NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Tuesday 7th February 2023

Freud Museum, 20 Maresfield Gardens, NW3 5SX and Virtual

Please refer to the agenda for timings.

MEETING OF THE BOARD OF DIRECTORS
HELD IN PUBLIC
Tuesday 7th February 2023 at 2.00pm - 4.30 pm, Freud Museum and Virtual

#	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, introductions, apologies and confirmation of quorum	Inform	Chair	Verbal	2.00 (5)
2.	Patient/Service User Story	Inform	[Executive Lead]		2.05 (20)
4.	Minutes of last meeting: • 29 November 2022	Approve	Chair	Enc.1a	
5.	Matters arising and action log	Review	Chair	Enc. 1b	
6.	Chairs Update – NED Commitments	Inform	Chair	Enc. 2	2.30 (10)
7.	Chief Executive's Report	Inform	Chief Executive Officer	Enc 3	2.40 (10)
Deliver High Quality Clinical Services					
8.	Quality Committee Highlight Report • 19 January 2022	Assurance	Committee Chair	Enc. 4	2.50 (10)
9.	Guardian of Safer Working Report – Quarter 3	Inform	Guardian of Safer Working	Enc. 5	3.00 (5)
10.	Emergency Preparedness, Resilience and Response Report	Inform	Chief Nursing Officer	Enc. 6	3.05 (5)
Deliver High Quality Educational services					
11.	Education and Training Committee Highlight report • 1 February 2023	Assurance	Committee Chair	Verbal	3.10 (5)
Comfort Break: 3.15 to 3.20 (5 mins)					
Improve the efficiency of what we do and deliver value for money					
12.	Performance, Finance and Resources Committee Highlight Report • 24 January 2023	Assurance	Committee Chair	Enc. 7	3.20 (5)
13.	Audit Committee Highlight Report 19 January 2023	Assurance	Committee Chair	Enc. 8	3.25 (5)
14.	Finance Report – Month 9	Inform	Chief Financial Officer	Enc. 9	3.30 (5)
15.	Performance Report – Month 9	Inform	Clinical Chief Operating Officer/ Chief Financial Officer	Enc. 10	3.35 (10)

Meet our ambitions to become a diverse, inclusive and anti-racist organisation					
16.	People, Organisational Development, Equality, Inclusion and Diversity Committee Highlight report • 12 January 2023	Assurance	Committee Chair	Enc. 11	3.45 (5)
Governance and Well Led					
17.	Board Assurance Framework – Q3 2022/23	Approval	Chief Executive Officer Interim Director of Corporate Governance	Enc. 12 To Follow	3.50 (15)
18.	Our Future Direction – Update & Next Steps	Discuss	Chief Executive Officer Interim Director of Strategy & Transformation	Enc. 13	4.05 (10)
19.	Board meetings dates 2023/24	Note	Interim Director of Corporate Governance	Enc. 14	4.15 (5)
CLOSING ITEMS					
20.	Any other business:	Note	Chair	Verbal	4.20 (10)
21.	Reflections and feedback from the meeting	Discuss	Chair	Verbal	
22.	Questions from the Public	Discuss	Chair	Verbal	
DATE AND TIME OF NEXT MEETING(S)					
• Tuesday 7th February 2023 at 5.30 to 7.30 pm: Trust Annual General Meeting /Annual Members Meeting, Video and Exhibition Room, The Freud Museum, 20 Maresfield Gardens, NW3 5SX • Tuesday 14th March 2023 at 10 am to 4 pm: Board Development Session • Wednesday 19th April 2023 at 10 am to 12 noon: Board Development Session • Wednesday 19th April 2023 at 2.00 to 4.30: Board Meeting in public					
Meeting Close					4.30

The Tavistock and Portman
NHS Foundation Trust

UNCONFIRMED MINUTES
OF A MEETING OF THE BOARD OF DIRECTORS

PART ONE: MEETING HELD IN PUBLIC

TUESDAY, 29th NOVEMBER 2022
Lecture Theatre, Tavistock Clinic and via Zoom

Present

Members

Mr John Lawlor	(Chair) Chair of the Trust
Dr Deborah Colson	Vice Chair, Non-Executive Director
Dr Michael Holland	Chief Executive Officer
Mr David Levenson	Non-Executive Director, Chair of the Education & Training Committee and, Joint Chair of the Audit Committee
Ms Aruna Mehta	Non-Executive Director, Chair of Performance, Finance and Resources Committee and, Joint Chair of the Audit Committee
Mr Shalini Sequeira	Non-Executive Director, Chair of the POD EDI Committee
Ms Claire Johnston	Non-Executive Director
Dr Sal Jarvis	Non-Executive Director
Prof Janusz Jankowski	Non-Executive Director
Ms Sabrina Phillips	Associate Non-Executive Director
Mr Terry Noys	Chief Financial Officer
Dr Sally Hodges	Deputy Chief Executive and Chief Clinical Operating Officer
Ms Elisa Reyes-Simpson	Interim Chief Education & Training Officer /Dean of Postgraduate Studies
Dr Caroline McKenna	Interim Chief Medical Officer

In attendance:

Ms Julie Dawes	Interim Director of Corporate Governance
Ms Kathy Elliott	Lead Governor
Prof Michael Rustin	Public Governor
Ms Paru Jeram	Staff Governor
Dr Emma Whicher	Clinical Director for Transformation NCL ICB (attended virtually)
Ms Laure Thomas	Director of Communications & Marketing
Ms Jenny Goodridge	Interim Chief Nursing Officer
Mr Alastair Hughes	Interim Director of Strategy & Transformation
Ms Denise Champagne Hope	Student (item 2)

Ms Katie Argent	Head of Child Psychotherapy Portfolio Manager Psychoanalytic Applied Supporting Ms Denise Champagne Hope
Dr Gurleen Bhatia	Consultant Psychiatrist (item 9) (attended virtually)

Apologies for absence

NONE RECEIVED

	Governance Matters
1.	**Chair's welcome, apologies, and confirmation of quorum**
	Mr Lawlor welcomed those attending and, after introductions, the meeting was noted to be quorate.
2.	**Student Story**
	Ms Argent introduced Ms Denise Champagne Hope who was attending to talk about her learning journey at the Trust. Ms Denise Champagne Hope introduced and gave a background about herself. Ms Denise Champagne Hope talked about her learning journey and her experiences as a student at the Tavistock and Portman. Dr Colson thanked Ms Denise Champagne Hope for such an eloquent summary of her journey. Dr Jarvis also thanked Ms Denise Champagne Hope for her presentation. Dr Jarvis wanted to know what Ms Denise Champagne Hope's motivation was. Ms Denise Champagne Hope responded that her personal circumstances changed and that was why she had to change careers from finance as she had taken custody of her twin nephews. Mr Lawlor thanked Ms Denise Champagne Hope for sharing her story and Ms Argent for supporting her.
3.	**Declarations of Interest**
	None.
4.	**Minutes of last meeting held 27 September 2022**
	Approved pending minor changes: 1) Item 9 – Should read Michael Fairbairn 2) Item 10 – should read "Mr Noys confirmed that '*the'* Committee" 3) Item 11 point 3 – should read "There has been great progress on performance '*reporting'*….

5.	**Matters arising and action log**
	Item AP1 (Information briefing session on the ICS) is rescheduled for November, so as to include Michael Holland (incoming CEO). It was reported at the meeting on 29th November 2022 that there was no progress made. This action still remains outstanding.
6.	**Chair's Update**
	Mr Lawlor welcomed the Dr Michael Holland the new CEO, Dr Sal Jarvis, Ms Claire Johnston and Prof Janusz Jankowski the new Non-Executive Directors and, Ms Sabrina Phillips, Associate Non-Executive Director to their first board meeting. Mr Lawlor informed the meeting that the Trust had successfully appointed a Chief People Officer which was in the process of being finalised. Mr Lawlor noted that he had joined the mock Care Quality Commission (CQC) inspection and had met with several administrators and, that the their patient focus was very impressive. Mr Lawlor informed the meeting that Gloucester House was going through an Ofsted inspection. The inspectors would be there for three days.
7.	**Chief Executive's Report**
	Dr Holland spoke to his report and highlighted the key points. **Changes to the Board** He welcomed the Non-Executive Directors. He informed the meeting that this was Ms Farrington's, interim Chief People Officer's last week with the Trust. He thanked her for the contributions she made that was extremely significant during her short time with the Trust. She reviewed all of HR functions, developing a robust People Strategy for the organisation and building the foundations for an effective and solid people function. **Cost of Living Crisis** Dr Holland informed the meeting that there was a dedicated group who would be working closely with other providers in the Integrated Care System (ICS), to ensure that the Trust is able to provide as much support and assistance to its staff who have been affected. This group has staff side and HR representation. We have committed to paying the living London wage and we do not have any staff employed on less than this level, in line with the ICS commitment. **New NHS England Operating Framework** Dr Holland informed the meeting that on 12 October 2022, NHS England published a new operating framework which set out how the NHS will operate in the new structure created by the 2022 Health and Care Act.

	The Health and Care Act formally established integrated care systems (ICSs) on a statutory basis, enabling local systems to plan and deliver health and care services more effectively. The new operating framework sets out the roles that NHS England, ICSs and providers will now play in the new structure. It describes how we would like to work together and shows how accountabilities and responsibilities will work. Integrated care boards (ICBs) will provide effective system leadership which balances immediate and longer-term priorities. They will work with providers, local authorities and other partners to create local integrated care strategies and deliver joint five-year forward plans for their system.
	Deliver High Quality Clinical Services
8.	**Committee Highlight Report: 16 November 2022**
	The report was taken as read and Ms Goodridge highlighted the salient points: • The new Staff Quality report was launched, and the second iteration of the new style was presented at the meeting. The report was impacted significantly by Carenotes outage which occurred in August 2022. This meant that there was no data reporting for Quarter 2. • The committee received information on the actions that are underway to address the issues raised within a letter from Ms Clare Murdoch, National Director for Mental Health following the BBC Panorama investigation into the Manchester Panorama Mental Health inpatient unit in Greater Manchester about the abuse, restraint on patients. • Royal College of Nurses (RCN) strike action – the outcome of the ballot was that the Trust was one of four North Central London Integrated Care Systems (NCL ICS) organisations who were in favour of taking strike action. This is the first time in 100 years nurses are striking and as a Trust need to recognise this and support the staff. • Care Quality Commission (CQC) – a programme of mock inspections were planned regarding quality improvement and also in response to the CQC action plan. The inspection teams included a mixture of service staff, senior clinical leads, experience experts, Non-Executive Directors and the Integrated Care Board (ICB) quality leads. The inspection followed the Key Lines of Enquiries (KLoEs) using the five CQC domains as a framework. The first report of the mock inspection following a visit to the Adult Complex Needs Service was presented to the committee outlining the findings. The mock inspection reports will continue to be presented to the committee. Dr Colson noted her thanks to everyone who worked on the mock inspections and informed the meeting that there was a big discussion on the Gender Identity Development Service (GIDS) who, were formally thanked by the committee for their hard work. Dr Colson noted that Deidre Malone, Director of Quality NCL was also present at the meeting. Dr Colson added that the papers presented to the committee were so much better and that it provides better challenge and assurance. Dr Colson thanked Ms Goodridge for all her invaluable work that she is doing.

	Ms Goodridge added that Deidre Malone would feed into the SOF3 and this will help the Trust in the exit of SOF3. Responding to a question from Prof Jankowski on how feedback is obtained from the younger patients, Dr Hodges advised that feedback has been done over the previous years however had not done it systematically. The children in Gloucester House have a council which is run by them. Responding to a question from Dr Jarvis on whether the school had an external friend, Dr Colson advised that the Quality Committee focussed on clinical rather than educational. However, we were starting to collect positive as well a negative comment. There is a forum of service users who meet regularly, and they bring interesting insights. Ms Johnston thanked Ms Goodridge for the informative report. In response to a question from Ms Johnston regarding the CQC mock inspection, Ms Goodridge noted that there have been weekly CQC meetings and that three mock inspections had been done. The Trust needs to get away from only preparing for CQC inspections and that it needs to get it better for patients. There is a CQC handbook and it has been updated on the website. Work still needs to be done on systems and processes and, we are aware of what needs to be worked on. In response to a question from Ms Phillips on the Carenotes outage, Ms Goodridge advised that information is coming back in phases and, that there was a process to get it back up and running which will take several weeks. We can see the platform but cannot see the data. This is being managed through the Emergency Preparedness Resilience and Response (EPRR) Gold and this has been pushed up in the priority with the providers.
9.	**Guardian of Safer Working Hours report**
	Dr Bhatia introduced herself and presented her Quarter 2 report by highlighting the salient points. • There have been issues of trainers logging into the DRS system. • New fine rates that were introduced in July 2022 where trainers in ST4-ST6 was calculated in accordance with the chart/timings. • There are 5 exception reports which resulted in one receiving a fine. • The Chid and Adolescent scheme has no vacancies and there are 11 trainees, and there has also been some sickness. • Non-residents on call are only allowed to do one locum. • A meeting with the Junior Doctors took place in October 2022 and was attended by trainees and Adam Harrison BMA/IRO for the Trust. The trainees highlighted the delay in payments and the issues they have with logging into DRS. • Attended an annual meeting at Great Ormond Street Hospital

	(GOSH) and it was mentioned there that they were looking into changing the DRS system. • Prior to 2016 the Junior Doctors were on a basic rate, however since then the rates were revised. Responding to a question from Ms Mehta about the fines, Dr McKenna advised that the amounts were very small. Responding to a question from Prof Jankowski about whether doctors are encouraged to report if they were worried about their training and handovers, Dr Bhatia noted that there was a formal handover system and that she met with the Junior Doctors regularly. They are aware of whom to contact if they have any issues or concerns. Dr McKenna added that there are monthly welfare meetings that are chaired by her.
	Deliver High Quality Educational Services
10.	**Education and Training Committee Highlight Report: 29 September 2022**
	The report was taken as read and, Mr Levenson and Ms Elisa Reyes-Simpson highlighted the salient points: • Dr Jarvis, Non-Executive Director and Ms Knight, Student Governor would both be joining the committee. • The Committee received an update on the return of education and training activity to in person face-to-face delivery, the success of Welcome Week, and the commitment of staff to delivering business as usual activities through the implementation of the strategic review and the associated uncertainties. • The committee received an update on the review and changed to the library policy. • The committee reviewed the process of the DET EDI Bursary programme that was implemented last year following a bequest. • The committee reviewed the Annual Student Survey and noted the drop in overall satisfaction to 76%. There was also a drop in the survey completion rate to 23%. The outcome is on par with the national survey outcomes. Ms Thomas informed the meeting that not being face-to-face had an impact for the low rates for the student survey. Ms Reyes-Simpson noted that there was a mixed picture in education within the NHS, and it would be useful to benchmark this against the rest of the sector. Responding to Ms Sequeira on whether the Digital academy was successful, Ms Reyes-Simpson noted that it has been successful and that it will be reviewed going forward. The EDI Bursary programme was also progressing. In response to a question from Ms Mehta relating to the growing offer in DET, Ms Reyes-Simpson noted that the perinatal course is an area that is growing.

	Improve the efficiency of what we do, and deliver value for money
11.	**Finance, Performance and Resources Committee (FPR) Highlight Report: 29 November 2022**
	Ms Mehta informed the meeting that the committee met in the morning. The first part of the meeting focused on finance and looking at the overhead reports for each service, and it brings it into sharp focus that the loss of GIDS will have a huge impact on the Trust. The Trust to be cognisant of the money. Tied to the performance report it is apparent that there is a long waiting list and vacancies. The Strategic Review process is about bringing in and making more clinically efficient savings by reviewing the clinical services. The reorganising of the clinical services bedded down in ESR will be down by the end of December. Dr Hodges noted that there were 5 key challenges that were the drivers for the Strategic Review: • Financial • Systems data management • Governance • Diversity • Role in the local system Ms Mehta informed the meeting that regarding the CareNotes cyber-attack, IT together with the provider are aiming to get it back up and running for some of the services by the end of January 2023. Ms Goodridge informed the meeting that in relation to the cyber-attack, it was confirmed by the company that has the network, that the Trust was not breached. There will be risks to finance with GIDs redundancies, TUPE and will need to be more robust with the HR processes. Progress is being made on the performance however there are concerns in relation to GIDS/GIC. SOF3 – there are four ratings and where the Trust was in one, it is now in three which means that the Trust is subjected to support and, that there have been challenging monthly meetings happening. Mr Noys noted that the Board would see the SOF3 presentation before it went to the ICS. Ms Mehta informed the meeting that the report that went to the ICS in October/November, going forward the FPR committee will have sight of the report before it goes to the ICS. The key risks are GIDS/GIC, CareNotes (critical dependency), the timeline for ESR baseline to be done by the end of the year with the alignment of the new SR structure. Dr Whicher noted that the SOF3 meeting should reflect what was going on at the Board and internal meetings.

