these concerns were related to bullying and harassment, lack of effective or supportive management, lack of development opportunities, invalidation of concerns and suggestions for improvements, and lack of progression and development opportunities.

3. Formal Speaking Up /Whistleblowing Investigations logged with HR and Executive Director of Raising Concerns

3.1 I understand from HR colleagues that there was one formal investigation conducted in 2021 following a concern raised prior to December 2020; this case was investigated and concluded. An internal interview was also conducted following this case, in order for lessons to be learnt regarding the investigation process itself. This review is complete, with recommendations implemented as part of the updated speaking up policy that is currently at the final review and approval stage within the Trust. Learning from the internal review is also due to be implemented as part of the speaking up policy implementation strategy, and broader policy framework review.

3.2 I have been informed that there have been zero formal speaking up/whistleblowing complaints logged or raised with HR or the Executive Director for Raising Concerns since December 2020. Complaints and subsequent investigations had previously been logged on the central register but it was established recently that this process had not been occurring in the same way since January 2021. This has been discussed and a consistent process is being re-established, with plans to improve the reporting

mechanisms moving forward, as concerns have been raised with other senior staff members and executives for investigation during the period, and these should also be logged centrally in an improved reporting framework.

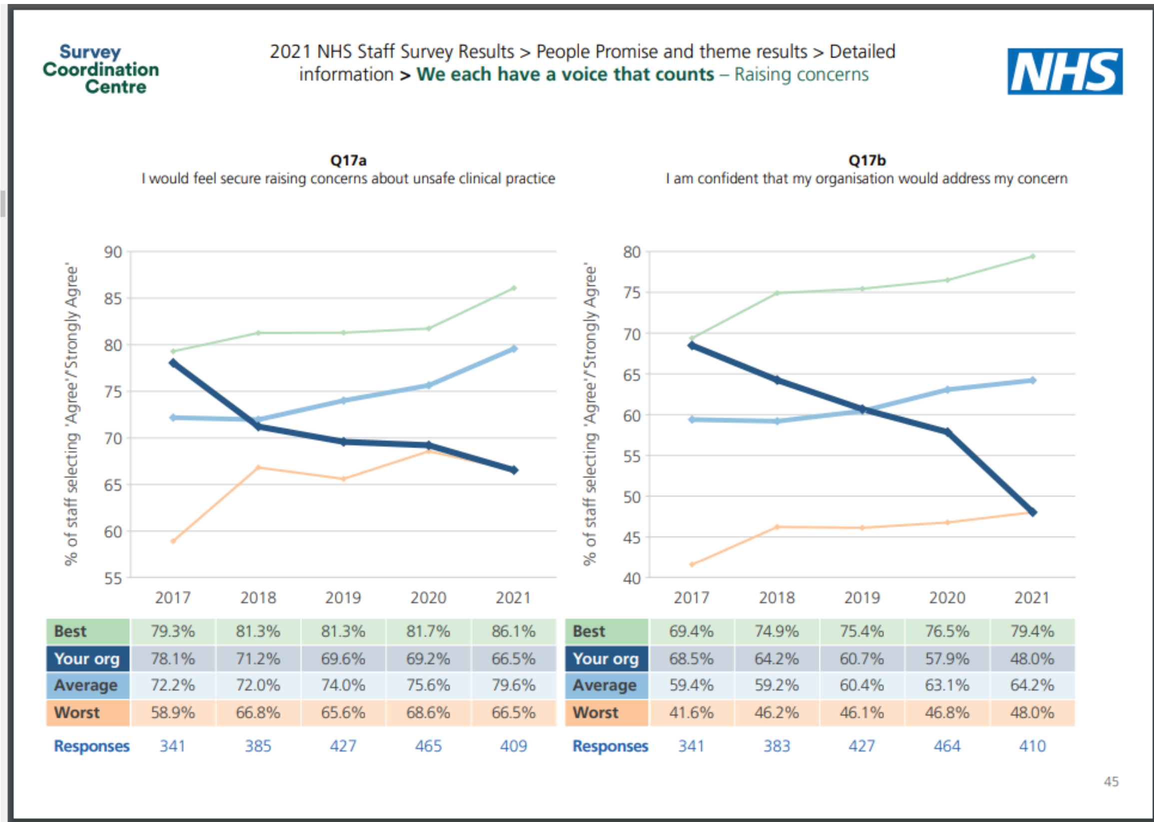
4. Staff Survey Results 2021

4.1 The Staff Survey is an invaluable source of information, with so many staff members offering anonymous feedback about the Trust. Below are excerpts from the Tavistock and Portman NHS Foundation Trust 2021 NHS Staff Survey Benchmark Report. The scores for the Trust indicate that significant action is required.

4.2 The NHS Annual Staff Survey captures data on raising concerns through four key questions. These four questions have previously been used to create a score on the Freedom to Speak Up Index, as reported by the National Guardian's Office; this was last published in May 2021 using data from the NHS Staff Survey in 2020. As reported in November 2020 by the previous FTSUG, the Trust score had declined significantly in the 2020 index report, changing from 81.6% to 77.5%. The Trust score in the 2021 Index report was 76.7%, declining further. The highest score for a Trust in the 2021 Index Report was 87.6%, and the lowest was 66.6%.

4.3 Looking to the most recent NHS Annual Staff Survey in 2021, we can review the four questions on raising concerns, and can see that each of these have declined further since 2020. When asked Q17a "I would feel secure raising concerns about unsafe clinical practice", the reported score is 66.5% for this Trust, declining from 69.2% in 2020; this is currently the worst score when compared to other organisations in the survey. When asked Q17b "I am confident that my organisation would address my concerns", this has dropped significantly from 57.9% in 2020 to 48% in 2021, which also sits as the worst score when compared to other organisations. When asked Q21e "I feel safe to speak up about anything that concerns me in this organisation", there has been another stark decline since 2020, dropping from 60.3% to 47.9% in 2021, which is ranked as the worst score when compared to other organisations. Finally, in a new question since 2021, Q21f "If I spoke up about something that concerned me I am confident my organisation would address my concern", the score for this Trust is 34.3%, which is the worst score when compared to other organisations. These scores reflect concerns raised with the FTSUG frequently about the lack of outcome or feedback after people have spoken up to their managers, and also the significant length of waiting time involved with any formal investigation into concerns when they are raised (including concerns raised under other relevant policies such as the grievance policy and the bullying and harrassment policy). Additionally, staff members have raised the impact of the publically reported detriment case in terms of how it has impacted on feeling safe to speak up in the Trust, and in

3 instances staff members during the December 2020 to March 2021 period have indicated that they themselves felt mistreated due to having spoken up.



Q17a

	2017	2018	2019	2020	2021
Best	79.3%	81.3%	81.3%	81.7%	86.1%
Your org	78.1%	71.2%	69.6%	69.2%	66.5%
Average	72.2%	72.0%	74.0%	75.6%	79.6%
Worst	58.9%	66.8%	65.6%	68.6%	66.5%
Responses	341	385	427	465	409

Q17b

	2017	2018	2019	2020	2021
Best	69.4%	74.9%	75.4%	76.5%	79.4%
Your org	68.5%	64.2%	60.7%	57.9%	48.0%
Average	59.4%	59.2%	60.4%	63.1%	64.2%
Worst	41.6%	46.2%	46.1%	46.8%	48.0%
Responses	341	383	427	464	410

Q21e

	2020	2021
Best	78.3%	78.7%
Your org	60.3%	47.9%
Average	68.3%	66.8%
Worst	59.0%	47.9%
Responses	464	408

Q21f

	2021
Best	71.3%
Your org	34.3%
Average	55.1%
Worst	34.3%
Responses	409

4.4 The 2021 NHS Staff Survey also asks relevant questions about Autonomy and Control; this is another area where scores have declined significantly. The excerpt below displays Q3d "I am able to make suggestions to improve the work of my team / department" and Q3f "I am able to make improvements happen in my area of work"; these are crucial areas in terms of speaking up culture, and further indicates that we do not currently have an open learning culture focused on learning from the insights of employees across the Trust. "Limited participation in decision-making or low control over one's area of work" has been highlighted by the World Health Organization as a risk factor for mental health at work (https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/mental-health-in-the-workplace).

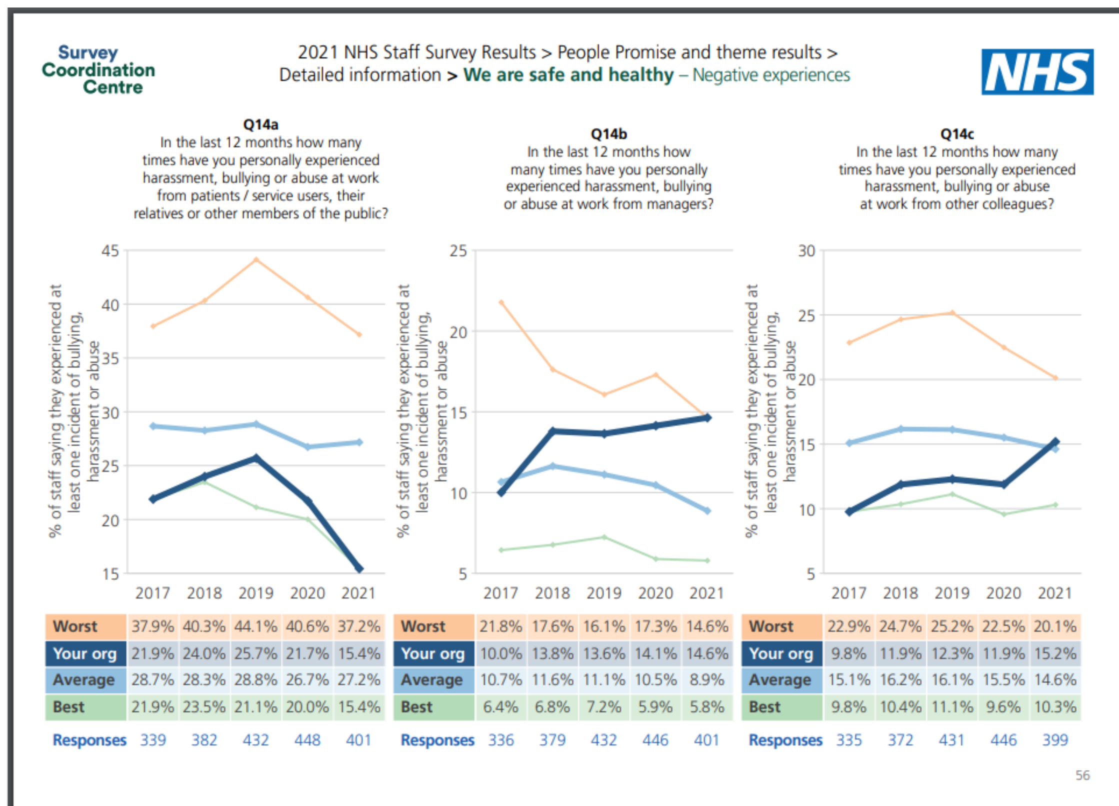
Q3d	2017	2018	2019	2020	2021
Best	82.4%	82.3%	84.2%	82.0%	82.1%
Your org	82.4%	80.7%	84.2%	80.1%	73.1%
Average	78.3%	78.2%	77.8%	77.9%	76.7%
Worst	69.3%	73.4%	71.5%	74.8%	70.7%
Responses	349	384	439	469	419

Q3e	2017	2018	2019	2020	2021
Best	65.7%	62.0%	61.5%	63.4%	61.4%
Your org	65.7%	61.7%	60.4%	57.2%	49.3%
Average	54.5%	54.6%	54.8%	55.4%	54.4%
Worst	41.9%	48.0%	47.3%	48.2%	46.8%
Responses	347	384	440	469	420

Q3f	2017	2018	2019	2020	2021
Best	66.0%	69.6%	69.0%	68.8%	68.4%
Your org	65.8%	67.6%	68.0%	66.8%	51.6%
Average	59.3%	59.5%	60.2%	61.1%	58.8%
Worst	46.7%	48.8%	51.3%	50.8%	51.2%
Responses	347	381	440	469	418

4.5 The 2021 NHS Staff Survey also reports on Harassment and Bullying; as shown in the excerpts below, Q14b "In the last 12 months how many times have you personally experienced harrassment, bullying or abuse at work from managers" has continued to increase each year, and is currently at 14.6% of employees, which is the worst score when compared to other organisations. Similarly in Q14c "In the last 12 months how many times have you personally experienced harrassment, bullying or abuse at work from other colleagues", this score has increased from 11.9% in 2020 to 15.2% in 2021. Additionally, the staff survey data indicates that significantly more BME staff members in our organisation have experienced harrassment and bullying as compared to white staff members. This fits with information we have about racism in the Trust, raised through and by the Race Review, EDI representatives, individual staff members, and the FTSUG. Bullying and harrassment is also the most

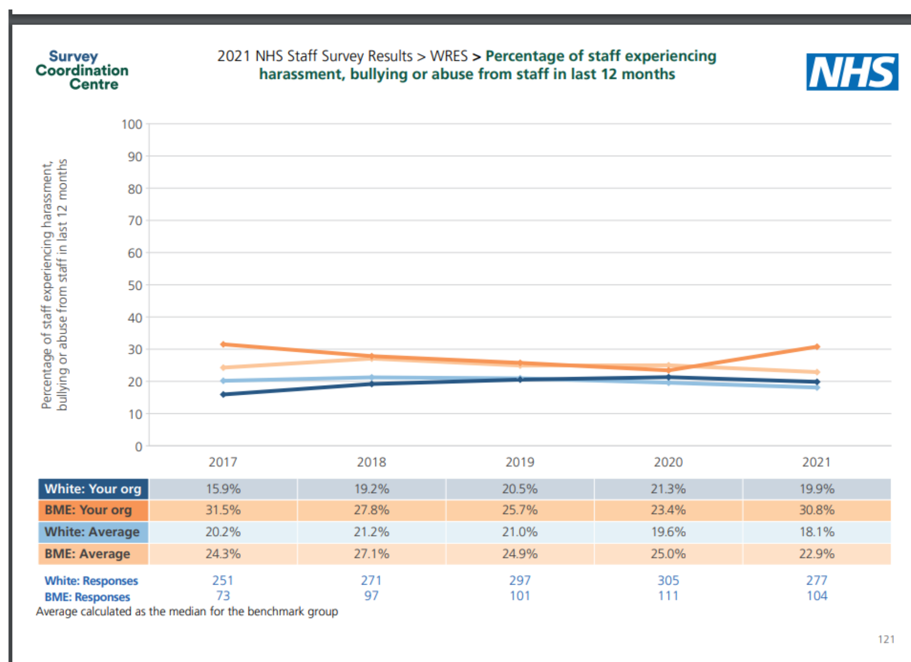
common concern raised with the FTSUG since December 2020. This combined data indicates that there is a significant problem with bullying and harrassment in this Trust, which affects worker safety, patient care, and staff retention. There is also considerable evidence that bullying and harrassment at work has a negative impact on the mental health of staff members (Verkuil, Atasayi & Molendijk, 2015). Concerningly, when asked in Q14d "The last time you experienced harrassment, bullying, or abuse at work, did you or a colleague report it", 49.7% of staff in this Trust stated that they did not, which is the worst score when compared to other organisations.



Q14a	2017	2018	2019	2020	2021
Worst	37.9%	40.3%	44.1%	40.6%	37.2%
Your org	21.9%	24.0%	25.7%	21.7%	15.4%
Average	28.7%	28.3%	28.8%	26.7%	27.2%
Best	21.9%	23.5%	21.1%	20.0%	15.4%
Responses	339	382	432	448	401

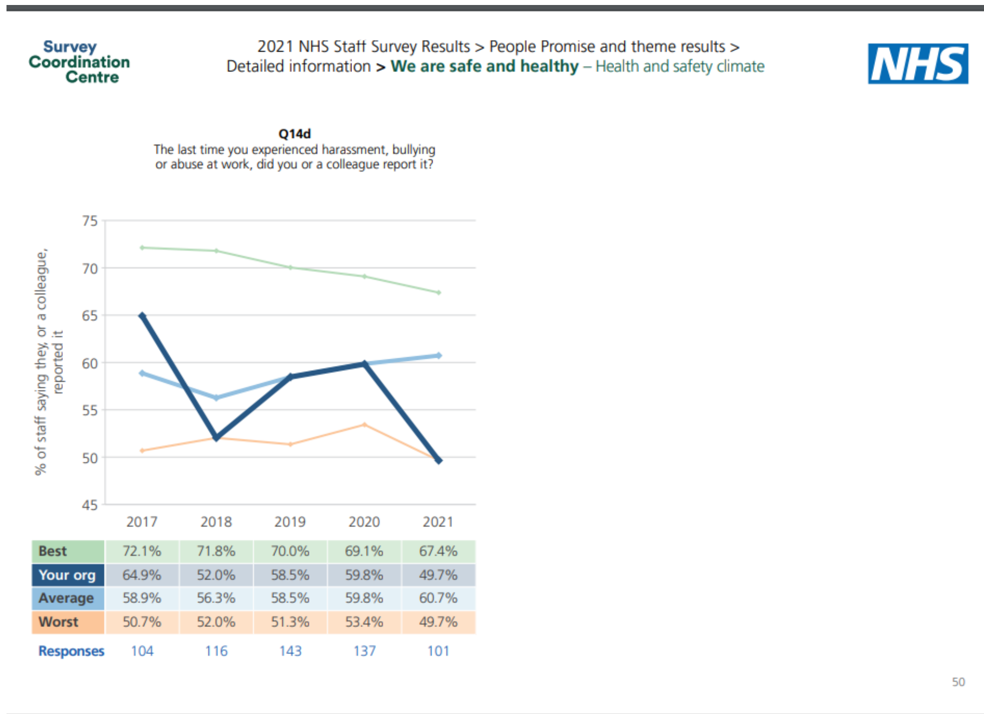
Q14b	2017	2018	2019	2020	2021
Worst	21.8%	17.6%	16.1%	17.3%	14.6%
Your org	10.0%	13.8%	13.6%	14.1%	14.6%
Average	10.7%	11.6%	11.1%	10.5%	8.9%
Best	6.4%	6.8%	7.2%	5.9%	5.8%
Responses	336	379	432	446	401

Q14c	2017	2018	2019	2020	2021
Worst	22.9%	24.7%	25.2%	22.5%	20.1%
Your org	9.8%	11.9%	12.3%	11.9%	15.2%
Average	15.1%	16.2%	16.1%	15.5%	14.6%
Best	9.8%	10.4%	11.1%	9.6%	10.3%
Responses	335	372	431	446	399



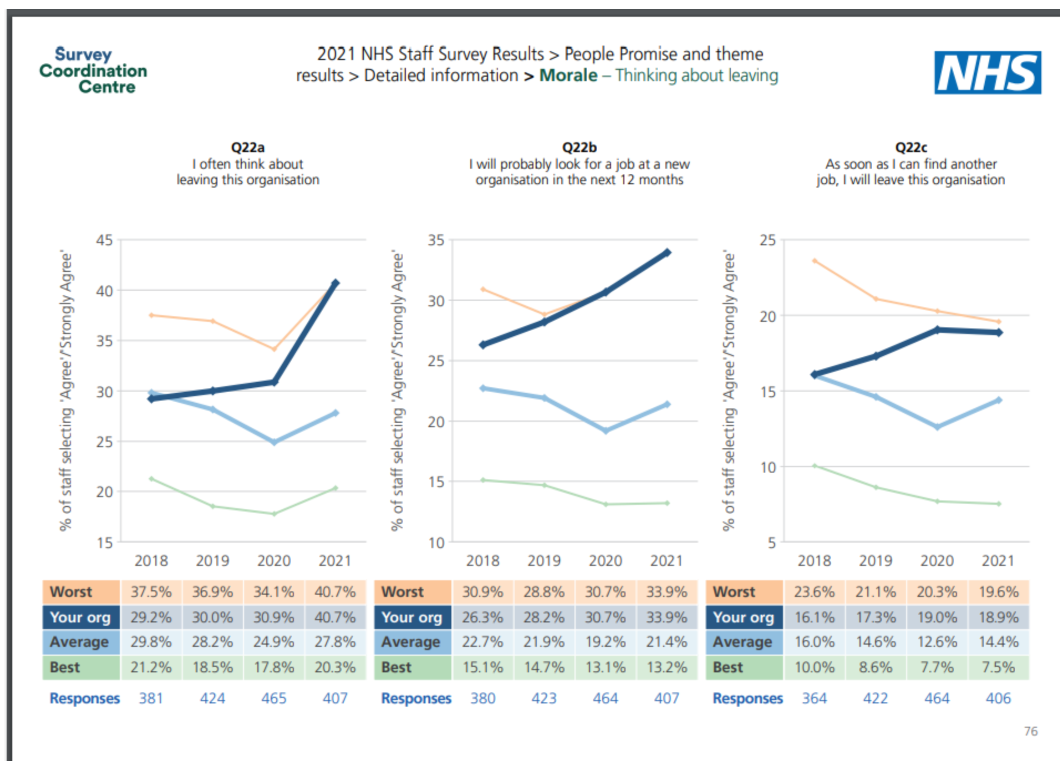
	2017	2018	2019	2020	2021
White: Your org	15.9%	19.2%	20.5%	21.3%	19.9%
BME: Your org	31.5%	27.8%	25.7%	23.4%	30.8%
White: Average	20.2%	21.2%	21.0%	19.6%	18.1%
BME: Average	24.3%	27.1%	24.9%	25.0%	22.9%
White: Responses	251	271	297	305	277
BME: Responses	73	97	101	111	104

Average calculated as the median for the benchmark group



	2017	2018	2019	2020	2021
Best	72.1%	71.8%	70.0%	69.1%	67.4%
Your org	64.9%	52.0%	58.5%	59.8%	49.7%
Average	58.9%	56.3%	58.5%	59.8%	60.7%
Worst	50.7%	52.0%	51.3%	53.4%	49.7%
Responses	104	116	143	137	101

4.6 Finally, the 2021 NHS Staff Survey reports on morale and whether staff members are considering leaving the Trust. As shown in the excerpt below, the scores on Q22a "I often think about leaving this organisation" and Q22b "I will probably look for a job at a new organisation in the next 12 months" have both increased significantly for this Trust, and are the worst scores when compared to other organisations. Staff frequently contact the FTSUG at the point that they have already decided to leave the Trust, often citing that concerns they have raised locally have not been addressed, or describing significant issues with how they are treated by managers and senior staff in their service.



Q22a

	2018	2019	2020	2021
Worst	37.5%	36.9%	34.1%	40.7%
Your org	29.2%	30.0%	30.9%	40.7%
Average	29.8%	28.2%	24.9%	27.8%
Best	21.2%	18.5%	17.8%	20.3%
Responses	381	424	465	407

Q22b

	2018	2019	2020	2021
Worst	30.9%	28.8%	30.7%	33.9%
Your org	26.3%	28.2%	30.7%	33.9%
Average	22.7%	21.9%	19.2%	21.4%
Best	15.1%	14.7%	13.1%	13.2%
Responses	380	423	464	407

Q22c

	2018	2019	2020	2021
Worst	23.6%	21.1%	20.3%	19.6%
Your org	16.1%	17.3%	19.0%	18.9%
Average	16.0%	14.6%	12.6%	14.4%
Best	10.0%	8.6%	7.7%	7.5%
Responses	364	422	464	406

5. Speaking Up Initiatives with the Trust

5.1 Although the data above indicates the need for urgent and focused action on improvement, there is a great deal of completed work with regards to speaking up within the Trust, which has been achieved through collaborative work with key involved individuals. There are also various ongoing or upcoming speaking up initiatives.

5.2 Completed Initiatives for Speaking Up:

5.2.1 Mandatory E-Learning is now in place for all staff on Speaking Up.

5.2.2 Introduction to speaking up and the FTSUG is now a core part of induction through the FTSU induction video.

5.2.3 All staff members are invited to regular (usually monthly) 1:1 drop-in sessions with the FTSUG. This is an effective way to remind people about speaking up, to offer rapid advice, guidance, and sign-posting, or to make initial contact with people who can then be booked in for a longer meeting to discuss concerns.

5.2.4 The Speaking Up Policy Update is now in final draft form, and will be reviewed by the JSCC and EMT over the next month.

5.3 Ongoing or Upcoming Initiatives Speaking Up:

5.3.1 Various colleagues were involved in a previous speaking up steering group that was established in June 2021; unfortunately all of these colleagues have since departed or are due to depart from their roles shortly. As a result, a new Project Plan group has been established in May 2022 in order to plan the implementation stage of the updated Speaking Up Policy, and ultimately launch this. Once the project plan is finalised, a wider working group will be tasked with taking forward the requirements of the plan. This group currently includes an HR Business Partner, the Acting Head of HR, the FTSUG and Staff-Side Chair.

5.3.2 A key objective for the project plan will be to implement a more effective reporting framework for speaking up at all levels of the organisation.

5.3.3 The project plan is due to include manager and senior leader training, incorporating "listen up, follow up" training, and practical training on how to record and report speaking up concerns within the Trust.

5.3.4 The plan is also due to include a communications strategy for the policy launch, and for increased sharing of "you said, we did" speaking up outcomes across the Trust.

5.3.5 The plan is due to include a strategy for introducing Speaking Up Champions – the objective is that these will be recruited, trained and introduced by the end of 2022.

5.3.6 There is due to be a broader policy framework review of other Trust policies and procedures, which the FTSUG will support with in an advisory capacity, utilizing feedback from staff members on their experiences of these in practice.

6. Ongoing Concerns

6.1 There is a consistent message of enthusiasm and support expressed by senior leaders across the organisation when discussing speaking up and other key initiatives related to staff wellbeing, Trust culture, EDI, and the race action plan. There is also progress that can be seen in the introduction of new plans and roles across the Trust to support with this. However, due to a range of challenges occurring over the last year and beyond, many key actions are still awaiting implementation. For example, the People Plan, Just Culture, the Race Action Plan, the launch of the Speaking Up Policy, and the broader policy framework review – each of these have been discussed and shared with staff members, but thus far most have or would be likely report that they see no evidence of these in action.

6.2 I have been involved in various conversations and meetings recently that highlight these as priorities, new roles have been introduced to champion these priorities, and there have been new oversight structures introduced such as the POD EDI Committee, which is highly encouraging in terms of progress occurring this year. However it would be remiss of me not to mention the feedback I have received about the delays to all of these things and the impact of this on morale, staff wellbeing, and how staff members feel about 'the Trust'. In many cases people report having little expectation of meaningful change, as reflected in the NHS Staff Survey Results. This also has a disproportionate negative impact on some staff members more than others, such as staff members currently suffering from racial discrimination, or those experiencing bullying and harassment from their managers.

6.2.1 In some cases this is due to delays in the changes being implemented, and in some cases I believe this is due to challenges with effective communication within the Trust. I'm aware that in some cases there is very regular communication via pre-existing channels, but I wonder whether further innovation is required in order to more effectively cascade information through services and teams.

6.3 I'm also aware that the Strategic Review aims to address some of the broader concerns raised about staff wellbeing and effective provision of care.

However, it has also been an understandably resource-heavy undertaking. This has led to delays of other action plans and initiatives. Equally, sometimes actions are delayed in order to avoid duplicating work that will have to be reviewed/revised when the strategic review changes are implemented.

6.4 With regards to speaking up culture specifically, we still have a significant way to go before we have an open learning culture that seeks to listen to all staff, learn from them, and thank them. As reported by the previous FTSUG, improving speaking up culture and addressing speaking up concerns should be something we are engaged in Trust-wide, and the FTSUG should be an additional independent safeguard for this, and yet there continue to be misunderstandings around shared responsibility for promoting and addressing this in the Trust. Additionally, the lack of effective and/or timely resolution and outcome sharing for concerns raised across the Trust is leading to people understandably feel increasingly reluctant to speak up about concerns. This is highly concerning for a range of reasons, including patient safety.

6.5 Looking at the scale of the problems reported here, in combination with the widely-held belief by many staff that nothing will change, staff members need evidence of positive change now. My recommendation is that we need to enter a period of action and iterative change, where actions are taken and then adjusted and redelivered as necessary, with staff feedback and collaboration involved. Whilst this may require some additional resource and perhaps some duplication of efforts, there is no time to delay for many of the significant issues occurring in the Trust right now, which is negatively affecting many staff members and leading to significant and often avoidable staff attrition.

7. Recommendations

7.1 We need to make timely progress with the Speaking Up Project Plan, in order to address some of the significant issues with listening up and following up in the Trust. With increased training, communication of outcomes at all levels, and a supportive framework for reporting and monitoring concerns, it is likely that we can make significant improvements in this area.

7.1.1 **Recommendation for the board:** In order to progress this work, I recommend that financial resource is put into staff training and a new reporting framework.

7.1.2 **Recommendation for the board:** In order to progress this work in a timely manner, I recommend that a colleague within the HR/People Management Structure has explicit ring-fenced time to work with me and others on the Speaking Up Project Plan as a job-planned priority. This has not been the case over the past year due to other understandably resource-heavy tasks taking priority. Given the data reported in this

report, we now need to prioritise speaking up work and meet concrete goals by the end of 2022.

7.2 The data above reveals a significant issue with regards to bullying and harassment across the Trust. In many cases this has been reported as occurring within management relationships, or not being addressed effectively by those in management and senior leadership roles. There are a range of reasons behind this, and from conversations with a wide range of colleagues over the past year, the lack of training and support for those in management and leadership positions has been consistently highlighted as a problem that reinforces this issue; in some cases employees even cite their awareness that their manager is also feeling bullied, harassed, or under-supported and that this is cascading down, which often leads to an increased sense of frustration and hopelessness.

7.2.1 **Recommendation for the board:** There needs to be mandatory interim training for all staff members involved in management, supervision, or leadership. This would include listening up and following up training, training on key management and people development skills, and training on effective policy usage with information on supportive escalation structures for difficult situations included. This would also include the importance of investigating concerns or requesting an alternative investigator with respect to each of the relevant policies.

7.3 I appreciate that this report is focused on concerns and urgent actions that are needed. Whilst this is the key and unavoidable focus of this report, I would also like to thank everyone who has worked hard and taken time to raise concerns with me and others in the Trust, to address concerns and create change, the continued invaluable conversations I have had with the wide range of individuals listed in my introductory section, and the support I have received to continue in this role from Paul Jenkins and other leaders in the Trust. I know from these conversations that people do care about the concerns and inequalities described in this report, so am hopeful that when I return to the board in November 2022 I will be able to report on positive changes and feedback.

Sarah Stenlake

Freedom to Speak Up Guardian

May 2022

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The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board	24 May 2022

Finance and Performance Report

Executive Summary

This paper summarises the results for the year ended 31 March 2022.
The results are still subject to audit.