12.	**Finance Report**
	Mr Noys spoke to his report and highlighted the salient points: • NHS Trust revenue and capital budgets have to have ICB approval. The Trust has a Plan for a revenue deficit for 2022/23 of £3.8m and for Capex of £3.4m with a year-end cash position of £6.2m, and we are expecting to meet the £3.8m. • NHS England had issued a protocol. • Concerns around the GIDS service and what happens to the staff, as it will be a problem if there are redundancies. • The capital of £3.4m had been downgraded to £3.3m and to achieve this, the Trust needs to start filling in the vacant roles. Ms Johnston noted that it would be worth looking at the Royal Free Apprenticeship Levy and if the Trust has not used this before, it would be worthwhile doing.
13.	**Performance Report Month 7**
	The report was taken as read. Dr Hodges noted that: • Carenotes outage has impacted on recording and having a full understanding of current performance. Although Carenotes mini was made available, there were still issues of recording patient appointments. • Staffing data was not yet complete. • Further to the development of the new structures and oversight, action plans have been developed and are being monitored alongside the data in the internal monitoring dashboard. • Each general Manager has their own action plan.
14.	**Audit Committee Highlight Report: 13 October 2022**
	Mr Noys noted that the committee met in October and there were updates/discussions on: • Debtors • Tender Waivers • Payroll • Cyber security • HFMA Self-assessment • Re-appointment of the external auditors • External auditors provided a draft Value for Money

	Meet our ambitions to become a diverse, inclusive and anti-racist organisation
15.	**People, Organisational Development, Equality, Inclusion and Diversity Committee Highlight report: 10 November 2022**
	Ms Sequeira noted that the committee met earlier in the month and there were updates/discussions on: • Appraisal compliance rates falling and that the feedback was that the appraisal had no value. • Share services recruitment backlog. • Payroll continues to be an issue and it needs a joined up approach to resolve this urgently. • Staff survey was at 28% and managers are trying to encourage staff to complete this before the deadline date. • There were detailed progress reports on EDI and Dr Mhlanga is trying very hard to move this forward, however with an action plan with 63 actions and a small team, this is not going to be possible. There needs to be an urgent review of the action plan. • Camburg HR people function have provided their conclusions and, immediate changes need to be made on role clarity and restructuring. Training and development have fallen behind. A review of all policies and procedures needs to be done. There needs to be an action plan for the new Chief People Officer (CPO). We need to get the basics right. • Health and wellbeing – as well as the Health and Wellbeing Steering group, there have been engagement sessions on cost of living. Ms Sequeira informed the meeting that she had taken on the role as Wellbeing Guardian in NCL. • Getting the right date on EDI and sickness absence. A new process is being trialled. • The number of vacancies need to be addressed. • The key risk for the HR function is when Ms Farrington, Interim CPO left, there is no one covering especially when there are concerns and issues that need to be addressed. The next PODEDI committee meeting is going to be in January and there will still be no CPO in role. Regarding appraisals, Dr Hodges noted that managers are being trained on this, however during the Strategic Review more time was given for the appraisal cycle and, that it would be done within the year. Responding to Ms Mehta regarding what needs to be accelerated for the vacancies, Mr Lawlor noted that this was not HRs job but the Managers to fill the vacancies with HR support. He added that they have made a good appointment of a new CPO and Deputy CPO however the start date for the CPO has not been agreed. The Deputy CPO will be starting in January 2023. Ms Mehta noted that regarding the Race Equality Action Plan, it needs to

	be relooked at and see what needs to be actioned immediately. Ms Reyes-Simpson suggested that it would be useful to reallocate/redistribute the actions and the Race Equality Network will need to be involved in this.
16.	**Governance**
	Mr Hughes noted that at the last Board Away Day the focus was on the immediate priorities for the Executive Management Team (EMT) and the wider board members on how to change to reflect the current situation. Executive Management Team have almost finalised the KPIs and within the next several days it will be formalised ad finalised. Ms Dawes noted that the Board Assurance Framework (BAF) would be taken to the Audit Committee in January 2023 for a risk audit, and then to the February 2023 Board. In January the plan is that each committee will received their risks and have a scoring on those risk appetites to inform Head of Internal (HoI) audit. The internal auditors are aware of the delay BAF. **ACTION:** Mr Hughes to re-circulate the objectives to the EMT and Board.
	Closing Items
17.	**Any other business**
	None.
18.	**Reflections and feedback from the meeting**
	None.
19.	**Questions from the Public**
	None.
	Date And Time of Next Meetings
	• Tuesday 7th February 2023

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Board of Directors Part 1 Action Log

Ref	Meeting Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
AP1	30 Nov 2021	2.1.2	Information briefing session to be arranged for the whole Board on the relationship with the ICS	CEO	Nov 2022 ~~Sept 2022~~	Following the arrival Chief Executive on 14 Nov, discussions are currently underway with the Chair and Lead Governor to arrange a joint development session with the Board of Directors and Council of Governors in Jan/Feb 2023. Whilst this is still work in progress it is considered to be a key priority. RECOMMENDATION: Remain Open	Overdue
	29 Nov 2022	16 Strategic Objectives 2022/23 Refresh and Board Assurance Framework Development Update	To circulate the objectives to the Board that were discussed at the Board Away day on 15th December 2022 Board Assurance Framework refreshed document to be made available at the next Board meeting	Mr Hughes Ms Dawes	As soon as possible February 2023	This was circulated by Mr Hughes RECOMMENDATION: to Close The draft was taken to the January Audit Committee meeting for review. Work is progressing.	

MEETING OF THE BOARD OF DIRECTORS:			7 February 2023
Chair's Update **Non-Executive Director Commitments 2022/23**			**AGENDA ITEM:** 2
Report Author and Job Title:	Julie Dawes, Interim Director of Corporate Governance	**Responsible Director:**	John Lawlor Trust Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Following changes to the composition of the Board of Directors, this report provides an update on the current Non-Executive Director (NED) commitments for 2022/23.		
Background	In December 2021, NHS England (NHSE) published guidance on a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. The Board received a report on 5 July 2022 of the outcome of a gap and assurance analysis undertaken to evaluate the Trust's position and to identify areas where assurance could be strengthened at committee level to ensure better alignment to the new guidance. The Board approved the recommendations made in the report in respect of new NED Champion roles and a refreshed board committee membership. Since that date there have been a number of board changes, including the subsequent appointment of four new NEDs on 1 November 2022. The Trust Constitution requires the Board to appoint one of the independent Non-Executive Directors as Senior Independent Director (SID). The SID position is currently vacant following the departure of David Holt whose third term of office ended on 30 October 2022, The SID provides two key roles in the Trust governance structure (i) availability to Members and Governors if they have concerns which contact through the normal channels of Trust Chair, Chief Executive or Finance Director has failed to resolve, or for which such contact is inappropriate; and (ii) annual performance evaluation of the Trust Chair.		
Assessment	Following the appointment of four new NEDs in November 2022, we have taken this opportunity to review both the membership of each of the Board Committees and the identified NED Champion		

	roles to ensure the Trust's alignment with NHSE best practice guidance. The Board has commenced the process for the appointment of a new SID. As required by the Trust Constitution, there will be the opportunity to consult with the Council of Governors concerning this matter at their meeting on 10 March 2023. Following this, confirmation of the SID appointment will be provided to the Board in April 2023.	
Recommendation	The Board is asked to **NOTE**: 1. The Non-executive Director commitments for 2022/23 and agree the adoption of the current commitments in 2023/24 and 2. That following the required consultation with the Council of Governors in March 2023, the Board will receive a recommendation in April 2023 concerning the nomination and proposed appointment of the Senior Independent Director.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, failure to have effective corporate governance arrangements in place will be detrimental to the Trust.	
Legal and Equality and Diversity implications	There are no legal or equality and diversity implications associated with this report.	
Strategic Objectives	Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve ☐	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration. ☐
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☐	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.☐
	Ensure we are well-led & effectively governed ☒	

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NON-EXECUTIVE DIRECTOR (NED) COMMITMENTS - 2022/23

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
John Lawlor	Trust Chairman	• Remuneration Committee (**Chair**)	None	• Council of Governors (Chair)	June 2022 (First 2-year term of office ends June 2024)
Aruna Mehta	NED	• Audit Committee (**Joint Chair**) • Performance, Finance & Resources Committee (**Chair**) • Remuneration Committee (Member)	None	None	November 2021 (First 3-year term of office ends November 2024)
David Levenson	NED	• Audit Committee (**Joint Chair**) • Education & Training Committee (**Chair**) * • Performance, Finance & Resources Committee (Member) • Remuneration Committee (Member)	• Security Management Champion	None	September 2019 (Second term of office ending September 2025 to be confirmed by the Council of Governors in March 2023)
Shalini Sequeira	NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (**Chair**) • Remuneration Committee (Member)	• Wellbeing Guardian/ Champion	None	November 2021 (First 3-year term of office ends November 2024)
Claire Johnston	NED	• Quality Committee (**Chair**)	None	None	November 2022

January 2023

Name	Board Role	Responsibilities			Date Appointed/ Term of Office
		Board Committees	NED Champion role	Other Boards/ Committees/ Groups	
		• People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)			(First 3-year term of office ends November 2025)
Sal Jarvis	NED	• Education & Training Committee (Member)* • Audit Committee (Member) • Remuneration Committee (Member)	None	None	November 2022 (First 3-year term of office ends November 2025)
Deborah Colson	Vice Chair, NED	• People, Organisational Development, Equality, Diversity and Inclusion Committee (Member) • Remuneration Committee (Member)	• Freedom to Speak Up (FTSU) Champion	• Gloucester House Steering Group (Member)	October 2017 (Second term of office ends September 2023)
Janusz Jankowski	NED	• Quality Committee (Member) • Education & Training Committee (Member) • Remuneration Committee (Member)	• Doctors Disciplinary Champion/ Independent Member	None	November 2022 (First 3-year term of office ends November 2025)
Sabrina Phillips	Associate NED	• Quality Committee (Member) • Remuneration Committee (Member)	None	None	November 2022 (First 3-year term of office ends November 2025)

*During 2023/24 Q1, the Chair of the Education & Training Committee will transfer from David Levinson to Sal Jarvis. David Levenson will however remain as a member of the Committee.

Table last updated on 31 January 2023

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC **Tuesday 7 February 2023**			
Chief Executive's Report			**AGENDA ITEM:** 7
Report Author and Job Title:	Chief Executive Officer	**Responsible Director:**	Chief Executive Officer
Action Required	Approve ☐ Discuss ☒ Inform ☐		
Situation	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.		
Background	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.		
Assessment	This report covers the period since the meeting on 29 November 2022.		
Recommendation	The Board of Directors is asked to receive this report as **ASSURANCE** and progress update against leadership responsibilities within the CEO portfolio.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	All BAF risks.		
Legal and Equality and Diversity implications	There are no specific legal or equality and diversity implications associated with this paper.		
Strategic Objectives	Improve delivery of high-quality clinical services which make a significant difference to the lives of the people and communities we serve ☒	Be a great and safe place to work, train and learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion, and collaboration. ☒	
	Develop and deliver a strategy and financial plan that supports medium and long-term organisational sustainability and aligns with the ICS. ☒	Be an effective, integrated partner within the ICS and nationally, supporting improvements in population health and care and reducing health inequalities. ☒	
	Ensure we are well-led and effectively governed ☒		

Chief Executive's Report

Purpose

1. This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.

Delivery against the Trust's Strategy/ Executive Portfolio Updates

2. Delivery of High-level Clinical services

The Care Quality Commission (CQC) Targeted Inspection

2.1. The CQC undertook a targeted inspection of our services at the Community Children and Adolescent Mental Health Services (CAMHs) from 23 to 27 January 2023. We will inform the Board as and when we receive the outcome of the inspection visits.

3. Great and Safe Place to Work, Train and Learn

Senior management changes

3.1. I'm delighted that we will have a new Chief People Officer (CPO) starting on 1 February, Gem Davies, who is coming to us from her Deputy CPO role at the Homerton Healthcare NHS FT, and Dayo Ajibola, who will be joining at the end of end January from the Royal Free as our new Associate Director for HR Operations. I would like to thank Karen Merchant and Sarah Mountain for everything they are doing to hold the fort and press on with the necessary improvements and also place on record our thanks to Alison Kingscott, who joined us as our Interim COP during January to provide invaluable support for a short period to the workforce team.

3.2. The recruitment process has commenced for the substantive appointments of the Chief Medical Director, Chief Nursing Officer, Director of Strategy, Transformation and Business Development, and the Director of Corporate Governance.

3.3. The Interim Director of Corporate Governance and Trust Secretary leaves the Trust in mid-February and we are currently in the process of recruiting a replacement.

NHS Staff Survey 2022

3.4. The Staff Survey results have been released but are embargoed nationally until mid-February 2023. The results will be discussed in detail at the next meeting of the Board of Director in April 2023.

Gloucester House Ofsted outcome

3.5. We were delighted to hear earlier last week about the outcome of the Gloucester House Ofsted inspection. The school was rated as Good overall and Outstanding for Behavior and attitudes. This is a huge achievement for

the school and a testament to the excellent care and teaching delivered by its dedicated staff. The full report will be published on the Ofsted site on Friday, 27 January 2023. The Board would like to express its thanks to all those involved.

Industrial Action Update

3.6. In my last CEO report to Board, several unions were in the process of, or had just completed, balloting their members on whether to take industrial action.

Royal College of Nursing (RCN)

3.7. In November 2022, RCN members at the Tavistock and Portman voted in favour of strike action. Since then, there have been four days of RCN strikes, two in December 2022 and two in January 2023. This Trust was not included in the first round of strikes in December but were included in the second round of strikes in January.

Although some of our nursing staff went out on strike on both days, there was only a picket line at the Belsize Lane site on the second day of strikes.

Further strikes have been announced for Monday 6 and Tuesday 7 February2023. The Tavistock and Portman have not been included in these strike days.

Unison

3.8. In November 2022, the results from the Unison ballot did not yield the 50% response rate at the Trust, however, the majority of those who did return their votes were in favour of industrial action. Unison is re-balloting members at organisations where the response rate was close to 50% and this includes the Tavistock and Portman. The ballot closes on 16 February 2023.

4. Development and Delivery of the Trust's Strategy and Financial Plan

Service Planning

4.1. Over the coming weeks the Strategy and Transformation Team will be working with each service to listen, understand and capture ambitions and plans. We want to understand each service's plans over the next 2 - 3 years and capture a set of priority objectives for delivery over the next financial year (2023/2024). Our goal is to develop a deeper understanding of the vision for each service and to align Trust-wide strategy development with service level views through an inclusive approach.

4.2. We are running this in parallel with the 2023/2024 budget planning process so that any planning assumptions can be discussed and joined-up.

Our Future Direction

4.3. I have been holding a series of 'Future Direction' sessions to hear directly from staff about their frustrations and hopes for the future. It's great to hear the themes that are emerging from the sessions so far as it feels the fundamentals for making the Tavistock and Portman an excellent place to work, receive care and train are there. Staff are clearly deeply attached to the organisation and their colleagues. There is a real passion for the work and commitment to patients and students.

The clear focus on treating people rather than symptoms has been a huge draw and motivator for staff. In addition, challenges have been highlighted. These range from the rapidly changing external landscape and the loss of relationships with longstanding stakeholders and commissioners, failings in some basic corporate functions like recruitment and payroll, and some of the difficult dynamics in the last few years.

5. Well-led and Effective Governance

Annual Members' Meeting (AMM)

5.1. The Trust's AMM will take place on Tuesday, 7 February 2023 (5.30 – 7.30p.m) at the Freud Museum, 20 Maresfield Gardens, London NW3 5SX. A notice of meeting is published on the Trust website.

This event is free and open to all Trust staff, members, students and stakeholders.

Letter from NHS England – London

5.2. I received a letter from NHS England (NHSE) on 19 January 2023 which is annexed to this report as Appendix A. The letter sets out NHSE's views on the ongoing support and oversight arrangements for the Trust. We will be working with NHSE and the ICB on next steps in the coming days. The Board of Directors will be updated regularly on progress.

Integrated Governance Task and Finish Group

5.3. An Integrated Governance Task and Finish Group has been established on a fixed time limited basis. The group is chaired by the Chief Executive Officer and comprises David Levinson, joint chair of the Audit Committee and the Interim Director of Corporate Governance. An inaugural meeting was held in December 2022 and the group is intended to meet on a fortnightly basis.

5.4. An improved action plan has been put in place which consolidates recommendations from last years Office of Modern Governance board and leadership review, the outstanding governance actions with the Single Oversight Framework (SOF 3) exit criteria, any significant outstanding actions from internal audit recommendations and any identified actions associated with our preparations for a CQC Well-Led inspection.

5.5. The group will adopt a project management approach with an emphasis on delivering sustained improvement and not 'box ticking'. The Trust Board of Directors are responsible for the successful delivery of the integrated governance plan however increased oversight now provided by the Audit Committee via the Executive Leadership Team.

Trust – Events update

6. Book launch update

6.1. I am delighted to announce that a hybrid event is being held on Wednesday, 8 February at 6.15 to 7.00 p.m, online and in-person at the Tavistock Centre to celebrate the publication of Margaret Rustin's latest publication. *Finding a Way to the Child: Selected Clinical Papers 1983-2021* by Margaret Rustin,

edited by Simon Cregeen and Kate Stratton, is a record of the clinical thinking of Margaret Rustin across her 50 years of work as a child psychotherapist at the Tavistock. It includes some of her well-known papers and some not previously published, and ranges from individual case studies to the challenges of assessment, and work with parents. Margaret's special interest in children with a troubled early history stands out, as does her conviction of the crucial relevance of psychoanalytic therapy for such children and adolescents.

National and Political Context

7. Joint Committee on the Draft Mental Health Bill 2022 report

The Joint Committee on the Draft Mental Health Bill was appointed by the House of Lords and the House of Commons in July 2022 to consider the government's draft Bill to reform the Mental Health Act 1983 (the Act). This is a Joint Committee report, with recommendations to government. The Government has two months to respond.

Key points noted by NHS Providers include:

- The committee welcomes the draft Mental Health Bill concluding it makes important changes to introduce more choice, accountability, and oversight into the use of the Mental Health Act 1983 (MHA). The committee would like to see the Bill introduced in this session of Parliament.
- However, the committee believes the measures in the draft Bill should be strengthened in several ways, such as by:
    - including the four principles – choice and autonomy, least restriction, therapeutic benefit, and the person as an individual – on the face of the Bill
    - creating a Mental Health Commissioner to oversee the direction of travel for the reforms and their implementation, monitoring outcomes and supporting cultural change. The commissioner would also serve as an advocate for patients, their families and carers and speak up about the stigma still attached to severe mental illness

8. NHSE - 2023/24 priorities and operational planning guidance

The document sets out the priorities for the next financial year including recovering core services, improving productivity, renewing focus on delivering the key NHS long-term plan ambitions and continuing to transform the NHS for the future.

NHS England acknowledges that 2023/24 will be a challenging year for the NHS, with ongoing Covid-19 pressures, rising demand and capacity issues. The guidance sets out ambitions to improve access to mental health services, tackling health inequalities and improving care for people with a learning disability and/or autism.

9. Foundation trust capital resource limits – statutory guidance

The Health and Care Act 2022 includes a new discretionary power allowing NHS England to make an order imposing a limit on the capital expenditure of an NHS foundation trust.

As part of the Act, NHS England must publish statutory guidance about the circumstances in which we are likely to make an order and the method we would use to determine the limit. This document provides that guidance.

10. Guidance on development of the Joint Forward Plan

The guidance supports integrated care boards (ICBs) and their partner NHS trusts and foundation trusts (referred to collectively in this guidance as partner trusts) to develop their first 5-year joint forward plans (JFPs) with system partners.

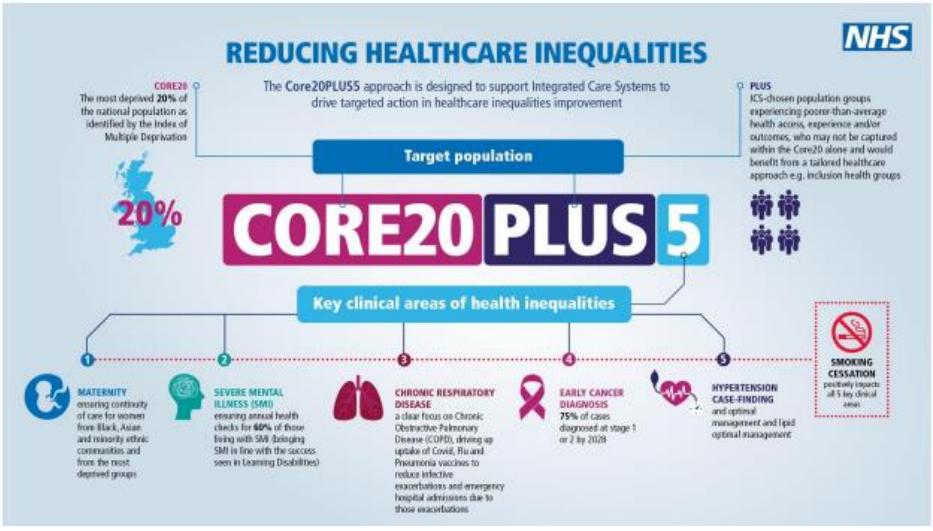
It covers specific statutory requirements that the plans must meet, such as setting out how an ICB and its partner trusts will meet the health needs of its population. The guidance also sets out how JFPs should be produced, including conducting consultations, involving health and wellbeing boards, and the role of NHSE.

ICBs and their partner trusts have a duty to prepare a first JFP before the beginning of 2023/24. However, for this first year of the process, NHSE requires systems to produce a version by 31 March, but consultation on further versions can continue beyond that date, in time for a final plan by 30 June.

This will mean the necessary governance arrangements will need to be made for the Board of Directors to consider and approve the Trust's submission to North Central London ICS prior to 31 March 2023.

11. CORE20PLUS5 framework for Children and Young People

Core20PLUS5 is a national NHS England approach which aims to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies 5 clinical areas of focus where improvement should be accelerated to reduce healthcare inequalities. The CORE20PLUS5 approach, which initially focused on adults, has now been adapted for children and young people.



12. The Hewitt Review: An independent review of integrated care systems

The Hewitt review will consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. Further details can be found in Appendix B.

The findings of the review are expected to be published in March 2023.

13. Conclusion and Recommendation

I would like to highlight a suite of important documents/briefings that have been issued since the last Board meeting in public (a number of which relate to items referenced in my report):

- Draft Mental Health Bill 2022 - Joint Committee on the Draft Mental Health Bill (parliament.uk)
- PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf (england.nhs.uk)
- NHS England » Foundation trust capital resource limits – statutory guidance
- NHS England » Guidance on developing the joint forward plan
- NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

To:
- Michael Holland: CEO (Tavistock & Portman NHS Foundation Trust)

Cc.
- Helen Pettersen: Interim Regional Director (NHS England-London)
- Martin Machray: Executive Director of Performance (NHS England-London)
- Frances O' Callaghan: CEO (North Central London Integrated Care Board)
- John Lawlor: Chair (Tavistock & Portman NHS Foundation Trust)

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 January 2023

Dear Michael,

I am writing to you to set out our thoughts on the ongoing support and oversight arrangements for the Tavistock and Portman NHS Foundation Trust which we have recently discussed with the NCL ICS.

When the Trust originally entered the NHSE System Oversight Framework (SOF) at level 3, as part of the mandated support and associated exit criteria it was agreed that the Trust would need to undertake a strategic review of its future financial and operational viability. The financial and organisational elements of the review were jointly commissioned from PWC by NHSE and the ICB with co-operation from the trust. This has run alongside the Trust's clinical strategy review. The draft report indicates that the Trust needs to look at its future form and sets out 4 potential options. From our discussions we are aware that you are proposing a 5th option that may include the creation of a Community Interest Company which we would be happy to see included. Ahead of the report being finalised it is important that we agree how the development and appraisal of the options is carried out between the Trust and the local system and the region. It will be important to acknowledge and agree at the beginning that a sustainable financial outlook in the both the short and longer term is essential, noting that the trust has worked hard to ensure that the deficit position has stablised. In addition, it will be important that NHSE and the ICB are briefed on your findings and consideration to date of the clinical strategy and how ensure a comprehensive approach over the next period.

Whilst this is clearly a key piece of work it must not detract from and indeed should be underpinned by the ongoing recovery and improvement activity across the whole of the organisation. We have discussed the Trusts capacity for this and the support that will be needed from other system partners for you to deliver on both of these agendas. In light of this we would propose to review the current level and nature of mandated support to ensure that it aligns with this endeavour. Specifically, within this we wish to ensure that you have capacity and capability to develop the options from the viability review and

agree the approach to appraisal and decision making. The draft report from PWC has indicated some limitations to the current capacity and capability and we need to be realistic about this in the context of the new team you are appointing but recognising that these would be significant challenges for any organisation.

Further we would propose that a high level Board be established comprising of, as a minimum, senior representatives from the Trust, ICB, NHSE and key system partners the purpose of which would be to oversee the development and options appraisal for the future form and high level assurance of the underpinning improvement activities. We do not wish to add to your reporting burden or duplicate meetings or processes to that end we will consider existing arrangements and how they might be reviewed if necessary.

Assuming that you will be supportive of this approach we will work with you and your team in the coming weeks to agree a revised support package and the terms of reference etc of the Oversight Board alongside the current SOF arrangements. We will also need to agree timescales.

Let me know if there are any elements of this that you wish to discuss further, if not I would suggest an initial meeting with yourself, Frances O'Callaghan and Martin Machray and/or me to agree immediate next steps.

Yours sincerely,

Paul Bennett
Director of Strategy & Transformation
NHS England- London

The Hewitt Review: an independent review of integrated care systems

Letter from Rt Hon Patricia Hewitt to stakeholders

18th January 2023

Dear Colleague,

As you know, the Chancellor of the Exchequer and the Secretary of State for Health and Social Care asked me to lead an Independent Review into how the oversight and governance of Integrated Care Systems (ICSs) can best enable them to succeed. The review covers ICSs in England and the NHS targets and priorities for which ICBs are accountable, including those set out in the Government's mandate to NHS England.

Since the Terms of Reference were published, I have had the opportunity to discuss the issues with over 300 ICB and ICP leaders, as well as other leaders from local government, NHS Trusts and Foundation Trusts, social care providers, VCSE groups, academics and others with an interest in the success of ICSs. I'm also delighted to say that I've received around 400 submissions from organisations and individuals in response to the Call for Evidence.

If you have been involved already in discussions or evidence, thank you very much. If you haven't yet been involved, I look forward very much to hearing from you in the coming weeks.

This Review covers a very wide range of issues and the timescale is very tight indeed (my final report is due by 15 March). It will be essential to distinguish between short-term recommendations that can be implemented within weeks or a few months, and those that need consistent action over the medium or longer term.

Fortunately the Review isn't starting from a blank sheet of paper. As well as the excellent evidence that has been submitted, the Review will build on a great deal of prior work, including the Messenger Review, the Fuller Stocktake of Primary Care, Sir Chris Ham's recent report on ICSs, the Integration White Paper and so on. And we can already see welcome change taking place, particularly in the way NHSE involved many ICS leaders in the recent Planning Guidance and the nature of that Guidance itself.

But fundamentally, this Review is an opportunity for all of us with a stake in ICSs to shape our future. As I've said to many of you, I certainly don't claim to have all the answers. But through this Review, I hope I can be a catalyst for crowd-sourcing! So the impact of the Review depends upon your contribution, personally as well as organisationally.

The next stage: Five Work Streams

The next stage of the review will focus on five work streams, led by colleagues from across the health and care system. These will cover:

Prevention and population health management, co-chaired by Patricia Miller (CEO, Dorset Integrated Care Board) and Joe Rafferty (CEO, Mersey Care FT);

Integration and place, co-chaired by Felicity Cox (CEO, Bedfordshire, Luton and Milton Keynes Integrated Care Board) and Cllr Tim Oliver (Chair, Surrey Heartlands Integrated Care Partnership and Leader, Surrey County Council);

Autonomy, accountability and regulation, co-chaired by Dr Kathy McLean (Chair, Nottingham and Nottinghamshire Integrated Care Board) and Rt Hon Paul Burstow (Chair, Hertfordshire and West Essex Integrated Care Board and Chair, SCIE);

Productivity and finance, co-chaired by Dr Penny Dash (Chair, North West London Integrated Care Board) and Sir Richard Leese (Chair, Greater Manchester Integrated Care Board);

Digital and data, co-chaired by Sam Allen (CEO, North East and North Cumbria Integrated Care Board) and Adam Doyle (CEO, Sussex Integrated Care Board).

Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, are all being included in the work streams, reflecting the partnerships that constitute ICSs. All the workstreams have access to the responses from our Call for Evidence, but if you would like to contribute further to a particular work stream, please contact the co-chairs and the secretariat at the Department of Health and Social Care, via **hewittreview@dhsc.gov.uk.**

Draft Principles

Six principles have emerged repeatedly from the discussions so far as well as from an initial reading of the evidence. They are set out, in draft, below. I'm grateful to everyone who has contributed to them, including the authors of the many documents I've drawn on.

These principles are not set in stone, although they will help provide a framework for the work streams. As discussions develop, so will the principles. But I intend my final report to set out principles that will, I hope, command as close to universal agreement as possible, and will therefore provide a touchstone for all of us, whether partners within ICSs or working at national and regional level, about how we should act in future.

> **Collaboration**: within each system as well as between systems and national bodies. Rather than thinking about the centre, regions, systems, and places as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. This means recognising the importance of collaboration between partners from the NHS, local government, social care providers and the VCSE in neighbourhoods, places and systems. Because different local partners have different accountability and funding

arrangements, only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets (for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog). On the other hand, it is also essential to recognise that, while the role of the centre should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore very helpful and should be followed by more joining up between DHSC, DLUHC, NHSE and other national bodies to mirror the integration within ICSs.

A limited number of shared priorities: the public's immediate priorities – access to primary care, urgent and emergency care, elective care and mental health services - are priorities for all of us, Ministers, NHSE and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs – and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.

Give local leaders space and time to lead: Effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential.

Systems need the right support: ICSs require bespoke support geared to the whole system and the partners within it, rather than to individual providers or sectors. But support also needs to be proportionate: less intervention for mature systems delivering results within budget; more intervention and support for systems facing greater challenges.

Balancing freedom with accountability: It is right that with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through ICPs, HealthWatch, Foundation Trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, may also have a role. This local accountability is complemented by NHSE's role to support and provide oversight for ICBs in line with the statutory framework including NHSE's support for NHS organisations within the ICS with greater challenges. The role of CQC as the independent inspector has itself been

strengthened by the 2022 Act. The CQC's remit now includes inspecting ICSs as a system, regulating local authorities in relation to their adult social care functions, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care. This will need to be done hand in hand with NHSE's role in overseeing systems.

Enabling timely, relevant, high-quality and transparent data: we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. Good data, used well, can generate actionable insights into outcomes and the drivers of inequalities, as well as productivity, quality and safety. ICSs should focus on enabling data sharing and digital innovation that supports real-time service improvement, Of course, effective data can also enable greater accountability, a learning culture and research, although simply doing this through uncoordinated data requests can create unnecessary administrative burdens rather than improvements. NHS England, working in collaboration with DHSC and local government (including through DLUHC, the LGA and CCN) have a key role to play. By defining standards on data taxonomy and services' interoperability, and coordinating data request to the system, they can create the conditions for wider transformation.

Do please let me know if you have any questions about the Review, any immediate comments on the draft principles or particular issues you would like to draw to the attention of the work streams.