Recommendation to the Board

The Board is asked to note the report

Trust strategic objectives supported by this paper

Services / Growth and Development / Finance and Governance

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

(UNAUDITED) RESULTS FOR THE YEAR ENDED 31 MARCH 2022

1. INTRODUCTION

1.1 This paper summarises the results for the year ended 31 March 2022.

1.2 The results are still subject to audit.

2. INCOME AND EXPENDITURE

Operating Performance

	Budget	Q3 Forecast	Actual
	£'000	£'000	£'000
Income	57,375	59,546	64,069
Staff costs	(49,186)	(48,128)	(49,321)
Non-staff costs	(13,967)	(16,657)	(18,929)
Operating deficit	(5,778)	(5,239)	(4,181)
Non-operating costs	(2,495)	(2,201)	(2,419)
Deficit before 'non-recurring' costs	(8,273)	(7,440)	(6,600)
'Non-recurring' costs	-	(7,080)	(5,716)
Deficit after 'non-recurring' costs	(8,273)	(14,520)	(12,316)

2.1 The draft result for the year is a deficit – before 'non-recurring' costs – of £6.6m, compared with a deficit of £7.4m forecast in December and a Budgeted deficit of £8.3m.

2.2 Staff costs are broadly as per Budget, although the actual result includes additional staffing costs, reflecting new Health Education England monies.

2.3 Income is higher than Forecast and Budget due to the HEE income and centralised funding for pensions.

2.4 Non-staff costs are higher than anticipated due, principally, to the reallocation of Relocation-related expenditure from capital to revenue.

Non-Recurring Costs

2.5 These relate to the write off of the fixed asset relating to Relocation of £3.4m and for other provisions including any potential redundancies as a result of the strategic review.

3. BALANCE SHEET AND CASH FLOW

3.1 Cash balances at 31 March 2022 amount to £14.8m which is significantly ahead of Budget. This reflects the facts that the deficit before non-recurring items is smaller than Budgeted; that any cash payment relating to the non-recurring items will occur post year end; and that the Trust received additional funding for capital expenditure (which was, in any case, lower than Budget).

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 12 **12** **Mar-22**

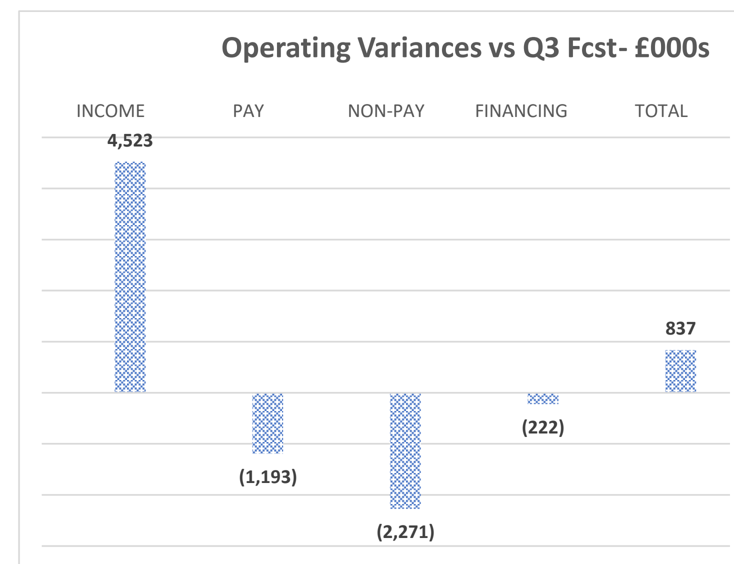
Section

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

Period 12
Mar-22

£000	Q3 Fcst	Actual	Variance	Var %
INCOME	59,546	64,069	4,523	8%
PAY	(48,128)	(49,321)	(1,193)	2%
NON-PAY	(16,657)	(18,929)	(2,271)	14%
EBITA	**(5,240)**	**(4,181)**	**1,058**	**(20%)**
Interest receivable	0	5	5	
Interest payable	(32)	(31)	1	(3%)
Depreciation	(1,760)	(1,957)	(197)	11%
Dividend	(409)	(435)	(26)	6%
Net Surplus /(Deficit)	**(7,441)**	**(6,600)**	**841**	**(11%)**
Exceptional costs				
Relocation impairment	(4,800)	(3,436)	1,364	(28%)
Provisions (redundancy etc)	(2,280)	(2,280)	0	0%
Total Exceptional costs	**(7,080)**	**(5,716)**	**1,364**	(19%)
Deficit	**(14,521)**	**(12,316)**	**2,205**	**(15%)**

(2,201)



	Q3 FCST	Act	Var
Projected closing cash - Mar 22	**9,588**	**14,816**	**5,229**
YTD Cash in/(out) flow - £000s	**(5,188)**	**40**	**5,228**
due to :-			
Net deficit			**2,195**
Other working capital			***2,019***
Capital expenditure			***949***
other			***66***

Income **4,523** above plan

HEE / NCL late period revenue and funding for Employers' NIC contriburion (£1,954k)

Pay costs **(1,193)** less than plan

Allocation of central funding for 6.3% employer's pension contribution and cost provisions re HEE/NCL funding

Non-pay costs **(2,271)** less than plan

E&T accrued costs and Impairment of relocation AUC

Debtors > 90 days	**Jan-22**	**Feb-22**	**Mar-22**
	£'000	£'000	£'000
NHS	56	32	41
Non-NHS	188	172	283
Student	344	385	310
Total	**589**	**589**	**634**

FINANCE AND PERFORMANCE REPORT **Balance Sheet**

Period 12

Mar-22

	Prior Year End £'000	Apr-21 £'000	May-21 £'000	Mar-22 £'000	Jul-21 £'000	Aug-21 £'000	Sep-21 £'000	Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000
Intangible assets	50	46	43	39	36	33	30	27	25	24	23	21	20
Land and buildings	24,045	24,031	24,039	24,046	24,079	24,026	24,072	24,267	24,191	24,467	24,555	24,607	21,803
IT equipment	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773	1,773
Property, Plant & Equipment	25,818	25,804	25,812	25,819	25,852	25,799	25,845	26,040	25,964	26,240	26,328	26,380	23,576
Total non-current assets	25,868	25,850	25,855	25,858	25,887	25,832	25,875	26,067	25,989	26,264	26,351	26,401	23,596
NHS Receivables	6,494	5,331	5,290	5,022	7,458	5,115	5,528	5,310	4,982	4,950	4,505	6,175	7,018
Non-NHS Receivables	3,322	2,475	3,172	3,404	2,946	2,683	4,154	3,722	4,215	3,379	3,284	2,689	1,262
Cash / equivalents	14,775	17,175	15,659	15,228	13,734	14,348	11,846	15,330	13,532	12,086	10,722	11,327	12,224
Other cash balances		(123)	(111)	(167)	(60)	1,130	1,606	1,653	1,744	2,061	2,130	2,099	2,592
Total current assets	24,591	24,858	24,009	23,488	24,078	23,276	23,134	26,015	24,473	22,476	20,641	22,290	23,095
Trade and other payables	(2,660)	(2,936)	(2,247)	(2,496)	(2,586)	(2,653)	(2,591)	(2,353)	(2,738)	(2,675)	(2,816)	(2,655)	(5,123)
Accruals	(8,090)	(8,406)	(8,471)	(8,114)	(9,172)	(8,852)	(9,211)	(12,278)	(12,021)	(10,539)	(9,739)	(11,468)	(11,239)
Deferred income	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)	(6,811)
Long term loans < 1 year	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)
Provisions	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)	(617)
Total current liabilities	(18,623)	(19,215)	(18,590)	(18,482)	(19,631)	(19,377)	(19,674)	(22,503)	(22,631)	(21,086)	(20,428)	(21,995)	(24,235)
Total assets less current liabilities	31,837	31,493	31,274	30,864	30,335	29,732	29,334	29,578	27,831	27,653	26,564	26,696	22,457
Non-current provisions	(70)	(65)	(65)	(24)	18	18	18	20	20	(53)	22	22	(2,585)
Long term loans > 1 year	(2,666)	(2,666)	(2,666)	(2,666)	(2,666)	(2,443)	(2,443)	(2,443)	(2,443)	(2,443)	(2,443)	(2,221)	(2,221)
Total assets employed	29,101	28,763	28,543	28,175	27,688	27,307	26,910	27,155	25,408	25,157	24,142	24,497	17,651
Public dividend capital	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(4,678)	(5,543)
Revaluation reserve	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)	(12,878)
I&E reserve	(11,546)	(11,207)	(10,987)	(10,619)	(10,132)	(9,751)	(9,354)	(9,599)	(7,852)	(7,601)	(6,586)	(6,941)	771
	0	(0)	(0)	(0)	(0)	(0)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Total taxpayers equity	(29,101)	(28,763)	(28,543)	(28,175)	(27,688)	(27,307)	(26,910)	(27,155)	(25,408)	(25,157)	(24,142)	(24,497)	(17,651)

FINANCE AND PERFORMANCE REPORT **Section 6** **FUNDS FLOW** **Page 4**

Period 12 12

Mar-22

	April Act £'000	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	Jan Act £'000	Feb Act £'000	Mar Act £'000	**YTD Act £'000**	**YTD Q3 Fcst £'000**	**YTD Var £'000**
Net Surplus/(Deficit)	**(338)**	**(220)**	**(368)**	**(487)**	**(381)**	**(397)**	**245**	**(1,747)**	**(251)**	**(1,015)**	**355**	**(7,711)**	**(12,316)**	**(14,511)**	2,195
Depreciation / amortisation	135	135	135	135	193	147	146	182	159	145	158	296	**1,966**	**1,832**	**134**
PDC dividend paid	41	23	32	76	43	41	82	0	0	0	0	97	**435**	**338**	**97**
Net Interest paid	2	2	2	2	5	0	5	2	2	2	2	2	**31**	**32**	**(1)**
(Increase) / Decrease in receivables	2,010	(656)	35	(1,978)	2,606	(1,885)	650	(164)	867	540	(1,075)	585	**1,537**	**1,487**	**50**
Increase / (Decrease) in liabilities	592	(625)	(108)	1,148	(254)	297	2,829	128	(1,545)	(659)	1,568	2,206	**5,579**	**2,675**	**2,904**
Increase / (Decrease) in provisions	(5)	0	(41)	(42)	0	0	(2)	0	73	(75)	(0)	2,607	**2,515**	**2,252**	**262**
Impairment												3,436	**3,436**	**4,800**	**(1,364)**
Non operational accural movement	(44)	(25)	(34)	(78)	(33)	364	(87)	(2)	(2)	(2)	12	(65)	**2**	**66**	**(64)**
Net operating cash flow	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,180**	**(1,433)**	**3,869**	**(1,601)**	**(696)**	**(1,064)**	**1,020**	**1,453**	**3,184**	**(1,030)**	**4,214**
Interest received													**0**	**0**	**0**
Interest paid					(15)						(14)		**(29)**	**(30)**	**1**
PDC dividend paid						(405)							**(405)**	**(405)**	**0**
PDC Funding received												865	**865**	**800**	**65**
Cash flow available for investment	**2,393**	**(1,365)**	**(347)**	**(1,224)**	**2,165**	**(1,838)**	**3,869**	**(1,601)**	**(696)**	**(1,064)**	**1,006**	**2,318**	**3,615**	**(665)**	**4,280**
Purchase of property, plant & equipment	18	(4)	(4)	(29)	55	(42)	(192)	77	(275)	(87)	(50)	(631)	**(1,164)**	**(2,247)**	**1,083**
Depreciation	(135)	(135)	(135)	(135)	(193)	(147)	(146)	(182)	(159)	(145)	(158)	(296)	**(1,966)**	**(1,832)**	**(134)**
Capital purchases - cash	**(117)**	**(139)**	**(139)**	**(164)**	**(138)**	**(189)**	**(338)**	**(105)**	**(434)**	**(231)**	**(209)**	**(927)**	**(3,130)**	**(4,079)**	**949**
Net cash flow before financing	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**2,027**	**(2,027)**	**3,531**	**(1,706)**	**(1,130)**	**(1,295)**	**797**	**1,391**	**485**	**(4,743)**	**5,229**
Repayment of debt facilities	0	0	0	0	(222)	0	0	0	0	0	(222)	0	**(445)**	**(444)**	**(0)**
Net increase / (decrease) in cash	**2,277**	**(1,505)**	**(486)**	**(1,388)**	**1,805**	**(2,027)**	**3,531**	**(1,706)**	**(1,130)**	**(1,295)**	**575**	**1,391**	**40**	**(5,188)**	**5,228**
Opening Cash	14,775	17,052	15,547	15,061	13,674	15,478	13,451	16,982	15,276	14,146	12,851	13,425	14,775	14,775	0
Closing cash	**17,052**	**15,547**	**15,061**	**13,674**	**15,478**	**13,451**	**16,982**	**15,276**	**14,146**	**12,851**	**13,425**	**14,816**	**14,816**	**9,588**	**5,229**

Period 12
Mar-22

PROJECT	April Act £'000	May Act £'000	June Act £'000	July Act £'000	Aug Act £'000	Sept Act £'000	Oct Act £'000	Nov Act £'000	Dec Act £'000	Jan Act £'000	Feb Act £'000	Mar Act £'000	**Full Yr Act £'000**	20/21 Bud £'000
Microsoft Office 365 E-Mail Migration	260	(252)	4	(4)	12	5	1	0	0	0	0	0	**27**	0
Endpoint Procure/Config/Compliance/Monitor	0	8	8	17	7	5	9	4	9	5	5	173	**249**	66
Tavistock Centre Data Centres Power Provision	0	0	0	0	0	0	0	0	2	0	8	258	**268**	32
Remote Working	(260)	260	0	0	0	0	0	0	0	0	0	(260)	**(260)**	0
Cyber Essentials	4	1	4	0	0	0	0	0	0	0	0	0	**10**	5
Health Information Exchange	0	0	0	0	0	0	2	1	3	1	1	1	**9**	0
MyTap Annual Upgrade 2019/20	3	0	0	0	0	0	0	0	0	0	0	0	**3**	0
Endpoint Replacement 2018/19	0	0	0	0	0	0	0	(71)	0	0	0	0	**(71)**	0
DET Record Management System	0	0	0	0	0	0	0	(3)	0	0	0	0	**(3)**	0
ICT Cyber Security Compliance 2020/21	1	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Core Infrastructure Update	0	0	8	10	(8)	0	1	1	5	1	1	13	**32**	63
Network - Upgrade (Wireless)	0	0	0	0	0	0	6	4	34	4	5	150	**203**	30
Cyber Essentials Plus	0	0	5	4	3	0	7	0	7	0	0	8	**33**	30
Endpoint Replacement 2021/22	0	0	0	2	34	33	42	0	41	41	84	97	**375**	200
ICT Cyber Security Compliance 2021/22	0	0	2	5	(4)	0	4	1	79	13	1	77	**178**	140
API for CareNotes Integration	0	0	0	0	0	0	1	1	1	1	1	97	**102**	0
Audio Video Upgrade for Remote Working	0	0	0	0	0	0	2	1	2	1	1	303	**310**	0
Connectivity Upgrade	0	0	0	0	0	0	2	6	3	1	1	37	**50**	0
Data Warehouse	0	0	0	0	0	0	1	3	15	14	17	86	**136**	0
Virtual Desktop Interface	0	0	0	0	0	0	1	1	4	2	1	242	**251**	0
IT	**9**	**18**	**31**	**34**	**43**	**43**	**79**	**(51)**	**205**	**85**	**125**	**1,281**	**1,903**	**566**
Ventilation	10	0	0	0	0	0	0	0	0	0	0	0	**10**	0
Pumps	0	9	2	0	0	0	0	0	0	0	0	0	**10**	0
Water	0	0	0	0	0	0	0	0	(0)	(0)	0	0	**(0)**	30
Electrics	8	(3)	3	8	16	13	68	6	16	95	0	0	**229**	223
PC Compliance	0	7	1	0	0	0	0	0	0	0	0	0	**8**	0
TC Compliance	1	9	3	6	(3)	(1)	0	19	(21)	0	0	0	**11**	0
GH Compliance	2	0	0	0	0	0	0	0	0	4	0	0	**6**	0
Finchley Road	1	0	0	0	0	0	0	0	0	0	0	0	**1**	0
Fire Safety & Compliance	0	2	2	3	3	13	3	3	1	14	0	0	**43**	96
Roofing - GH	0	0	0	0	0	22	0	0	23	5	0	0	**50**	35
Catering Equipment	0	0	0	0	0	0	0	0	0	0	0	0	**0**	20
Basement Sprinkler System	0	0	0	0	0	0	0	0	19	4	0	0	**23**	10
Toilets - Anti Ligature / Gender Neutral	0	0	0	0	0	0	0	0	0	0	0	0	**0**	50
Roofing - TC	0	0	0	0	0	0	0	0	19	0	0	0	**19**	0
ESTATES	**22**	**23**	**10**	**17**	**15**	**47**	**71**	**27**	**56**	**121**	**0**	**0**	**410**	**464**
Relocation	**85**	**99**	**86**	**125**	**80**	**99**	**171**	**104**	**169**	**22**	**60**	**(1,102)**	**(0)**	
Digital Academy	**1**	**(1)**	**12**	**(12)**	**0**	**0**	**17**	**22**	**0**	**0**	**0**	**0**	**39**	**122**
Projected Underspend / Contingency	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**752**
TOTAL	**117**	**139**	**139**	**164**	**138**	**189**	**338**	**102**	**431**	**229**	**186**	**179**	**2,351**	**1,903**

Report to	Date
Board of Directors	24 May 2022

2022/23 Budget

Executive Summary

This paper provides summary details on the 2022/23 Budget for the Trust.

Recommendation to the Board

The Board is asked to approve the report

Trust strategic objectives supported by this paper

Finance and Governance

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

2022/23 TRUST BUDGET

1. INTRODUCTION

1.1. This paper provides summary details on the 2022/23 Budget for the Trust. This is an update on the previous 'indicative' Budget provided to the Board in March and is based on the submission the Trust made to the ICS on 9 May 2022.

1.2. As the ICS has not yet finalised its Budget with NHSEI, these figures still remain draft.

2. OVERVIEW

£m	2021/22 Out-Turn	2022/23 Indicative Budget	Change	
Income	64.0	64.9	0.9	1.4%
Pay costs	(49.3)	(50.5)	(1.2)	(2.4)%
Non-pay costs	(18.9) ----	(17.9) ----	1.0 ----	5.2%
Operating deficit	(4.2)	(3.5)	0.7	
Other costs	(2.4)	(2.5)	0.1	(4.1)%
	----	----	----	
Deficit before 'exceptional' items	(6.6)	(6.0)	0.6	
'Exceptional' items	(5.7)	Nil	7.1	
	----	----	----	
Net deficit	(12.3)	(6.0)	6.3	

2.1. The Budget shows the Trust making a deficit of £6.0m on income of £64.9m.

3. INCOME

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

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

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

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

3.5. The figures for 2020/21 include £2.2m of covid / top-up funding which does not repeat in 2022/23 and £2m of centrally funded pension contribution costs (which is not shown in the 2022/23 figures).

4. REVENUE EXPENDITURE

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

4.2. Set against this increase is a vacancy efficiency factor of £3m (5.5% of gross staffing costs).

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

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

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

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

5. BALANCE SHEET, CASH FLOW AND CAPITAL EXPENDITURE

5.1. Cash is expected to reduce in the period from £14.8m to £4.5m reflecting:

- Deficit for the year of £6m
- Proposed capital expenditure of £3.5m
- Utilisation of provisions.

5.2. The budget for Capital Expenditure of £3.5m is the level permitted by the ICS. The use of these monies has yet to be determined, with the Trust's Change Board (a committee of EMT) set to review competing demands for this money at its next meeting.

6. SERVICE LINE REPORTING

6.1. A Budget, showing service line reporting, will be produced once the ICS has confirmed the acceptability of the Trust's Budget.

The Tavistock and Portman NHS
NHS Foundation Trust

Report to	Date
Board of Directors	24 May 2022

Name of report: UCL Health Alliance Business Plan & Articles of Association

Executive Summary

The purpose of this document is to seek formal approval from member organisations to launch the UCL Health Alliance as a new legal entity. The submissions for approval comprise two principal documents:

i. Business plan for 2022/23: providing information concerning the governance and model for delivery through the UCL Health Alliance, the multi sector provider collaborative for North Central London **[pages 4-54]**.
ii. Articles of Association: setting out in more detail the governance for how the Alliance will function as a corporation limited by guarantee, similar to arrangements in place governing UCL Partners **[pages 56-69]**.

The steps for launching the Alliance as a legal entity, operating within the stated business plan has followed an extensive process:

i. Initiating the Alliance: work began in 2020 to bring provider CEOs and Chairs together with the leadership of UCL to shape the vision and operational model for the UCL Health Alliance to function as a provider collaborative for North Central London.
ii. Scoping priorities: workshops in early 2021 identified priorities which members jointly recognised as priorities for collective action and would be best addressed through collaboration at system level.
iii. Corporate Board: appointments to a corporate board model were made in April 2021, establishing decision making governance concerning the strategic direction and constitution of the Alliance.
iv. Branding: in summer 2021 members agreed for the Alliance to operate under the banner of the UCL Health Alliance, receiving formal approval from UCL.
v. Exploring form: during the winter of 2021 members of the Alliance Executive explored costs and benefits associated with different organisational forms which could be used for the Alliance.
vi. Determining form: the January 2022 Alliance Board reviewed options for the organisational form of the Alliance and determined a corporation limited by guarantee as the preferred model.
vii. Developing the formal governance: following the January Board decision members of the Alliance Executive and wider trust leadership (such as directors of corporate affairs) worked with the Alliance Managing Director and Chair to develop the Articles of Association and Business Plan.
viii. In parallel, the Alliance Managing Director has been working alongside leads from NHSE/I regional team and NHSE/I national provider development team to ensure that the governance documentation being submitted to member boards and governing bodies sufficiently addresses requirements set out in the regulations concerning the formation of NHS subsidiaries. Once members have provided approval, the key documents will be submitted to NHSE/I for review.

The intention is to launch the new legal entity in July 2022.

Recommendation to the Board/Committee	
• Approve a recommendation for Tavistock & Portman to be a founding member of the UCL Health Alliance legal entity, as set out in the business plan and articles of association. • Approve the business plan for 2022/23. • Approve delegation of authority for board certification required by NHS England and Improvement as part of their subsidiary approval process [only required for NHS Foundation Trust members]. • Take assurance from the details provided in the business plan and articles of association that this course of action represents the optimal model for system level collaboration between organisations in North Central London.	
Trust strategic objectives supported by this paper	
Relevant to member objectives concerning: - Improving patient and population health outcomes - Reducing health inequalities - Increasing impact through research and innovation - Financial sustainability - Workforce ambitions concerning education, training and leadership development	
Author	**Responsible Executive Director**
Nick Kirby, Interim Managing Director, UCL Health Alliance	Paul Jenkins, Chief Executive

PART A: UCL HEALTH ALLIANCE BUSINESS PLAN
MAY 2022

The purpose of this document is to provide information concerning the governance and model for delivery through the UCL Health Alliance, the multi sector provider collaborative for North Central London.

CONTENTS

Section 1: Introduction & Context **[page 4]**
Section 2: Governance Arrangements **[page 6]**
Section 3: Programme Development & Delivery **[page 21]**
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Section 5: Financial Plan **[page 27]**

Appendix 1: Options for the organisational form of the UCL Health Alliance **[page 29]**
Appendix 2: External tax advice **[page 38]**
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Appendix 4: UCL Health Alliance Objectives **[page 43]**
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Appendix 6: Resourcing through provider members **[page 52]**
Appendix 7: Decision making governance **[page 54]**
Appendix 8: Glossary of Terms **[page 55]**

1. INTRODUCTION & CONTEXT

1.1 Overview of the UCL Health Alliance

The UCL Health Alliance is the multi sector provider collaborative for North Central London. Our purpose is to enable effective partnership working to improve the outcomes and experience for the population we serve. This scope includes people across North Central London as well as people travelling in across the wider region and in some cases nationally to receive specialised care.

Provider collaboratives are self convening partnerships, driven by the need to span organisational boundaries that exist within the NHS. Guidance from NHS England published in 2021 set out the requirement for all acute and mental health providers to participate in at least one provider collaborative.[1] Our Alliance model maintains the sovereignty of all member boards and involves the delegation of authority for certain collective decision making to the provider alliance for specific shared initiatives.

Through the Alliance, NHS and university partners are working together to respond to the most pressing health and care priorities for our organisations and the communities we serve, and to rapidly put our findings into practice in health services, education and research. The Alliance looks at the whole pathway from prevention, to treatment and both physical and mental health needs. We have a duty to demonstrate best value for taxpayers and support member organisations sustain high quality care within resource constraints. The UCL Health Alliance has been formed by member boards and governing bodies with the intention that it functions as the principle vehicle for collaborative working at system level across North Central London. The Alliance is in effect the provider collaborative for North Central London.

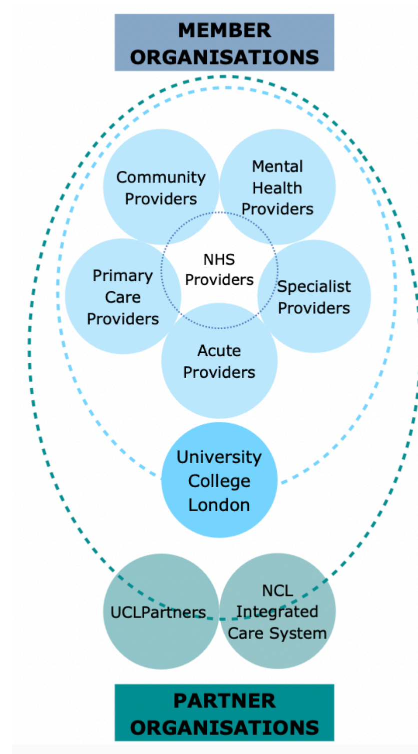
The Alliance comprises:
- 14 member organisations
- 2 formal partner organisations
- Global university as a founding member
- All inclusive provider collaborative model
- Combined revenue of £5.3bn
- Combined workforce of 54,000
- 60 percent of patients waiting for care are from outside NCL

Chief Executives and Chairs from across the Alliance convene on a regular basis to direct a shared agenda addressing priorities which lend themselves to action at system level.

The Alliance Executive comprises Chief Executives, system clinical and finance leads and the ICB Accountable Officer. Its monthly meetings are focused on strategic updates from each Chief Executive concerning priorities which they lead on behalf of the wider Alliance, as well as on steps required to establish programme and organisational capabilities as the Alliance formalises its approach.

The Alliance Board comprises a combination of Chairs and Chief Executives as voting members and functions as a corporate board, with appointments to each portfolio being confirmed in April 2021. The Board focuses on approval of strategic direction and matters concerning the constitution of the Alliance.

Figure 1: UCL Health Alliance - the provider collaborative for North Central London



[1] Working Together At Scale: Guidance on Provider Collaboratives (August 2021), NHS England and Improvement

1.2 Rationale for the 'All-in' Model

The starting point for the Alliance reflects a paradox that exists in North Central London. Specifically, within our geography there are some nationally and internationally regarded centres of expertise and a globally leading university; despite this, patient outcomes and experience are not as good as they should be and the system is characterised by extreme health inequalities. Historically, the health system is delivering less than the sum of its parts for the populations we serve and effective partnership working will be a critical factor in resolving this.

NHS leaders across North Central London have deliberately chosen to form a provider collaborative which spans the boundaries between different sectors within the NHS. This mirrors the reality experienced by patients, where many of the opportunities for improvement exist in the space between out of hospital and in hospital care, and strengthening the integration between mental and physical health.

An important dimension of our 'All-in' model is the inclusion of UCL as a founder member of the provider collaborative. This reflects the alignment of ambitions that exist between UCL, as a global university anchored in North Central London, and those of NHS partners. Clear opportunities exist in three areas:

i. **Research:** providing a direct connection between academic expertise in UCL and clinical communities in the NHS, with a particular emphasis on amplifying opportunities for patients, populations and staff to benefit from research in part of our system which have experienced substantially lower investment in recent decades.

ii. **Education & training:** realising synergies between the capabilities that exist within UCL and the workforce needs of the NHS. Closer strategic working though the Alliance will enable the co-design of innovative programmes that leverage and extend the reach of the university, concurrently strengthening the supply of skilled staff into the NHS labour market and equipping current staff with the skills and capabilities required for the future.

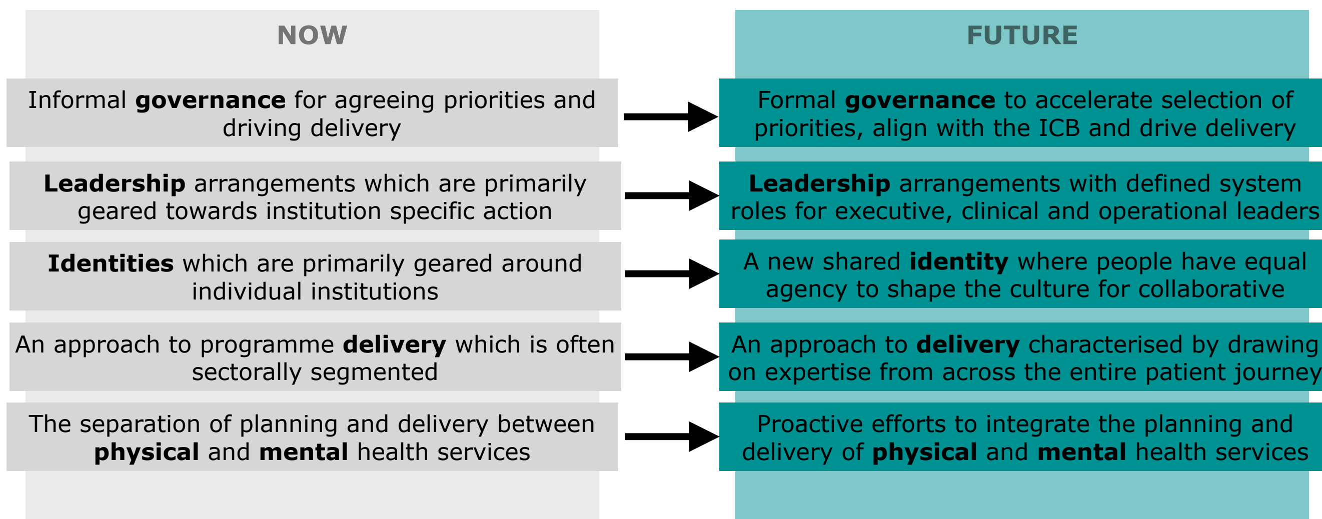
iii. **Anchor mission:** sharing insights and developing new practices concerning how members of the Alliance can better effect the social determinants of health in North Central London through our responsibilities as employers, purchases of goods and services, and stewards of large estates and facilities.