Yours sincerely,

Rt Hon Patricia Hewitt

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS **Tuesday 7 February 2023**			
Quality Committee Report			**AGENDA ITEM:** **8**
Report Author and Job Title:	Jenny Goodridge, Chief Nursing Officer	**Responsible Director:**	Jenny Goodridge, Chief Nursing Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper is to provide a high-level summary of the Quality Committee that was held on Thursday 19 January 2023.		
Background	The Quality Committee is a sub-committee of the Board of Directors and therefore has delegated function to gain assurance that the services we deliver are safe, effective and of high quality. Any key risks/issues/concerns, where the Quality Committee assesses the need for Board oversight/awareness/decision, will be escalated to the Board		
Assessment	Items for escalation from the Quality Committee to the Board are: • **Children's Mortality Rates Internal Clinical Audit for the Gender Identity Clinic** – On agenda for part II of Board • **Care Quality Commission (CQC)** – targeted inspection of Portman, North and South Child and Adolescent Mental Health Service (CAMHS) and the Camden Adolescent Intensive Support Services (CAISS) • **NHS National Industrial Action** – Update on industrial action taken to date and upcoming planned dates for strikes		
Recommendation	Members of the Board are asked to: note the summary of the Quality Committee		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report provides assurance that there is robust oversight of Quality and that risks are highlighted, and mitigation/plans put in place to address them.		
Legal and Equality and Diversity implications	Some of the actions identified, that are already being monitored by the Quality Committee, will assist the Trust in meeting it's legal and statutory functions e.g. complaints handling, safeguarding.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☐	

	Drive operational performance ☐	Long term financial sustainability ☐
	Develop clinical and commercial strategies ☐	

Quality Committee Report (meeting held on 19 January 2023)

1.0 Summary of meeting

The following provides an overview of the Quality Committee meeting held on 19 January 2023.

2.0 Gender Identity Development Service (GIDS) Demobilisation Update

2.1 The Director of Clinical Operations provided a verbal update in relation to the progress of the demobilisation of the GIDS.

2.2 Concerns were raised around the current workforce, both in terms of morale and retention.

2.3 Further discussion of the risks and issues were previously escalated to Board (part II) from Quality Committee

3.0 Children's Mortality Rates Internal Clinical Audit for the Gender Identity Clinic

3.1 The Chief Medical gave a presentation to the Quality Committee on the outcome of a clinical audit into children's mortality rates within the gender identity service

3.2 In order to protect the identity of the children and their families, a separate paper will be presented to part II of the Board

4.0 Quality Report

4.1 The third iteration of the new style quality report was presented to the quality committee

4.2 The report was significantly impacted by the CareNotes outage that occurred in August 2022 (to December 2022). This meant that we were not able to report on Quarter 3 (Q2) data for many elements of the report

4.3 Progress continues with the Care Quality Commission (CQC) 'should do' actions, with a further two ambers progressing to green

5.0 Quality Framework Improvement Plan

5.1 The Quality Committee was presented with an improvement plan, developed in response to gaps identified as part of an internal review of quality governance, function, systems and processes

5.2 The improvement plan, along with the new style quality report, aims to provide the Trust with assurance that we provide high quality, safe services to our population

5.3 The improvement plan is presented as assurance to the System Oversight Framework (SOF) meetings to aid in moving quality governance out of level 3

5.4 Since the submission of the improvement plan to the November Quality Committee:

- 8 actions have been completed and closed
- 1 new action has been added (in relation to the implementing the quality governance structure that feeds into the Quality Committee)
- 2 actions have turned Amber (1 related to developing a quality sub-committee structure and just missed the deadline, but is now

complete. The other relates to increasing safeguarding supervision rates; anecdotally, it appears to have increased, however, we are unable to fully evidence the increase due to the CareNotes outage

6.0 NHS National Industrial Action

6.1 The Chief Nursing Officer provided an update to the Quality Committee in relation to the current industrial action, which took place on 18 and 19 January 2023

6.2 This trust was not included in the first round of strikes in December but were included in the second round of strikes in January.

6.3 Although some of our nursing staff went out on strike on both days, there was only a picket line at the Belsize Lane site on the second day of strikes.

6.4 Intense planning for the strike days ensured that the risk to patient safety was at a minimum

6.5 Further strikes have been announced for Monday 6 and Tuesday 7 February2023. The Tavistock and Portman have not been included in these strike days.

6.6 Unison are currently reballoting their members at the Trust, which is due to end on 16 February 2023

7.0CareNotes Update

7.1 A paper was provided to the Quality Committee in relation to the CareNotes outage update

7.2 The main point is that progress continues as planned with the rebuilding and reinstating of the CareNotes system

7.3 It is expected that the manual upload will be complete by the end of January 2023, however, it is a very time consuming and resource intensive task

7.4 We have stepped down from ‘major incident’ status

8.0 Board Assurance Framework (BAF)

8.1 Three ‘quality’ BAF risks were presented to the Committee for approval of description and rating

8.2 The Committee approved the description of the risks

8.3 The Committee was unable to approve the rating of the inherent risk because the controls and mitigation were not available

9.0 Care Quality Commission (CQC) Compliance and Update on Preparedness for Inspection

9.1 The paper on assurance of the Trust’s readiness for a CQC well-led inspection was deferred to the next Quality Committee meeting

9.2 The Committee noted that it is important that work commences in this area to prepare the Board and the organisation for an inspection

9.3 The Chief Nursing Officer informed the Committee that she had been contacted by the CQC, on Thursday 19 January 2023, and informed that they would be undertaking unannounced targeted inspections commencing Monday 23 January 2023

Update

9.4 The CQC sent three inspection teams to visit the Portman, North and South Camden Child and Adolescent Mental Health Service (CAMHS) and the Camden Adolescent Intensive Support Services (CAISS)

9.5 At the time of writing this report, the inspection teams continue to speak with staff and patients and review information that we sent them as requested

9.6 The CQC have not highlighted any concerns that need an immediate remedy and the very limited feedback they have provided has been largely positive, although heavily caveated. They were all quick to point out that staff have been friendly and helpful

9.7 They understand the issues and impact of the CareNotes outage and will take this into consideration when producing their report

6.1 We are expecting the reports from the CQC in six to eight weeks

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS **Tuesday 7th February 2023**			
Guardian of Safer Working Report – Q3			**AGENDA ITEM:** **9**
Report Author and Job Title:	Dr Gurleen Bhatia(GOSWH)	**Responsible Director:**	Dr Caroline McKenna (CMO)
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This is the report for the Q3 period		
Background	The report details the issue of DRS login, new fine rates introduced from July 2022. DRS login issues noted and resolved.		
Assessment			
Recommendation	Members of the Trust Board of Directors are asked to note the report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper."		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☐	Long term financial sustainability ☐	
	Develop clinical and commercial strategies ☐		

Guardian of Safe working hours Q3 report 2022/23

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q3 (October- December 2022)

2. Exception reports (with regard to working hours)

Total exception reports: 10

Month	Total reports	Toil	Fine	NFA
October	5	1	4	1
November	3	0	3	0
December	2	2	2	0

2.2 Work schedule reviews

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

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

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

The trainees do 1 locum shift/month in addition to their normal working schedules and on call rota (1 in 9.8)

2.5 Fines- as per new penalty rate guidance circulated by BMA and GOSWH regional meeting

	Extra hours worked Normal Enhanced		Total fine	Amount paid to trainees	Fine Remaining
	hrs	hrs	£	£	£
October	0	18hrs	2942.3	1098.52	1843.78
November	0	12hrs	1924.68	721.81	1202.87

December	0	7hrs	1057.98	396.76	661.22
Total	0	37hrs	5924.96	2217.09	3707.87

3. Junior Doctors Forum (JDF)

New Trainee representatives in post. Next JDF meeting is planned prior in 3rd week January 2023. Adam Harrison BMA/ IRO for the trust is requested attend.

4. Local Negotiating Committee (LNC)

This report will be shared with the LNC chair Dr Sheva Habel for meeting on 16th January 2023.

5. Conclusions and Recommendations

Members of the Board are asked to note the report

We continue monitoring the impact of the post -COVID climate on the exception reports.

Dr Gurleen Bhatia
Guardian of Safer Working Hours

MEETING OF THE Board **Tuesday 7 February 2023**			
Emergency Preparedness, Resilience and Response			**AGENDA ITEM:** **10**
Report Author and Job Title:	Lisa Tucker Health and Safety Manager, Risk Manager Emergency Planning Officer MHFA Instructor	**Responsible Director:**	Jenny Goodridge Chief Nursing Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper informs the Board that we have been assessed by NHS England (NHSE) to be non-compliant with our Emergency Preparedness, Resilience and Response (EPRR)		
Background	NHS England (London) uses an annual EPRR assurance process to assure themselves that all NHS organisations in London are prepared to respond to an emergency and have plans, and the resilience, in place to continue to provide safe patient care during a Major Incident (MI) or Business Continuity (BC) event. Our assurance self-assessment and relevant plans and policies were submitted in September 2022 and then reviewed with NHSE EPRR leads at our assurance review meeting attended by the Tavistock and Portman Chief Nurse.		
Assessment	In accordance with the requirements laid out in the EPRR 2022-23 Assurance Process Letter (01 August 2022), the overall level of compliance is based on the total percentage of amber and red ratings. In respect of Tavistock and Portman NHS Foundation Trust for Core Standards, the following RAG ratings were agreed at the review meeting:		

Red Ratings	Amber Ratings	Green Ratings
0	16	39

This means that the Tavistock and Portman NHS Foundation Trust has an assessed level of compliance of **NON-COMPLIANT**.

Deep Dive - Evacuation and Shelter Plans

As an Outpatient Mental Health and Education provider, we had imitated the arrangements and tailored assurance in line with our emergency Fire Safety Policy and Local Evacuation Plans. We

	have rare and limited need for onsite and critical delivery appointments and no transportation provision. The adjustment for appointments and training delivery was reflected in our Pre-pandemic Business Continuity Plans (BCPs). We were able to quickly transfer and ensure service delivery virtually, without the requirement to have patients, students and staff on any site and with pre-planned arrangements. *Adjustments during the Pandemic;* We had rapidly adjusted the service delivery and arrangements for patients, students and staff, and worked with our Information Management and Technology (IMT) team to be linked virtually. We evaluated the necessity to have any critical appointments to be on site and face to face appointments, ensuring virtual translation services and accessible support for training. We reflected our Evacuation and Shelter arrangements to 'loss of facilities' Trust-wide throughout the Pandemic. We ensured that patients, students and staff were aware and regularly communicated to the changes via Team meetings, telephone calls, texts, emails with links for virtual appointments and through our Website and social media outlets. Our Department for Education has a Moodle website for student and trainees. *Alternative arrangements;* We have a mixture of highly specialised Adult Forensic and Child and Adolescent Mental Health Services (CAMHS) provided throughout the trust estate facilities and community health environments. We ensured service delivery by utilising Video Software such as Microsoft Teams and Zoom for virtual appointments and teaching sessions, and with the loss of face to face service delivery during 'lockdown' periods. We identified that some appointments would have to be face to face, with stringent Infection Prevention and Control (IPC) measures put in place for onsite access, outreach work and community health settings. We applied, and received, funds and support for 'Digital Poverty' from the Captain Tom Foundation for our families and children. iPads and additional data was provided during home schooling and beyond, to ensure remote assistance for all of our patients and families. *Moving forward;* We now have plans to reassess our critical services (Business Impact Assessments) in the event of an emergency and loss of a

	building, how we ensure the safety of patients, students and staff and agree to a practical plan for all services. We will review our plans with the revised local/service specific BCPs (identifying loss of facilities), review mutual aid arrangements, support for the community with our local Camden Borough Resilience Forum, local NHS Trusts within the NCL footprint and agree our plans in an appropriate and relevant response with our NHS Stakeholders and Commissioners. ***Additional areas requiring development*** The Tavistock and Portman NHS Foundation Trust has gone through extensive organisational change, including changes to the Executive Team. As such this has impacted the Trust business continuity management processes, training and on-call mechanism. In addition, there is a requirement to develop our Chemical, Biological, Radiological and Nuclear planning. The NHSE EPRR panel commended the Trust's committed to improving its EPRR standards. Overall, the panel felt that the Trust's self-assurance submission of non-compliant was an accurate reflection of Trust position. For the outstanding Amber Ratings, we have an agreed action plan (Appendix A) and will provide updates to the Quality Committee.	
Recommendation	Members of the Trust Board are asked to: Note the self-assessment and NHSE rating of non-complaint for EPRR and the plans in place to ensure compliance in 2023/24.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Having robust EPRR plans/processes in place will support mitigation/controls across many of the BAF risks.	
Legal and Equality and Diversity implications	As an NHS organization, there are a number of regulations that we have a legal responsibility for in order to ensure the safety of patients, visitors and our staff.	
Strategic Objectives	Improve delivery of high quality clinical services which make a significant difference to the	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel

	lives of the people & communities we serve ☐	proud in a culture of inclusivity, compassion & collaboration. ☒
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☐	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.☐
	Ensure we are well-led & effectively governed ☒	

2022 EPRR Assurance Report

Tavistock and Portman NHS Foundation Trust

Version number: 1.0

First published: 24/10/2022

Prepared by: Andrea Jesikova and Liz Rogers, NHS England (London)

Classification: OFFICIAL

NHS England

Contents

1 2022-23 Assurance review summary

Annually, all NHS funded organisations are asked to provide an assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The London regional office then holds individual review meetings with each organisation to discuss and agree a level of compliance.

This year we recognise the role of the newly formed Integrated Care Boards (ICBs) and will be conducting our process in partnership with ICB EPRR leads.

A number of standards have been added for this year's process and other modifications have been made to core standards to ensure language is clear and the core standards clearly layout expectations.

The regional team will use the results of the assurance process to highlight targeted support for the system through the regional business plan, work programme and ongoing EPRR engagement activities.

Within North East and North Central London, the NHS England – London Network undertook an assurance review process with the following organisation types:

- Acute hospital service providers
- Community service provider (this includes NHS Trusts, Foundation Trusts and social enterprises)
- Mental health service providers
- Specialist health service providers
- Integrated Care Boards (ICB)

For acute Trusts additional site visits were arranged to review specific requirements regarding Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe).

All organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR which would provide the framework for the assurance review meetings. Furthermore, the review meetings provide broader oversight and ensure that plans and arrangements were being updated with relevant learning and guidance.

At the review meeting the Panel recognised the organisational changes, mainly in leadership posts, that have taken place at the Trust. Currently they have an interim AEO until November 2022 when a new permanent AEO starts. The Emergency Planning Officer has, despite challenges due to the organisational changes, continued to maintain the EPRR function within the Trust.

The challenges faced by the Trust over the last 12 months has impacted the overall level of compliance. The level of compliance has moved from substantially compliant in 2021/22 to non-complaint in 2022/23. The Trust is committed to improving its EPRR standards and resolving the issues identified during the 2022/23 assurance process.

2 Assurance review process

The assurance process for Tavistock and Portman NHS Foundation Trust was conducted as follows:

Assurance Meeting	Date of Visit	Assurance Review attendance
Main Assurance Meeting	20/10/2022	**NHS England (London):** Liz Rogers (Chair) and Andrea Jesikova (Notes) **Tavistock and Portman NHS Foundation Trust:** Jenny Goodridge (AEO) and Lisa Tucker (EPLO) **North Central London Integrated Care Board:** Nathan Welch (ICB Reviewer)

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2022-23 Assurance Process Letter (01 August 2022), the overall level of compliance is based on the total percentage of amber and red ratings.

In respect of Tavistock and Portman NHS Foundation Trust for Core Standards 1 – 68, the following RAG ratings were agreed at the review meeting:

Red ratings	Amber ratings	Green ratings
0	16	39

Total number of red / amber ratings	16

This means Tavistock and Portman NHS Foundation Trust has an assessed level of compliance of ***NON-COMPLIANT***.

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

Amber ratings were received for the following core standards:

- Core Standard 16 – Evacuation and Shelter
- Core Standard 21 – Trained on call staff
- Core Standard 24 – Responder training
- Core Standard 25 – Staff Awareness and Training
- Core Standard 29 – Decision Logging
- Core Standard 44 – BC policy statement
- Core Standard 45 – BCMS scope and objectives
- Core Standard 46 – Business Impact Assessment
- Core Standard 47 – Business Continuity Plans (BCPs)
- Core Standard 49 – Data protection and Security Toolkit

- Core Standard 50 – BCMS monitoring and evaluation
- Core Standard 55 – Telephony advice for CBRN exposure
- Core Standard 56 – HAZMAT/CBRNe planning arrangement
- Core Standard 57 – HAZMAT/CBRNe risk assessments
- Core Standard 65 – Training programme
- Core Standard 67 – Staff training – decon

Full details of the assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.1.2 Deep dive outcomes – Evacuation and Shelter

Amber ratings were received for the following core standard:

- Deep Dive 1 – Up to date plans

Red ratings were received for the following core standards:

- Deep Dive 2 – Activation
- Deep Dive 3 – Incremental planning
- Deep Dive 4 – Evacuation patient triage
- Deep Dive 5 – Patient movement
- Deep Dive 6 – Patient transportation
- Deep Dive 7 – Patient dispersal and tracking
- Deep Dive 8 – Patient care receiving
- Deep Dive 9 – Community Evacuation
- Deep Dive 10 – Partnership working
- Deep Dive 11 – Communications – Warning and informing
- Deep Dive 12 – Equality and Health Inequalities
- Deep Dive 13 – Exercising

Full details of the deep dive review, agreed RAG ratings and discussion points can be found in appendix A. The deep dive does not contribute to the overall compliance level.

4.2 Assurance review meeting agreed actions

NHS England (London) EPRR / Panel-agreed actions as follows:

Tavistock and Portman NHS Foundation Trust to:

- Trust to review EPRR Framework 2022 when updating policies, plans and procedures. (Core Standard 2 - EPRR Policy Statement)
- Trust to review all risks in line with the Borough Resilience Forum and the NHS England Risk Register. (Core Standard 7 – Risk assessment)
- Trust to update information relating to mass casualty in their Major Incident Plan by referring to latest guidance. (Core Standard 15 – Mass Casualty)
- Trust to update evacuation procedure by adding shelter information into the plan. (Core Standard 16 – Evacuation and shelter)
- Trust to include information about excess fatalities in the Major Incident Plan (Core Standard 19 – Excess fatalities)

- Trust to implement revised on-call packs (Core Standard 20 – On-call mechanism)
- Trust to ensure all on-call directors have completed the Principles of Health Command as part of their EPRR training (Core Standard 21 – Trained on-call staff)
- Trust to align responder training with National occupational standard (Core Standard 24 – Responder Training)
- Trust to set up an EPRR induction as part of the mandatory training for new starters. (Core Standard 25 – Staff Awareness and Training))
- Trust to ensure to test and record the functionality of equipment used in the ICC a minimum of quarterly (Core Standard 26 – Incident Co-ordination Centre)
- Trust to increase number of trained loggists (Core Standard 29 – Decision Logging)
- Trust to separate local Business Continuity Policy from Business Continuity Plan (Core Standard 44 – BC policy statement)
- Trust to include information about local BCPs into Business Continuity Plan (Core Standard 45 – BCMS scope and objectives)
- Trust to review Business Impact Assessment (Core Standard 46 – Business Impact Analysis/Assessment (BIA))
- Trust to review Business Continuity Plan (Core Standard 47 Business Continuity Plan (BCP))
- Trust to provide confirmation that '21/22 Standards are met' using the (Core Standard 49 - Data Protection and Security Toolkit)
- Trust to update Key Performance Indicators (KPI) (Core Standard 50 - BCMS monitoring and evaluation)
- Trust to update action cards with telephone advise for managing patients involved in CBRNe incidents (Core Standard 55 – Telephony advice for CBRN exposure)
- Trust to review action cards relating to HAZMAT/CBRNe (Core Standard 56 – HAZMAT/CBRNe planning arrangement)
- Trust to review HAZMA/CBRNe risk assessments (Core Standard 57 – HAZMAT/CBRNe risk assessment)
- Trust to ensure all staff in the Trust HQ are CBRNe fully trained (Core Standard 65 – Training programme)
- Trust to provide programme of delivery for decontamination training (Core Standard 67 – Staff training – decontamination)

NHS England (London) to:

- NHS England (London) to share detailed paged by page comments of the assurance submissions to the Emergency Planning Team.

5 Next Steps: Action Plans and Governance

Tavistock and Portman NHS Foundation Trust is required to submit within two weeks of the date of this report, but no later than 16 December 2022 the following documentation to england.london-assurance@nhs.net:

- The organisation's final EPRR RAG scores, as agreed at the review meeting

using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Red or Amber using the self-assessment tool
- A declaration from the AEO of the overall level of compliance achieved

5.1 Identified key priorities

The Trust is advised to prepare a robust work plan for the next twelve months which will set out the reviews of plans, policies and the testing and exercising of plans.

6 Conclusion

Tavistock and Portman NHS Foundation Trust has gone through extensive organisational change, including changes to the Executive Team. As such this has impacted the Trust business continuity management processes, training and on-call mechanism. The Panel identified further areas of development including evacuation and shelter, and CBRNe planning.

At the time of the assurance review meeting the Panel agreed to 16 Amber ratings for core standards as per section 4.1 Main Assurance Visit Outcomes. The Trust will use the next 12 months to address these and will work with NHS England NENC EPRR Network who will continue to support the Trust to achieve improvement.

This year's deep dive question centred on evacuation and shelter. The Trust has fire evacuation policy which covers some elements of evacuation. As a result, 12 of the 13 deep dive course standards were marked as non-compliant.

The Panel recognised the efforts undertaken by the Trust Emergency Planning Officer to maintain the EPRR function considering the challenges experienced by the Trust. The Panel commended the Trust's committed to improving its EPRR standards.

Overall, the Panel felt that the Trust's self-assurance submission of non-compliant was an accurate reflection of Trust position.

Finally, on behalf of the NHS England (London) NENC EPRR Network, thank you to all colleagues involved in this assurance process.

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2022 RAG rating	RAG rating rationale & meeting comments
Governance					
1	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.			**Interim AEO started in post in May 2022 and has background in EPRR. New AEO will be in post in November 2022.** Panel agreed that the self-assessed compliance rating as being appropriate.
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.			**Overall, the EPRR Policy is a well written document. There are some minor areas to update, these will be shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
3	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements			The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.			The Panel agreed that the self-assessed compliance rating as being appropriate.
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.			The Panel agreed that the self-assessed compliance rating as being appropriate.
6	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.			The Panel agreed that the self-assessed compliance rating as being appropriate.
Domain 2- Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.			**The Trust to review all risks, in line with the Borough Resilience Forum and the NHS England Risk Register.** The Panel agreed that the self-assessed compliance rating as being appropriate.
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally			The Panel agreed that the self-assessed compliance rating as being appropriate.

Domain 3 - Duty to maintain Plans					
9	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.			The Panel agreed that the self-assessed compliance rating as being appropriate.
10	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.			**The Trust has a Major Incident Plan meets the standard; however, the Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
11	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.			The Panel agreed that the self-assessed compliance rating as being appropriate.
12	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.			The Panel agreed that the self-assessed compliance rating as being appropriate.
13	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic			The Panel agreed that the self-assessed compliance rating as being appropriate.
14	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment			**The Panel recommended that the Trust engage with the regional countermeasures lead when updating Trust arrangements.** The Panel agreed that the self-assessed compliance rating as being appropriate.
15	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.			**As an in-hours specialist Trust it was noted that the ability to support mass casualty planning and response differs from other NHS organisations in London. The Panel discussed the role the Trust could play in a mass casualty response. The Trust identified the possibility of providing mutual aid with junior doctors and providing physical space within Trust buildings. The Panel made recommendation for Trust to look at regional plan for mass casualty.** The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.
16	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.			**The Trust has local evacuation procedures in place, however due to the way clinical services are delivered shelter planning had not been undertaken and sheltering patients would be difficult. However, the Trust recognised the role it could play in sheltering the general public. The Panel recommended to add shelter information into the plan.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.
17	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.			**The Trust advised that only one of their buildings has an open reception. All other sites have controlled video entry systems and patients are escorted in and out by their clinician.** The Panel agreed that the self-assessed compliance rating as being appropriate.

18	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.			**VIPs can be politicians, royalty, and prisoners. The Trust completes a clearance process and the Communication Team is involved throughout the process.** The Panel was satisfied with the evidence and assurance offered by the Trust to support the self-assessed compliance rating as being appropriate.
19	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.			**As an in-hours specialist Trust it was noted that the ability to support excess fatalities differs from other NHS organisations in London. The Panel discussed the role the trust could play and explained that it could provide mutual aid in the form of space at the main site e.g. weather protected car park, and office space. The Panel requested that the Trust include this information in the major incident plan.** The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.
Domain 4 - Command and control					
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.			**The Trust met the standard for a number of the communication exercises held by NHS England – London EPRR. The AEO stated that the Trust was working to implement revised on-call packs in light of the recent organisational changes.** The Panel agreed that the self-assessed compliance rating as being appropriate.
21	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions			**The Panel was made aware of the ongoing challenges within the Trust due to the organisational changes and the impact this had to the cadre of trained Directors on Call. As the Trust Executive became established and embedded, they would receive on-call training. The Panel requested the Trust ensure all on-call directors have completed the Principles of Health Command as part of their EPRR training.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.
Domain 5 - Training and exercising					
22	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.			The Panel agreed that the self-assessed compliance rating as being appropriate.
23	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)			The Panel agreed that the self-assessed compliance rating as being appropriate.
24	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role			**The Panel advised that this need to be in line with National occupational standards.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.
25	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.			**The Panel advised to set up EPRR element of training as part of mandatory training.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.

Domain 6 - Response					
26	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.			**The Panel advised that there are new requirements under the EPRR Framework 2022 to test the functionality of equipment used in an ICC, a minimum of quarterly.** The Panel agreed that the self-assessed compliance rating as being appropriate.
27	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.			The Panel agreed that the self-assessed compliance rating as being appropriate.
28	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).			The Panel agreed that the self-assessed compliance rating as being appropriate.
29	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker			**The Panel strongly recommends for Trust to increase the number of trained loggists.** The Panel accepted the evidence provided at the assurance meeting and agreed that with a partially compliant rating.
30	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.			The Panel agreed that the self-assessed compliance rating as being appropriate.
31	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.			
32	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)			

Domain 7 - Warning and informing					
33	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.			The Panel agreed that the self-assessed compliance rating as being appropriate.
34	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.			**The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
35	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.			The Panel agreed that the self-assessed compliance rating as being appropriate.
36	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media			The Panel agreed that the self-assessed compliance rating as being appropriate.
Domain 8 - Cooperation					
37	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.			The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.
38	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.			The Panel agreed that the self-assessed compliance rating as being appropriate.
39	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.			The Panel agreed that the self-assessed compliance rating as being appropriate.
40	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			
41	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.			
42	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.			
43	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.			The Panel agreed that the self-assessed compliance rating as being appropriate.

Domain 9 - Business Continuity					
44	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.			**The Panel advised to separate Business Continuity Policy from Business Continuity Plan.** The Panel agreed that the self-assessed compliance rating as being appropriate.
45	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.			**The Trust has separate local BCPs. The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
46	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).			**The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
47	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure			**The Trust Business Continuity Plan, however in light of the organisational changes the Panel determined the plan fell short of the required standard. The Trust has a work programme in place to address the areas of improvement. The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.
48	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.			**The Trust explained how the recent Advanced Outage incident had tested business continuity arrangements. The learning from this incident was being incorporated into the development of the Trust business continuity planning.** The Panel agreed that the self-assessed compliance rating be amended to fully compliant.
49	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.			**Trust to provide confirmation that '21/22 Standards are met' using the Data Protection and security Toolkit.** The Panel agreed that the self-assessed compliance rating as being appropriate.
50	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.			**The Trust engages in weekly BCMS monitoring however evidence of KPIs was lacking in the business continuity plan submitted. The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the evidence provided was not sufficient and further work is required, therefore rated as being partially compliant.
51	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.			The Panel agreed that the self-assessed compliance rating as being appropriate.

52	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.			The Panel agreed that the self-assessed compliance rating as being appropriate.
53	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.			The Panel agreed that the self-assessed compliance rating as being appropriate.
54	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon			
Domain 10 - CBRN					
55	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.			**The Panel queried whether the Trust knew where to go for advice. The Trust advised that the information was on the relevant action card but felt that further work was needed to ensure that Trust staff were fully cognisant of the arrangements.** The Panel agreed that the self-assessed compliance rating as being appropriate.
56	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.			**The Trust advised that the information was on the relevant action card but felt that further work was needed to ensure that Trust staff were fully cognisant of the arrangements.** The Panel agreed that the self-assessed compliance rating as being appropriate.
57	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.			**The Panel made a number of recommendations for improvements which have been shared separately.** The Panel agreed that the self-assessed compliance rating as being appropriate.
58	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.			
59	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/			The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.

60	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.			
61	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks			
62	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment			
63	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.			
64	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training			
65	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.			**The Trust advised that there was further work to be completed to ensure that staff in the Trust HQ were fully trained. The Trust was recommended to engaged with the NHS England – London EPRR CBRNe lead with regards to the Trust training programme.** The Panel agreed that the self-assessed compliance rating as being appropriate.
66	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.			
67	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.			**The Trust has decontamination training in place; however a programme of delivery was outstanding at the time of the assurance meeting.** The Panel agreed that the self-assessed compliance rating as being appropriate.
68	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.			The Panel accepted the evidence provided at the assurance meeting and agreed that with a fully compliant rating.

2022 Deep Dive

Ref	Standard	Deep Dive question	Self-assessed RAG	Agreed 2022 RAG rating	RAG rating rationale & meeting comments
Deep Dive - Evacuation and Shelter					
Domain: Evacuation and Shelter					
DD 1	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.			**The Trust has local evacuation procedures in place, however due to the way clinical services are delivered shelter planning had not been undertaken and sheltering patients would be difficult. However, the Trust recognised the role it could play in sheltering the general public. The Panel recommended to add shelter information into the plan.**
DD 2	**Activation**	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 3	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical, full building, full site and off-site evacuation.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 4	**Evacuation patient triage**	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 5	**Patient movement**	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 6	**Patient transportation**	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 7	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 8	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisation's inpatient facility. This could with little advanced notice.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.

DD 9	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 10	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 11	**Communications- Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 12	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.
DD 13	**Exercising**	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.			The Trust did not provide a self-assessment score. After discussion, the Panel determined that a non-complaint rating was appropriate due to the limited planning with regards to shelter and evacuation.

Appendix A - **Emergency Preparedness, Resilience and Response Action Plan**

Improvement required	Action	Completion Date	Owner	Status	Update/comments
Have a safe and effective Evacuation and Shelter Plan in place to enable us to respond to the needs of the local community, requiring refuge, in an emergency.	To Develop the Evacuation and Shelter Plan, reflecting on our response during the Covid-19 pandemic, to ensure service delivery and clarity on the role the Trust would play in sheltering the General Public and in Mutual Aid.	30 June 2023	Lisa Tucker		
Ensure we have a responsive Executive on-call function to respond to emergency situations outside of trust working hours.	Executive Directors to undertake the 'Principles of Health Command' training.	30 April 2023	Lisa Tucker and Executive Directors		
	Develop an on-call rota that identifies the Director on-call for at least twelve weeks	28 February 2023	Amanda Hawke		
	Develop a process of communicating who the Director on-call is for each week	28 February 2023	Laure Thomas		
Ensure we are well-led and responsive to major incidents and emergency situations.	Individual responders and key decision makers to undertake training that will allow them to fulfil their role in a major incident/emergency situation. Live exercises and Table top exercises to take place Staff Awareness and training	30April 2023	Lisa Tucker		
	Live and table top emergency response scenarios to be	December 2023	Jenny Goodridge		

	enacted with key decision-makers/responders to test effectiveness of plans and training.				
	Increase the number of trained 'loggists' so we have a minimum of five at all times	30 April 2023	Lisa Tucker		
	Develop a Business Continuity Policy that is separate to the Business Continuity Plan	30 April 2023	Lisa Tucker		
Ensure we are a safe and effective organisation in the event of a major incident/emergency situation	Undertake an annual Business Impact Analysis assessment on the impact of disruption to services through.	30 April 2023	Lisa Tucker		
Ensure we have robust systems/processes in place to manage data safely	Trust to provide confirmation that '21/22 Standards are met' using the Data Protection and Security Toolkit.	30 June 2023	Information Governance Lead		
	Staff Information Governance training to reach 95%	30 June 2023	Sarah Mountain		
Ensure we are able to safely respond to and, where required, manage Chemical, Biological, Radiological and Nuclear emergencies (CBRNe)	Update the Action cards for all sites	31 March 2023	Lisa Tucker		
	Ensure all front of house staff are aware of the process and script for calling emergency services	31 March 2023	Lisa Tucker		
	Ensure decontamination provision is included in the	28 February 2023	Benita Mehra		

	Hazardous Materials Removal contract				

MEETING OF THE BOARD OF DIRECTORS – 7 February 2023			
Performance, Finance and Resources Committee Highlight Report			**AGENDA ITEM: 12**
Report Author and Job Title:	Aruna Mehta, Non Executive Director and PFRC Chair	**Responsible Director:**	Aruna Mehta, Non Executive Director and PFRC Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Provides a summary of key matters arising at the PFRC meeting held on 24 January 2023		
Background			
Assessment	Key (ongoing) challenges around ESR and Carenotes. Need to make CIP a core part of 'business as usual'. Need to develop IQPR		
Recommendation	Members of the Trust Board are asked to: - Note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Provides assurance regarding Risk 1 - Delays to treatment, long Wait times/demand Risk 6 - Delivering financial sustainability targets Risk 7 - Maintaining an effective estate function Risk 8 - Sustainable income streams Risk 9 – IT infrastructure and cyber security Risk 12 - Effective Performance and Risk management arrangements		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve ☒	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration. ☐	
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☒	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.☐	
	Ensure we are well-led & effectively governed ☒		

1 ACTIVITY / PERFORMANCE

1.1 Progress continues to be made in this area, with contracts that are at risk and not delivering to the required targets identified. However, due to delays in mapping in ESR (Electronic Staff Record), it is not yet possible to get the data in the new organisational format.