1.3 Positioning the Alliance within an evolving health and care ecosystem

In framing the role and ambitions the Alliance has, it is important to recognise that the starting point is not a blank canvas. The current NHS ecosystem is characterised by a complex tapestry of organisations, some of which are changing as a result of the new Health and Care Act.

The simplest explanation of the Alliance is that it is not being set up to create a separate part of the health ecosystem - the Alliance *is* the provider members. When the leadership community set out an intention to deliver a priority through the Alliance, this is short hand for describing an intention to deliver by working better together.

Figure 2: The role of the Alliance in having a positive impact of collaborative working



2. GOVERNANCE ARRANGEMENTS

2.1. Development of the UCL Health Alliance

Provider Collaboratives are emerging as the principal model for provider organisations to work more effectively together. The initial model for the UCL Alliance has been characterised by three main features:

i. **Sovereignty:** all partner boards remain sovereign and delegate authority for collective decision-making to the Alliance only for those shared initiatives and activities with resident or taxpayer benefit across more than one borough.

ii. **Devolved:** the Alliance operates a devolved partnership model with partner trusts able to opt-in to shared initiatives and activities and seeking devolved accountability to partners wherever possible (easier to achieve with clarity in advance on agreed "leads" for service areas and support functions).

iii. **Corporate board:** in order for the Alliance to operate effectively as a delivery vehicle and also in order not to confuse accountabilities for holding to account/assurance elsewhere in the ICB, the Alliance (and the future intended legal entity) is governed as a "corporate board" rather than a "stakeholder board".

These features have been adopted as core principles in the governance of the new organisational entity.

The Alliance intends to operate alongside, and to enable, **new care models** and **organisational innovation**, such as lead providers. The inclusion of lead roles in the initial Alliance priorities supports focusing work to get this right. One example of how the two can work would be that there may be areas which the Alliance Board of Directors agree are best approached through a lead provider model. The Alliance Board of Directors can then take steps to agree the detail of this model. Once agreed, the lead provider model would operate within the existing organisational governance arrangements (such as CQC registration and employment of staff through an existing provider organisation). Work has already begun with the ICB to understand what the right decision making and governance arrangements would be for agreeing changes in service provision, following an initial conversation at the February 2022 Alliance Executive.

2.2. Rationale for the Corporation Model

In 2021 and early 2022 the Alliance Executive and Board members accelerated work to select the preferred organisational form for the Alliance. The approach considered the broad spectrum of capabilities and functions which the Alliance would need to undertake in order to optimise collaborative efforts across the community of provider organisations. Different governance models were considered including the status quo (informal collaboration), charitable forms, committees in common, joint committees and a variety of corporate models. **Appendix 1** provides a detailed breakdown comparing the option to establish the Alliance as a corporation limited by guarantee with the status quo, committee in common and joint committee options. This includes the specification of evaluation criteria which were used in the Alliance Board decision in January 2022, along with both quantitative and quantitative evaluations of these options. A discussion section is included as part of this appendix, expanding on concerns relating to the committee in common and joint committee options.

The **status quo** was considered non viable. This is because the Alliance would not be able to deliver the agenda which has been set out by the Alliance Executive and Board under its current informal governance arrangements. The inability to employ staff, transact finances, enter into contracts with other organisations and undertake binding decisions within delineated delegated authorities means that the Alliance would fail to operate as a Provider Collaborative - either as intended by founding members or as expected in national guidance.

There are a range of limitations concerning the **committee in common** and **joint committee** models. These include:

1. **Corporate model:** the committee in common and joint committee models are designed for members to have a representative role, rather than CEOs and Chairs taking on Alliance board leadership for system wide priorities.

2. **Complexity of scale:** the complexity of a large scale provider collaborative of fourteen organisations and the implications this has concerning the complexity of a committees in common in common and joint committees models.
3. **Collaborative identity:** the benefits associated with a corporation having a new and distinct entity which can both bring member organisations closer together as equal partners as well as in interacting more directly with commissioning organisations. It also creates a clear entity for purposes of accountability, both to member organisations as well as to bodies which commission work from the Alliance.
4. **Long term evolution:** The versatility that the corporation model provides for members to deploy it as a vehicle for delivering a wide range of priorities in the medium to long term.
5. **Exclusion:** these models would exclude the participation of members who are neither Foundation Trusts or NHS Trusts on an equal basis.

The various iterations of **charitable** governance were excluded, primarily due to a combination of the additional regulatory burden, the unlimited liability associated with some models and the constraints on commercial activities, which Alliance members wanted to be able to consider in the long term.

There are advantages of the **corporation limited by guarantee** which can act independently of the member decision making structures - within a clearly agreed and defined scope of activities - and which can as a legal entity enter into contracts, manage its own financial affairs which will make the operations of the business simpler, and once the entity is actively trading and anticipating the generation of surpluses for distribution to the members, then it is far easier to have a clear route to share financial benefits in a corporate entity.

External advice indicates that there is a cost in running the Alliance as a legal entity, but it is likely to be in scale with the activities flowing through it. Although at the initial stages a corporate form has not been necessary, it is more flexible in allowing for rapid development if opportunities such as bidding for research funding or taking on a particular activity which may require entering into contracts.

The governance of a company is being carefully constructed so as to ensure that members are clear what the remit of the company is, and the extent of collective controls over it. This is achieved through either the articles of association and ancillary governance agreements between the members.

2.6. Guarantees concerning taxation

In developing plans for its organisational form, external legal advice has been sought (**appendix 2**). The Alliance is being designed to ensure two things in relation to tax obligations:

i. Value for money: the Alliance will not be used as a vehicle for transacting finances on behalf of member organisations wherever it results in a new or additional tax burden which would otherwise not be the case were the finances transacted through a member organisation.

ii. HMRC compliance: the Alliance will not be used as a vehicle for transacting finances on behalf of member organisations wherever it creates a reduced tax burden compared to what would have been the case were the finances transacted through a member organisation.

2.7. System Alignment

Early steps have been set out in the design and operational functioning of the Alliance to ensure alignment and synergy with the North London ICB.

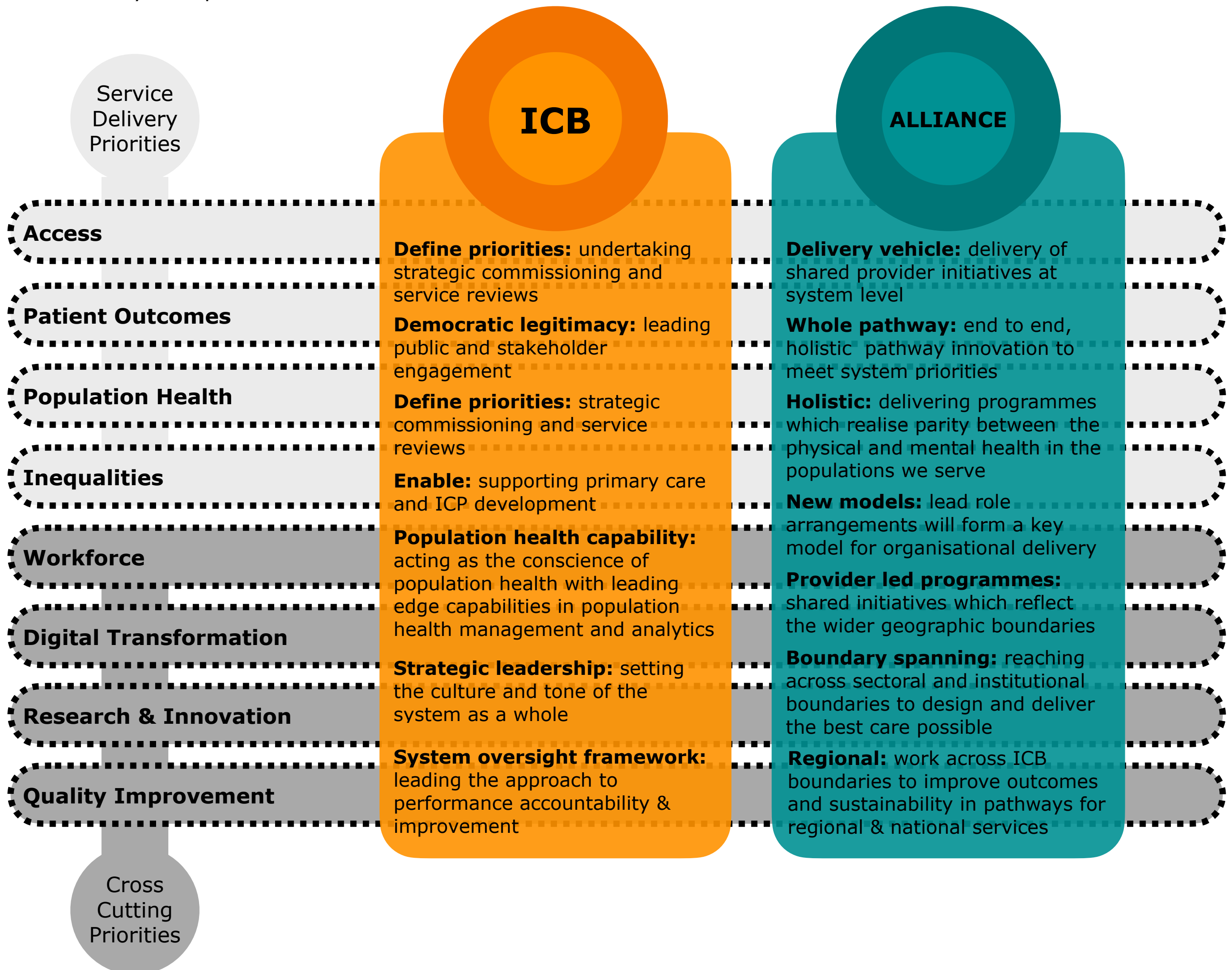
Design

Initial work to shape the Alliance in 2020 was led by Mike Cooke, now chair of the ICB. This included approval from member boards of an Alliance Charter (**appendix 3**), establishing principles for how the Alliance would be deigned to work. These enshrine an approach committed to collaboration. Early work also set out how the Alliance would function alongside the ICB.

The governance of meetings across the Alliance and ICB are also designed to synergise and avoid duplication. Arrangements include:

- **Representation:** of the ICB Accountable Officer on the Alliance Executive & Board and of the ICB Chair on the Alliance Board; of the Alliance on NCL System Management Board, Transition Board, NCL Elective Recovery Board, NCL ICB shadow board and on the new ICB Board as a partner member.
- **Integrated programme delivery:** with a harmonised approach to delivering Alliance programmes on waiting times and workforce, where there is a deliberate alignment with ICB priorities. Notable features include the role of a provider CEO in chairing the various meetings which comprise the NCL elective recovery programme; the establishment of a dedicated ICB PMO to support HVLC networks; the leading roles of provider clinicians and operational managers in HVLC networks. A similarly synergistic approach is being established across other priorities including workforce, community services and mental health.
- **Delivery vehicle:** collectively leaders across the ICB and provider community are developing the Alliance to be a core platform for delivering improvements which have been informed by work led by the ICB. Early examples include the role of the Alliance in delivering outputs resulting from the Community Services and Mental Health Services reviews, undertaken by the ICB.

Figure 3: how the UCL Health Alliance aligns with the North Central London ICB to deliver on system priorities



Understanding place based partnerships
The Alliance should function as a collaborative vehicle to support the effective integration of care at system level. This recognises that the default for most services will be for decision making concerning the optimal approach to vertical service integration and allocation of resources will be at place level and therefore guided by borough based Integrated Care Partnerships (ICPs), which the ICB is investing in establishing.

2.8. Board Assurance
The governance for providing regular board assurance comprises the following aspects:

i. **Routine reporting:** there will be a combination of monthly one page executive briefings which are circulated through CEOs and documented at the monthly executive meetings, as well as quarterly reports from the Managing Director to the Board of Directors.
ii. **Escalation:** the Managing Director is responsible for ensuring robust arrangements are in place for the timely escalation of risks or concerns to the Alliance Executive and where appropriate, to the full Board of Directors.
iii. **Participation:** there is a requirement for all members to contribute to the strategic and operational decision making, oversight and direction of the Alliance. This will happen through the mandatory attendance at a minimum number of Executive and Board of Director meetings over the course of the financial year as well as through participation in Alliance programmes which function as the primary driver of collaborative action. The role of Chief Executives in leading every Alliance programme is an important characteristic of how the Alliance operates, providing visible and accessible senior leadership to the communities across the Alliance membership who shape and deliver the shared priorities of members through the Alliance. This model also provides another mechanism for board level assurance by establishing a direct line of sight from board level leaders to programmes across the Alliance.
iv. **Control over the Alliance scope of activities and decision making powers:** through the chairs and chief executives, member organisations have direct control over the scope of activities and decision making power vested in the Alliance. Should there be a view that additional mechanisms are required to provide the right level of assurance to member boards, this will be within the purview of Alliance members to design and establish requisite changes to Alliance governance arrangements.
v. **Risk management:** the Managing Director will oversee the maintenance of the corporate risk register which will be reported to the Audit Committee, with risks above an agreed threshold featuring on the Board Assurance Framework, escalating to the Board of Directors.
vi. **Remuneration and appointments:** a Remuneration Committee will be responsible for all executive and non executive board level appointments to the Alliance.
vii. **Policies & Procedures:** at the agreement of the Alliance Executive, the Alliance will adopt and iterate a core suite of formal policies and procedures based on those of an existing member organisation. These will enable the Alliance to function according to governance practices which have been subject to significant scrutiny in their development and will address conflicts of interest, internal audit, counter fraud, standing financial instructions and the scheme of delegation.

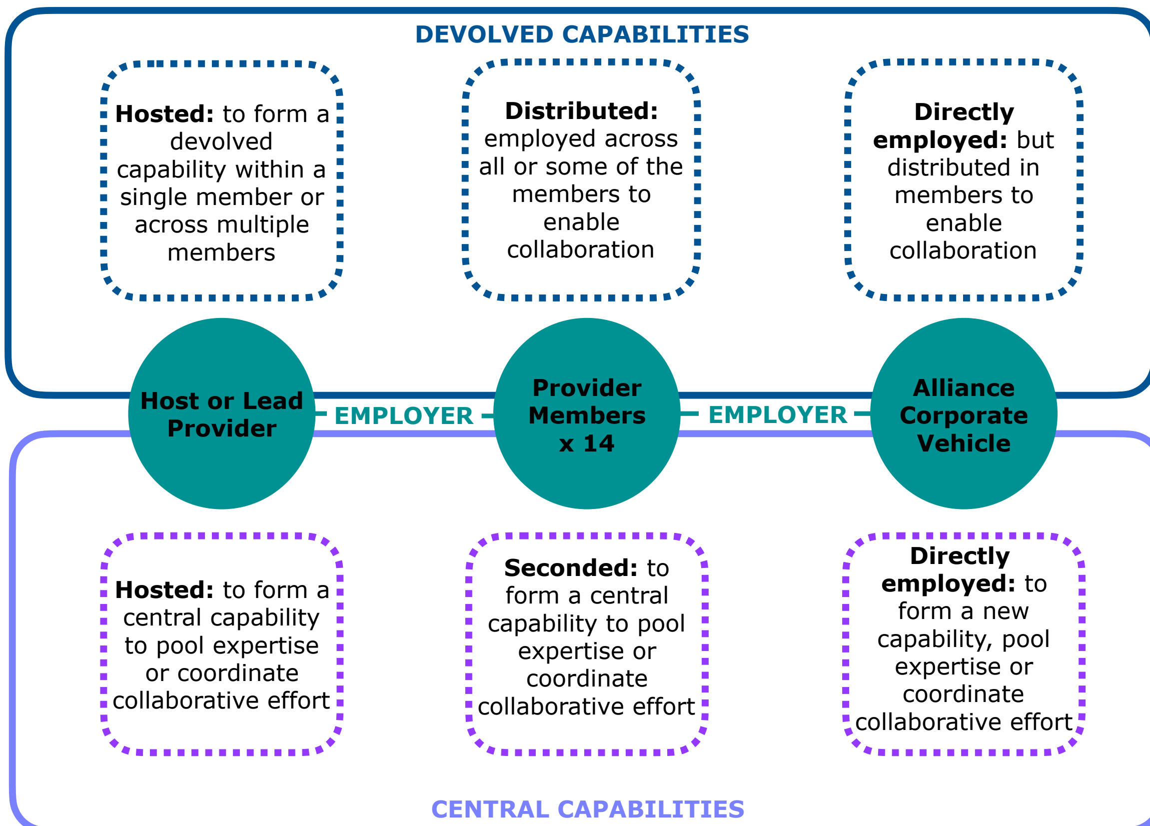
Additional information concerning the approach to board assurance is included in section 2.10 [board leadership], 2.11 [board decision making] and 2.15 [accountability arrangements] as well as section 3, concerning the Alliance delivery model. The Alliance model comprises the establishment of decision making, scrutiny and mutual accountability at both board level as well as in executive bodies.

2.9. Workforce Plan
There are no planned transfers of staff from the NHS into the Alliance Corporation. In order to deliver on shared priorities which have been delegated by members to the Alliance, the following workforce model will be deployed:

- **Distributed:** the Alliance is being set up to amplify the impact of provider members by strengthening what can be achieved through collaboration. It is therefore intended that much of the collective resource required for successful collaboration will be devolved within individual members, who will then function in new ways to deliver shared system level priorities. Examples of this approach include the dedication of clinical and operational management resource to ensure the effective delivery of clinical networks across the Alliance.
- **Seconded:** the Alliance will be able to second staff from within and beyond the membership, through a secondment agreement and financial recharge. In this approach, the member of staff remains an employee of their existing organisation and works for the Alliance under terms set out in the secondment agreement.
- **Hosted:** the Alliance will have the ability to employ staff through a lead provider or hosting model, whereby a member trust employs staff under standard NHS terms and conditions, with the contract of employment making it explicit that the member staff works for the Alliance. This is used extensively across the NHS for a variety of hosted functions, such as NIHR LCRNs and Cancer Alliances.
- **Directly employed:** the Alliance will have the ability to employ staff directly through contracts with the new corporate entity. This is expected to be relevant for some new roles created by providers through the Alliance. The model of employment will draw heavily on the established practices in use through UCLPartners. This approach includes the Alliance contracting people externally on a sessional or short term basis to establish a new or enhanced collective capability for delivering on shared priorities.

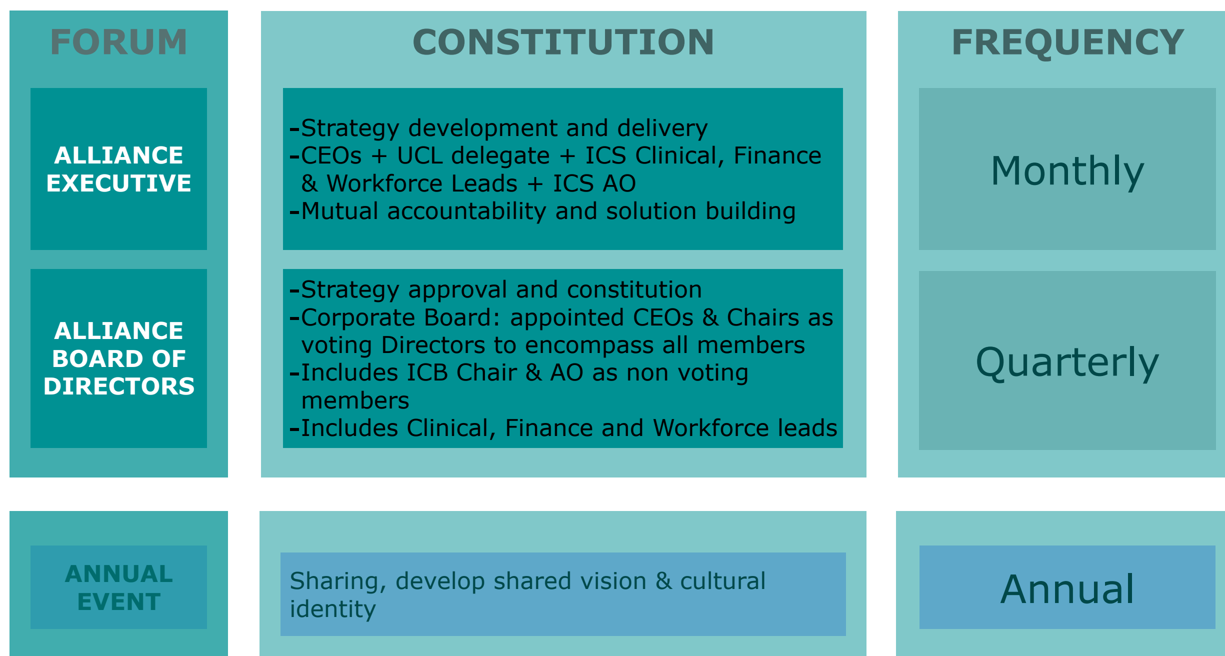
The intention is for the Alliance to operate primarily through the hosted and distributed models, with only the Chair being directly employed. Any changes to this would need to be agreed through the Board of Directors or through the annual business planning process.

Figure 4: Workforce resourcing model



2.10.Board leadership model
The principles of the current corporate board model will be carried through into the next iteration of the Alliance.

Figure 5: Meeting governance arrangements for the UCL Health Alliance



There is an intention to consider how the Annual General Meeting and Annual Event could be helpfully linked. This will be subject to the determination of the Board of Directors.

Non executive roles
The Alliance has been constituted to embed non executive functions as a feature of its governance and leadership arrangements. This is recognised best practice and is consistent with the models of governance within the NHS. Non executive leadership on the Alliance Board of Directors provides independence, impartiality, wide experience, special knowledge and personal qualities.

NEDs bring an independent judgement to bear on issues of strategy, performance and resources including key appointments and standards of conduct. They provide an independent view that is removed from day-to-day running. NEDs, then, are appointed to bring to the board:

- Strategy formation: provide a creative and informed contribution and to act as a constructive critic in looking at the objectives and plans devised by the chief executive and the executive team.
- Monitoring performance: responsibility for monitoring the performance of executive management, especially with regard to the progress made towards achieving the determined strategy and objectives.
- Remuneration: determining appropriate levels of remuneration of directors employed directly by the Alliance, specifically through the remuneration committee, the objective of which is to ensure there is an independent process for setting remuneration.
- Communication: connecting the Alliance and board with networks of potentially useful people and organisations.
- Risk: seeking assurance over the integrity of financial information and that financial controls and systems of risk management are robust and defensible.
- Audit: it is the duty of the whole board to ensure that the company accounts properly to its members by presenting a true and fair reflection of its actions and financial performance and

that the necessary internal control systems are put into place and monitored regularly and rigorously. An NED has an important part to play in fulfilling this responsibility, specifically through a formal audit committee (composed of NEDs) of the board which will bee constituted though the Alliance corporation.

The Alliance Chair is a role which is distinct from those of member chairs, providing valuable independent strategic leadership and experienced scrutiny of the Alliance.

2.11.Board decision making arrangements

Objectives
The planned decision making arrangements are set out in the Articles of Association for the new corporation. Given the emphasis on the corporate model providing a more effective vehicle for collective decision making, this is a particularly important aspect of the Alliance plans. Objectives of the decision making model are:

i. **Differentiate between constitutive and delivery decision:** establishing rules for unanimous approval concerning the constitution of the Alliance, including annual agreement of the scope of authority pooled within the Alliance; establishing rules for consensus based and majority decision making on determining the optimal approach to delivering.
ii. **Accelerate pace of delivery:** designing decision making governance to be both responsive to emerging priorities as well as providing a faster alternative to existing forms of decision making across large communities of providers.
iii. **Inculcate collective purpose rather than institutional interest:** whilst all members are required to participate on the board, their roles and portfolios are defined separate to their duties within their member institution.
iv. **Align with wider governance:** providing clarity regarding how decisions relate to wider governance at place, system and regional levels. This includes explicit acknowledgement over the need to ensure appropriate public consultation and the role of local authorities.

Determining scope of decision making powers
There is an explicit specification of deliverables intended for each financial year in the **annual business plan**. This is intended for member CEOs and Chairs to approve, using whatever internal governance arrangements are required by their organisations. Once a final business plan is approved, the Alliance Board of Directors is intended to have a licence to act and take decisions in order to deliver the approved business plan, notwithstanding the potential requirement for some decisions (such as those involving service reconfiguration) to be subject to approval by the ICB and potentially other bodies (such as overview and scrutiny committees).

Exclusions
The Alliance Executive have considered and agreed the explicit **exclusion** of items from the following list in the the formation of the Alliance corporation:
i. Prevent the Alliance taking on provision of **CQC licensed services**, for example through the employment of staff responsible for patient care or ownership of premises used for patient care, without first re-engaging with NHSE/I.
ii. Prevent the Alliance being used as a vehicle to **transact large contract values** for the provision of CQC licensed services, without first re-engaging with NHSE/I; this does not prevent the Alliance agreeing that a member can function as a lead provider to fulfil this purpose and is consistent with the NHSE/I guidance for collaboratives to consider governance models as not being mutually exclusive.
iii. Prevent the Alliance being used as a vehicle for **avoiding the incursion of taxes** (such as VAT) which would otherwise be born by member organisations.

Inclusions
The Alliance Executive have considered and agreed the explicit **inclusion** of items from the following list in the the formation of the Alliance corporation:
i. Ensure the powers enable the Alliance to take **binding decisions concerning the optimal configuration of service provision**, insofar as these are endorsed by the ICB / NHSE (for

specialised services) and are within the scope of deliverables set out in the annual Alliance Business Plan or otherwise agreed unanimously by members.

ii. Ensure the powers enable to Alliance to take binding decisions concerning the optimal **allocation of capital resources**, insofar as these are endorsed by the ICB and are within the scope of deliverables set out in the annual Alliance Business Plan or otherwise agreed unanimously by members. It is worth clarifying that this requires the explicit inclusion of capital within the scope of deliverables, which is not currently the case in the 2022/23 business plan. To change this mid year, or indeed in future years through the annual business planning process, would require unanimity from members.

iii. Ensure the powers enable the Alliance to agree the use of recognised **new care models, such as lead provider arrangements**, to achieve optimal provision of both patient facing and corporate services.

iv. Ensure the powers enable the Alliance to agree to the optimal usage of **finances** made available for **research** (eg. NIHR, Innovate UK, and charitable investment), **innovation** (eg. NHSE/I, Health Foundation), **education** (eg. HEE) and are able to function as the organisation responsible for financial administration of these resources, where it represents best value for the member organisations. These powers are circumscribed to what is set out in the 2022/23 business plan, detailed at programme plan level. For research, this limits the joint powers to (a) new funding that results from joint bids and (b) a subset of research funding which may be devolved to the Alliance to improve access across the North Central London geography. In the first year of the Alliance, the expectation is that the Board of Directors will chose to use hosting and lead provider models to hold contracts and transact resource, with the Alliance governance functioning to make decisions and manage delivery.

v. Recognise the role of the **annual business plan** in setting out the scope of objectives pertaining to research, education and patient care which members ascribe to the Alliance and do not require further processes for individual board level authorisations.

The scope of decisions is also linked to the voting arrangements through which the Alliance agree a specific course of action.

Designed to enable participation

The Articles of Association have been drafted to assert the decision making powers of the Alliance within the Board of Directors, which will be modelled on the current corporate board approach. This is important, as it enables organisations which are either not a legal entity (specifically the GP provider alliance), or face restrictions on their role in a corporate model (specifically, NHS Trusts) to participate in devision making on an equal basis to members who do not face these restrictions. Primary care and NHS Trusts will therefore have a role with equal decision making powers to those Directors who are also able to (and choose to) function as owners.

Dispute resolution

Any disputes within the Alliance will be approached through the spirit of collaboration, recognising that failing to work effectively together is to fail our staff and the populations we serve. The following steps are recognised as a reasonable path of escalating effort to reconcile major differences:

i. **Managing Director:** to function as the initial point of contact for members of the Alliance Executive, CEOs and Chairs in highlighting potential differences and acting early and swiftly to reach agreement.

ii. **Chair and Vice Chairs:** depending on the topic in question, the Chairs and Vice Chairs will function as a point of initial escalation from the Managing Director where there are issues which have the potential to endure or create a barrier to improving patient care.

iii. **External mediation:** where steps (i) and (ii) have not been successful in reconciling differences, there is an option for commissioning expert external mediation to support resolution.

In addition to these steps, there may be situations where it is appropriate to draw on expertise from the ICB or NHS England & Improvement to support dispute resolution. It is also worth reflecting, that should the Alliance reach a point where there are regular or major disputes between members, there will be a case for revisiting its strategy and potentially its constitution. Furthermore, the Articles of Association encompass the scenario of any member choosing to withdraw from the Alliance.

2.12.Funding model

The funding model for the Alliance is expected to comprise two elements: member subscriptions and funding from organisations outside the Alliance membership to establish a specific functional capability across member organisations or as a vehicle for members to deliver on an external contract specification.

Subscription

CEO programme leads have supported the annual business planning process (agreed at the 4 February Alliance Executive meeting), which will inform the resource requirement for 2022/23, along with the central corporate team (which will be set out by the Managing Director). Section 5 sets out the high level financial plan for 2022/23, with programme level business plans detailed in **appendix 5**. The financial detail is subject to a further review by NCL finance leads.

External funding (grants, commissions and devolved budgets)

The Alliance intends to act as a vehicle for securing external investment in **research**, **innovation, transformation** and **education**, which is expected to form a major aspect of the long term resourcing arrangements. There is also the option for the ICB or NHS England and Improvement to commission the Alliance to undertake specific programmes at work with the agreement of members. Whilst other provider collaboratives are already receiving substantial funding through work commissioned by their ICB as well as through the distribution of core programme funding from both CSUs and ICBs, this is not anticipated in North Central London.

2.13.Contingency arrangements for exit

In the process of establishing the Alliance, steps have been taken to enable members to leave without destabilising the wider collaboration. These include:

- **Exit process:** is established in the Articles of Association, detailing the steps a member organisation should undertake in order to withdraw from the Alliance. Section 6 of the Articles of Association includes the following provisions:

6. **PARTNERS AND MEMBERS**

6.4. Subject to all moneys presently payable by it to the Company pursuant to any rules or bye-laws made by the Directors pursuant to Article 26 or otherwise having been paid, a Partner may at any time resign from the Company by giving at least six months' notice in writing to the Company provided that after such resignation the number of Partners remaining is not less than two.

6.5. Partnership is not transferable and will terminate where:

6.5.1. the Partner ceases to exist or operate;

6.5.2. the Partner becomes insolvent, enters into receivership or administration or makes any arrangement or composition with its creditors generally; or

6.5.3. if all of the other Partners resolve that it is in the best interests of the Company to terminate such Partnership following a material breach by that Partner of the terms of these Articles or any agreement between the affected Partner and the Company and/or some or all of the Partners relating to the Company.

6.6. The liability of each of the Partners is limited to £1.

- **Ongoing collaboration:** even if a member chooses to withdraw from the Alliance, the duty to collaborate in service of patients and the population we collectively serve will remain. It is therefore a principle for the Alliance to sustain collaborative working relationships with any member having left the Alliance. This principle will be realised primarily through the ongoing involvement of all organisations in Alliance programmes. It would however not be possible to maintain any form of material decision making rights for departed members through the Alliance Executive of Board of Directors.
- **Winding up:** should the Alliance be no longer required as the vehicle for achieving collective action across providers at system level, there are clear provisions for winding up the corporate entity. Section 27 of the Articles of Association state:

27. WINDING UP

27.1. Every Partner of the Company undertakes to contribute £1 to the Company's assets, being the amount to which each Partner's liability is limited under Article 6.8, in the event that the Company be wound up while he is a Partner, or within one year after he ceases to be a Partner, for payment of the Company's debts and liabilities contracted before he ceases to be a Partner, and for the costs, charges and expenses of winding up, and for the adjustment of the rights of the contributories among themselves.

If upon the winding up or dissolution of the Company there remains, after the satisfaction of all its debts and liabilities, any property whatsoever, the same shall be paid to or distributed among the Partners of the Company, unless the Company be a registered charity in which case such property shall be given or transferred to some other charitable institution or institutions having objects similar to the Objects of the Company, and which shall prohibit the distribution of its or their income and property to an extent at least as great as is imposed on the Company under or by virtue of Article 5, such institution or institutions to be determined by the Partners of the Company at or before the time of dissolution, and if and so far as effect cannot be given to such provision, then to some other charitable object.

2.14. Future changes

There is an explicit requirement for the UCL Health Alliance to comply with national regulations. The choice to establish the governance of the Alliance as a corporation limited by guarantee means that there is a particular need for the Alliance to comply with NHS England and Improvement regulations concerning the formation of subsidiaries. The plans for the Alliance to launch in the 2022/23 financial year are therefore subject to formal authorisation of NHS England and Improvement.

It is important for Alliance members to understand that once authorised, the Alliance has permission to function within the scope of functions and scope set out in this business plan. Any decision from members to use the Alliance corporation as a vehicle for more material activities will therefore require further authorisation from NHS England and Improvement in compliance with national regulations concerning the activities of subsidiaries. Potential changes that would trigger prior authorisation from NHS England and Improvement include:

i. **Ownership:** changes which extend NHS ownership beyond Foundation Trusts to include NHS Trusts.
ii. **Non NHS roles:** changes to ownership, membership or inclusion on the Board of Directors of any non NHS bodies, with two exceptions
    i. UCL, as a founding university member of the Alliance.
    ii. The Alliance of GP Federations across North Central London as founding members of the Alliance.
iii. **Financial scope:** the deployment of the Alliance corporation as a vehicle for transacting NHS contracts for the provision of CQC licensed services.
iv. **Workforce:** the transfer of staff from NHS contracted employment to employment through the Alliance corporation or any material expansion in the number of staff directly employed by the new legal entity.
v. **Clinical services:** the deployment of the Alliance corporation as the legal entity responsible for the provision of CQC licensed services.

2.15.Accountability arrangements

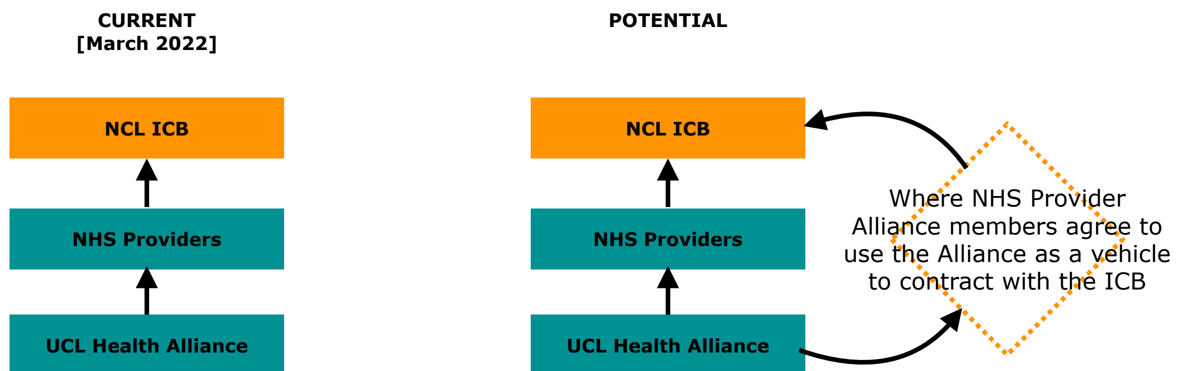
The Alliance Accountability Framework explains how members set the direction for the Alliance to underpin initial implementation of the priorities facing the NHS. These priorities are all derived from national priorities set out in the Operating Framework and Long Term Plan, as well as a wider spectrum of government policy in relation to research and life sciences.

Figure 6a: Defining scope of responsibility and accountability arrangements

Body or Organisation	Scope of Responsibilities	Line of Accountability
NHS Alliance member organisations	- Defined in trust constitutions - Specified in commissioning contracts - Subject to terms of CQC licence - Subject to NHS System Oversight Framework	- Board and Governors] - ICB for commissioned services - NIHR & Innovate UK for research
Alliance Board of Directors	- Defined in powers specified by member organisations - Scope of activity specified in annual business plan by member organisations - Potential to take on contracts at agreement of members, whereby responsibilities are set out under contract	- Member boards - Potential for accountability directly to other authorities where members agree to use the Alliance as the optimal vehicle for delivering services contracted by NHS commissioners or research funding bodies

MAIN BODIES HOLDING NHS PROVIDERS TO ACCOUNT	North Central London ICB	NHS England and Improvement	Care Quality Commission

Figure 6b: Line of accountability in relation to the ICS for NHS activities



Within the scope of this accountability framework it is useful to consider the arrangements for designing, deciding and delivering any major patient service changes. The role of the Alliance in this scenario is circumscribed to the development of options and recommendations concerning new care models, optimal clinical pathways and the case for change. Decisions concerning the commissioning of any new care models or clinical pathways will be the responsibility of the ICB for most NHS services, recognising retained duties within NHS England and Improvement for a spectrum of specialised services.

2.15 Launching the new corporation

Incorporation

- An application for incorporation may be undertaken on paper or electronically, either in person by the subscribers (i.e. those wishing to incorporate a company and become the initial partners) or by a formation agent on their behalf.
- Incorporation requires submission of a completed application form IN01 to the Registrar of Companies setting out the name, registered office, list of directors, company secretary (if any), members and class, value and rights attaching to shares) together with a £40 fee (or £100 for the "same-day" service for applications received by 3pm Monday to Friday) for paper applications and £10 (or £30 for the "same day" service) for electronic incorporations.
- A memorandum and articles of association must also be submitted to Companies House with form IN01 (if no articles are submitted, the company will be incorporated with "model articles").
- The members often enter into a members' agreement setting out the ways in which they will regulate the business of the company. This document is intended to be a private document and, if drafted correctly, does not need to be filed at Companies House. This enables the members to keep more "commercial" terms of their relationship confidential.
- The word "limited" can be removed from the corporate name of the company in certain circumstances.

Ongoing regulatory requirements for the corporation

- A company is subject to the regulation of the Registrar of Companies and must file with the Registrar:
    - its memorandum and articles of association;
    - its registered office address and any alternative location where its statutory registers may be inspected;
    - details of the directors, people with significant control over the company and any company secretary (if any);
    - the audited accounts (certain exemptions apply to this rule for smaller companies);
    - details of any charges registered against the company;
    - its confirmation statement; and
    - certain resolutions and other company forms.
- This disclosure of information will entail a level of public disclosure of the company's internal governance and performance.
- Details of the members (and any changes to the membership) do not need to be notified to Companies House on an annual basis.

Ownership and changes in ownership

- The company is not "owned" by members as such, because membership does not confer proprietary rights. It can exist with only one member. The members can exercise all rights detailed in the Companies Act 2006, articles of association and any members' agreement.
- Subject to the Companies Act 2006 and the terms of the articles / any members' agreement, new members can be admitted to membership of the company and existing members can cease to be members. However, membership is not "transferred" (as there is nothing to transfer; new members merely agree to provide the guarantee.
- The liability of a member – in that capacity – is limited to the value of its guarantee. Each member guarantees a nominal sum, to be paid to the company in the event of the company being wound up whilst the member is a member, or within one year of ceasing to be a member. A member of a CLG may have liability towards the company or third parties in other capacities.
- A member's guarantee in a CLG does not represent an investment as the guarantee represents a future liability; whilst the members of a CLG could in theory agree to "transfer the company" for value to a third party, a CLG is not a suitable vehicle if members ultimately want to exit and realise the value of the company.

Governance

- Most decisions are delegated to the board of directors. The default rule is that each organisation represented by a director has one vote, although there may be circumstances

where a director cannot vote (e.g. in relation to a conflict of interest). Directors may delegate some of their functions to other persons or committees if it is reasonable for them to do so.
- Directors owe duties to the company including under the Companies Act 2006 and at common law (e.g. in relation to confidentiality). They may also incur personal liability for the company's debts if they have been guilty of wrongdoing, such as wrongful or fraudulent trading.
- Some decisions are reserved to members through the Companies Act 2006 (e.g. adopting new articles), requiring either a special resolution (75% approval) or an ordinary resolution (simple majority approval) are passed by reference to the voting rights held by each member. The articles and any members' agreement may impose higher thresholds than the Act requires – for example, the shareholders may agree certain matters require their unanimous consent, rather than merely majority consent.
- In addition, the members will require additional control through the company's governance processes if the company is to be established as a "Teckal" company.

Funding
- As there is no shareholder, there is no ability to raise "equity" funding but equally no liability on members to contribute to the company's capital or rules surrounding the return of capital to members.
- The company can borrow, either from the members or third parties and may need to grant security for repayment of the debt.
- Any equity or debt funding provided by the members will need to comply with State aid rules.

Treatment of profit / surplus
- A CLG can make distributions of profit to members in accordance with members' rights under articles of association. If the articles do contain a provision prohibiting distributions or profit (which is common with CLGs), then profits/surpluses must only be utilised for the company's purposes.

Insolvency
- On liquidation members (or former members who have resigned within 12 months of liquidation) will have to contribute up to the value of their guarantee to the company for payment of debts and liabilities, costs and expenses of winding up and adjustment of the rights of contributories among themselves.
- Provisions of Insolvency Act 1986 apply and a company can enter into a moratorium, voluntary arrangement, administration or liquidation.
- If a company becomes insolvent or goes into liquidation, Directors may have to contribute to assets of the company if liable for misfeasance, fraudulent trading or wrongful trading (a director found guilty of fraudulent trading may also be imprisoned). Transactions which are classed as "preferences" and transactions at undervalue may be set aside.
- Directors have a duty to co-operate with the insolvency office holders and to prepare and file a statement of affairs and may be disqualified under the Company Directors Disqualification Act 1986 if:
  - they are convicted of an indictable offence in connection with the promotion, formation or management of a company (e.g. fraudulent trading);
  - they persistently breach companies legislation;
  - they are found guilty of fraudulent trading in the course of the winding up of a company; or
  - they are found to be "unfit" to be concerned in the management of a company.
- Surplus assets remaining after satisfaction of the liabilities can be paid to members.

2.16 Potential evolution of the Alliance

The governance of the Alliance has been established to enable accelerated delivery against system level priorities. It has also been designed with the intention that it can be iterated in future years as required by the members, with the agreement of the ICB and relevant approvals from NHS England and Improvement. Such changes are subject to unanimous approval by member organisations.

IMMEDIATE PRIORITIES ENABLED BY THE ALLIANCE	POTENTIAL LONG TERM PRIORITIES ENABLED BY THE ALLIANCE
What Objectives agreed by the Alliance Board in March 2022, underpinned by programme level business plans. **How** 1. Effective collective decision making: formal governance for agreeing action within the parameters set out in this business plan and the Articles of Association. 2. Platform for investment: agreeing value propositions for North Central London to secure external investment in transformation, innovation, research, training and education.	**What** Objectives agreed by the Alliance Board in in future years, underpinned by programme level business plans **How** In addition to the arrangements to deliver immediate priorities, the Alliance governance can be updated to enable: 1. Direct commissions from the ICB and NHSE/I 2. Provision of CQC licensed services 3. Provision of corporate services 4. Development of commercial capabilities and revenues, such as the commercialisation of intellectual property

2.17 Information Governance

The Alliance will not hold any patient information. All performance information concerning commissioned services will be within the governance of member organisations and the ICB. Staff working for the Alliance in programme and secretariat roles will be hosted by a member organisation and are therefore subject to the mandatory training and policies of their host employer.

2.18 Financial Control

Circumscribing the activities of the Alliance corporation has a material bearing on controlling financial risks to members and wider public sector. In particular:

- Employment: the intention is for only the Chair to be directly employed by the corporation. This significantly limits financial risk.
- Non pay budget: the projected non pay budget for the Alliance is £29k. Areas of expenditure covered by this include legal advisory services, costs relating to the registration and statutory requirements of operating as a corporation, non pay costs relating to staff working for the Alliance but hosted by member organisations and a small allocation for professional development of those staff.
- Transactional vehicle: the intention of the Board is to avoid using the corporation for transacting funds outside the scope of the non-pay budget. This restriction would apply to:
  - Direct commissioning: where the ICB or NHS England and Improvement decide to commission the Alliance of providers to deliver services as a collective; in this scenario, the Alliance corporation Board of Directors would be involved in the decision making process but any finances would be managed through an existing NHS member organisation functioning as a host or lead provider.
  - Grant awards: where funding is made available to members of the Alliance to deliver on transformation, research or education priorities as a collective; in this scenario, the Alliance corporation Board of Directors would be involved in the decision making process but any finances would be managed through an existing NHS member organisation functioning as a host or lead provider.

Should these arrangements change, they would be both subject to the unanimous approval of members and would trigger a resubmission to NHS England and Improvement under the subsidiary regulations.

2.19 Policies and Procedures to promote good governance

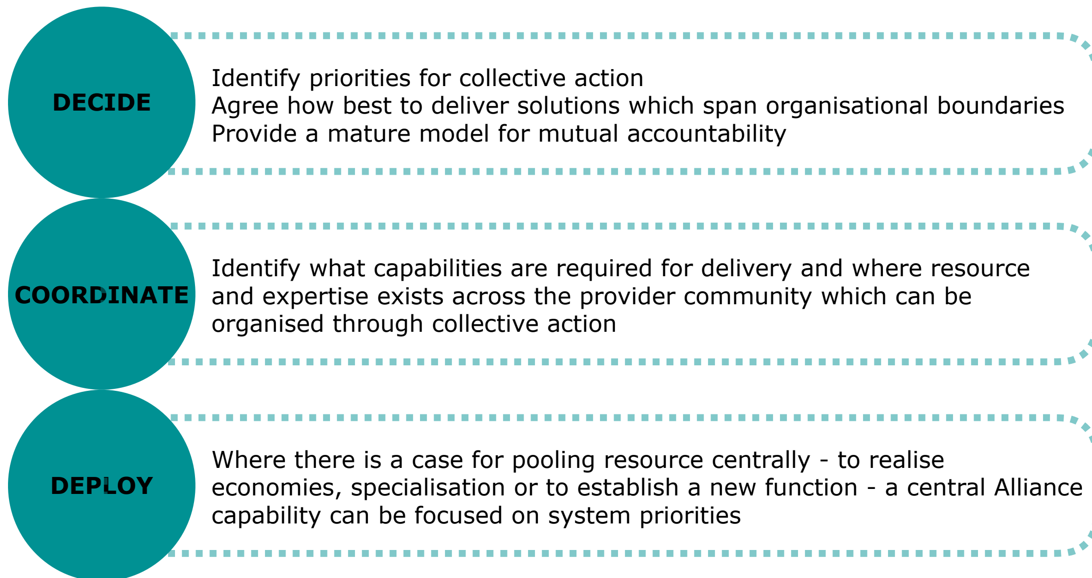
There exists a recognised spectrum of policies and procedures required for effective governance. The full spectrum of these policies and procedures is currently being specified and will be in place before the Alliance corporation is formed. There is an expectation for these policies and procedures to be derived from a combination of member organisations and from UCLPartners, given the parallels that exist with their corporate model.

3. PROGRAMME DEVELOPMENT & DELIVERY

3.1. Delivery model

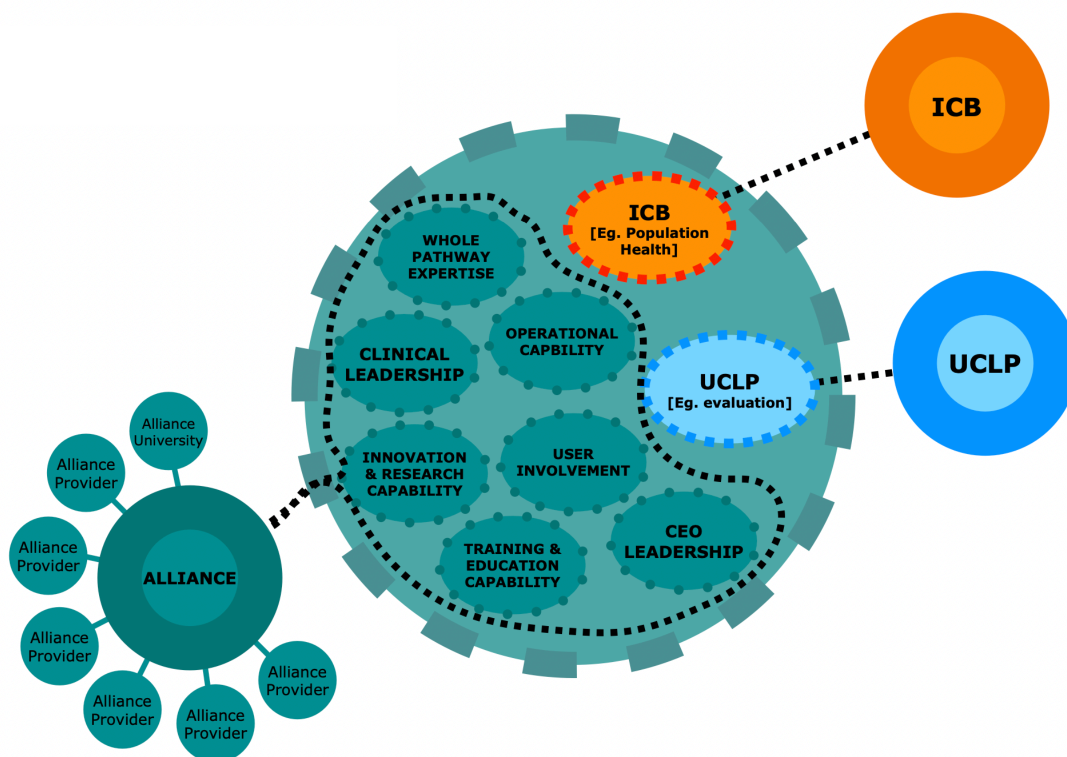
There are three different categories of collaborative action which can be undertaken through the Alliance.

Figure 7: Achieving impact through joint decisions, coordinating effort and pooling capabilities



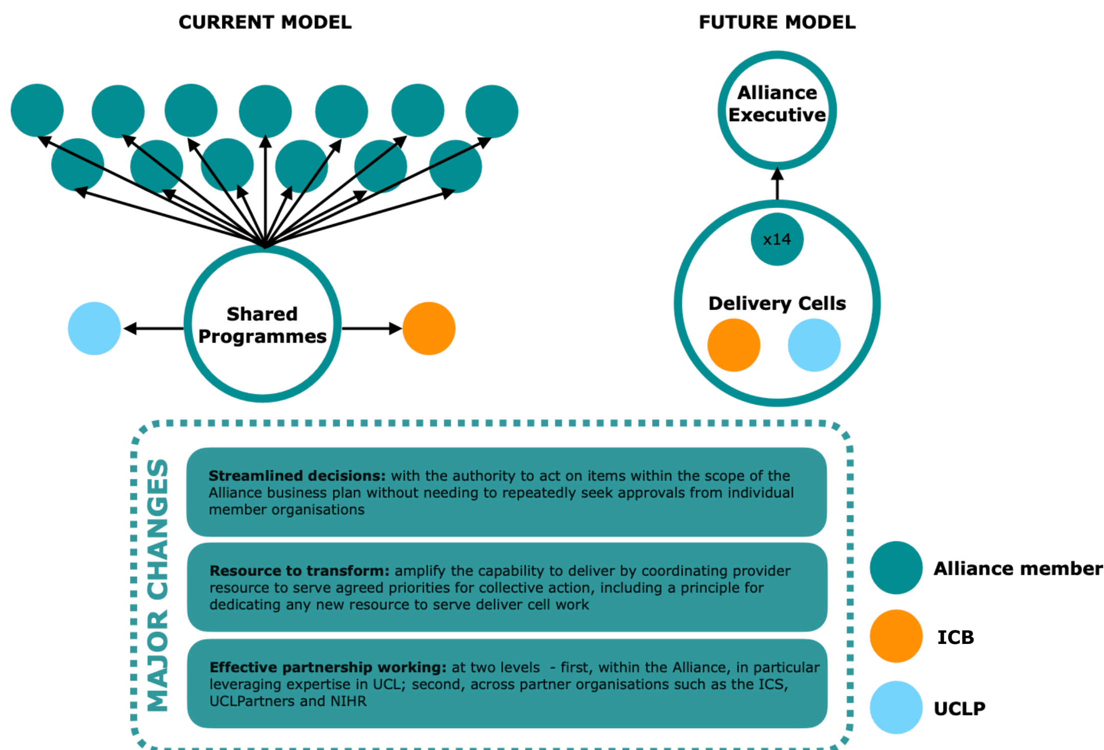
The principle model for undertaking collaborative action is through a variety of delivery cells, which are constituted to have a high degree of autonomy to direct and deliver improvement within the scope of the Alliance business plan.

Figure 8: Alliance Delivery Cell model



The delivery cell model, combined with the unanimous member authorisation of the Alliance business plan is intended to empower clinical and operational teams. The model is designed to accelerate pace of delivery by removing the need for multiple institutional levels of decision making approvals for those priorities which members have determined to be within scope of collective action through the Alliance governance arrangements.

Figure 9: Comparing current programme model with the Alliance delivery cell model



Principles for realising the potential of delivery cells as platforms for strategic and operational delivery have been set out as follows:

i. **CEO lead:** all delivery cells are led by a chief executive on behalf of the Alliance; where needed, CEO leadership bandwidth is amplified by the inclusion of lead directors from within the Alliance membership community.

ii. **Leveraging diverse capabilities:** the model has been designed to involve a greater plurality of organisations than has often been the case in programme delivery models. For example, all delivery cells will include provider and ICB expertise; most will include expertise from UCLPartners and UCL; some will include expertise from a wider community of organisations, such as the NIHR, London Ambulance Service or local government, depending on the scope of priorities which a delivery cell has been set up to address.

iii. **Lean supporting infrastructure:** the model is able to draw on cross cutting programme management and analytical capabilities depending on where they already exist in the system. For NCL, much of this supporting infrastructure is established through the ICB, with a relatively small input from the Alliance.

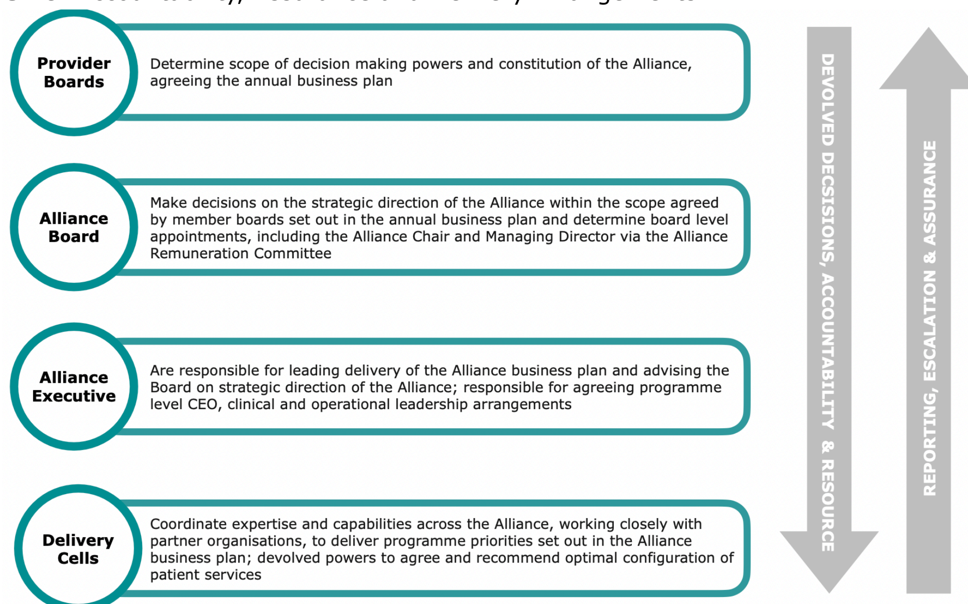
iv. **User and community involvement:** the Alliance leadership have been consistent in their determination to use the Alliance as a vehicle to strengthen the voice of users and community partners in the development of service strategies and approach to operational implementation. A new Alliance role focusing on community and user engagement will bring essential expertise to support delivery cells in their approach to this.

v. **Clinical and operational leadership:** all delivery cells will be clinically led, with the exception of those which focus on corporate priorities. In addition to this, delivery cells

will be populated by operational leaders for whom the Alliance will represent an efficient model for delivering against priorities which they face.

3.2 Performance and Accountability
The delivery cell model has an important position in the Alliance governance arrangements for delivering on priorities for collective action. Figure 7 illustrates the high level role of provider member boards, the Alliance Board, Alliance Executive and Delivery Cells in the Alliance model.

Figure 10: Accountability, Assurance and Delivery Arrangements



Establishing the right model and business processes relating to accountability arrangements has been discussed by the Alliance Executive. The following principles have been set out to guide the approach:

Alignment:
- avoid extra performance reporting;
- make use of existing governance arrangements (eg. through the ICB);
- make use of existing reporting and performance information

Mutual accountability:
- at delivery cell level, encouraging members to provide constructive challenge and jointly own the design and delivery of solutions.
- at Alliance executive level, between CEOs focusing on major strategic decisions or significant issues that have required escalation through CEO leads

These principles recognise that there already exists a substantial performance management architecture within the provider sector, which is embedded in the ICB performance management arrangements. The Alliance will avoid establishing a separate channel for performance reporting, making use of existing forums and performance information to shape decisions taken within the Alliance Executive and Board of Directors.

3.3 Agreeing Priorities for the Alliance
Identifying priorities for the Alliance will follow an annual business planning process, whereby the Alliance Executive, including the ICB leadership, agree the scope of priorities which necessitate collaboration between providers at system level. These priorities will be translated into objectives, with all delivery cell programmes having a CEO lead. Objectives for future years will be scrutinised and ratified by the Alliance Board of Directors, before authorisation of the business plan is sought by member boards and governing bodies.

The objectives for the first year of the Alliance have been developed using this model, with the Alliance Executive iterating priorities in January and February 2022, before the Alliance Board agreed final revisions before formally approving objectives at the March Board meeting. These objectives were then translated into programme level plans, specifying:

- Leadership arrangements: in particular the responsible CEO lead, clinical leads and operational leads.
- High level deliverables: to achieve within the coming 12-18 months.
- Benefits: which can be expected in four domains: (1) financial; (2) quality, safety and outcomes; (3) access and; (4) health and workforce inequalities.
- Resourcing arrangements: both those devolved within the member organisations as well as any central resource requirement.
- Governance: highlighting governance arrangements outside of the Alliance, such as into the ICB.

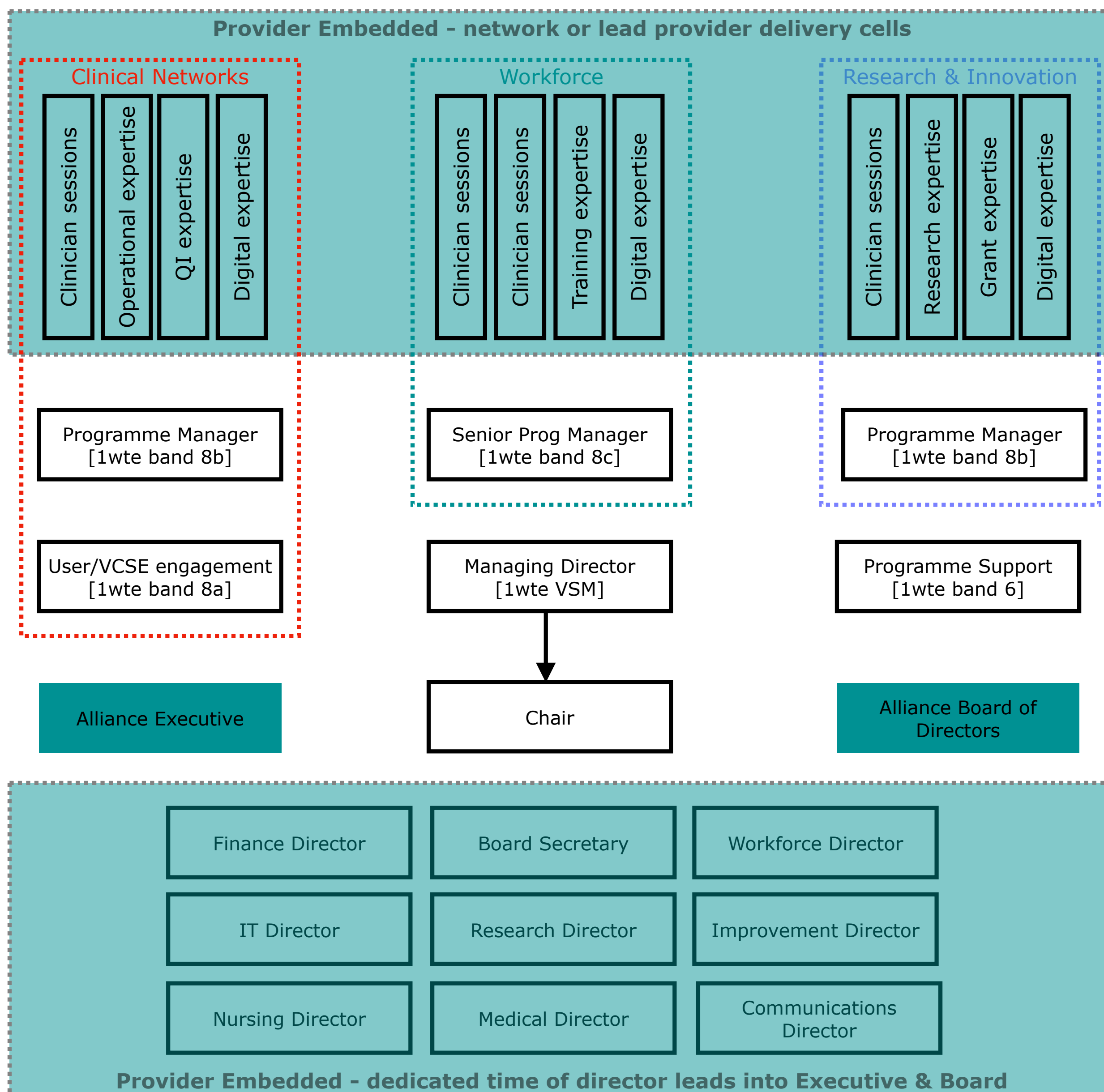
This process of prioritisation, programme level planning and approvals is an important feature for how the resource and workforce arrangements are determined. **Appendix 4** details the objectives that have been agreed by the UCL Health Alliance Board for the coming 12-18 months. **Appendix 5** includes the high level programme plans that have been set out by CEOs and delivery cell leads in each programme area.