1.2 In addition, challenges with Care Notes has meant performance metrics are not complete.

1.3 Noted that Job Planning still requires progress to be made with clinicians in Community and Integrated at 57% and around 75% for Complex Mental Health. Compliance for trainees and honourees is much lower.

1.4 An IQPR (integrated Quality and Performance Report) is being developed, however, this will take time to put in place and longer for the processes around the IQPR to develop improved outcomes.

1.5 The Committee notes that the Trust is in receipt of some very good qualitative data, and reassurance that SR posts are starting to be filled.

1.6 Noted that CAHMS has the best wait times across the NCL ICS; that the NCEL CAHMS collaborative has won HSJ award and that in its recent Ofsted inspection Gloucester House was judged Good with some outstanding features.

1.7 Key concerns remain in GIDS, where there are very high levels of staff attrition and the phase 1 meeting for handover has not happened. Harm reviews continue to be undertaken on those on waitlist.

1.8 Action plans were shared, demonstrating progress but also the extent of work that needs to be completed.

2. CARE NOTES

2.1 An update was provided regarding Carenotes. There are significant challenges related to the amount of manual input required – in particular by clinicians. This is a significant risk to the organisation.

3. ESTATES

3.1 A report on Estates and Projects provided good assurance regarding mitigation for programs such as fire doors that are behind on plan.

4. FINANCE REPORTS

4.1 The Month 9 Finance report was received, showing the Trust slightly ahead of Plan for the period and on target to deliver to the agreed deficit £3.8m for the year. The main risk to the full year out-turn is associated with the ongoing uncertainty of whether GIDS staff are – as the Trust believes they should – subject to TUPE.

4.2 Agency costs which represent 7.5% against the recent NHSE guideline of 3.7% - these are concentrated in Corporate areas.

4.3 A slight increase in debtors over 90 days was noted – with ETC to look at the student debt proportion.

4.4 There was a discussion around CIPS (Cost Improvement Programmes) and the risks of trying to achieve this via headcount alone. A budget methodology paper will be presented at board on 7/2.

5. BOARD ASSURANCE FRAMEWORK

5.1 The BAF was discussed and the good progress made noted.

5.2 A number of other risks were raised for consideration for inclusion and there was a discussion around risk appetite.

6. SOF 3

6.1 SOF updates were noted – and it was confirmed that NEDs would be given sight of this before it was sent to the ICS.

7. IMT PROGRESS REPORT

7.1 The report was noted.

MEETING OF THE BOARD OF DIRECTORS - Tuesday 7 February 2023			
Audit Committee Highlight Report			**AGENDA ITEM: 13**
Report Author and Job Title:	David Levenson, NED and joint Chair of the Committee	**Responsible Director:**	David Levenson, NED and joint Chair of the Committee
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	This paper is to provide a high-level summary of the key matters arising at the Audit Committee meeting held on Thursday 19 January 2023		
Background	The Audit Committee is a sub-committee of the Board of Directors and therefore has delegated function to gain assurance that the services we deliver are safe, effective and of high quality. Any key risks/issues/concerns, where the Audit Committee assesses the need for Board oversight/awareness/decision, will be escalated to the Board		
Assessment	Key items for the Board to note are: • Delays in closing Internal Audit recommendations – particularly in Payroll • Progress made with regards to the BAF		
Recommendation	Members of the Board are asked to: - note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk 12 - Effective Performance and Risk management arrangements		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve ☐	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration. ☐	
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☐	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.☐	
	Ensure we are well-led & effectively governed ☒		

1. OVERVIEW

1.1 The Committee was assured by the CEO and Executive team's focus in recent months on key priorities for the Trust; improved performance, data management, systems and processes, and business development.

1.2 That said, the Committee concluded that clearer accountability and ownership of problems by relevant executives and staff will enable improvements in performance, quality and governance.

1.3 Members of the Executive team should attend Audit Committee meetings to field questions on items for which they hold accountability.

1.4 The Committee welcomed the positive response from NCL to the Executive report presented at the latest SOF meeting on January 12th.

1.5 The Committee recognised the mitigating factors that have impacted on delivery of process improvements and management actions, notably the Strategic Review, GIDS and instability in the leadership of the HR function.

2. GOVERNANCE AND RISK MANAGEMENT

2.1 The Committee noted the first draft of the revised Board Assurance Framework (BAF) is a work in progress and will come back to the Committee for further scrutiny when there is more detail available from corporate and operational risk registers.

2.2 The Committee agreed that the second line defence for the monitoring of operational risks is the responsibility of the respective service committees. Similarly "deep-dive" reviews of operations are in future to be undertaken by other committees. The role of the Audit Committee will be to review the risk monitoring and deep dive reports received from the service committees and advise the Board about the levels of assurance being afforded by the reports.

3 FINANCIAL SUSTAINABILITY (HFMA SELF ASSESSMENT)

3.1 The HFMA self assessment is a mandatory requirement introduced by the NHS in 2022 to gauge organisations' financial governance and as a means to track its financial sustainability. RSM (Internal Auditor) has validated the results of the self assessment and indicated where improvements are needed.

3.2 The Committee noted the self assessment's findings, that the Trust's budgeting processes are reasonably robust however there are significant weaknesses in other areas, notably the absence of a cost improvement programme (CIP). The Committee will keep under review the action plan for delivering improvements on the weaknesses identified by the self assessment.

4 FINANCIAL REPORTING AND EXTERNAL AUDIT - Y/E 31 MARCH 2023

4.1 The Committee approved the Trust's proposed timetable for the Annual Report and Accounts process and noted the External Auditor's plan for y/e 2022/23. The target is that both the year-end process and audit will run more smoothly and remain on schedule this year.

5 INTERNAL AUDIT REPORTS AND MANAGEMENT ACTIONS - 2022-23

5.1 The Committee expressed concern about the number of open audit actions since the last meeting. Out of 23 actions, 2 had been completed, 8 were in progress with revised deadlines and 13 were overdue and not implemented. The Payroll audit follow-up report stated that only 1 (low priority) out of 11 management actions had been completed. The 10 actions still in progress or not implemented were either high priority (5) or medium priority (5). These will continue to remain under review by the Committee.

5.2 In the light of known challenges, the Committee also expressed reservations about some deadlines for management actions and asked the Executive team to consider whether the targets for completing actions are realistic and requested that these be reviewed. The Committee has tasked the Executive team to focus on controls and emphasise the need for standard operating procedures (SOPs).

6 INTERNAL AUDIT PLAN - 2023-24

6.1 The Committee endorsed the Internal Audit plan for 2023/24 which had been agreed by the Executive team, with the proviso that there be scope to flex the programme and bring forward other priorities later in the year, for example on performance improvement and data quality. The Committee would like Internal Audit to review assurance levels in the Trust's Integrated Quality & Performance Report (IQPR) as part of next year's plan.

7 OTHER MATTERS

7.1 The Committee noted a report from the CFO on tender waivers which increased significantly due to reliance on agency and contract staff throughout the SR period, but now appear to have peaked. The CFO has recommended that use of procurement framework agreements should be increased. The Committee agreed that the detail of such tenders need not be reported in order that the Committee focus on more risky – no framework – tenders.

7.2 The Committee requested that the Education & Training Committee review in more detail underlying reasons for the increase in aged student debts.

7.3 The Committee noted positive progress in the Local Counter Fraud Service (LCFS) report, Cyber Security, CareNotes update and Governance Assurance reports.

MEETING OF THE BOARD OF DIRECTORS: 7 February 2023			
Finance Report: 9 months ended 31 December 2022			**AGENDA ITEM: 14**
Report Author and Job Title:	Udey Chowdhury, Deputy CFO	**Responsible Director:**	Terry Noys, Chief Financial Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	Attached is the Month 9 (period to December 22) Finance Report. **Income & Expenditure** This shows that the Trust has incurred a net deficit of £3.3m. This is a positive variance against a Plan / Budget position of a deficit of £3.5m. Cost pressures – notably CQC, SR and HR– are being offset by savings on staffing. A reforecast – in line with new SR structures – is being produced and will, as agreed at the meeting of the Board of Directors on 15 December 2022, show an unchanged year end Plan position of a deficit of £3.8m. **Capital Expenditure** At £1,347k Capex is significantly behind Plan, reflecting the late agreement of Plan and thus late starting of procurements. The situation has also been adversely affected by the situation with Carenotes. Accordingly, the programme has been amended to allow for greater expenditure on estates projects – notably fire doors – with IT projects carried over into the 2023/24 financial year. **Cash** Cash is £11.2m versus a Plan figure of £7.8m. The positive variance reflects the lower Capex to date plus positive (to Plan) movements in working capital – largely income received but deferred and accrued costs not paid out.		

Background	The Trust has a Plan for a revenue deficit for 2022/23 of £3.8m and for Capex of £3.4m with a year-end cash position of £6.2m	
Assessment	**Income & Expenditure** The Trust faces cost pressures in a number of areas, but most notably in GIDS, the Strategic Review and in HR, however, the Trust has sufficient balance sheet flexibility to cope with these. The key potential risk currently facing the Trust on the delivery of its Plan deficit figure of £3.8m is the potential need to provide redundancies relating to the GIDS service. These are estimated at £2.6m and are not included in Trust forecasts. Current legal advice received by the Trust is that these liabilities should not accrue as the GIDS staff group should be subject to TUPE, however, this continues to be an area of uncertainty. **Capital Expenditure** The Trust has revised its full year plan down slightly, to £3.3m. This has been agreed with the ICB. **Cash** Year end cash is expected to be ahead of the Plan figure at around £8m	
Recommendation	The Board of Directors is asked to: I. Note the position outlined above	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk 6 – Delivering financial sustainability	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	High quality clinical and educational services ☐	Excellence in employee experience ☐
	Organisational effectiveness ☒	Long Term Financial sustainability ☒
	Data quality / Decision making ☐	

FINANCE REPORT – MONTH 8: PERIOD ENDED 31 December 2022

1. OVERVIEW

1.1 For the period ended 31 December 2022, the Trust recorded a deficit of £3.3m, compared with a Planned / Budgeted deficit of £3.5m.

1.2 A full year reforecast is currently being prepared, however, as agreed with the Board, this will show an unchanged year end position.

1.3 Ongoing cost pressures – notably around GIDS, the Strategic Review and HR – are expected to be compensated by a higher than Plan vacancy factor.

1.4 The key risk to achieving the year end Plan would be if the Trust was required to provide for redundancy costs for GIDS – see Key Risks and Opportunities in section 9.

2 INCOME

2.1 Income was £46.9m, £1.9m adverse to Plan income of £48.8m.

2.2 This is due to DET income being £1.2m lower than Plan, CYAF income being £0.5m lower than Plan, and Clinical Support being £0.2m lower than Plan.

2.3 DET income shortfall is largely a phasing issue and is expected to be recovered later in the financial year.

2.4 The shortfall on CYAF reflects £0.5m of Trust unidentified new income that was Budgeted within CYAF and deferred block income relating to Eating disorders and Crisis Hubs, where under-recruitment has led to reduced activity.

3 STAFFING COSTS

3.1 Staff costs of £36.8m are £1.4m lower than Plan. This is after factoring in a year-to-date Plan vacancy factor of £4.0m.

3.2 Lower than Plan staff costs reflect vacancies across all elements of the Trust.

3.3 Agency costs in the period total £2.8m.

4 OPERATING NON-PAY COSTS

4.1 Operating non pay costs of £12.2m are £0.5m lower than Plan of £12.7m.

4.2 This is primarily due to lower DET costs (reflecting the timing of activity noted in 2.3 above).

5 OTHER COSTS (Depreciation, Interest, PDC)

5.1 Non-operating costs are £93k lower than Plan, due primarily to higher interest receivable reflecting increases in interest rates and higher than Plan cash balances.

6 SERVICE LINE PERFORMANCE

6.1 All services are broadly ahead of Plan in terms of surplus and margin.

Education And Training

6.2 Education and Training is £545k ahead of Plan due primarily to positive variances in NSWDU and Short Courses.

6.3 NSWDU is £875k ahead of Plan reflecting, primarily, poor planning assumptions around 2022/23 income and expenditure. Short courses are £255k ahead of Plan due primarily to lower venue / catering costs.

CYAF (Child, Young Adults, Families)

6.4 CYAF is £637k ahead of Plan due primarily to lower staff costs in Camden CAMHS and vacancies across all service lines.

6.5 Gloucester House contracts have been reduced below those planned.

6.6 Plan unidentified income - shown within CYAF - will be received across various directorates, not just CYAF.

Gender

6.7 Gender services are £352k positive to plan, a non-recurrent reduction in blood testing costs of £300k masking ongoing CQC cost pressures / decommissioning planning, which were originally planned to be wound down by October 2022.

AFS (Adult and Forensic)

6.8 AFS is £261k positive to Plan due primarily to lower staff costs, notably in the Portman Clinic and Complex Needs.

Clinical Support

6.9 Clinical Support is £128k adverse to Plan due to lower PGMDE income.

Corporate Costs

6.10 Corporate costs are £1,306k adverse to Plan, reflecting additional costs, most notably associated with HR, the Strategic Review and utilities.

6.11 Additionally, due to the Capital Expenditure programme being behind schedule, consultancy costs in Finance and Estates have not been capitalised at the rate assumed in the Plan. This will be reviewed again at the year end, in the light of progress made with the Capital programme. Higher Finance expenditure also reflects higher than envisaged external audit costs.

7 BALANCE SHEET / CASH FLOW / CAPITAL EXPENDITURE

7.1 Debtors overdue by 90 days or more have increased to £762k (compared with £635k in the previous month). The increase is across all elements – NHS, non-NHS and students.

7.2 The Trust has a bad det provision of £0.3m which is considered adequate for the purpose.

7.3 Cash as of 31 December 2022 was £11.2m, compared with a Plan figure of £7.8m.

7.4 The £3.7m improvement reflects:

Lower than Plan capital expenditure	£1.3m
Changes in working capital (deferred income/accrued costs)	£2.0m
	-------
	£3.3m

7.5 Capital expenditure is behind Plan; however, this slippage is still expected to be largely caught up during the year.

8 COMPARISON WITH PRIOR YEAR

8.1 Compared with the same period in the prior year (2021/22) the Trust deficit is £0.6m better reflecting higher levels of income.

8.2 Both pay and non-pay costs are higher than at the same time last year.

9 FULL YEAR OUTLOOK / KEY RISKS AND OPPORTUNITIES

9.1 As previously indicated, based on the position to date, it is expected that the Trust will meet its Planned full year deficit of £3.8m.

9.2 Emerging cost pressures arising from delays in strategic review, CQC review and associated GIDS decommissioning planning, utilities inflation, together with retrospective salary payments for increments not paid and the requirement to update Carenotes following the issue with Advanced Systems data will be offset by higher than Plan staff vacancies and in-year revenue allocation, together with possible releases of balance sheet provisions.

Run Rate

9.3 The Finance Report now includes a section on 'Run Rate'. This uses the ICB methodology of taking the year to date ("YTD") position and extrapolating that for the remainder of the year.

9.4 The extrapolated run rate shows that, based on the YTD position, the Trust would incur a full year deficit of £4.5m, against the Plan deficit of £3.8m.