The Alliance is being established to address priorities that providers and the ICB determine are best addressed at system level. For example, the ICB has recently published the community services review, setting out a spectrum of objectives to improve outcomes, address inequalities and financial sustainability. Provider CEOs and executives have been leading discussions to shape the approach to delivery. Within this, CEOs have agreed priorities for collective action, which include workstreams on data, virtual wards, P2 beds, children's community nursing, tissue viability and diabetes. Providers are working on collaboration to mobilise and deliver these shared projects under the structure of the Alliance, alongside transformation and PMO resource being made available via the ICB. Specific steps the Alliance has taken so far to achieve this alignment to accelerate delivery include:

- Explicitly including community services within its objectives
- Agreeing a CEO level lead for the Alliance leadership of this work
- Enabling delivery through the contribution from the physical and mental health programme manager and lead for community and service user involvement
- Updating the Alliance governance to ensure all community provider CEOs are represented on the Alliance Executive
- Emphasising the significance of community services in work to develop the Alliance's long term vision.

The integration of central Alliance capabilities with devolved provider capabilities is illustrated in figure 10.

Figure 11: Integration of devolved and central Alliance capabilities for delivery



Insights into the approach:

- **Director roles:** (1) feed into existing system level communities of directors; (2) opportunity for aspiring executives to undertake a role; (3) some directors will have a key role in major programmes (eg. workforce, improvement and research)
- **Programmes:** three broad programme areas used to structure work across the Alliance are clinical networks (eg. red cell and CAMHS); (2) workforce (focused on planning and the academy); and (3) research & innovation. Each area has central programme support with devolved resource (existing and new) to ensure collaborative working is resourced.
- **Cross cutting:** digital expertise cuts across all programmes (as could QI) given the ambitions for the Alliance to be the most digitally advanced collaborative in the UK.
- **User and community engagement:** dedicated expertise for clinical networks to engage service users and communities through VCSE organisations.

4. ALLIANCE COORDINATING FUNCTIONS

Establishing a provider collaborative demands the establishment of some core coordinating capabilities. The majority of these will apply regardless of the organisational form which is used for a provider collaborative. This section outlines which the categories of cost associated with the coordinating functions for the NCL provider collaborative, differentiating between those which apply regardless of the organisational form and those which are specific to the formation of a corporation limited by guarantee.

4.1. Deminimus costs for an Alliance

The absolute minimum level of resource required to undertake the functions of the UCL Health Alliance are:

i. Senior Leadership: a full time Managing Director and part time Chair.
ii. Alliance secretariat: roles to coordinate core business, including corporate governance and organisation of Alliance meetings.
iii. Delivery capabilities: reflecting programme strategies regarding the extent to which these capabilities are deployed through providers (for both existing and new resource) or are pooled at Alliance level. Based on development of other collaborations within NCL and insights from other provider collaboratives, there is a case for establishing a small Alliance capability focusing on programme delivery, encompassing a core skill set that aligns with Alliance priorities - such as quality improvement; digital transformation; adoption of innovation; education & training; and grant/business case development.
iv. Corporate functions: a relatively small amount of resource from across providers to ensure that provider collaboratives have effective corporate functions, including:
    i. Finance mangement
    ii. Human resources management, including recruitment, payroll and advisory functions
    iii. Communications expertise
    iv. Procurement capabilities
    v. Corporate governance, drawing from existing policies and provider expertise

These costs would be required regardless of the organisational form adopted by the Alliance - they are independent of the decision to pursue forming the Alliance as a corporation limited by guarantee.

4.2. Deminimus costs for a Corporation

Over and above the costs of managing a basic Alliance function, the following costs result in order to sustain the Alliance as a corporation limited by guarantee:

i. Company status: annual submissions to companies house
ii. Accounting: accountancy resource to prepare formal annual accounts and quarterly reports for the board of directors (10 days per year; existing member to take on the responsibility would be most cost effective, estimate at band 7 with senior sign off). It is worth noting that even this category of accounting costs does have an equivalent in other governance models, which regardless of status will require accountancy resource to ensure effective financial administration of resources within a provider collaborative.
iii. Audit: external audit to provide board members and external authorities with assurance over the governance of the corporation.
iv. Payroll: covering costs associated with remunerating the Chair, employed directly by the Alliance corporation.
v. Directors indemnity insurance: to protect directors and partners in the event that they stand accused of a wrongful act. The significant limits to the scope of the corporation provides a significant mitigation to this risk and the costs associated with this insurance.

5. FINANCIAL PLAN

Understanding the spectrum of resource dedicated to these programme priorities through the delivery cells is a work in progress. The existence of a significant infrastructure within the ICB geared towards enabling collaboration between NCL providers has an important bearing on how the UCL Health Alliance creates value. The current narrative distinguishing ICB and Alliance roles broadly emphasises the role of the ICB as the strategic commissioner, with notable responsibilities for transacting system finances and its role within the System Oversight Framework, whereas the UCL Health Alliance is being established to function as a delivery vehicle. Nonetheless, the reality is that the ICB is resourced to undertake programme management and analytical functions to improve collaboration between providers which extends across HVLC networks, workforce, community services, mental health services, corporate services, digital and diagnostics. The ICS governance arrangements are also established to promote collaboration between providers, involving a wide spectrum of leaders across the provider community.

The Alliance is being set up with the intention of leveraging new investment into the transformation of care, education and research in NCL. Resourcing opportunities for the Alliance include:

i. **North Thames NIHR LCRN:** scope for resource to support recruitment into research studies in less well resourced parts of the system.
ii. **Innovate UK:** position NCL as a system able to deliver government life sciences priorities in commercial clinical trials, the adoption of health and digital technology and the integration of genomics into preventative models and across patient pathways.
iii. **HEE:** secure devolution of resource to support the education and training agenda reflected in the Alliance workforce programme plan.
iv. **National transformation:** provide the most effective platform available for coordinating transformation efforts across NCL providers and serve as an efficient vehicle for any resource devolved by NHS England and Improvement.

Tables 1 and 2 provide details of the central Alliance capability required to support delivery. This would represent a total pay budget of £602k, equivalent to a cost of £43k per member organisation. In addition to this, there is an estimated requirement for a non pay budget of £29k, or £2k per member organisation. This takes the estimated cost per member to **£45k** per year. The following budget has been agreed through the UCL Health Alliance Executive, following a review of programme level plans at the April Alliance Executive meeting and is undergoing additional scrutiny through ICB and provider finance and performance leads.

Table 1: Core Alliance Team & Estimated Pay Budget

ROLE	Grade	WTE	Cost (incl on costs)	Cost per member
Chair	-	-	£60,000	£4,286
Managing Director	VSM	1	£145,966	£10,426
Senior Programme Manager	8c	1	£99,053	£7,075
Programme Manager	8b	1	£84,525	£6,038
Programme Manager	8b	1	£84,525	£6,038
User & Community Liaison	8a	1	£72,824	£5,202
Programme Administrator	6	1	£55,496	£3,964
TOTAL		**6**	**£602,389**	**£43,028**

Table 2: Core Alliance Non Pay Budget

COST CENTRE DESCRIPTION	Budget	Description
Annual event	£2,500	Venue and catering costs for Alliance annual event; minimise cost by using member facilities
Legal costs	£5,000	Based on costs for establishing the corporate vehicle of the Alliance; represents a non-recurrent spend
Audit costs	£3,000	Basic external audit of Alliance accounts.
Staff IT costs	£10,000	One off costs associated with laptops and enabling remote working
Staff mobile phone costs	£2,520	TBC whether this is required
Indemnity insurance	£3,000	TBC subject to quotes
Staff coaching and development	£3,000	TBC what members typically budget for staff development
TOTAL	**£29,020**	

A central principle to resourcing delivery through the Alliance and the spectrum of delivery cells is for this to provide the most effective model for providers to work together, and with partner organisations, to achieve impact against those priorities which are best addressed by working across NCL. The resource that provider organisations dedicate to collective action through the delivery cells is therefore the most important aspect of resourcing and will account for the largest quantum of resource. **Appendix 6** provides a qualitative overview of resource dedicated by member organisations to delivery through the Alliance.

Overview

Options for the organisational form considered in this paper are:

Option 0: Status quo - the Alliance exists as an informal collaboration with limited collective delivery capabilities.
Option 1: Joint Committees or Committee in Common - trusts form common committees that could exercise functions and jointly take decisions that have been delegated by their individual organisations, in line with their schemes of delegation.
Option 2: Joint Committee - subject to legislation, trusts form joint committees that could exercise functions and jointly take decisions that have been delegated by their individual organisations, in line with their schemes of delegation.
Option 3: Company Limited by Guarantee (CLG) - registered at Companies House with articles of association which determine the nature of the company.

Evaluation Criteria

The following criteria are used to evaluate each option.
Criteria 1: Exclusion - does the form exclude participation of any existing member?
Criteria 2: Costs - what are the set up and running costs associated with each option?
Criteria 3: Regulatory - what regulatory implications are there for existing regulatory relationships and what are the implications of new regulatory requirements of each form?
Criteria 4: Workforce - how does the option secure required human resources and what costs and benefits are there to the workforce model?
Criteria 5: Accounting - what accounting implications are there for the Alliance?
Criteria 6: Risks - what are the risks associated with each option?
Criteria 7: Benefit realisation - how effectively does the organisational form enable delivery against the agreed and anticipated priorities of the Alliance?
Criteria 8: Identity - how effective is the option in establishing an identity which all members of the Alliance feel they can engage under as equals and a vehicle which can enter into contracts with commissioning organisations (eg. ICS, NHSEngland, NIHR and HEE)?

QUALITATIVE EVALUATION

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
1. Exclusion	All organisations can participate in the current model of collaboration, which does not include any formally binding governance.	All organisations can be signatories of the MOU setting out how members work together under the Provider Collaborative. The model excludes both primary care and UCL as members in their own right, although representatives can be appointed to the committee.	All organisations can be signatories of the MOU setting out how members work together under the Provider Collaborative. Foundation Trust involvement in Joint Committee model is subject to the legislation currently passing through Parliament. The model excludes both primary care and UCL as members in their own right, although representatives can be appointed to the committee.	All organisations can be voting directors of the corporation. Not all organisations will be able to function as partners, due to the requirement to exist as a legal entity and potential constraints on NHS Trusts. An ancillary agreement between the members can cater for organisations which are not currently able become members of the organisation.

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
2. Costs	Running costs in the current model will be capped at a low level as the scope for meaningful collaboration is limited in scope and depth. Whilst the costs are minimal, the benefits are also negligible and the major challenges facing the NHS will be unresolved.	Running costs for a Committee in Common, driven primarily by the additional costs of executive time required in Committee in Common model from every organisation being represented. The hosting organisation will also incur additional finance and human resources costs in transacting Alliance business on behalf of members. Legal costs would be of a similar order of magnitude to options 2 and 3.	Running costs for a Joint Committee, driven primarily by the additional costs of executive time required in Joint Committee model from every organisation being represented. The hosting organisation will also incur additional finance and human resources costs in transacting Alliance business on behalf of members. Legal costs would be incurred for both options.	Higher set up costs higher for corporation due to administration of setting up company as well as separate audit and accounting. Legal costs would be incurred for both options.
3. Regulatory	There are no new regulatory requirements. The failure to establish a formal model for provider collaboration would be a justifiable cause of concern for how the CQC would evaluate well led aspects under the current regulatory regime.	There are no new regulatory requirements resulting from a joint committee or committee in common arrangement. The effectiveness of this model for decision making across a collaboration of 14 organisations may raise questions over organisational effectiveness.	There are no new regulatory requirements resulting from a joint committee or committee in common arrangement. The effectiveness of this model for decision making across a collaboration of 14 organisations may raise questions over organisational effectiveness.	Current proposals for the Alliance would not require separate registration with the CQC, although this may be required in future should directors decide to use the Alliance as a vehicle for providing registered services. The corporation would need to comply with company law and ensure compliance with HMRC requirements. The model presents a robust approach to system leadership across the provider sector.
4. Workforce	The Managing Director and Chair would continue to be hosted by member organisations, although without plans to establish a formal provider collaborative, there would need to be consideration over the purpose of these and any additional roles.	Staff working for the Alliance will need to be hosted by member organisation as the committee in common is not a legal entity with the ability to employ or contract with staff directly.	Staff working for the Alliance will need to be hosted by member organisation as the joint committee is not a legal entity with the ability to employ or contract with staff directly.	Staff can be employed directly or through member organisations; additional considerations exist under the direct employment model concerning terms and conditions, pension and apprenticeship levy would need to be resolved.

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
5. Accounting	There are no accounts under the current model of informal joint working.	Accounting function hosted by member organisation and reports through annual NHS reporting arrangements. Limitations on carry forward between financial years and application of CDEL.	Accounting function hosted by member organisation and reports through annual NHS reporting arrangements. Limitations on carry forward between financial years and application of CDEL.	Accounts submitted to companies house and HMRC. Potential to create mechanisms for carrying forward income generated across financial years and to create a vehicle for investing in capital infrastructure, where funds are not from within the public sector. The Alliance is receiving further advice on tax considerations; there are recognised issues arising from VAT in that the company will not be a group company of any NHS body, and is likely to need separate VAT registration and there are likely to be issues over VAT charges on services back to members, and also the risk of members losing Contracted Out services exemptions if the corporation takes on NHS contracts and subcontracts to the Trusts as was identified in the Uniting Care LLP case in Cambridgeshire.

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
6. Risks	This option represents an unacceptable level of risk concerning failure to deliver priorities which either necessitate or would benefit from collaboration at system level between provider organisations.	A committee in common is likely to prove unmanageable for a provider collaborative comprising 14 members, with challenges set out in **appendix 5**.	A joint committee (subject to passing of legislation) would still present risks concerning the role of NEDs and the lack of clarity over accountability for decisions and subsequent actions from a joint committee. Further information is provider in **appendix 5**.	This model requires the authorisation of NHSE/I under their subsidiaries approval requirement. Steps have been taken to understand the detail of this process, including assurance requirements and the expected timescales for completing it. Liability to members is limited by guarantee. This model would require effective communication with a wide range of stakeholder to ensure its purpose is not misunderstood (eg. explicitly not as a vehicle for privatisation, set out in appendix 5).
7. Benefits realisation	This option fails to provide a credible route for delivering benefits associated with priorities which either necessitate or would benefit from collaboration at system level between provider organisations.	Legislative requirements concerning committees in common are administratively unwieldy, requiring committees to be held in a particular way. The pace of decision making and resulting action and impact for patient, population and staff benefit, may reasonably be considered to take more time under this model.	Legislation may simplify current complexities which prevent Foundation Trusts operating joint committees, but these too are unwieldy, requiring representation from all organisations to be quorate. The pace of decision making and resulting action and impact for patient, population and staff benefit, may reasonably be considered to take more time under this model.	In order for the corporation to function with authority and pace, there is a need to set out clearly in the articles of association / objects which items of decision making will require further authorisation from constituent owner/member boards. The corporation should aim to function without recourse to member organisation boards within a clear scheme of delegation, a business plan and agreed financial envelope.

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
8. Identity	The current arrangements depend on the historic model of providers operating with single institutional identities, which is reflected in both the culture of the NHS and in the regulatory arrangements that will exist for holding the provider sector to account for delivery.	Model requires financial and employment responsibilities to be hosted by a member organisation, presenting questions over whether the Alliance is a truly shared identity of equals. The Alliance Board has already been established as a corporate model, with members explicitly choosing to pursue this rather than a representative board. Committees in Common predicate a model based on representation of member organisations. This model carries a further challenge relating to clarity of accountability, as it is not an entity which can be held directly to account by NHS commissioners and regulators; accountability would be discharged directly to individual organisations.	Model requires financial and employment responsibilities to be hosted by a member organisation, presenting questions over whether the Alliance is a truly shared identity of equals. The Alliance Board has already been established as a corporate model, with members explicitly choosing to pursue this rather than a representative board. Joint Committees predicate a model based on representation of member organisations. This model carries a further challenge relating to clarity of accountability, as it is not an entity which can be held directly to account by NHS commissioners and regulators; accountability would be discharged directly to individual organisations.	Corporation is a distinct legal entity through which Alliance members will collaborate. This allows a new shared identity which does not require individual members to host different functions on behalf of the wider Alliance, such as employment, contracting for bids and management of Alliance finances. The model carries a potential benefit in offering a clear route for commissioning bodies to hold it to account.

QUANTITATIVE EVALUATION

CRITERIA	Option 0: Status Quo	Option 1: Committee in Common	OPTION 2: Joint Committee	OPTION 3: Corporation Limited by Guarantee
1. Exclusion	5	0	0	5
2. Costs	5	4	4	3
3. Regulatory	1	3	3	3
4. Workforce	1	4	4	4
5. Accounting	5	3	3	2
6. Risks	0	3	3	4
7. Benefits realisation	0	4	4	5
8. Identity	1	2	2	5
TOTAL	**18**	**23**	**23**	**29**

0 = Option represents a critical level of failure or insoluble problems in relation to the evaluation criteria
1 = Option presents significant challenges in relation to the evaluation criteria, which may reasonably persist in the long term
2 = Option presents challenges which are either moderate in their impact or are expected to be short term in their nature
3 = Option presents limited costs or benefits in relation to the criteria in question
4 = Option presents benefits which are either moderate in their impact or are expected to be short term in their nature
5 = Option presents significant opportunities and expected benefits in relation to the evaluation criteria, which may reasonably be sustained in the long term

DISCUSSION

Plurality of organisations

The UCL Health Alliance brings together a broad spectrum of organisations as formal members:

- NHS Trusts
- NHS Foundation Trusts
- GP practices collaborating through the GP Provider Alliance (which is not a legal entity), which are also members of GP Federations (which are legal entities).
- University College London

The regulatory arrangements under which these different organisations operate needs to be factored into decision making over the optimal organisational vehicle for driving delivery of collaborative objectives.

A corporation limited by guarantee provides an option for organisations who either are not legal entities or choose not to be members / owners to be involved as directors in the company. This may be most of all relevant for the GP Provider Alliance (which is not constituted as a legal entity) and NHS Trusts (which are subject to different rules regarding corporation ownership compared to Foundation Trusts).

In addition to formal members, the Alliance has specified a commitment to close partnership working with two other organisations:

- North Central London ICB (with the ICB to be formally constituted from July 2022)
- UCLPartners (a company limited by guarantee bringing together a spectrum of partners from NHS and university sectors across multiple ICB geographies)

Complexity relating to committees in common

There are two types of committee in common:[1] an advisory committee and a decision making committee. The Alliance would require a decision making committee in order to discharge the range of its intended functions.

Decision making committees in common take decisions for the member organisations. This encompasses committees that take irreversible decisions, those taking decisions that can be overturned by member organisations and those where decisions have to be subsequently “ratified” by the member organisations.

Each organisation’s decision is taken by its own representatives. The appointment of the organisation’s representatives - and the way in which the representatives take decisions - must comply with that organisation’s internal governance structure and the terms on which they have delegated authority to those who represent them at the committee’s meetings.

The rules about delegation are different for different types of organisation. For **NHS Trusts**, under the usual NHS Trust Standing Orders, the Board of the Trust can delegate its authority to a committee, to an executive director or an employee of the Trust. For **Foundation Trusts**, the board can delegate its authority to a committee of directors or an individual executive director (but not to an employee who is not a director of the FT). An FT can not change its constitution to allow decision-making to be delegated to a non-executive director or an employee (including a “non-voting director”), because the NHS Act does not allow that.

[1] https://www.mills-reeve.com/insights/legal-publications/operating-effective-committees-in-common

Within a committee in common, each organisation takes its own decisions. This means, for example, that the representative of an NHS Trust or an NHS Foundation Trust at a decision-making committee in common cannot be the Chairman or another non-executive director, although a duly constituted and authorised committee of the Trust consisting entirely of Non-Executive Directors could take the decision. This has a number of practical consequences:

i. **Delegates:** it is necessary to check that the delegate has the authority to take the decisions they are required to take.
ii. **Quoracy:** needs to be understood for each of the member organisations. It is meaningless to suggest that a committee in common is quorate and able to take decisions for all of the organisations if one or more of the organisations is not represented at the required level or is not itself quorate (for example, if the organisation has decided to delegate internally to a committee rather than an individual). Put simply, if an organisation is not represented at the required level or at all, it is not possible for others to take a decision for that organisation. This means provision for substitutes needs to happen at authorisation level, as well as at committee level. The committee in common terms of reference need to state that organisations can send substitutes; member organisation's internal delegation also needs to make provision for that.
iii. **Unanimous decision making:** an organisation cannot be outvoted on a committee in common. Each represented organisation takes its decisions, separately – so essentially this translates into unanimity or nothing. If an organisation's delegate abstains then that organisation has not taken any decision at all.
iv. **Responsibility:** responsibility for the decisions taken by each organisation lies with its delegates. Therefore, organisations should choose their delegates with care.

The consequences of procedural errors within these governance arrangements can be serious, including legal challenge to decisions. There can be internal issues too. For example, an organisation may take its decision in the mistaken belief that other organisations have bound themselves to the same decision. This is why it is important for each participating member organisations to understand both their own delegation, as well as the delegation of the other organisations on the committee in common. To add to the difficulty, actions cannot be justified by a decision that hasn't been taken. Furthermore, the work of committees in common is often public and potentially contentious. The complexity of orchestrating committees in common across fourteen member organisations could generate regulatory concern over the organisational abilities of the Alliance and participating members.

Complexities associated with Joint Committees

Joint committees may provide another form of structure for integration and collaboration, helping to accelerate system working, and for organisations to pool their sovereignty. In a joint committee, each organisation would nominate its representative member(s) and the committee would have delegated authority to make binding decisions on behalf of each of the Alliance members. It requires Alliance members to reflect this in their internal governance arrangements to allow this delegated authority to take place.

Generally, within the NHS to date, decision making through joint committees has been encouraged to take place by consensus. It is however possible to set out eligibility, voting and casting vote arrangements in order to achieve decisions by a majority vote.

It is already possible for NHS Trusts (but not for Foundation Trusts) to establish joint committees and delegate accountabilities; Foundation Trusts will only be able to pursue this option subject to the passing of legislation, expected in 2022.[2] The draft health and care bill also indicates the intent for NHS

[2] The current draft of the Health and Care Bill (accessed 12 January 2022) includes a new provision for Foundation Trusts: "47A Joint exercise of functions. An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person."

England to publish guidance for Trusts, Foundation Trusts and other relevant bodies about the exercise of their powers under a joint committee. This would mean that some of the current legal requirements necessitating the use of committees in common to make aligned (rather than joint) decisions will no longer be applicable.

The joint committee option carries its own complexities. NHS Providers have set out a range of observations relating to the governance of joint committees:[3]

i. **Accountability:** Joint committees can cloud which entity has ultimate power and accountability, potentially setting up rival sources of authority – in the case of providers, the joint committee or the trust board. This becomes particularly important when the joint committee makes decisions with which the unitary trust board might disagree. Given the considerable risk managed by NHS Trusts and Foundation Trusts, and in combination with the lack of clarity over how responsibilities are held, this presents a pressure on collective board responsibility and accountability. In the worst case scenario, how would a patient be able to pursue any given claim where a provider or commissioner points to a joint committee as the decision making body responsible for the harm described? That committee does not hold accountability, and yet the providers within the Joint Committee may have been bound to a decision not of their making, and is now answerable for it. Patients may find themselves in a grey area, while the relevant boards may find themselves liable for factors outside their reasonable control. This is an inadequate situation for all concerned and must be properly addressed.

ii. **Non-executive directors (NEDs):** are not mentioned as part of legislation. Depending on how the joint committee is constituted, the participants in the decision making can be very different from that of a board, diluting the power and effectiveness of a full unitary board. A joint committee is often composed of executive directors and, sometimes, a single non-executive participant or an independent chair. This does not create the balance or challenge of a full complement of NEDs, and is very different, and potentially significantly less robust, from having ultimate decision-making power clearly resting with a full unitary board. NEDs provide valuable challenge and assure robust decision making. The value of NEDs is recognised – and has been consistently strengthened over time – within the governance codes for the private sector, and NHS Providers encourage the same within the NHS. Their role should be maintained within trusts and included within joint committees.

A challenge relating to both joint committees and committees in common is that they are fundamentally geared to the functioning of provider collaboratives as **representative bodies**. The UCL Health Alliance has already determined that its board should function as a **corporate board**, providing parity across the system to mental health, primary care, community care, acute services, specialised care and academic health.

[3] https://nhsproviders.org/media/643924/nhs-providers-response-to-nhs-legislation-engagement-document-april-2019-final.pdf

2. APPENDIX: External tax advice

Private & Confidential
Subject to legal privilege

UCL HEALTH ALLIANCE – NOTE RE VAT
ROYAL FREE LONDON NHS TRUST

1. BACKGROUND AND ADVICE REQUESTED

1.1. The following list of organisations ('the Members') are looking to establish a corporate vehicle ('the Provider') to act as their provider alliance:

1.1.1. Barnet Enfield and Haringey Mental Health NHS Trust

1.1.2. Camden & Islington Mental Health NHS Foundation Trust

1.1.3. Tavistock & Portman NHS Foundation Trust

1.1.4. Central & North West London NHS Foundation Trust

1.1.5. Central London Community Healthcare NHS Trust

1.1.6. Moorfields Eye Hospital NHS Foundation Trust

1.1.7. Great Ormond Street Hospital NHS Foundation Trust

1.1.8. Royal National Orthopaedic Hospital NHS Trust

1.1.9. NCL GP Provider Alliance

1.1.10. University College London NHS Foundation Trust

1.1.11. Royal Free London NHS Foundation Trust

1.1.12. Whittington Health NHS Trust

1.1.13. North Middlesex University Hospital NHS Trust

1.1.14. University College London

1.2. The entity is expected to provide some services to Members – back office services, and may in the medium term want to provide some clinical services such as new diagnostic services, or potentially private health services, and also some carrying out of functions including spreading best practice, and contributing to planning of service development. It anticipates employing some staff.

1.3. The questions to be answered are:

1.3.1. Given that NHS bodies do not pay corporation tax on mainstream activities, would they be able to avoid tax on profits generated from trading activity of the Provider?

1.3.2. If the Provider is providing back office services back to the Members does that attract VAT?

1.3.3. If at least one member is a body jointly owned by GPs, would that mean that provision of services to the GPs would need to be treated differently?

1.3.4. Is the problem identified in relation to a joint venture scheme in Cambridgeshire between two trusts and UnitingCare Partnership relevant in this situation? Would it only apply in relation to the Provider being contracted to provide clinical services by the CCG/ Integrated Care board?

1.4. The note below provides a high level overview based on the above information. The advice below has been set out by Ross Birkbeck, a specialist Tax Counsel from Old Square Tax Chambers who has been engaged by Bevan Brittan LLP to provide the required tax advice.

2. CORPORATION TAX TREATMENT

2.1. The exemption from corporation tax for ‘health service bodies’ in section 985 CTA 2010 is not conditional, nor limited. They are simply outside its scope, and not liable to corporation tax at all. So any profits or dividends derived from the Provider will be exempt from corporation tax.

2.2. In some cases they can be liable to income tax, but none are relevant here.

3. VAT ON BACK OFFICE SERVICES

3.1. Back office services supplied by the Provider to the Members are *prima facie* supplies in the course of a business for VAT purposes, and therefore subject to VAT.

3.2. However, the Members will be able to claim a refund of any VAT paid on these supplies under section 41 VATA 1994 and Heading 45 of the Contracted Out Services (‘COS’) regime if they fall within the list of qualifying bodies (see VATGPB9720). This includes NHS Trusts and NHS Foundation Trusts, but not the University or the GP Alliance.

3.3. This means that whilst the Provider would not have to treat the GP Alliance differently to the other Members – all would be charged VAT on the services - the GP Alliance (and University) would not get the same VAT treatment, and would effectively be paying more for the services (this assumes that they could not reclaim the VAT because the services were being used for exempt medical or educational supplies under Schedule 9 Groups 6 & 7 VATA).

3.4. I note that goods supplied to the Members, if any (IT equipment provided by the Provider, perhaps), are not covered by COS 45, and so no refund can be claimed in relation to them unless they are used for non-exempt supplies or bound up with a supply of services. However, the latter situation is probably more likely than not, so this is of small concern.

4. UNITINGCARE PARTNERSHIP

4.1. The issue in the UnitingCare Partnership (‘UCP’) situation was as follows:

4.1.1. NHS organisations make use of divisional VAT registration, which means that they do not need to charge VAT on supplies to most other NHS bodies.

4.1.2. When the Trusts in the UCP case outsourced the supply of services to UCP, this involved the supply *to* UCP of many services by other NHS bodies which would previously have been supplied direct to the Trusts. Once redirected in this way, the supplies became subject to VAT, and furthermore UCP was not able to reclaim this VAT because it was making exempt supplies of medical services and not covered by the COS regime.