9.5 The run rate analysis fails to take into account that, for the Trust, the last quarter tends to be the most 'profitable' quarter for the year. However, should this seasonality not occur, the Trust has sufficient balance sheet flexibility to ensure that it meets its Plan position – subject to the issue of Key Risks, noted below.

Key Risks and Opportunities

9.6 The key risk facing the Trust in achieving its Plan deficit of £3.8m is the potential need to provide for redundancies for GIDS.

9.7 Legal advice received by the Trust states that TUPE should apply and no redundancy provision is, therefore, required. However, as NHSE have yet to finalise the service specification for the new GIDS services, it is possible that this advice may need to be revised.

9.8 The ICB are fully aware of this issue.

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE REPORT

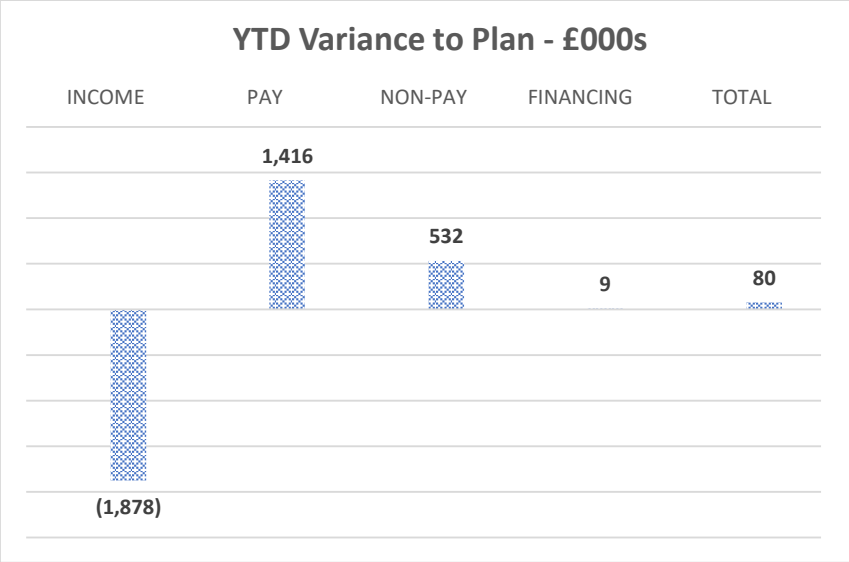
Period 9 **9** **Dec-22**

FINANCE REPORT **I & E Summary** **Page 2**

Period 9

Dec-22

£000	Plan	Actual	Variance	Var %
INCOME	48,809	46,931	(1,878)	(4%)
PAY	(37,724)	(36,308)	1,416	(4%)
NON-PAY	(12,684)	(12,152)	532	(4%)
EBITA	**(1,600)**	**(1,529)**	**70**	**(4%)**
Interest receivable	9	92	83	
Interest payable	(20)	(10)	10	
Depreciation	(1,727)	(1,727)	(0)	
Dividend	(162)	(162)	0	
Other non-operating		(0)	(0)	
Net Surplus /(Deficit)	**(3,499)**	**(3,337)**	**162**	**(5%)**



	Plan	Act	Var
Projected closing cash	**7,833**	**11,164**	**3,331**
YTD Cash in/(out) flow - £000s	**(6,982)**	**(3,652)**	**3,330**
due to :-			
Operating flows - accrued costs and deferred income			***2,068***
Captial slippage			***1,263***
			0
Capital Expenditure - £000s	**(2,610)**	**(1,347)**	**1,263**

Debtors > 90 days	**Oct-22**	**Nov-22**	**Dec-22**
	£'000	£'000	£'000
NHS	143	89	167
Non-NHS	116	218	230
Student	298	328	366
Total	**557**	**635**	**762**

	Current Year Run Rate						Prior Year Comparison		
£000	Plan	YTD Actual	Full Year Run Rate	Adjustments	Full Year Fcst	Variance	YTD Prior Yr	YTD Actual	Variance
INCOME	**65,078**	**46,931**	**62,575**	**0**	**62,575**	**(2,504)**	**45,041**	**46,931**	**1,889**
PAY	**(50,036)**	**(36,308)**	**(48,411)**	**250**	**(48,161)**	**1,875**	**(35,986)**	**(36,308)**	**(322)**
NON-PAY	**(16,277)**	**(12,152)**	**(16,202)**	**455**	**(15,747)**	**529**	**(11,275)**	**(12,152)**	**(877)**
EBITA	**(1,235)**	**(1,529)**	**(2,039)**	**705**	**(1,334)**	**(99)**	**(2,220)**	**(1,529)**	**690**
Interest receivable	12	92	122		122	110	0	92	91
Interest payable	(26)	(10)	(13)		(13)	13	(24)	(10)	14
Depreciation	(2,302)	(1,727)	(2,303)		(2,303)	(1)	(1,362)	(1,727)	(365)
Dividend	(216)	(162)	(216)		(216)	0	(338)	(162)	176
Other non-operating		0	0		0	0			
Net Surplus /(Deficit)	**(3,768)**	**(3,337)**	**(4,449)**	**682**	**(3,767)**	**0**	**(3,944)**	**(3,337)**	**607**

Income	Revenue contracts deferred	NCL increases and other inflationary increases - less
Pay	£500k Annual leave provision reduction for Mar23, offset by £250k back dated increments provision	inflatonary increases less vacancies
Non-Pay	Mar 23 provision release of £690k less £250k Carenotes repair	Inflationary increases - incl Utilities

FINANCE REPORT **Balance Sheet** **Page 4**

Period 9

Dec-22

	Prior Year End £'000	Apr-22 £'000	May-22 £'000	Jun-22 £'000	Jul-22 £'000	Aug-22 £'000	Sep-22 £'000	Oct-22 £'000	Nov-22 £'000	Dec-22 £'000	Jan-23 £'000	Feb-23 £'000	Mar-23 £'000
Intangible assets	92	92	92	85	82	80	77	75	72	70			
Land and buildings and equipment	25,150	24,368	25,388	24,323	24,810	24,748	24,675	24,880	25,081	24,793			
	0	0	0	0	0	0	0	0	0	0			
Property, Plant & Equipment	25,150	24,368	25,388	24,323	24,810	24,748	24,675	24,880	25,081	24,793	0	0	0
Total non-current assets	25,242	24,460	25,480	24,407	24,892	24,828	24,752	24,955	25,153	24,862	0	0	0
NHS Receivables	2,410	1,491	1,183	729	315	303	955	726	312	(9)			
Non-NHS Receivables	5,245	5,633	5,048	4,242	5,149	6,403	7,115	7,461	7,382	6,193			
Cash / equivalents	9,043	6,531	7,821	7,181	8,140	6,157	5,375	6,883	5,063	3,746			
Other cash balances	5,773	5,737	5,786	5,986	6,090	6,274	6,523	6,819	7,007	7,418			
Total current assets	22,471	19,392	19,838	18,138	19,693	19,136	19,969	21,889	19,764	17,348	0	0	0
Trade and other payables	(5,671)	(5,491)	(4,623)	(4,636)	(4,148)	(4,028)	(5,371)	(5,060)	(4,547)	(4,365)			
Accruals	(7,861)	(7,019)	(7,174)	(4,735)	(7,847)	(8,319)	(8,331)	(10,860)	(9,955)	(7,791)			
Deferred income	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)	(7,849)			
Long term loans < 1 year	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)	(445)			
Provisions	(4,322)	(4,336)	(4,305)	(4,218)	(3,936)	(3,922)	(3,921)	(3,791)	(3,753)	(3,753)			
Other		0	0	(1)	(1)	(1)	(1)	(2)	(2)	(2)			
Total current liabilities	(26,148)	(25,140)	(24,397)	(21,884)	(24,225)	(24,564)	(25,919)	(28,007)	(26,550)	(24,204)	0	0	0
Total assets less current liabilities	21,565	18,712	20,921	20,661	20,360	19,401	18,801	18,837	18,367	18,006	0	0	0
Non-current provisions	(32)	(32)	(32)	(32)	(32)	(32)	(32)	(32)	(32)	(32)			
Long term loans > 1 year	(2,221)	(2,221)	(2,221)	(2,221)	(2,221)	(1,998)	(1,998)	(1,998)	(1,998)	(1,998)			
Total assets employed	19,312	16,460	18,668	18,408	18,107	17,370	16,771	16,807	16,337	15,975	0	0	0
Public dividend capital	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)	(5,543)			
Revaluation reserve	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)	(14,239)			
I&E reserve	470	3,323	1,114	1,373	1,675	2,412	3,011	2,975	3,445	3,807			
Total taxpayers equity	(19,312)	(16,460)	(18,668)	(18,408)	(18,107)	(17,370)	(16,771)	(16,807)	(16,337)	(15,975)	0	0	0

FINANCE REPORT **FUNDS FLOW** **Page 5**

Period 9

Dec-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**
Net Surplus/(Deficit)	**(2,853)**	**2,208**	**(259)**	**(301)**	**(737)**	**(599)**	**36**	**(470)**	**(362)**	**0**	**0**	**0**	**(3,337)**
Depreciation / amortisation	0	384	107	164	164	164	164	164	418	0	0	0	**1,727**
PDC dividend paid	0	36	18	18	18	18	18	18	18	0	0	0	**162**
Net Interest paid	(2)	4	2	2	4	0	0	0	0	0	0	0	**10**
(Increase) / Decrease in receivables	531	893	1,260	(493)	(1,242)	(1,364)	(117)	493	1,509				**1,471**
Increase / (Decrease) in liabilities	(1,021)	(713)	(2,427)	2,624	352	1,356	2,218	(1,419)	(2,346)				**(1,375)**
Increase / (Decrease) in provisions	14	(30)	(88)	(282)	(14)	(0)	(131)	(38)	0				**(569)**
Non operational accural movement	851	(1,272)	966	(624)	(10)	198	(17)	(18)	(18)				**57**
Net operating cash flow	**(2,481)**	**1,510**	**(420)**	**1,108**	**(1,465)**	**(228)**	**2,170**	**(1,270)**	**(780)**	**0**	**0**	**0**	**(1,854)**
Interest received													**0**
Interest paid					(12)								**(12)**
PDC dividend paid						(216)							**(216)**
PDC Funding received													**0**
Cash flow available for investment	**(2,481)**	**1,510**	**(420)**	**1,108**	**(1,477)**	**(444)**	**2,170**	**(1,270)**	**(780)**	**0**	**0**	**0**	**(2,082)**
Purchase of property, plant & equipment	125	20	86	118	64	76	(203)	(199)	291				**380**
Depreciation	(192)	(192)	(107)	(164)	(164)	(164)	(164)	(164)	(418)				**(1,727)**
Capital purchases - cash	**(67)**	**(172)**	**(21)**	**(45)**	**(99)**	**(88)**	**(366)**	**(362)**	**(126)**	**0**	**0**	**0**	**(1,347)**
Net cash flow before financing	**(2,547)**	**1,339**	**(441)**	**1,063**	**(1,577)**	**(532)**	**1,804**	**(1,632)**	**(907)**	**0**	**0**	**0**	**(3,429)**
Repayment of debt facilities	0	0	0	0	(222)								**(222)**
Net increase / (decrease) in cash	**(2,547)**	**1,339**	**(441)**	**1,063**	**(1,799)**	**(532)**	**1,804**	**(1,632)**	**(907)**	**0**	**0**	**0**	**(3,652)**
Opening Cash	14,816	12,268	13,607	13,167	14,230	12,430	11,899	13,703	12,070				14,816
Closing cash	**12,268**	**13,607**	**13,166**	**14,229**	**12,430**	**11,899**	**13,703**	**12,070**	**11,164**	**0**	**0**	**0**	**11,164**

FINANCE REPORT **Capital Expenditure**

Period 9

REPORTING MONTH																			
Dec-22	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**ANNUAL**				**Y.T.D**		
	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Act	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 Budget	£000 Delta Fav (Adv)		£000 Actual	£000 Budget	£000 Delta Fav (Adv)
PROJECT																			
Endpoint Procure/Config/Compliance/Monitor	7	21	0	1	-	-	-	30	-	-	-	-	**59**	28	**(31)**		**59**	**28**	**(31)**
Tavistock Centre Data Centres Power Provision	10	3	-	-	-	-	105	7	7	(7)	-	-	**124**	13	**(111)**		**132**	**13**	**(119)**
Health Information Exchange	(1)	-	-	-	-	-	-	-	-	-	-	-	**(1)**	(1)	-	(3)	**(1)**	**(1)**	-
Scheduling & Robotic Process Automation	-	-	-	-	-	-	(0)	0	-	-	-	-	**(0)**	-	**0**	(0)	**(0)**	**-**	**0**
Core Infrastructure Update	(1)	-	-	-	-	-	-	15	-	-	-	-	**13**	(1)	**(15)**		**13**	**(1)**	**(15)**
Network - Upgrade (Wireless)	4	(0)	0	5	(5)	5	(4)	12	2	-	-	-	**19**	4	**(15)**		**19**	**4**	**(15)**
Cyber Essentials Plus	-	-	-	-	-	-	-	23	-	-	-	-	**23**	-	**(23)**		**23**	**-**	**(23)**
Endpoint Replacement 2021/22	-	21	-	-	76	(76)	2	13	-	-	-	-	**36**	21	**(15)**		**36**	**21**	**(15)**
ICT Cyber Security Compliance 2021/22	4	7	-	-	-	-	-	23	(0)	-	-	-	**34**	11	**(23)**		**34**	**11**	**(23)**
API for CareNotes Integration	(1)	-	-	-	-	-	-	-	-	-	-	-	**(1)**	(1)	-	(3)	**(1)**	**(1)**	-
Audio Video Upgrade for Remote Working	(2)	41	-	5	-	4	9	20	3	(3)	-	-	**78**	39	**(39)**		**81**	**39**	**(42)**
Connectivity Upgrade	(0)	6	(0)	-	-	-	-	8	-	-	-	-	**14**	6	**(8)**		**14**	**6**	**(8)**
Data Warehouse	(7)	9	-	1	-	11	6	30	15	(8)	-	-	**57**	2	**(55)**		**65**	**2**	**(63)**
Virtual Desktop Interface	(1)	-	-	-	-	-	-	15	-	(1)	-	-	**13**	(1)	**(14)**		**14**	**(1)**	**(15)**
Endpoint Replacement Programme 2022/23	-	-	-	-	-	87	-	-	-	8	4	17	**117**	100	**(17)**		**87**	**60**	**(27)**
Windows 10 Trust-Wide Rollout - Phase 2	-	-	-	-	-	-	-	5	6	21	12	12	**56**	50	**(5)**		**10**	**30**	**20**
Online Outcome Monitoring Phase I & 2	-	-	-	-	-	-	6	(3)	3	(6)	11	11	**22**	72	**50**		**6**	**28**	**22**
Health & Social Care Network Phase II (Internet Connectivity)	-	-	-	-	-	-	-	-	-	-	1	1	**2**	32	**30**		**-**	**32**	**32**
Remote Monitoring Tools	-	-	-	-	-	-	-	-	-	8	9	5	**23**	26	**3**		**-**	**26**	**26**
Digital Care Platform Phase I (Patient portal/personal health record)	-	-	-	-	-	-	7	(1)	7	6	43	48	**109**	113	**4**		**13**	**64**	**51**
Cloud Transformation Phase 2-3 (21/22)	-	-	-	-	-	-	-	17	4	30	25	25	**102**	161	**59**		**21**	**71**	**50**
Cyber Security Compliance (CE, CE+)	-	-	-	-	-	-	-	-	-	11	6	11	**28**	60	**32**		**-**	**38**	**38**
Data Warehouse for data services 2nd Phase	-	-	-	-	-	-	6	(3)	3	(6)	-	-	**0**	152	**152**		**6**	**80**	**74**
Integration Engine / Platform	-	-	-	-	-	-	-	2	3	11	46	46	**109**	158	**50**		**5**	**100**	**95**
Core Infrastructure Hardware/Licence Compliance	-	-	-	-	-	-	-	2	5	5	9	4	**25**	227	**202**		**7**	**150**	**143**
Student Data Reporting - Phase 2	-	-	-	-	-	-	-	14	6	16	16	16	**68**	123	**55**		**20**	**60**	**40**
IT	**12**	**107**	**0**	**11**	**71**	**31**	**134**	**231**	**63**	**87**	**182**	**197**	**1,128**	**1,393**	**265**		**662**	**857**	**195**