4.1.3. The Trusts and UCP had failed to account for this additional VAT liability.

4.2. This issue is unlikely to be an issue here because:

4.2.1. It is not anticipated that the Provider will be buying in significant services from NHS bodies; and

4.2.2. The Provider is not currently planning to make exempt supplies of medical services, but standard rated supplies of back office services, research services etc, and so will be able to reclaim VAT it is charged.

4.3. However, certain possible uses of the Provider could put it in a ‘UCP’ position, e.g:

4.3.1. Supplies of educational services, where it is hiring in the trainers from NHS bodies;

4.3.2. Supplies of clinical services where it is buying in resources from NHS bodies.

4.4. In these cases it will be necessary to properly account for and fund the VAT liability (this was the error for UCP), and in may be the case that it is more efficient to keep these services in house.

4.5. If there are any queries in respect of this note then please don’t hesitate to contact us.

Bevan Brittan LLP

21 January 2022

3. APPENDIX: Alliance Charter

1. ***Delivery at pace****: the ethos of the partnership will be to deliver results and prove itself by getting things done, and fix things as we go to deliver patient/service user, staff and tax payer benefits*

2. ***Collaboration as the default:*** *we will only 'opt out' where an existing binding contract precludes us from participation*

3. ***Devolution****: we will be biased towards devolving delivery accountability to individual partners to act on behalf of the overall partnership*

4. ***Sovereignty****: all partner boards will remain sovereign and will delegate authority for collective decision making to the provider alliance for an agreed agenda of shared initiatives*

5. ***Mutual support****: we will expect each partner to act on behalf of the system/resident and taxpayer interest even when that is not in individual institutional benefit but the quid pro quo is that we will strive to "keep each other whole"/we will work to ensure no partner fails*

6. ***No duplication and shared resources****: ICS-HQ workstreams and Provider Alliance-delivery work should be stepped-up and stepped-down in lockstep –we will avoid duplication and be clear about accountability. We should seek to share resources across partner organisations to enable health services, education and research to be focused on the population we serve. A number of people will have different roles / 'wear different hats' and we will use this to be as efficient as possible.*

7. ***Embedded with the system team:*** *Same set of people in the room wherever we can (e.g., transparency between ICS HQ & Provider Alliance Board)*

8. ***Data and analysis****: we will make data-driven decisions and monitor our performance.*

9. ***Honest and transparent****: we do difficult things, we talk about difficult things, we are direct and transparent with each other*

10. ***Learning system****: we have an ethos of 'continuous improvement' adopting a QI approach. Innovation and the spreading of proven best practice will be key.*

Source: October 2020 Paper to Boards

4. APPENDIX: UCL Health Alliance Objectives

UCL HEALTH ALLIANCE DRAFT OBJECTIVES [18 months]

March 2022

The scope of the Alliance covers health services, education and research. The focus is on both physical and mental health needs and considering whole pathways, working with other partners, from prevention through to complex tertiary treatment to address health inequality and access to treatment and care. The focus is on delivery.

Strategic

5. Establish our long-term **vision** for transformation as an alliance and how we will measure our success [NK/DD]
6. **Transformation:** Position the alliance and NCL to gain above "natural share" of national transformation resources/pilot site for national transformation projects eg in digital and diagnostics [NK/DD]
7. Make progress on capturing the promise of an "**all-in**" partnership [NK/DD]
8. Help to foster greater trust and better working relations across our **clinical teams**, co-designing clinical leadership models for the future [Alliance Clinical Leads]

9.

10. Establish the **legal basis** for the Alliance, its initial **team** and its on-going **funding**, forming new capabilities for delivery [NK]
11. Learn by doing in delineating the separate roles of the **Alliance** vis-a-vis the **ICS** with a focus on the Alliance as the shared delivery vehicle [NK/DD/FO'C/MC]

Programme Delivery

12. Waiting & Access:

a. Support **accelerated** elective recovery through delivery of the lead role approach to wave 1 services (urology, ENT, MSK, ophthalmology, mental health, gynaecology, dermatology). Effective lead networks managing sector-wide PTLs, with an innovation focus ie., addressing the seven parts of the "playbook" [CEO leads]:
   i. Enable the **organisation of frontline provision at scale** through new primary care/ direct access/first contact care/telemedicine/community diagnostic hub models
   ii. Improve **referral smoothing** across providers via better information to patients and primary care and at point of secondary care
   iii. Better ways to **cohort and/or consolidate** secondary care activity given total partnership assets
   iv. Define best practices in managing the patient pathway (eg. OP models, day case & ambulatory care) and how can we generalise them to **reduce unwarranted variation**
   v. Deploy **new workforce models** and roles for increasing capacity & throughput
   vi. Specify how and where to use **new technology** to improve pathways
   vii. Cross-partner work on **prevention** reduce future PTL growth

b. Help put in place the conditions for a much better winter in 2022/23.

13. Workforce:

a. Develop a shared workforce plan, integrated with service and financial planning, for the Alliance which identifies demand, supply, gaps and options for new roles/approaches to addressing gaps [JK/NK]
b. Support delivery of the "academy" [JK/NK]
c. Develop a wider education plan working alongside HEE [JK/NK]

14. Research into action:

a. Expanding access to research across the NCL population, working with the CRN and UCLP [DP/BW/NM/NK]
b. Harness BRC expertise and infrastructure to amplify impact for our population and opportunities for our workforce to be research active [DP/BW/NM/NK]

15. Lead roles:

a. Expand scope of wave 1 lead roles beyond elective recovery: diagnostics [including pathology] & digital as cross cutting priorities; CAMHS, acute mental health, red cell haematology, community services [focusing on virtual wards] as service priorities [CEO leads]
b. Establish a second wave of lead roles [through Alliance Executive]
c. Bring NLP Shared Services under the aegis of the Alliance [DD/CC]

UCL HEALTH ALLIANCE - BUSINESS PLANNING - 2022/23

Programme: Research

CEO lead(s):David Probert

Date completed: 7th March 2022

Clinical lead(s): Professor Bryan Williams

Operational lead(s): Dr Nick McNally

1: Objectives

Which of the agreed Alliance objectives does this programme address?

"Research into action".
Also "Strategic" and "Workforce"

2: Deliverables

What will be delivered by April 2023?

An increase in the number of collaborative research projects involving >1 member organisation [level of increase to be determined], including more projects that include community, mental health and primary care.

3: Benefits

(a) Financial

What is the expected value of benefits resulting from the programme?

New research grant income [value to be determined].

(b) Quality, Outcomes & Experience

What is the expected impact on service quality, patient and population outcomes?

There is growing evidence that shows that better clinical outcomes are achieved in research active organisations. A growth in research in the Alliance will therefore drive improvements in outcomes in NCL by virtue of the fact that (a) more patients will access research and (b) an intrinsic research ethos in itself drives up clinical outcomes for patients even when they are not enrolled on research projects.

(c) Access

What is the expected impact on access priorities set out in the NHS operational guidance?

None specifically although it is feasible that specific research programmes in access to healthcare will be carried out.

(d) Health and workforce inequality

What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?

The Research Programme will facilitate more opportunities for hard-to-reach and socially-disadvantaged populations to access research. Greater research collaboration in NCL will also enable more projects that specifically leverage UCL's leading expertise in health inequalities to drive greater insights into the differential burden of ill-health and disease in NCL's communities. General practice and primary care have significant expertise in the implementation and supporting of deprived and diverse communities in North Central London and is a knowledge base which can be used effectively.

4: Resourcing

(a) Devolved

What existing or new resource within providers will be deployed?

Existing research resources within providers will be deployed to work on collaborative projects. As growth in research is achieved across NCL the research workforce and delivery workforce will need to grow. It is anticipated that research grants will fund much of the increased capacity. There will also be a need to NIHR CRN resources to be deployed flexibly to enable providers to deliver projects.

(b) Central

What existing or new resource needs to be established centrally?

Programme management support (1 x Band 8b) is required to enable the research opportunities of the Alliance to be fully realised. Opportunities need to be identified, publicised within the Alliance, collaborators identified and projects set up.

5: Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed

The UCLH BRC Partner Hospitals Board, with a membership of R&D leaders from across the Alliance, has been established to drive new collaborative research across NCL. The Board includes representation from all members, including NoCloR on behalf of primary care. The NIHR LCRN for North Thames are also included.

UCL HEALTH ALLIANCE - BUSINESS PLANNING - 2022/23

Programme: Red Cell Haematology

CEO lead(s): Nnenna Osuji

Date completed: 15/03/22

Clinical lead(s): Emma Drasar

Operational lead(s): TBC

1: Objectives

Which of the agreed Alliance objectives does this programme address?

- Support and amplify existing networks to accelerate improvement to patient access, outcomes and experience, addressing health inequalities.

2: Deliverables

(i) Adoption of MTFM; (ii) ICS case for community service investment; (iii) resourcing for community engagement improvement programme; (iv) ; (v) .

3: Benefits

(a) Financial

What is the expected value of benefits resulting from the programme?

- The programme will support uptake of the 2022/23 Med Tech Funding Mandate (MTFM) Spectra Optia apheresis cell collection system for the treatment of sickle cell disease. NICE financial modelling here.
-

(b) Quality, Outcomes & Experience

What is the expected impact on service quality, patient and population outcomes?

- Align with deliverables set for sickle cell and thalassemia networks, including recommendations from CQC and APPG.
- Improve experience for patients attending ED with severe pain.
- Engage with NHSE London Region in planned improvement programme based on engaging user and voluntary sector organisations.

(c) Access

What is the expected impact on access priorities set out in the NHS operational guidance?

- ED pain compliance
- Access to 24/7 apheresis across NCL.
- Access to community services across all NCL boroughs

(d) Health and workforce inequality

What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?

- Initial analysis of ICS HealtheIntent system to help inform approach to addressing health inequalities.

4: Resourcing

(a) Devolved

What existing or new resource within providers will be deployed?

- Current network resource: existing networks have service manager and network management resource dedicated to their effective functioning.
- Community engagement: proposed resourcing is based on NHSE London region work undertaken in HIV services, which has been signalled as a framework for red cell haematology in 2022/23.
- ? case for additional clinical time to enable system service provision or

(b) Central

What existing or new resource needs to be established centrally?

- ? Part of programme manager
- ? Part of QI or digital support
- ? Part of Network patient / user engagement person

5: Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed

The Alliance programme needs to serve to amplify and accelerate work led by the existing red cell haematology networks for patients across North Central London.

UCL HEALTH ALLIANCE - BUSINESS PLANNING - 2022/23

Programme: Workforce	CEO lead(s): Jinjer Kandola	Date completed: 16/03/22

Clinical lead(s): TBC	Operational lead(s): TBC

1: Objectives [from 2022/23 objectives agreed by the Alliance Board]

a. Develop a shared workforce plan for the Alliance, which includes alignment with the NCL Training Hub(s)
b. Support delivery of the "academy", defining it through the membership
c. Develop a wider education plan working alongside HEE

2: Deliverables

(i) Agreed strategy for connecting academy models across the Alliance; (ii) launch and support new professional education collaborations (including Alliance apprenticeship); (iii) launch new leadership programmes and collaborate on best practice

3: Benefits

(a) Financial

What is the expected value of benefits resulting from the programme?

- **Best value:** (i) realise value from better utilisation of member apprenticeship levy; (ii) realise value from existing infrastructure, such as NCL Training Hub and NHS Elect.
- **Revenue generation:** develop and package Alliance education, training and leadership programmes for external markets; revenue not anticipated in year 1.
- **Devolution:** in partnership with ICS leads, make a case for the successful devolution of HEE funding, with specific components under the management of the Alliance workforce programme.

(b) Quality, Outcomes & Experience

What is the expected impact on service quality, patient and population outcomes?

- **Role development:** support existing staff to realise their full potential.
- **Role innovation:** create and scale up innovative workforce models.

(c) Access

What is the expected impact on access priorities set out in the NHS operational guidance?

- **Network alignment:** proactively connect with HVLC and wider Alliance networks to ensure workforce programme informed by priorities and aspirations identified by these service areas.

(d) Health and workforce inequality

What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?

- **Race equality:** design and deliver leadership programmes specifically designed to address inequalities experienced by staff from black, Asian and ethnic minority backgrounds.
- **Anchors:** develop a strategy for creating new career entry points which forge stronger connections with communities across NCL.

4: Resourcing

(a) Devolved

What existing or new resource within providers will be deployed?

- **Training & education leads:** harness the expertise and experience of professional education and training leads across the Alliance to ensure that the programme address shared priorities, draws on existing work and adds value by amplifying and accelerating impact.
- **CPO leadership:** appropriate access to Alliance CPOs and NCL Training Hub leads, including to ensure effective alignment with ICS People Board.

(b) Central

What existing or new resource needs to be established centrally?

- **Programme management:** resource and expertise to coordinate and deliver this ambitious programme of work. This includes expertise in faculty management, business development, to both support making the case for external investment (eg. from HEE) as well as in commercialising Alliance education and training products to generate revenue. This needs to avoid any reassignment of HEE funds from frontline priorities (such as resource deployed in practices and primary care) into programme costs.
- **Administrative support:** small level of admin support for organising meetings as part of a professional secretariat.

5: Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed

The plan is to form a Learning and Education sub committee to the **Alliance Executive** to shape and drive programme delivery. Planned arrangements include:

- Reporting to Alliance Executive [as with all programmes]
- CEO leadership
- Selected CPO & NCL Training Hub leadership [to connect to the **ICS People Board** and wider CPOs community]
- Convenes training and education leads as core members
- Connects with GPPA and ICP work at borough level, and UCLP on innovation

UCL HEALTH ALLIANCE - BUSINESS PLANNING - 2022/23

Programme: CAMHS	CEO lead(s): Jinjer Kandola	Date completed: 14/03/22

Clinical lead(s): TBC	Operational lead(s): TBC

1: Objectives

Which of the agreed Alliance objectives does this programme address?

Deliver more accessible to flexible service offers for children and young people across NCL, which is meaningful and resonates with patients.

2: Deliverables

(i) Service user voice; (ii) Reduce waiting times; (iii) Financial plan for investment in services across NCL to deliver best service model; (iv) Adopt digital tech (eg. Apps) for specific cohorts with view to scale up; (v) standardisation of service offer across NCL; (vi) secure workforce and models of care to manage more complex needs, including capacity in primary care.

3: Benefits

(a) Financial

What is the expected value of benefits resulting from the programme?

- To be confirmed as part of subsequent financial planning for service improvements across NCL and linked to ICS review outputs.

(b) Quality, Outcomes & Experience

What is the expected impact on service quality, patient and population outcomes?

- Empower service users to engage with service providers to make change happen.
- Reduce variation in access and outcomes across NCL boroughs.

(c) Access

What is the expected impact on access priorities set out in the NHS operational guidance?

- Support operational adoption of waiting list to direct efforts on reducing the number of patients waiting a long time to access CAMHS.

(d) Health and workforce inequality

What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?

- Analysis from HealtheIntent system to inform work to address health inequalities.
- Effectively navigate issues concerning digital inclusion and risks associated with the provision of services in patients' homes.

4: Resourcing

(a) Devolved

What existing or new resource within providers will be deployed?

- Clinical support from provider trusts
- Operational leadership from provider trusts

(b) Central

What existing or new resource needs to be established centrally?

- Access to project/programme support within the Alliance.
- Access to service analytics (most likely from the ICS)
- Draw on digital capabilities in UCLPartners
- Funding for external clinical input to improvement programme

5: Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed

The Alliance programme should provide a vehicle for delivering outputs from the ICS led review of mental health and community services.

Programme: **Orthopaedic Network**	CEO Lead: Paul Fish	Date completed: 16 March 2022
Clinical Lead: Fares Haddad	Ops Lead: Chris Dann	Programme Lead: Ali Malik/Sarah Young

1. Objectives

Which of the agreed alliance objectives does this programme address?
Strategic – Transformation, Clinical Teams
Programme Delivery – Waiting & Access, Lead Roles

3. Benefits

a) Financial: What is the expected value of benefits resulting from the programme?
TBC

b) Quality, Outcomes & Experience: What is the expected impact on service quality, patient and population outcomes?
NCL services should become more equitable in terms of access to services as waiting times even out amongst providers. Patient experience will improve through improved "waiting well" and earlier access to conservative treatment pathways and surgery.

c) Access: What is the expected impact on access priorities set out in the NHS operational guidance?
104 week waits will be eradicated. Performance against 78 and 52 week standards will improve. Validation and continued alignment of triage will ensure earlier access community and primary care treatment or to diagnostics. Both approaches will also reduce unnecessary secondary care referrals.

d) Health and workforce inequality: What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?
Waiting list validation and active management through super weekends will reduce waiting times and impact on variation by area across NCL. Monitoring of equity of impact should equalise equity of access for patients. Established standalone hubs will continue to minimise the impact of Covid pathways.

2. Deliverables

What will be delivered by April 2023?
- NCL waiting list validation of 1st appointments by April 22 & analysis to inform NCL action plan by June 22
- Plan & organise an outpatients super long weekend to provide diagnostics (for 1000 patients) by June 22
- Review workforce availability vs capacity required to address backlog by [date]
- Continued surgical hubs model consolidation including development and delivery of one stop shop services (e.g. Hand Service) and maintain and grow complex and tertiary services in NCL by [dates]
- MSK: refine NCL & national flows into hubs and community diagnostic pathways. Develop plan for an NCL single point of access: confirm the 'as is' by May 2022 and agree 'to be' plan by [date]
- Review potential of MSK & Pain Management community services for diagnostics & post surgery mgt
- Review MDTs and super-specialist NCL Regional MDTs to identify how these can be strengthened
- Update governance to clarify NCL priorities for MSK and to regional priorities.

4. Resourcing

a) Devolved: What existing or new resource within providers will be deployed?
- Co-creation & co-ownership across all levels; with effective workforce & communication plans

b) Central: What existing or new resource needs to be established centrally?
- Workforce planning for waiting list management and pathways into community & primary care
- Cross organisation financial agreements
- Clinical leadership capacity and strong project support
- Investment into digital capital (i.e. image sharing capabilities) and better IT integration

5. Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed?
Regional: Engagement with the regional MSK Programme Board
NCL: The Network to lead strategic transformation and programme delivery to include an MSK Steering Group to lead on MSK pathway alignment including an NCL SPOA.

Programme: **General surgery**	CEO Lead: Mat Shaw	Date completed: 16 March 2022
Clinical Lead(s): Chetan Bhan	Ops Lead(s): Danya Taylor	Programme Lead: Shirena Counter

1. Objectives

Which of the agreed alliance objectives does this programme address?
Strategic – Transformation, Clinical Teams
Programme Delivery – Waiting & Access, Workforce

3. Benefits

a) Financial: What is the expected value of benefits resulting from the programme?
To be determined.

b) Quality, Outcomes & Experience: What is the expected impact on service quality, patient and population outcomes?

- Concentrating high complexity surgery (cancer and benign work) onto two sites will improve outcomes by ensuring specialist skills are maintained through sufficient procedure volumes
- Development of two surgical hubs (with ring-fenced green beds and access to HDU facilities) in the north and south of the sector to provide medium and low complexity work (including daycase) will reduce waiting times particularly for P3 and P4 medium complexity patients who comprise the majority of 104 and 52 week waits
- Development of one-stop clinics and diagnostic hubs will improve patient experience as they can have all pre-op investigations locally and will only need to travel for their surgery

c) Access: What is the expected impact on access priorities set out in the NHS operational guidance?
Improved performance against 104, 78 and 52 week standards as there will be sufficient capacity (both beds and theatres) to operate on P3 and P4 medium complexity patients. Clinical pathways for primary care, clinical triage/ advice & guidance, community diagnostics and move to PIFU will expedite pathways and release capacity for new patients.

d) Health and workforce inequality: What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?
Reduced unwarranted variations in patient access, experience and outcomes.
The consultant workforce will be enabled to work across-site supported by adequate administrative, nursing and clinical staff.

2. Deliverables

What will be delivered by April 2023?

- Joint clinician appointments in place between WH and RFL/UCLH and between RFL and NMUH
- Highgate still in use as a HVLC hub
- Agreed which medium complexity procedures should be centralised in the hub sites
- WH fully resourced and operating as a designated south hub for medium complexity general surgery
- NMUH up and running as a north hub for daycase and HVLC work, with a clear timeline for becoming a medium complexity hub
- Centralised colorectal cancer surgery on UCLH/RFH sites with dedicated colorectal cancer surgeons operating on adequate pt volumes in line with GIRFT standards & national guidance
- Agreement of a strategy for bariatric surgery with a clear timeline for realising the benefits [date]
- Pilot of advice & guidance and the development of clinical pathways for primary care underway

4. Resourcing

a) Devolved: What existing or new resource within providers will be deployed?
Will require additional operational, clinical and project management capacity to deliver within each trust

b) Central: What existing or new resource needs to be established centrally?
Medium complexity hubs at WH and NMUH
Community diagnostic centres and one-stop clinics (with associated estates, staffing etc)

5. Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed?

Regional: London Region is planning to provide intensive support within the next few months for all London general surgery networks and ICSs to address the non-admitted PTL

NCL: The general surgery network to lead on strategic transformation and programme delivery with the support of WH, NMUH and NCL and reporting into the Network Oversight and Elective Strategy groups

Programme: **Urology**		CEO Lead: Caroline Clarke		Date completed: 16 March 2022
Clinical Lead: Ravi Barod	GIRFT Lead: Paul Erotocritou	SRO: Beth Foley	Ops Lead: Alice Rickarby	Programme Lead: Shirena Counter

1. Objectives

Which of the agreed alliance objectives does this programme address?
Strategic – Transformation, Clinical teams
Programme delivery – Waiting & access, Workforce

3. Benefits

a) Financial: What is the expected value of benefits resulting from the programme?
- Workforce benefit in realigning on-call rotas and workforce plan; reduction in LOS, theatre productivity gains, reduction in FU appts; avoidance of unnecessary referrals

b) Quality, Outcomes & Experience: What is the expected impact on service quality, patient and population outcomes?
- End to end pathways for Urology in NCL to reduce unwarranted variation and provide timely and equitable access to patients
- Single PTL, with single point of access to secondary care with clinical triage and diagnostics in advance of outpatient appointment (reduction in unnecessary FU appointments)
- GIRFT principles to improve day case rate in common surgical procedures, decreasing LOS
- HVLC hubs to improve theatre productivity and reduce unwarranted variation
- Provision of consistent sector wide-catheter management in community care to reduce emergency presentations and improve discharge, reducing LOS.

c) Access: What is the expected impact on access priorities set out in the NHS operational guidance?
- Ability to meet 104% (increased daycase/productivity)
- Recovery against 52ww
- Delivery of 28day FDS
- Reduction of FU appts (25%)

d) Health and workforce inequality: What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?
- Reduced unwarranted variation in patient access, experience and outcomes
- Collaboration as a sector to work jointly to provide a clinically safe workforce model across all sites.

2. Deliverables

What will be delivered by April 2023?
- Clinical strategy for the provision of Urology services in NCL
- More joint appointments to facilitate cross-site working
- Introduction of single point of access for new referrals, including an NCL-wide clinical triage model
- Model for clinical triage of all referrals waiting on non-admitted PTL, and similar plan for follow ups, will be developed and ready for implementation in 2023/24 [date]
- Diagnostic model developed and piloted [date]
- Development of enhanced community catheter management in community
- Optimisation of HVLC hubs
- Integrated workforce plan aligned to the clinical model

4. Resourcing

a) Devolved: What existing or new resource within providers will be deployed?
Community provision, local triage of PTL backlog, workforce, clinic space, theatre lists for HVLC

b) Central: What existing or new resource needs to be established centrally?
Single point of access and triage of new GP referrals, NCL contracts for joint appointments, community diagnostics service specification

5. Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed?

Regional: The London Region Urology Transformation programme is also supporting work around advice & guidance and clinical triage

NCL: The Urology Network to lead strategic transformation and programme delivery, reporting into the Network Oversight Group and Elective Strategy group

Programme: Gynaecology	CEO Lead: Nenna Osuji	Date completed: 17 March 2022
Clinical Lead(s): Arvind Vashisht	Ops Lead(s): Cait Kielty-Adey	Programme Lead: Tom O'Gorman

1. Objectives

Which of the agreed alliance objectives does this programme address?
Strategic – Transformation, Clinical Teams
Programme Delivery – Waiting & Access, Lead Roles

3. Benefits

a) Financial: What is the expected value of benefits resulting from the programme?
To improve equity through equalising waiting times, and improved productivity through better use of existing resources.

b) Quality, Outcomes & Experience: What is the expected impact on service quality, patient and population outcomes?
To scope use of A&G as default as part of regional initiative. This will reduce unnecessary referrals to secondary care and reduce waiting times on PTL
- Patients with low-complex conditions will be have procedures delivered quicker through the HVLC hub arrangements and be less susceptible to cancellations due to winter pressures
- Consolidating sub-specialties should deliver consistent and improved patient experience and outcomes across NCL
- Standardising community provision should provide coverage for patients in Camden and deliver standardised pathways

c) Access: What is the expected impact on access priorities set out in the NHS operational guidance?
By reducing the PTL and ensuring that all patients who are eligible for the HVLC hub are seen in the hub, should have a positive impact on number of patients waiting 104, 78 and 52 week.
Reviewing the pathways, including 2ww pathway with improved diagnostics, should reduce unnecessary interventions or delays in instituting correct management.

d) Health and workforce inequality: What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?
Capacity changes should reduce impact on variation by area across NCL. Equity of waiting times should equalise equity of access for patients Ensuring that outcomes for complex and specialist gynaecology delivers enhanced outcomes and reduced variation.
Equity of access and investigation

2. Deliverables

What will be delivered by April 2023?
- Continued growth in delivery of HVLC day case activity at hub sites throughout 2022. Northern hub utilisatoni to be 85% or greater by April 2022. Scope requirement for second southern hub by Sept 2022
- Reduction of unnecessary interventions by improving diagnostics across NCL particularly in relation to 2ww. This to be scoped and modelled by December 2022 with a view to implementation by July 2023
- To consolidate out patient sub-specialties at reduced number of sites, to create centers of excellence with improved patient outcomes for specific areas such as Menopause, recurrent miscarriage, fertility and family planning. Scoping of this work to be completed by September 2022 with implementation by March 2023
- Engage and feed into the strategic plans re surgical hubs/wider gynae services and play a supporting role in implementation.
- Enhanced triage model, including A&G by default model to deliver reduced PTL by September 2022. review role of community services and how this can be enhanced particularly in relation to post referral/ triage
- Eradication of 104 and 52 week waiters
- Ensure that each trusts list has been clinically and quality assured.

4. Resourcing

a) Devolved: What existing or new resource within providers will be deployed?
Protected time for clinical and operational leadership (this is likely to be more than 1pa per month)
Temporary resource for additional sonography and consultant overseen scanning to avoid unnecessary procedures. This will need to run alongside normal resourcing levels initially

b) Central: What existing or new resource needs to be/have been established centrally?
Regional gynecology CLG established, which has identified 5 priority workstreams, including A&G, Menopausal Bleeding pathways, Hub Working and PIFU

5. Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed?
Regional: Engagement with regional gynaecology CLG
NCL: The Gynaecology Network to lead strategic transformation and programme delivery.
NCL: The NCL Cancer alliance to be engaged with around any changes to 2ww pathways

Programme: ENT Clinical Network	CEO Lead: David Probert, UCLH	Date completed: 17 March 2022
Clinical Lead(s): Peter Andrews	Ops Lead(s): Michael Burslem	Programme Lead: Jaimie Cross

1. Objectives

Which of the agreed alliance objectives does this programme address?
Strategic – Transformation, Clinical Teams
Programme Delivery – Waiting & Access, Lead Roles

3. Benefits

a) Financial: What is the expected value of benefits resulting from the programme?
Community pathways expected to efficiently direct patients to the most cost-effective / local service.

b) Quality, Outcomes & Experience: What is the expected impact on service quality, patient and population outcomes?
ENT services will be more equitable in terms of access as waiting times even out amongst providers. Patients should have closer access to diagnostic care which will improve patient experience as they can have initial investigations locally to support treatment plans, reducing the need to travel. Expanded community diagnostic offer should reduce unnecessary referrals to secondary care and reduce waiting times on PTL.

c) Access: What is the expected impact on access priorities set out in the NHS operational guidance?
Clinical pathways for primary care, clinical triage/advice & guidance, community diagnostics and move to PIFU will expedite pathways and release capacity for new patients.
Additional capacity should reduce the PTL and have a positive impact on number of patients waiting 104, 78 and 52 weeks.

d) Health and workforce inequality: What is the expected impact on health inequalities and on inequalities facing the NHS workforce in NCL?
Capacity changes should reduce impact on variation by area across NCL. Equity of waiting times should equalise equity of access for patients.

2. Deliverables

What will be delivered by April 2023?
- Straight-to-test pathways with diagnostics & initial review completed prior to OP appointment.
- Expanded Advice & Guidance and PIFU pathways.
- Saturday day case working across NCL.
- Expanded community services.
- Agree data reporting/targets around model hospital metrics to reflect NCL practice.

4. Resourcing

a) Devolved: What existing or new resource within providers will be deployed?
Image/diagnostic review undertaken by clinicians within acute providers through virtual clinics.

Will require additional operational and clinical capacity to deliver within each trust, as well as project management resources. Executive support from each organisation is crucial to delivery.

b) Central: What existing or new resource needs to be established centrally?
Community diagnostic centres and one-stop clinics (with associated estates, staffing etc); Clarity on ongoing plans to manage funding arrangements for acute, community and diagnostic services and overall governance arrangements.

5. Governance

In addition to the UCL Health Alliance Executive, are there any other arrangements for delivery to be overseen and managed?
Regional: Relationship with regional elective recovery programme, GIRFT, ENT CLG.
NCL: The Network to lead strategic transformation and programme delivery.
We would be interested in hearing more about the support the Alliance can provide as we build the future model of ENT.

6. APPENDIX: Resourcing through provider members

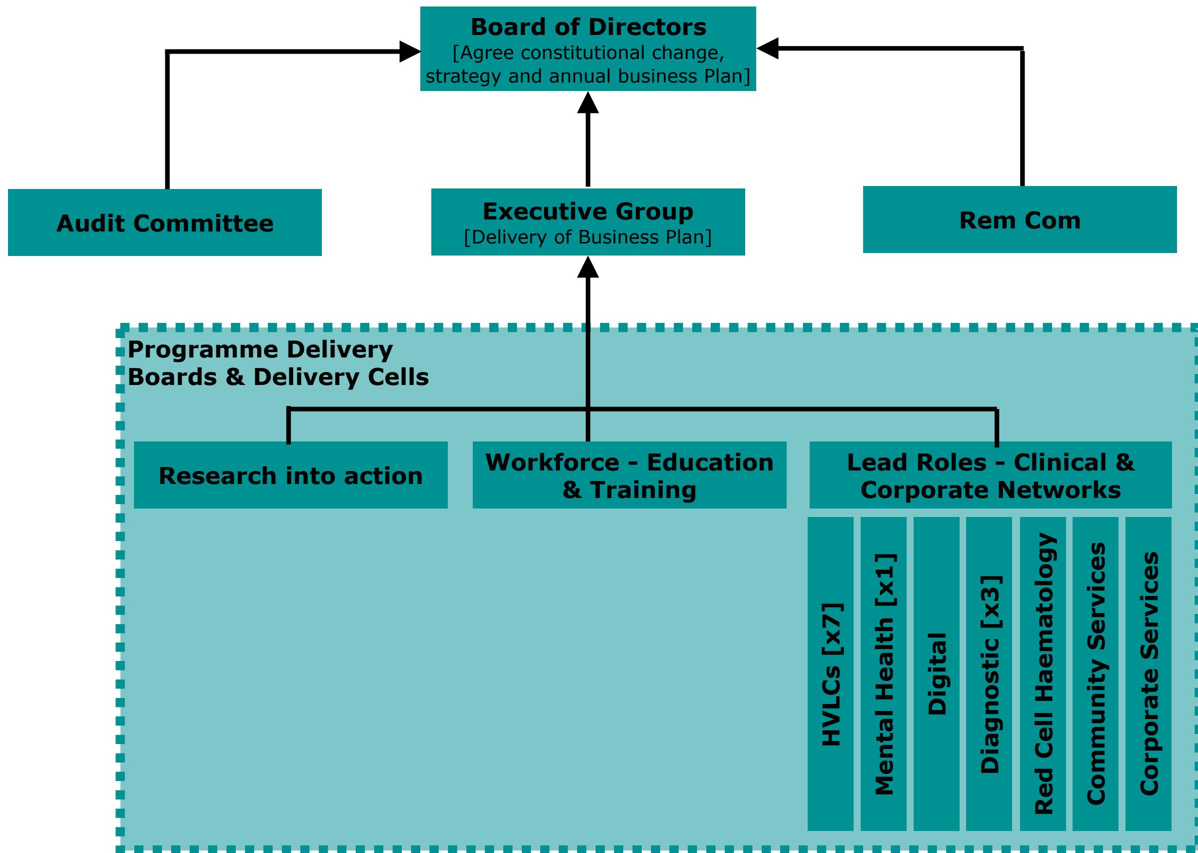
Table 1: Assignment of existing resource for collaboration as an Alliance of providers

ITEM	Estimated Value	Description
Network clinical leadership	14 Programmed Activities	- HVLC networks (x7); CAMHS; Red Cell Haematology; Diagnostics (x4 modalities); Community services - Principle that at least one programmed activity of weekly job plan (or equivalent for AfC clinical leads) is required to provide clinical leadership - Member organisations to ensure relevant staff are resourced to deliver the collaborative agenda.
Network operational management	14 days per week of a band 8d	- HVLC networks (x7); CAMHS; Red Cell Haematology; Diagnostics (x4 modalities); Community Services - Principle that at least one day per week should be planned to drive integration of provision across organisational boundaries. - Recognise operational leadership will be from managers across a range of grades from 8b to 9. - Member organisations to ensure relevant staff are resourced to deliver the collaborative agenda.
Alliance programmes		- Digital, Workforce and Research Programmes - Requirement of director level leadership required; also essential for securing necessary subject matter expertise for programmes. - Input from relevant digital, training and research leads across all members
CEO leadership		- HVLC networks (x7); CAMHS; Red Cell Haematology; Diagnostics (x4 modalities); Community Services; Research & Innovation; Workforce; Digital; Corporate Services. - Monthly Alliance Executive Meetings; Quarterly Board of Directors meetings - Member CEOs to ensure time allocated to deliver the collaborative priorities either directly or through agreed delegation to a member of their executive team.
Executive leadership		- The Alliance Executive has identified the value of amplifying CEO leadership within the delivery cells by appointing leads at director or executive level to work alongside CEOs. - The resource consequence of this is difficult to assess: CEO, director and executive involvement in the Alliance should represent the most effective route to deliver on existing priorities and an important evolution in the model for system working, where sovereign organisations define new models for delivering impact through collective action.
Corporate Affairs		- Director of corporate affairs from within the membership to support both the Alliance Board of Directors as well as Alliance Executive meetings.

Table 2: Member non financial resource contributions

ITEM	Equivalent Budget	Description
Office accommodation	£5-10k	- Access to UCLPartners workstations for central team - Access to UCLPartners boardroom for executive and board meetings - Represents contributions from member organisations to the running costs of UCLP
Accountancy	£5k	- Accountant preparation of quarterly and annual accounts - Review of submissions by senior accountant - Represents contribution from a member organisation(s) undertaking a host function for elements of the Alliance operational costs
Recruitment and payroll	£20k	- Access to trust recruitment team to support advertisement and administration for the recruitment of Alliance roles. - Payroll services for staff appointed to the Alliance, working on NHS contracts hosted by one member on behalf of others.
TOTAL		

7. APPENDIX: Decision making governance



NB: Includes wave 2 programmes, such as diagnostics, digital and community services

8. APPENDIX: Glossary of Terms

Alliance - abbreviation of the UCL Health Alliance

CSU - Commissioning Support Unit

CLG - Corporation Limited by Guarantee

CQC - Care Quality Commission

HEE - Health Education England

ICB - Integrated Care Board

ICP - Integrated Care Partnership, also known as place and borough based partnerships

NHSE/I - NHS England and Improvement

NIHR - National Institute for Health & Care Research Research

UCL - University College London

UCLP - UCL Partners

PART B: ARTICLES OF ASSOCIATION FOR APPROVAL

PRIVATE COMPANY LIMITED BY GUARANTEE
AND NOT HAVING A SHARE CAPITAL

ARTICLES OF ASSOCIATION
OF
[UCL HEALTH ALLIANCE LIMITED]

1. PRELIMINARY

The regulations contained in Schedule 2 Regulation 3 of The Companies (Model Articles) Regulations 2008 in force at the time of adoption of these Articles shall not apply to the Company and these Articles alone shall constitute the regulations of the Company.

2. DEFINITIONS AND INTERPRETATION

2.1. In these Articles the following expressions have the following meanings unless inconsistent with the context:

1. **these Articles** means these Articles of Association, whether as originally adopted or as from time to time altered by special resolution

2. **Company** means [UCL Health Alliance Limited], being the company intended to be regulated by these Articles

3. **clear days** in relation to the period of a notice means that period excluding the day when the notice is given or deemed to be given and the day for which it is given or on which it is to take effect

4. **Commission** means the Charity Commission for England and Wales

5. **Companies Act 1985** means the Companies Act 1985 (as amended from time to time)

6. **Companies Act 2006** means the Companies Act 2006 (as amended from time to time)

7. **Directors** means the directors for the time being of the Company or (as the context shall require) any of them acting as the board of Directors of the Company. If the Company becomes a registered charity, the Directors are Company trustees as defined by section 97 of the Charities Act 1993

8. **electronic address** means any address or number used for the purposes of sending or receiving documents or information by electronic means

9. **electronic form** AND **electronic means** have the meaning given in section 1168 of the Companies Act 2006

10. **executed** includes any mode of execution

11. **hard copy form** has the meaning given in section 1168 of the Companies Act 2006

12. **Members** means the associate members for the time being of the Company, who have been admitted in accordance with Article 6.2 and who shall not be members of the Company for the purposes of the Statutes and "Membership" shall be construed accordingly

13. **Objects** means the objects of the Company set out in Article 3

14. **ordinary resolution** has the meaning given in section 282 of the Companies Act 2006

15. **Partners** means the subscribers to the Memorandum of Association and these Articles and any other persons admitted as members from time to time in accordance with Article 6.1 and who shall be members of the Company for the purposes of the Statutes and "Partnership" shall be construed accordingly (for the avoidance of doubt, Partnership shall not refer to a partnership under the Partnership Act 1890, a limited partnership established under the Limited Partnerships Act 1907 or a limited liability partnership established under Limited Liability Partnerships Act 2000)

16. **Powers** means the powers of the Company set out in Article 4

17. **seal** means the common seal of the Company (if any)

18. **Secretary** means the secretary of the Company or any other person appointed to perform the duties of the secretary of the Company, including a joint, assistant or deputy secretary

19. **special resolution** has the meaning given in section 283 of the Companies Act 2006

20. **Statutes** means the Companies Acts as defined in section 2 of the Companies Act 2006 and every other statute, order, regulation, instrument or other subordinate legislation for the time being in force relating to companies and affecting the Company

21. **United Kingdom** means Great Britain and Northern Ireland.

22. **in writing** means hard copy form or to the extent agreed by the recipient (or deemed to be agreed by virtue of a provision of the Statutes) electronic form or website communication

2.2. Unless the context otherwise requires, words or expressions contained in these Articles shall bear the same meaning as in the Statutes but excluding any statutory modification thereof not in force when these Articles become binding on the Company.

2.3. References to any Statute or statutory provision in these Articles include, unless the context otherwise requires, a reference to that Statute or statutory provision as modified, replaced, re-enacted or consolidated and in force from time to time and any subordinate legislation made under the relevant Statute or statutory provision.

2.4. Where the word "address" appears in these Articles it is deemed to include postal address and electronic address and "registered address" shall be construed accordingly

3. OBJECTS

3.1. The Company's objects are the advancement of education, health, learning and research and (without prejudice to the generality of the foregoing) in furtherance thereof:

3.1.1. to bring leaders of healthcare, education and research together to focus on improving health inequalities and outcomes; and

3.1.2. to maintain recognition from the North Central London NHS Integrated Care Board of its status as a formal Provider Collaborative, anchored in the North Central London.

4. POWERS

In furtherance of the Objects but not further or for any other purpose the Company shall have the following powers:

4.1. to borrow and raise money in such a manner and on such security as the board of directors may think fit;

4.2. to raise funds and to invite and receive contributions from any person or persons whatsoever by way of subscription, donation or otherwise provided that this shall be without prejudice to the ability of the Company to disclaim any gift, legacy or bequest in whole or in part in such circumstances as the board of Directors may think fit and provided also that the Company shall not undertake any permanent trading activities in raising funds for the above mentioned charitable objects;

4.3. to lend and advance money and give credit to, to take security for such loans or credit from, and to guarantee and become or give security for the performance of contracts and obligations by, any or company subject to such conditions or consents as may from time to time be required or imposed by law;

4.4. to draw, make, accept, endorse, discount execute and issue promissory notes, bills of exchange, bills of lading, warrants and other negotiable, transferable, or mercantile instruments;

4.5. to subscribe for either absolutely or conditionally or otherwise acquire and hold shares, stocks, debentures, debenture stock or other securities or obligations of any other company;

4.6. to invest the moneys of the Company according to the furtherance of its Objects in or upon such investments, securities or property as the board of directors may think fit, subject to such conditions and such consents as may for the time being be imposed or required by law;

4.7. to purchase, take on lease or in exchange, hire or otherwise acquire any real or personal property and any rights or privileges and to construct, maintain and alter any buildings or erections which the board of directors may think necessary for the promotion of the Company's Objects;

4.8. to sell, let, mortgage, dispose of or turn to account all or any of the property or assets of the Company with a view to the furtherance of its Objects;

4.9. subject to Article 5, to employ and pay such architects, surveyors, solicitors and other professional persons, workmen, clerks and other staff as are necessary for the furtherance of the Objects of the Company;

4.10. to make all reasonable and necessary provision for the payment of pensions and superannuation to or on behalf of employees and their widows and other dependents;

4.11. to purchase and maintain, for the benefit of any Director or officer of the Company, indemnity insurance to cover their liability:

4.11.1. which by virtue of any rule of law would otherwise attach to them in respect of any negligence, default, breach of trust, or breach of duty of which they may be guilty in relation to the Company; and/or

4.11.2. to make contributions to the assets of the Company in accordance with the provisions of section 214 of the Insolvency Act 1986,

save that any such insurance in the case of Article 4.11.1 shall not extend to any liability of a Director:

4.11.3. resulting from conduct which the directors knew, or must be assumed to have known, was not in the best interests of the Company, or where the Directors did not care whether such conduct was in the best interests of the Company or not;

4.11.4. to pay the costs of unsuccessfully defending criminal prosecutions for offences arising out of the fraud or dishonesty or willful or reckless misconduct of the Directors;

4.11.5. to pay a fine; or

4.11.6. to make such a contribution where the basis of the Director's liability is his knowledge prior to the insolvent liquidation of that Company (or reckless failure to acquire that knowledge) that there was no reasonable prospect that the Company would avoid going into insolvent liquidation;

4.12. subject to the provisions of, and so far as may be permitted by, the Companies Act 2006, to fund the expenditure of every Director, alternate Director or other officer of the Company incurred or to be incurred:

4.12.1. in defending any criminal or civil proceedings; or

4.12.2. in connection with any application under sections 144(3), 144(4) or 727 of the Companies Act 1985.

4.13. to subscribe to, become a member of, or amalgamate or co-operate with any other organisation, institution, society or body formed for any of the purposes included in the Objects;

4.14. to establish and support or aid the establishment and support of any charitable trusts, associations or institutions and to subscribe or guarantee money for charitable purposes in any way connected with or calculated by the board of Directors to further any of the Objects of the Company;

4.15. to acquire, merge with or to enter into any partnership or joint venture arrangement with any other Company formed for any of the Objects;

4.16. to do all or any of the things hereinbefore authorised either alone or in conjunction with any other charitable organisation, institution, society or body with which this Company is authorised to amalgamate;

4.17. to pay all or any expenses incurred in connection with the promotion, formation, incorporation and registration of the Company;

4.18. to enter into any arrangements with any government or authority (supreme, municipal, local, or otherwise) that may to the board of Directors seem conducive to the attainment of the Company's Objects or any of them, and to obtain from any such government or authority any charters, decrees, rights, privileges or concessions which the board of Directors may think desirable and to carry out, exercise, and comply with any such charters, decrees, rights, privileges and concessions;

4.19. to do all such other lawful things as are necessary for the attainment of the above Objects or any of them and so that:

4.19.1. where the Company shall take or hold any property which may be subject to any trusts, the Company shall only deal with or invest the same in such manner as allowed by law, having regard to such trusts;

4.19.2. none of the Objects or Powers shall be restrictively construed but the widest interpretation shall be given to each such Object or Power, and none of such Objects or Powers shall, except where the context expressly so requires, be in any way limited or restricted by reference to or inference from any other Objects or Powers or inference from the name of the Company;

4.19.3. none of the Objects therein specified shall be deemed subsidiary or ancillary to any of the Objects specified in any other Article, and the Company shall have full power to exercise each and every one of the Objects.

5. APPLICATION OF INCOME

5.1. The income and property of the Company shall be applied solely towards the promotion of the Objects and if the Company is registered as a charity, no portion of such income and property shall be paid or transferred, directly or indirectly, by way of dividend, bonus or otherwise by way of profit to Partners of the Company, save (i) to a Partner which is a charity or NHS Trust or NHS Foundation Trust; or (ii) to the extent as would not infringe section 30(3) Companies Act 1985 (or any replacement therefor); and (iii) that a Partner who is not also a Director may receive benefit from the Company in their capacity as beneficiary and/or receive reasonable and proper remuneration for any goods or services supplied to the Company) PROVIDED THAT nothing herein shall prevent any payment by the Company in the best interests of the Company if the Directors follow the procedure and observe the conditions set out in Article 5.2 and if one of the following conditions applies:

5.1.1. if the Company is a registered charity, no Director shall be appointed to any office of the Company paid by salary or fees or receive any remuneration or other benefit in money or money's worth from the Company unless the Directors first obtain the prior written approval of the Charity Commission;

5.1.2. the payment is of reasonable and proper remuneration to any Partner, officer or servant of the Company (not being a member of its board of Directors) for any services rendered to the Company;

5.1.3. the payment is of interest on money lent by any Partner of the Company or of its board of Directors at a reasonable and proper rate per annum not exceeding two per cent less than the published base lending rate of a clearing bank to be selected by the board of Directors;

5.1.4. the payment is of reasonable and proper rent for premises demised or let by any Partner of the Company or of its Directors;

5.1.5. the payment is of fees, remuneration or other benefit in money or money's worth to any company of which a Director may also be a member holding not more than 1% (one percent) of the capital of that company;

5.1.6. the payment is to any Director of reasonable out-of-pocket expenses;

5.1.7. the payment is to any Director in their capacity of a beneficiary of the Company;

5.1.8. the payment is to a director under a contract for the supply of goods or services to the Company, other than for acting as a Director;

5.1.9. the payment is of a premium in respect of any indemnity insurance to cover the liability of the Directors purchased or maintained in accordance with Article 4.11.

5.2. The Company and Directors may only rely upon the authority provided by Article 5.1 if each of the following conditions is satisfied:

5.2.1. the remuneration or other sums paid to the Director do not exceed an amount that is reasonable in all the circumstances;

5.2.2. the Director is absent from the part of any meeting at which there is discussion of:

(a) that Director's employment or remuneration, or any matter concerning their employment contract; or

(b) their performance in employment, or of their employment contract; or

(c) any proposal to enter into any other contract or arrangement with that Director or to confer any benefit upon them that would be permitted under Article 5.3 or any other matter relating to a payment or the conferring of any benefit permitted by Article 5.3;

5.2.3. the Director does not vote on any such matter and is not to be counted when calculating whether a quorum of directors is present at the meeting;

5.2.4. the other Directors are satisfied that it is in the interests of the Company to employ or to conduct with that Director rather than with someone who is not a Director. In researching that decision, the Directors must balance the advantage of employing a Director against the disadvantages of doing so (especially the loss of the Director's services as a result of dealing with the Director's conflict of interest);

5.2.5. the reason for their decision is recorded by the Directors in the minutes of the relevant meeting.

5.3. The employment or remuneration of a Director includes the engagement or remuneration of any firm or company in which the Director is:

5.3.1. a partner;

5.3.2. an employee;

5.3.3. a consultant;

5.3.4. a director; or

5.3.5. a shareholder, unless the shares of the company are listed on a recognised stock exchange and the Director holds less than 1% of the issued capital.

6. PARTNERS AND MEMBERS

6.1. The subscribers to the Memorandum of Association of the Company and such other persons as are admitted to Partnership in accordance with these Articles shall be the Partners of the Company. No person be admitted as a Partner of the Company unless it is approved by unanimous resolution of all the then Directors. Every person who wishes to become a Partner shall deliver to the Company an

application for Partnership in such form as the Directors require to be executed by it agreeing to be bound by the Memorandum of Association of the Company and these Articles and on being so admitted its name shall be entered in the register of Partners of the Company. The Directors shall have an absolute discretion in determining whether to accept or reject any application for Partnership and shall not be bound to assign any reason for their decision.

6.2. In addition to the Partners of the Company admitted under Article 4.1, the Company shall also have a category of member called Member. The terms and conditions of Membership shall be determined by the Directors under Article 26 hereof but so that Members shall have a right to appoint and remove Directors in accordance with Article 13.1, shall not be members of the Company for the purposes of the Statutes and shall have no other rights or obligations unless expressly attributed to such category.

6.3. The Directors shall have an absolute discretion in determining whether to accept or reject any application for Membership and shall not be bound to assign any reason for their decision.

6.4. The Directors may by unanimous resolution establish classes of Partnership with different rights and obligations and shall record those rights and obligations in the register of Partners. The rights allotted to a class of Partnership may only be varied with the approval of a:

6.4.1. a written special resolution passed by the Partners belonging to that class; or

6.4.2. a special resolution passed at a separate general meeting of the Partners belonging to that class.

6.5. Subject to all moneys presently payable by it to the Company pursuant to any rules or bye-laws made by the Directors pursuant to Article 26 or otherwise having been paid, a Partner may at any time resign from the Company by giving at least six months' notice in writing to the Company provided that after such resignation the number of Partners remaining is not less than two.

6.6. Partnership is not transferable and will terminate where:

6.6.1. the Partner ceases to exist or operate;

6.6.2. the Partner becomes insolvent, enters into receivership or administration or makes any arrangement or composition with its creditors generally; or

6.6.3. if all of the other Partners resolve that it is in the best interests of the Company to terminate such Partnership following a material breach by that Partner of the terms of these Articles or any agreement between the affected Partner and the Company and/or some or all of the Partners relating to the Company.

6.7. The liability of each of the Partners is limited to £1.

7. GENERAL MEETINGS

7.1. The Company may, if determined by the Directors, hold an annual general meeting in accordance with the Statutes in addition to any other meetings in that year and shall specify the meeting as such in the notice calling it. Any such annual general meeting shall be held at such time and place as the Directors shall appoint. All meetings of the Partners and Members including the annual general meetings shall be called general meetings. Meetings will take place with an interval no greater than 15 months.

7.2. The Directors may call general meetings at any time.

7.3. If at any time there are not within the United Kingdom sufficient Directors capable of acting to form a quorum in order to call a general meeting, any Director or any two Partners of the Company may convene a general meeting in the same manner as early as possible as that in which meetings may be convened by the Directors.

8. NOTICE OF GENERAL MEETINGS

8.1. General meetings shall be called by at least fourteen clear days' notice in writing. The notice shall specify the time and place of the meeting and, in case of special business, the general nature of the business to be transacted.

8.2. All business shall be deemed special that is transacted at a general meeting, and also all that is transacted at an annual general meeting, with the exception of the consideration of the profit and loss account, balance sheet, and the reports of the Directors and auditors, and the appointment, and the fixing of the remuneration, of the auditors.

8.3. Subject to the provisions of these Articles, notice of and other communications relating to a general meeting shall be given to all Partners, Members, Directors and the auditors.

8.4. Notwithstanding the foregoing provisions of these Articles, a general meeting may be called by shorter notice if it is so agreed in accordance with section 307 of the Companies Act 2006.

8.5. The accidental omission to give notice of a meeting to, or the non-receipt of notice of a meeting by, any person entitled to receive notice shall not invalidate the proceedings at that meeting.

8.6. The Company may send a notice of meeting by making it available on a website or by sending it in hard copy form or electronic form and if notice is sent in either way it will be valid provided it complies with the relevant provisions of the Companies Act 2006.

9. PROCEEDINGS AT GENERAL MEETINGS

9.1. No business shall be transacted at any general meeting unless a quorum of Partners and Members is present. Partners and Members holding at least 50% of the votes eligible to be cast at a general meeting and entitled to vote upon the business to be transacted, each being a Partner or Member or a duly authorised representative of a corporate Partner or Member, shall be a quorum save that, if and for so long as the Company has only one person as a Partner, one Partner present in person shall be a quorum.

9.2. If within half an hour from the time appointed for the general meeting a quorum is not present the general meeting shall stand adjourned to the same day in the next week, at the same time and place, or to such other day and at such other time and place as the Directors may determine; and if at the adjourned general meeting a quorum is not present within half an hour from the time appointed therefore the Partner(s) and Member(s) present in person or (being a body corporate) by representative and entitled to vote upon the business to be transacted shall constitute a quorum and shall have power to decide upon all matters which could properly have been disposed of at the meeting from which the adjournment took place.

9.3. The chairperson, if any, of the Directors shall preside as chairperson at every general meeting of the Company, or if there is no such chairperson, or if he or she shall not be present within fifteen minutes after the time appointed for the holding of the meeting or is unwilling to act, the Directors present shall elect one of their number to be chairperson of the meeting.

9.4. If at any meeting no Director is willing to act as chairperson or if no Director is present within fifteen minutes after the time appointed for holding the general meeting, the Partners and Members present shall choose one of their number to be chairperson of the meeting.

9.5. A Director shall, notwithstanding that he or she is not a Partner or a Member, be entitled to attend and speak at any general meeting.

9.6. The chairperson may, with the consent of any meeting at which a quorum is present (and shall if so directed by the meeting), adjourn the meeting from time to time and from place to place, but no business shall be transacted at any adjourned meeting other than the business which might properly have been transacted at the meeting had the adjournment not taken place. When a meeting is adjourned for 30 days or more, notice of the adjourned meeting shall be given as in the case of an original meeting. Save as aforesaid it shall not be necessary to give any notice of an adjournment or of the business to be transacted at an adjourned meeting.

9.7. At any general meeting a resolution put to the vote of the meeting shall be decided on a show of hands, with each member organisation accounting for one vote.

9.8. A declaration by the chairperson that a resolution has been carried or carried unanimously, or by a particular majority, or lost, or not carried by a particular majority and an entry to that effect in the

minutes of the meeting of the Company shall be conclusive evidence of the fact without proof of the number or proportion of the votes recorded in favour of or against such resolution.

10. VOTES OF PARTNERS AND MEMBERS

10.1. On a show of hands every Partner and Member (being an individual) present in person or (being a corporation) present by a duly authorised representative shall have one vote per member organisation.

10.2. No Partner or Member shall be entitled to vote at any general meeting unless all moneys presently payable by it to the Company pursuant to any rules or bye-laws made by the Directors under Article 26 or otherwise have been paid.

10.3. No objection shall be raised to the qualification of any voter except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote not disallowed at the meeting shall be valid. Any objection made in due time shall be referred to the chairperson whose decision shall be final and conclusive.

11. WRITTEN RESOLUTIONS OF PARTNERS AND MEMBERS

11.1. A written resolution, proposed in accordance with section 288(3) of the Companies Act 2006, will lapse if it is not passed before the end of the period of 28 days beginning with the circulation date.

11.2. For the purposes of this Article 11 "circulation date" is the day on which copies of the written resolution are sent or submitted to Partners and Members or, if copies are sent or submitted on different days, the first of those days.

12. NUMBER OF DIRECTORS

Unless otherwise determined by ordinary resolution the number of Directors shall not be subject to any maximum but shall not be less than three.

13. ALTERNATE DIRECTORS

13.1. A Director shall be entitled to appoint an alternate Director being a person

13.1.1. in the case of a Director who is appointed by a Partner being an NHS Trust or an NHS Foundation Trust who is a member of the Board of such NHS Trust or NHS Foundation Trust or

13.1.2. in the case of a Director appointed by a Partner being a higher education institution who is either a member of the governing body of such higher education institution or a member of its senior management team or

13.1.3. in the case of any other Director by a member of the governing board or equivalent of the member appointing the Director

and so that if such alternate shall cease to be so qualified then such person shall automatically cease to be an alternate Director. An alternate Director shall be treated as a Director for all purposes.

14. DUTIES AND POWERS OF DIRECTORS

14.1. Subject to the provisions of the Statutes, these Articles and any directions given by special resolution, the business of the Company shall be managed by the Directors who may exercise all the powers of the Company.

14.2. No alteration these Articles and no such direction given by special resolution shall invalidate any prior act of the Directors which would have been valid if that alteration had not been made or that direction had not been given.

14.3. The powers given by this Article 14 shall not be limited by any special power given to the Directors by these Articles and a meeting of Directors at which a quorum is present in accordance with Article 19.4 may exercise all powers exercisable by the Directors.

14.4. The Directors shall be responsible for preparing the annual business plan for the Company and shall procure that the draft business plan is circulated to the Partners and Members ahead of the annual general meeting so that it may be approved at that meeting. Once approved at a general meeting in accordance with these Articles, the Directors shall implement the business plan in such a manner as to best further the Company's Objects. Any matters that fall outside of the scope of the business plan as approved by the Partners and Members shall be determined by the Partners and Members as they may in their absolute discretion see fit.

14.5. All cheques, promissory notes, drafts, bills of exchange and other negotiable instruments, and all receipts for moneys paid to the Company, shall be signed, drawn, accepted, endorsed or otherwise executed, as the case may be, in such manner as the Directors shall from time to time by resolution determine.

14.6. A Director must absent himself or herself from any discussions of the Directors in which it is possible that a conflict will arise between his or her duty to act solely in the interests of the Company and any personal interest (including but not limited to any personal financial interest).

15. DELEGATION OF DIRECTORS' POWERS

The Directors may delegate any of their powers to any committee consisting of one or more Directors and such other persons (if any) not being Directors co-opted on to such committee as the Directors think fit. Any such delegation may be made subject to any conditions the Directors may impose and may be collateral to their own powers and may be revoked or altered. Subject to any such conditions the proceedings of a committee with two or more members shall be governed by the Articles regulating the proceedings of Directors so far as they are capable of applying.

16. APPOINTMENT AND RETIREMENT OF DIRECTORS

16.1. Each Partner and Member shall be entitled by notice to the Company to appoint and remove two persons to act as a Director, such notice having effect with immediate effect upon valid receipt of the notice by the Company or by such other date as may otherwise be specified in the notice. Such persons shall be, in the case of a Partner or Member being an NHS Trust or an NHS Foundation Trust, the chief executive and chair of such Trust and, in the case of a Partner or Member being a higher education institution, shall be members of the senior management team of such higher education institution. In all other cases the Partner or Member may appoint such persons to act as a Director as they in their absolute discretion consider fit.

16.2. The Directors shall not be subject to retirement by rotation.

17. DISQUALIFICATION AND REMOVAL OF DIRECTORS

17.1. The office of a Director shall be vacated if that Director:

17.1.1. ceases to be a Director by virtue of any provision of the Statutes; or

17.1.2. is removed as a Director in accordance with Article 16.1; or

17.1.3. becomes prohibited by law from being a director; or

17.1.4. ceases to hold the relevant office by virtue of which he or she was appointed as a Director in accordance with Article 16; or

17.1.5. becomes bankrupt or makes any arrangement or composition with their creditors generally; or

17.1.6. is, or may be, suffering from mental disorder and either:

(a) is admitted to hospital in pursuance of an application for admission for treatment under the Mental Health Act 1983 or, in Scotland, an application for admission under the Mental Health (Scotland) Act 1960; or

(b) an order is made by a court having jurisdiction (whether in the United Kingdom or elsewhere) in matters concerning mental disorder for that Director's detention or for

the appointment of a receiver, curator bonis or other person to exercise powers with respect to that Director's property or affairs; or

17.1.7. resigns his or her office by notice to the Company; or

17.1.8. where the Company be registered as a charity, is not eligible to be the trustee of a charity; or

17.1.9. is absent for more than six consecutive months from meetings of Directors held during that period without permission of the Directors and the Directors resolve that that Director's office be vacated.

18. DIRECTORS' REMUNERATION

The Company may employ or remunerate a Director only to the extent it is permitted to do so by Article 5 and provided it complies with the conditions in that Article.

19. PROCEEDINGS OF THE DIRECTORS

19.1. Subject to the provisions of these Articles, the Directors may regulate their meetings, as they think fit. A Director may, and the Secretary (if such a role exists) at the request of a Director shall, call a meeting of the Directors.

19.2. Notice of every meeting of the Directors shall be given to each Director, including Directors who may for the time being be absent from the United Kingdom and have given the Company an address within the United Kingdom for service.

19.3. The Directors will appoint a person to be the chairperson of the board of Directors and may remove him or her from that office. Such person shall be appointed for a term of three years renewable for one further term of three years but otherwise on terms agreed by the Directors. Such person shall be independent of the Partners and shall have an ordinary vote in addition to the casting vote at meetings of the board of Directors. Unless he or she is unwilling to do so, the chairperson so appointed shall preside at every meeting of the Directors at which he or she is present. If there is no Director holding that office, or if the Director holding it is unwilling to preside or is not present within five minutes after the time appointed for the meeting, the Directors present may appoint one of their number to be chairperson of the meeting.

19.4. Questions arising at a meeting shall seek decision by consensus led by the chairperson; where necessary decisions shall be determined by a casting vote of the chairperson. In the absence of consensus, the chairperson will determine in discussion with the Directors the process for reaching agreement or deciding a matter. If the chairperson considers that a matter shall be determined by voting, each member organisation shall have one vote. In the case of an equality of votes, the chairperson shall have a second or casting vote.

19.5. Any Director may participate in a meeting of the Directors or a committee constituted pursuant to Article 15 of which he or she is a member by means of a conference telephone or similar communications equipment provided that all persons participating in the meeting can hear each other. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting and, subject to these Articles and the Statutes, and all Directors so present shall be entitled to vote and be counted in a quorum accordingly. Such a meeting shall be deemed to take place where the largest group of those participating is assembled or, if there is no such group, where the chairperson of the meeting then is.

19.6. The quorum for the transaction of the business of the Directors may be fixed by the Directors, and unless so fixed at any other number, shall be one third of the membership of the Board of Directors.

19.7. Notwithstanding any vacancies in their number, the continuing Directors or where there is only one, the sole continuing Director, may continue to act but, if the number of Directors is less than the number fixed as the quorum they (or in the case of a sole Director he/she), may act only for the purpose of filling vacancies, or of calling a general meeting.

19.8. All acts done by any meeting of the Directors or of a committee constituted pursuant to Article 15, or by any person acting as a Director shall, notwithstanding that it be afterwards discovered that there was some defect in the appointment of any Director or person acting as aforesaid, or that they or any of them were disqualified from holding office or had vacated office, or were not entitled to vote,

be as valid as if every such person had been duly appointed and was qualified and had continued to be a Director and had been entitled to vote.

19.9. A resolution in writing, signed by all the Directors entitled to receive notice of a meeting of Directors or of a committee constituted pursuant to Article 15 shall be as valid and effectual as if it had been passed at a meeting of the Directors or (as the case may be) such a committee duly convened and held and may consist of several documents in the like form each signed by one or more Directors or members of the committee (as the case may be).

20. INTERESTS OF DIRECTORS

20.1. A Director shall declare any pecuniary, personal or family interest in any matter under discussion and shall take no part in the consideration of any such matter in which he or she shall have any such interest and shall not vote thereon and shall withdraw during the course of discussion, other than where proposals for the insurance of members of the board of Directors against liabilities are being discussed. If necessary, the chairperson shall determine whether or not there is a conflict of interest for any Director at a particular time. In the case that the chairperson's interests are to be considered and the other one of them is absent, a chairperson of a committee of the board of Directors shall determine the matter.

20.2. For the purpose of this and the preceding Article, a Director shall be deemed not to be interested in any contract or arrangement or any matter arising thereout if his or her interest therein arises solely by virtue of that Director:

20.2.1. being a member, director, chief executive, officer or representative of a Partner or a member of a company in which he or she holds not more than one per cent of the capital; or

20.2.2. owing a duty of loyalty to a Partner or Member.

20.3. Directors shall withdraw from the meeting room if there is discussion of any matter which directly concerns their own individual position.

20.4. If a conflict of interests arises for a Director because of a duty of loyalty owed to another organisation or person and the conflict is not authorised by virtue of any other provision in these Articles, the unconflicted directors may authorise such a conflict of interests where the following conditions apply:

20.4.1. the conflicted Director is absent from the part of the meeting at which there is discussion of any arrangement or transaction affecting that organisation or person;

20.4.2. the conflicted Director does not vote on any such matter and is not to be counted when considering whether a quorum of directors is present at the meeting; and

20.4.3. the unconflicted Directors consider it is in the interest of the Company to authorise the conflict of interest in the circumstances applying.

20.5. There shall be an exclusion to 20.4 in regards to any perceived or actual conflict that arises for a Director of a duty of loyalty owed to the organisation within the Alliance membership by which they are employed.

20.6. There shall be a Register of Directors' Interests maintained by the Secretary or, in the absence of a Secretary, by such other individual that the Directors may from time to time determine. The board of Directors shall make procedures for the declaration of interests from time to time. The Register of Directors' Interests shall be made available for inspection on request by any Director, any Partner, any Member or any member of the public.

20.7. The Directors may be repaid by the Company travelling, hotel and other expenses properly incurred by them in attending and returning from meetings of the board of Directors or any committee of the board of Directors or any general meetings of the Company or in rendering any other service in their capacity as Directors, but shall not be entitled to any remuneration for their services as Directors, subject to Article 18.

21. AUDITORS' APPOINTMENT AND RE-APPOINTMENT

21.1. Auditors must be appointed for each financial year of the Company and shall be appointed by the Directors. Other than the Company's first financial year, the appointment must be made in the period for appointing auditors as defined in section 485 of the Companies Act 2006.

21.2. Auditors cease to hold office at the end of the next period for appointing auditors unless and until they are re-appointed.

22. SECRETARY

22.1. Subject to the provisions of the Statutes, the Secretary shall be appointed by the Directors for such term, at such remuneration and upon such conditions as they may think fit and any Secretary so appointed may be removed by them provided always that no Director may hold office as Secretary where such office is remunerated.

22.2. A provision of the Statutes or these Articles requiring or authorising a thing to be done by or to a Director and the Secretary shall not be satisfied by its being done by or to the same person acting both as Director and as, or in place of, the Secretary.

23. MINUTES

The Directors shall cause records to be kept for the purposes of recording:

23.1. The names and addresses of all Partners; and

23.2. The names and addresses of all Members; and

23.3. All appointments of officers made by the Directors; and

23.4. All proceedings at meetings of the Company and of the Directors and of committees constituted pursuant to Article 15 including the names of Directors, Partners and Members (as appropriate) present at each such meeting.

24. THE SEAL

If the Company has a seal it shall only be used with the authority of the Directors or of a committee constituted pursuant to Article 15 which is comprised entirely of Directors. The Directors may determine who shall sign any instrument to which the seal is affixed and unless otherwise so determined, every instrument to which the seal is affixed shall be signed by one Director whose signature shall be attested in the presence of a witness or by one Director and the secretary or by two Directors.

25. ACCOUNTS AND ANNUAL REPORT

25.1. No Partner shall (as such) have any right of inspecting any accounting records or other book or document of the Company except as conferred by statute or authorised by the Directors or by ordinary resolution of the Company.

25.2. The Directors must prepare accounts and keep accounting records as required by the Statutes.

25.3. If the Company is a registered charity, the Directors shall comply with the requirements of the Charities Act 1993 with regard to statement of accounts, preparation of an annual report, preparation of an annual return and their transmission to the Commission.

25.4. The Directors shall if the Company is a registered charity notify the Commission of any changes to the Company's entry on the Control Register of Charities.

26. NOTICES

26.1. Any notice to be given to or by any person pursuant to these Articles (other than a notice calling a meeting of the Directors) shall be in writing and shall be sent to an address for the time being notified for that purpose to the person giving the notice.

26.2. The Company may give any notice to a Partner or Member either personally or by sending it by first class post in a prepaid envelope addressed to the Partner or Member at its registered address or by

leaving it at that address or by giving it in electronic form to an address for the time being notified to the Company by the Partner or Member. A Partner or Member who gives to the Company an address either within or outside the United Kingdom at which notices may be given to him, or an address to which notices may be sent in electronic form, shall be entitled to have notices given to him at that address, but otherwise no such Partner or Member shall be entitled to receive any notice from the Company.

26.3. A Partner or Member present in person, at any meeting of the Company shall be deemed to have received notice of the meeting and, where requisite, of the purposes for which it was called.

26.4. Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. Proof that a notice in electronic form was sent in accordance with guidance issued by the Institute of Chartered Secretaries and Administrators shall be conclusive evidence that the notice was given. A notice shall be deemed to be given at the expiration of 24 hours after the envelope containing it was posted or, in the case of a notice contained in electronic form, at the expiration of 24 hours after the time it was sent.

26.5. If at any time by reason of the suspension or curtailment of postal services within the United Kingdom the Company is unable effectively to convene a general meeting by notices sent through the post, a general meeting may be convened by a notice advertised in at least one national daily newspaper and such notice shall be deemed to have been duly served on all Partners and Members entitled thereto at noon on the day when the advertisement appears. In any such case the Company shall send confirmatory copies of the notice by post if at least seven days prior to the meeting the posting of notices to addresses throughout the United Kingdom again becomes practicable.

27. WINDING UP

27.1. Every Partner of the Company undertakes to contribute £1 to the Company's assets, being the amount to which each Partner's liability is limited under Article 6.8, in the event that the Company be wound up while he is a Partner, or within one year after he ceases to be a Partner, for payment of the Company's debts and liabilities contracted before he ceases to be a Partner, and for the costs, charges and expenses of winding up, and for the adjustment of the rights of the contributories among themselves.

27.2. If upon the winding up or dissolution of the Company there remains, after the satisfaction of all its debts and liabilities, any property whatsoever, the same shall be paid to or distributed among the Partners of the Company, unless the Company be a registered charity in which case such property shall be given or transferred to some other charitable institution or institutions having objects similar to the Objects of the Company, and which shall prohibit the distribution of its or their income and property to an extent at least as great as is imposed on the Company under or by virtue of Article 5, such institution or institutions to be determined by the Partners of the Company at or before the time of dissolution, and if and so far as effect cannot be given to such provision, then to some other charitable object.

28. INDEMNITIES FOR DIRECTORS

28.1. Subject to the provisions of, and so far as may be permitted by, the Statutes and if the Company is a registered charity the Charities Act 1993 but without prejudice to any indemnity to which the person concerned may be otherwise entitled, every Director, auditor, or other officer of the Company shall be entitled to be indemnified out of the assets of the Company against all costs, charges, lasses, expenses and liabilities incurred by him in the execution and discharge of his or her duties or the exercise of his or her powers or otherwise in relation to or in connection with his or her duties, powers or office, including any liability which may attach to him or her in respect of any negligence, default, breach of duty or breach of trust in relation to anything done by him or her as a Director, auditor or other officer of the Company.

28.2. The Company shall have the power to purchase and maintain indemnity insurance for the benefit of any Director or office of the Company in accordance with Article 4.11.

29. RULES OR BYE-LAWS

29.1. The Directors may from time to time make such rules or bye-laws as they may deem necessary or expedient or convenient for the proper conduct and management of the Company and for the purposes of prescribing classes of and conditions of Partnership or Membership, and in particular but without prejudice to the generality of the foregoing, it may by such rules or bye-laws regulate:

29.1.1. The admission and classification of Partners or Members of the Company, and the rights and privileges of such Partners or Members, and the conditions of Partnership or Membership and the terms on which Partners or Members may resign or have their Partnership or Membership terminated and the entrance fees, subscriptions and other fees or payments to be made by Partners or Members;

29.1.2. the conduct of Partners or Members of the Company in relation to one another, and to the Company's servants;

29.1.3. the setting aside of the whole or any part or parts of the Company's premises at any particular time or times or for any particular purpose or purposes;

29.1.4. the procedure at general meetings and meetings of the Directors and committees constituted pursuant to Article 15 in so far as such procedure is not regulated by these Articles;

29.1.5. and, generally, all such matters as are commonly the subject matter of such rules, provided, nevertheless, that no rule or bye-law shall be inconsistent with, or shall affect or repeal anything contained in these Articles,

29.2. The Company shall have power to alter or repeal the rules or bye-laws referred to in Article 29.1 and to make additions thereto. The Directors shall adopt such means as they deem sufficient to bring to the notice of Partners or Members (as the case may be) all such rules or bye-laws made pursuant to this Article 29 which, so long as they shall be in force, shall be binding on all Partners and Members.

30. DOCUMENTS SENT IN ELECTRONIC FORM OR BY MEANS OF A WEBSITE

30.1. Where the Statutes permit the Company to send documents or notices to its Partners in electronic form or by means of a website, the documents will be validly sent provided the Company complies with the requirements of the Statutes.

30.2. Subject to any requirement of the Statutes only such documents and notices as are specified by the Company may be sent to the Company in electronic form to the address specified by the Company for that purpose and such documents or notices sent to the Company are sufficiently authenticated if the identity of the sender is confirmed in the way the Company has specified.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	**24th May 2022**

Provider Licence Self-Assessment

Executive Summary

NHS Improvement requires Trusts to self-assess against the NHS provider licence on an annual basis. Two declarations are required:

1. Condition G6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution
2. Condition FT4(8) Providers must certify compliance with required governance standards and objectives

NHS provider Board's must sign off the self-assessment by 31 May 2022 for condition G6 and 30 June for condition FT4. Evidence of self-certification must be published within a month following Board sign-off and NHS Improvement provide templates to support this.

NHS Improvement do not require any submission however will carry out spot checks to ensure that Boards have self-assessed and published details of their self-assessment (i.e. the templates).

The self-certification templates relating to condition GS6 and condition FT4 are set out in attachments one and two respectively with the Trust response. The Board is asked to approve the draft self-certification return as set out in the attachments for the period of 2021/22

Recommendation to the [Board / Council]

The Board is asked to approve the draft self-certification return as set out in the attachments for the period of 2021/22

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Interim Director of Corporate Governance	Chief Executive Officer

1. Background

The Health and Social Care Act 2012 introduced the concept of a Licence for providers of NHS services, and the NHS Provider Licence was subsequently introduced in February 2013.

Foundation Trusts were licensed from April 2013, with other providers being licensed from April 2014, but it was later confirmed that the Licence would not apply to NHS Trusts. Despite this, in April 2017, NHS Improvement (NHSI) confirmed that NHS Trusts must undertake a self-certification against the NHS Provider Licence, on the basis that, despite their exemption, directions from the Secretary of State required NHSI to ensure that NHS Trusts complied with conditions equivalent to the Licence, as it deemed appropriate.

As NHSI's Single Oversight Framework (SOF) bases its oversight on the Licence, NHS Trusts are therefore legally subject to the equivalent of certain Provider Licence conditions, and must self-certify under these licence provisions.

These conditions are:

The Board considered the following evidence to form its conclusion:

1.1. The Trust has a governance structure in place with regular reporting of issues, decisions and actions through to the Board committees and the Board on a regular basis.

1.2. This includes a focus on risk management, with the Executive Leadership team reviewing the Board on a regular basis reporting directly into the Board, providing transparency and focus on risk at Board level. In addition, the Audit Committee seeks assurance over the risk management processes and controls in place.

1.3 Paragraph 2(b) itself refers to the need to regularly review whether the processes and systems have been implemented and how effective they are. During 2021/22 the Board undertook an External Review of its Governance against the NHS Improvement / CQC Well-Led Framework.

1.4 Where the review have highlighted areas where the Trust needs to enhance processes and systems, action plans have been developed to ensure that associated actions are implemented on a timely basis.

1.5 The Head of Internal Audit Opinion concluded that partial assurance could be provided for 2021/2022 which provides positive evidence of the effectiveness of systems and processes.

1.6 The Trust's 'good' rating from CQC indicated a positive level of compliance with CQC's fundamental standards and governance requirements.

1.7 Both the Board and Governors have been provided with regular updates on the Trust's segment position in respect of the Single Oversight Framework. The letters from NHS Improvement confirming the quarterly position. The Trust has undoubtedly faced challenges during the year, both operationally and financially, but has consistently achieved a segmentation rating of 1 (on a scale of 1 to 4 with 1 being the best segment score).

Worksheet "FT4 declaration"

Financial Year to which self-certification relates Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust in year as undertaken a proactive Governance Review, the review did not identify any serious breaches in governance or weaknesses in the Trusts governance. The review did identify areas of further imporvment. An aciton plan is in place to address the areas of improvmement. A detailed explanation about the Trust's corporate governance systems is set out in the Trust's annual governance statement and in other parts of the Trust's annual report 2021-2022	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Audit Committee recieves regular reports from Internal and External Audit on relevant changes to governance and seeks assurance from the Executives that changes have been implmented. The Trust is currently taking actions which will imporve overall governance and ensure compliance with all relvant guidence	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Governance administration for Board and all Sub-Committees in operation; clear agendas, timely paper distribution, action logs which are reviewed at each meeting, minutes are recorded and approved and cover page for all papers. The Trust has in place an Audit Committee which oversees the effectiveness of Board Governance. The Trust in line with the NHSEI code of Governance, has in place a constitution, Standing Financial instructions, standing orders and scheme of delegation.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board has both directly and through its Committee structure been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year timely actions have been implemented to improve these areas. The Board has commenced a review of the Trust Strategy and expects to complete this and implement the outcome of the Strategic Review in August 2022. Key risks and associated assurance has been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded over the Trust corporate risk and assurance processes. Financial performance is discussed at each Board meeting. In addition, the Board as part of the response to the Governance review, the Board has established Finance, Performance and Investment Committee which meets bi-monthly to review financial performance, contracts, the capital programme, financial viability, etc the terms of reference and information flow to and between committees and the Board have been reviewed and updated to ensure they reflect the changes to the Trust service provision and in preparation for Integrated Care Systems	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	It is recommended that a "confirmed" declaration is made as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. The Board both directly, and through its Committee structures, ensures that a focus is maintained on the delivery of quality services. The Trust's Quality Priorities continue to be set in consultation with the Council of Governors and other stakeholders. The Trust engages postively with Regulators and provides regular updates on progress agaisnt the GIDS Action plan. The Trust has been engaging with stakeholders and the community on a revised PPI strategy, which aims to streghen paitetnt and community voice within the organsation. Quality Improvement and coproduction remain an integral part of the Trust's strategy	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	It is recommended that a "confirmed" declaration is made. The Trust has undertaken appraisals with all directors. In addition, it has reviewed the skills and experience of its Non-Executive Directors, this review is currently being considered this against committee membership and other portfolio responsibilities. The Trust has also established a process that ensures that all Board Members are "fit and proper" persons. The Board has estblished a People, Organsational Development, Equality, Diversity and Inclusion Committee has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Rigorous and transparent recruitment process for new Board Directors includes testing against the values of the Trust and stakeholder panels including Governors, service users and carers, and external stakeholders. All current Board Directors comply with the requirements of the Fit and Proper Persons Regulation and are appropriately qualified to discharge their functions effectively. All Board Directors and senior decision makers complete declarations of interest	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Burstow	**Name**	Paul Jenkins

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2021/22 — Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Terry Noys	**Name**	Paul Jenkins
Capacity	Director of Finance	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

NHS
The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24th May 2022

Committee Chair Report:
Education and Training Committee (ETC)

Executive Summary

The Education and Training Committee (ETC) met on 5th May conducting its normal business obtaining assurance and updates in relation to various workstreams.

- **Student Recruitment**: The Committee received and update on the recruitment pipeline, with the number of applications received having fallen by 15%, and the targeted action being taken both to process applications and in relation to deferred students.

- **Return to Building**: The Committee noted the positive developments in relation to an increased number of students returning for face-to-face teaching, following an agreement with the CQC to reduce social distancing for educational activities to 1-metre.

- **Litigation**: The Committee was notified of litigation being commenced by a student against the Trust.

- **Graduation**: The Committee expressed its best wishes to the graduands who would be attending the in-person graduation ceremony at the Peoples' Palace, Queen Mary University on 7th May.

- **Risk Management in Education & Training**: The Committee received assurance of the progress being made in relation to risk management within education and training. In particular, the Committee discussed the need to align risk reporting across the Trust, and to develop a Trust-wide template for reporting on risk, consequence and mitigation. The Committee noted the work needed at Board level to agree the Board Assurance Framework and the need to link this to operational risk management.

- **Strategic Review**: The Committee discussed the feedback received in relation to the consultation, with particular attention paid to the areas of portfolio configuration, course leadership and consolidation, and banding of posts, as well as the education and training – clinical interface.

- **Nursing Project**: The Committee discussed the recommendations within the Nursing Project report, and agreed to progress these, given the demand for the Trust's provision, and its expertise in this area. The Committee noted the need for resource prioritisation within DET, to then develop a business case.

- **Quality Report**: The Committee received a presentation on the proposed Quality Report template, which brings together various elements of assurance on quality, reflecting the expectations of the Quality Assurance Agency. The evidence-based annual report would provide a robust set of measures and ways in which we assess our provision and quality on a routine basis, to give assurance, drive new developments, and identify areas of improvement.

- **EDI update**: The Committee received a brief update on equalities, diversity and inclusion within education and training, in relation to the recruitment gap and awards. The Committee noted the report and will be receiving a full update at the July ETC.

- **Governance**: The Committee agreed the proposal to set up a time-limited task and finish group within education and training to draw together the various threads of governance, including what would be required for a future application for degree-awarding powers. The Committee discussed and agreed membership of the group, and the need to ensure alignment to the Trust-wide governance task and finish group.

- **Student Retention**: The Committee received a presentation on student retention, a key performance indicator. The Committee noted the potential impact of the No Detriment Policy (in AY2019-20 and AY2020-21) on progression, and that further analysis is required. The Committee agreed that there would be future reporting on student deferrals.

- **Student Complaints**: The Committee received an update on active complaints, including two investigations with the Office of the Independent Adjudicator, and on improvement measures being taken. Key highlights included
    - Work with course leads to improve guidance for resolving informal complaints, and the information available to students and staff.
    - Work to improve processes, following advice from Trust legal advisors.
    - The process which has been developed for reviewing and updating policies and procedures in education and training, with a view to making the changes highlighted through complaint investigations.

- **Reflection**: The Committed reflected on the need to further develop the scheduled annual programme of agenda items, to be set out alongside the academic year, to allow for development of reporting and full discussion at the Committee. The Committee also reflected on the need to review the groups effectiveness as a Committee.

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

- *Director's Report*
- *Annual Student Survey Recommendations Progress Report*
- *Risk Management in DET*
- *Governance in DET*
- *EDI Strategy and Plan*
- *Student Recruitment Status Report*
- *Short Course Performance update*

Recommendation to the Board

The Board of Directors are asked to:

- **Note the following**:
  - The progress on returning students to face-to-face teaching as part of the Covid-19 recovery.
  - The actions being taken in relation to deferred students and the processing of applications
  - Development work underway on improving the logging and monitoring of risk in education and training on upwards reporting
  - The approach to governance within education and training
  - The assurance received in relation to managing student complaints and taking improvement measures
- **Confirm**:
  - The Committee's agreement to the progression of the recommendations from the Nursing Project report
  - The creation of a time-limited task and finish group to consider and establish governance channels within DET with a forward-facing view to Degree Awarding Powers

Trust strategic objectives supported by this paper

(2021/2022) Corporate Objective/Associated BAF risks:
Obj 1,/ Risk ref 189(7) Obj 6,/Risk Ref 189(7), Risk Ref 108(6) Obj 11,/Risk Ref 187(4)

Author	
David Levenson	Chair ET Committee
Brian Rock	Director of Education & Training/ Dean of Postgraduate Studies

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	24th May 2022

Committee Chair Report: People, Organisational Development, Equality, Diversity, and Inclusion Committee (POD EDI) held 12th May 2022

Executive Summary

The POD EDI committee met on the 12th May 2022 it is subject to formal authorisation by the Board as part of the Governance task and finish group work.

- **TOR:**The committee reviewed and made final minor amendments to its draft Terms of Reference for formal Board sign off at its May meeting.

- **Comms plan**: The committee agreed the parameters for a comms and engagement strategy for the Committee and specifically for the Trust's Race Equality work. A communications plan for committee sign off will be received at the next meeting.

- **Data dashboard:** The committee received a first draft of the revised 'People Metrics dashboard' and gave feedback for its next iteration, with particular focus on benchmark data, data trends and focusing the data against the key performance indicators to enable the committee to properly oversee and be assured on performance. The committee noted that recruitment data still needed to be imported from shared services and that ESR employee relations casework data would be included in future reports. The committee noted that the dashboard would be the template for people reporting at all levels in the organisation, allowing managers at all levels to clearly see their team's relative performance against key metrics.

- **People Plan**: The committee received the working draft of the 'People Plan' which will be the Trust Workforce, People and OD strategy and action plan. The committee endorsed the work to date and requested that the mapping to the staff survey action plan was clarified, that clear metrics for each year were described, that diversity was given greater priority and that Talent management, Learning and development, line manager development and policy and procedure development were more clearly articulated. The committee requested that the People Plan came to the next meeting with an intention to sign off and recommend to the Board and that in the meantime drafts could be developed virtually.

- **Recruitment process assurance**: The committee had sought assurance on the process checks in recruitment at its last meeting and it took a presentation describing the normal processes followed; the committee will take a further report at its next meeting with assurance data on recruitment KPIs and performance. The committee raised issues that members had heard in visits to service regarding the

NLPSS (shared services) recruitment service, the committee heard the current operational management and escalation processes that were in place to address these problems and planned further line manager recruitment process training and will receive a report on NLPSS performance and recovery at its next meeting.

- **Freedom to Speak Up Policy and framework**:The committee received a report on the progress and planned sign off of the revised Freedom to Speak Up policy and the context of the wider work being undertaken on creating the policy framework to support a 'restorative justice' culture. The committee noted that the Trust would shortly be receiving support from the NHSEI FTSU lead and would develop a wider 'speaking up culture' action plan following that input. The committee noted that the NED with leadership of FTSU was Halen Farrow, the Exec with FTSU lead responsibility was the CPO and the FTSU Guardian was Sarah Stenlake.

- The committee paid attention to the health and wellbeing of its members and took a planned health and wellbeing break during its meeting

- **Freedom to Speak Up Report**: The committee received a report from the FTSUG and noted the activity to date and the need to undertake the planned work as described above. It was noted that the FTSUG would continue to report formally to the full Trust Board annually but that she would provide data to the 'People dashboard' on a quarterly basis and would attend the POD EDI committee twice a year to explore FTSU issues in more detail and enable triangulation of data sources to support Board assurance in this area.

- **Race Strategy and Plan**: The committee received a report against the Trust Race strategy and Race Action Plan. The committee received a presentation from Dr Thanda Mhlanga the newly appointed Associate Director of HR for EDI. The committee was deeply moved and very grateful to Dr Mhlanga for his candid insight into the EDI position of the Trusts and welcomed the presentation which reiterated the Trust's need to focus on EDI and especially race related issues. The committee noted and supported the guidance from Dr Mhlanga that the Race Strategy was incorporated into a wider EDI strategy and plan, but that it was still given priority, the committee requested that Dr Mhlanga bring the proposed Trust EDI strategy and Plan to its next meeting for sign off and recommendation to the Board and that drafts of this could be received virtually for comment in the meantime.

- **Gender Pay Gap**: The committee noted the Gender pay gap report on behalf of the Board with the conclusion that the Trust had a pay gap , that it was smaller than the UK organisation average and that it was slowly reducing year on year, and the intention to capture actions to close it further in the wider EDI strategy and plan.

- **Staff Network Reporting**:The committee had received a report from the LGBTQI+ network champion and the Trans staff associate Champion and supported the

request for clarification of the planned support for champions that would be provided by the AD HR EDI and their office. The report requested that the Trust considered membership of the Stonewall Diversity champions network, the committee was supportive but requested that the Champions undertook further work on the risks (including potential reputational risks) and benefits of membership of this and the Stonewall diversity index scheme and any other schemes that may deliver similar benefits. The committee also asked that the requests were considered by the Associate Director of EDI in the context of his whole EDI strategy and plan for this year.

- **BAF risks allocated to the committee**: The committee held over the report against current BAF risks and requested that an updated paper was produced once the BAF had been refreshed as part of the governance review.

- **AOB**: Under AOB the Committee noted the SOF3 requirements and support in the areas of staff survey / staff experience and on speaking up culture and noted that the agenda would have specific items devoted to these topics and reports that would be used by the Director of Governance to form the overall Trust reports.

- **Reflection**: The committee reflected on its meeting and reviewed its meeting structure, papers and effectiveness for future working. It was noted that some of the papers were not of the requisite quality and that training and support for those writing board and committee papers is needed, to enable the committee to carry out its assurance function effectively and efficiently. Papers need to be less operational.

- **Next meeting items**: At the committee';s next meeting it will consider the following topics as per its agenda planner:

- *EDI Strategy and Plan*
- *People Strategy and Plan (SOF3 Item)*
- *Speaking up Culture action plan (SOF3 item)*
- *Workforce metrics dashboard*
- *Report on Mandatory and Statutory (MaST) training processes and performance*
- *Report on establishment control processes and performance*
- *HR Recruitment processes & checks – KPIs and performance / Shared services*
- *Race Equality Staff network champions report*
- *Race Equality Network Allies Group (RENAG) chairs report*

Recommendation to the Board

The Board of Directors are asked to:

1. **Receive and sign off** the POD EDI Terms of Reference at the May Board meeting and agree to formal adoption of the committee.

2. **Note**
   - the plans for the PODEDI Communications and engagement strategy and plan
   - progress on the workforce metrics dashboard as a tool of assurance
   - progress on the Trust People plan and the intention to bring it to July Board
   - scrutiny of the recruitment process checks and further KPI / assurance work planned
   - progress on FTSU policy and wider work to be developed with SOF3 support.
   - the plan to develop an integrated EDI and Race strategy and plan for July Board
   - the Gender pay gap report scrutiny and approve public reporting
   - the planned agenda for the July meeting of the POD EDI committee

3. **Approve**
   - the approach to considering membership of the Stonewall diversity champions scheme
   - the approach to FTSUG reporting and engagement with the PODEDI committee
   - the approach to BAF risks
   - the approach to SOF3 actions and reporting

Trust strategic objectives supported by this paper	
People	
Author	
Shalini Sequeira	NED Chair POD EDI Committee
Ian Tegerdine	Acting Director of Human Resources