FINANCE REPORT
Period 9

Capital Expenditure

REPORTING MONTH																			
Dec-22	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**ANNUAL**				**Y.T.D**		
	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Actual	£000 Act	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 Budget	£000 Delta Fav (Adv)		£000 Actual	£000 Budget	£000 Delta Fav (Adv)
PROJECT																			
LED Lighting	13	-	-	-	-	-	-	-	-	-	-	-	**13**	13	**-**		**13**	**13**	**-**
Electrics	(1)	22	5	-	14	0	-	-	(0)	-	-	-	**41**	57	**16**		**41**	**57**	**16**
TC Compliance	(0)	11	(11)	-	-	-	(0)	0	(0)	-	-	-	**(0)**	(0)	**0**	(0)	**(0)**	**(0)**	**0**
Tavistock Reconfiguration	(14)	-	17	-	-	-	-	-	-	-	-	-	**3**	3	**-**		**3**	**3**	**-**
Finchley Road	-	(0)	-	-	-	-	(1)	1	0	-	-	-	**0**	(0)	**(0)**	(0)	**0**	**(0)**	**(0)**
Fire Safety & Compliance	10	10	7	15	10	(12)	8	2	2	(2)	-	-	**50**	27	**(23)**		**52**	**27**	**(25)**
TC - Monroe Service Desk & Furniture	10	1	5	1	-	40	63	5	-	3	-	4	**132**	121	**(11)**		**125**	**121**	**(4)**
TC - Kitchen & Breakout Space	13	-	-	(0)	-	1	7	34	1	44	-	25	**126**	113	**(12)**		**56**	**113**	**57**
Gender Neutral Toilets	8	-	1	2	-	1	41	2	0	(0)	-	-	**54**	54	**(1)**		**55**	**54**	**(1)**
Touchless Entry & Access Control	4	7	13	23	4	15	15	16	21	18	23	22	**182**	89	**(92)**		**118**	**79**	**(39)**
Lockers - hybrid working / space utilsation	-	-	-	-	-	-	-	-	-	-	-	-	**-**	30	**30**		**-**	**30**	**30**
Fire doors GH and glazing (compliance)	-	-	-	-	-	1	19	35	4	73	9	-	**141**	102	**(39)**		**59**	**102**	**43**
Tavistock fire doors (compliance) & fire stopping (compliance)	-	-	-	-	-	10	11	11	21	28	468	462	**1,011**	250	**(761)**		**53**	**150**	**97**
Portman fire doors (compliance & compartmentation)	-	-	-	-	-	-	-	-	3	3	71	107	**185**	45	**(140)**		**3**	**45**	**42**
Portman flexihoses / water (compliance)	-	-	-	-	-	-	-	-	-	-	-	-	**-**	15	**15**		**-**	**10**	**10**
Water - hot and cold dead legs / sink removal over 2 years (compliance)	-	-	-	-	-	-	-	-	-	64	0	8	**72**	115	**43**		**-**	**80**	**80**
Wave on taps (compliance)	-	-	-	-	-	-	-	-	-	-	60	65	**125**	90	**(35)**		**-**	**90**	**90**
Project Management for 22/23 projects - to be allocated across all projects	-	-	-	-	-	-	-	-	-	-	-	-	**-**	100	**100**		**-**	**40**	**40**
Backlog - Physical / Statutory & Quality / Function	-	-	-	-	-	-	-	-	-	27	30	54	**110**	-	**(110)**		**-**	**-**	**-**
DET space	-	-	-	-	-	-	-	-	-	-	-	-	**-**	120	**120**		**-**	**100**	**100**
Showers & Ambulant Toilet	-	-	-	-	-	-	-	-	-	30	30	30	**90**	-	**(90)**		**-**	**-**	**-**
AV Enabling works	-	-	-	-	-	0	61	15	8	2	-	-	**86**	120	**34**		**84**	**120**	**36**
Wifi enabling works	-	-	-	-	-	-	-	19	4	8	-	-	**31**	30	**(1)**		**23**	**30**	**7**
CAFM - Computer aided facilities management	-	-	-	-	-	-	-	-	-	-	-	-	**-**	65	**65**		**-**	**65**	**65**
4th Floor - LED Lighting / Waiting Rooms / standardise Clinic & Hot desk rooms	-	-	-	-	-	-	-	-	-	-	64	80	**144**	70	**(74)**		**-**	**70**	**70**
3rd Floor - LED lighting / Waiting Rooms / standardise Clinic rooms	-	-	-	-	-	-	-	-	-	-	-	-	**-**	30	**30**		**-**	**30**	**30**
2nd Floor - LED lighting / Waiting rooms / standardise clinic rooms	-	-	-	-	-	-	-	-	-	-	-	-	**-**	40	**40**		**-**	**40**	**40**
1st Floor - Clinical furniture / Waiting Rooms / standardise Clinic rooms	-	-	-	-	-	-	-	-	-	53	29	37	**119**	40	**(79)**		**-**	**40**	**£40,000**
ESTATES	**44**	**52**	**38**	**41**	**28**	**57**	**223**	**140**	**64**	**352**	**785**	**891**	**2,714**	**1,739**	**(974)**		**686**	**1,509**	**823**
RELOCATION - Cost	11	13	(17)	(7)	0	-	8	(8)					**(0)**	-	**0**	(0)	**(0)**	**-**	**0**
RELOCATION	**11**	**13**	**(17)**	**(7)**	**0**	**-**	**8**	**(8)**	**-**	**-**	**-**	**-**	**(0)**	**-**	**0**	(0)	**(0)**	**-**	**0**
SUB-TOTAL	**67**	**172**	**21**	**45**	**99**	**88**	**366**	**362**	**126**	**438**	**967**	**1,088**	**3,841**	**3,132**	**(709)**		**1,347**	**2,366**	**1,019**
Contingency / Future Projects for Approval / Other												(511)	**(511)**	350	**861**	##	**-**	**-**	**-**
TOTAL	**67**	**172**	**21**	**45**	**99**	**88**	**366**	**362**	**126**	**438**	**967**	**577**	**3,330**	**3,482**	**152**		**1,347**	**2,366**	**1,019**

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Page 7

The Tavistock and Portman
NHS Foundation Trust

Meeting of the Board of Directors: 7 February 2023			
Activity Reporting: Performance and Contracts – Month 9			**AGENDA ITEM: 14**
Report Author and Job Title:	Amy Le Good, Acting Director of Commercial / Terry Noys Chief Financial Officer	**Responsible Director:**	Sally Hodges, Clinical Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Situation	In order to demonstrate value for money and to meet the expectations of its commissioners, it is important that the Trust monitors clinical activity and, where appropriate, has in place improvement plans. This report was discussed by the Performance, Finance and Resources Committee at its meeting on 24 January 2023.		
Background	Although the Trust does not have PBR (Payment by Results) contracts, each year the Trust agrees a range of KPIs with commissioners including activity / financial targets		
Assessment	**Carenotes** Whilst Carenotes is now back 'online' there is a substantial amount of work required to get it updated for information that was gathered whilst the system was down. Getting clinical engagement with this work is proving to be a challenge. **Activity Reporting** With Carenotes still waiting to be fully updated, the available information needs to be treated carefully, however, it is clear that for many of the Trust's services activity levels are substantially below what they should be. This poses a potential threat in terms of reputation and the Trust's longer term financial position. It is hoped that the introduction of job plans will help with the process of improving activity, however, this area is behind schedule with only 57% completed for clinical staff in the new Community and Integrated service line (and none for trainees and honoraries). The figures are better in the Complex Mental Health service line (at around 75% for clinical staff) but also low for trainees and honoraries. Reporting is further inhibited by the fact that ESR (Electronic Staff Record) still does not fully reflect post SR structures. It is understood that this will be completed by end February. **Contracts** The situation regarding GIDS is well known. A number of other contracts are at some risk but, currently, are still assumed to continue into 2023/24.		

Recommendation	The Board of Directors is asked to: - Note the report	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The report helps provide assurance around: - Risk 1: Delays to treatment, long Wait times/demand - Risk 2: Maturity of Data quality to support transformation - Risk 3: Quality of service provision - Risk 6: Delivering financial sustainability targets - Risk 8: Sustainable income streams	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve ☒	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration. ☐
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☒	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.☐
	Ensure we are well-led & effectively governed ☒	

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Performance Report January 22/23

Internal

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Positive Developments

- Carenotes and Reporting services has been restored
- Going though this process has highlighted key areas we could improve.
- The online dashboard for clinical care phase 1 is being rolled out and Informatics has rolling training programme
- Our School, Gloucester House, was recently inspected by OFSTED, we are pleased with the provisional outcome of this inspection.
- Staff engagement with new systems and process has been very encouraging and the structures are embedding.
- Recruitment has increased and SR posts have started to be filled.
- The latest benchmarking data for CAMHS shows us as having the best wait times within the ICS.
- The integrated front door (single point of entry across local authority and mental health commissioning) will have a soft launch in February.
- CCOO has been asked to take up the clinical lead for the ICS.
- Part of the NCEL CAMHS collaborative which won the HSJ provider collaborative of the year.

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Key Performance Issues - Clinical

- SR Nomenclature Implementation not complete and impacting on Delivery of reporting for clinical services
- Carenotes recovery taking longer to complete than originally planned for owing to capacity issues in clinical staff. We are looking at work arounds to allow staff to take on the additional activity
- Phased validation of carenotes recovery has been delayed due to delays in recovery, however initial validation has found issues around data entry. Further investigation in order to put in mitigation measures.
- Staffing data not received from all services, owing to capacity issues, so not yet complete.
- Budgets and infrastructure in relation to the new structure not fully signed off, planning meetings in diary for new financial year.
- Initial data runs suggest underperformance in activity against all service lines

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Contracts Position Current and Future - Trustwide

	Total Contracts Open During Year		New Contracts 2022/23		Contracts with risk for 2023/24	
	No	£	No	£	No	£
CYAF	149	£21,264,022	39	£1,008,185	18	£2,907,634
AFS	60	£5,649,991	11	£35,731	4	£1,426,237
Gender	9	£15,241,217	2	£1,150	3	£8,799,859
DET	108	£16,298,361	35	£235,724	7	£291,164
Total	**326**	**£58,453,591**	**87**	**£1,280,791**	**32**	**£13,424,895**

Current Live Contracts		Closed in year
No	£	
120	£20,193,256	29
46	£5,621,518	14
8	£15,240,067	1
75	£15,887,714	33
249	**£56,942,556**	**77**

- Core Contracts with risk (unchanged from last report):
  - Well-being Hub (£1.4m)
  - GIDS and associated LVAs (£8.8m)
  - PCPCS (£1.5m)
  - Surrey Mindworks (£1.3m)
  - Returning Families(£0.5m)
  - **NCL ICB Core contracts (£2m) currently not in table above as only part of the funds at risk due to under-activity.**
- Additional risk from the NHSE GIC contract, due to the nature of the contract, NHSE can recoup funds. We are working through the detail with NHSE currently.

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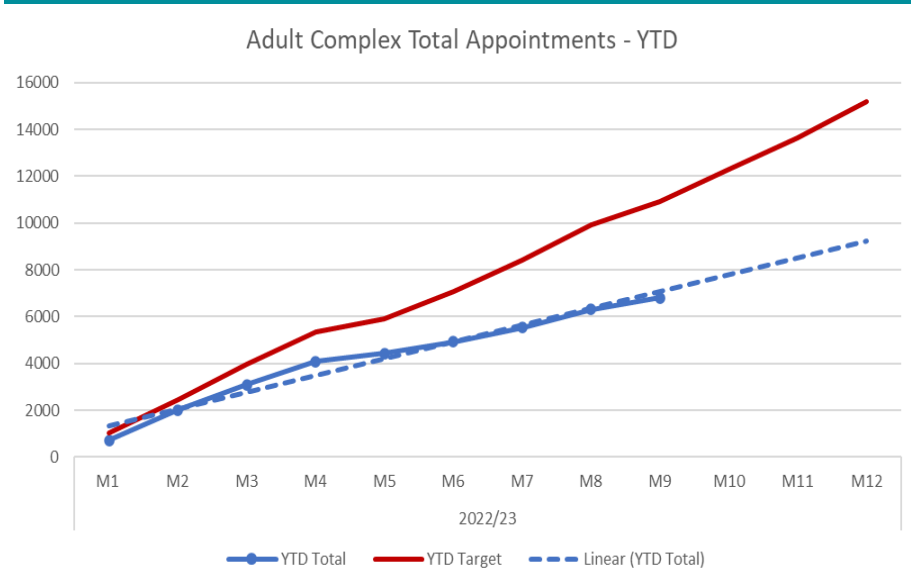
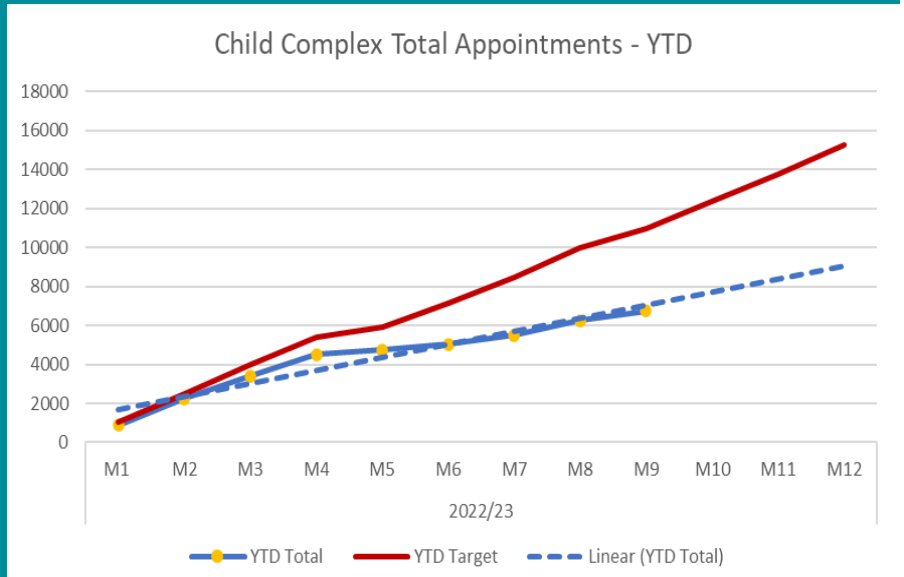
Complex Mental Health – All Age

- Action plans highlighting key areas of improvement have been updated and monitored across the service line, completion rate at Appendix 1.
- The scale of work to be undertaken shown in the action plans means that there will need to be a process to prioritise areas, in line with strategic objectives.
- The following data should be taken in the context that there are approx. 1000 unoutcomed appointments and there is an unknown number of appointments still to be added to carenotes through the recovery plan.





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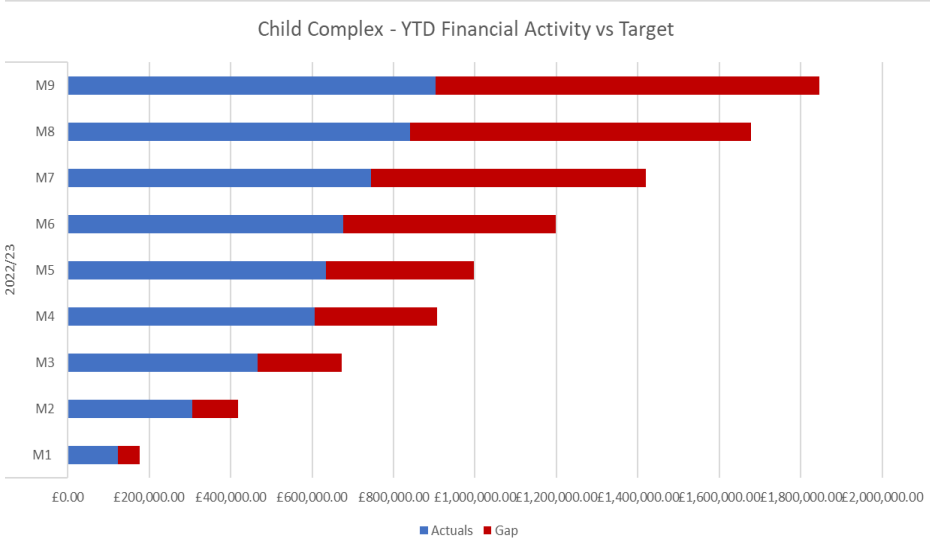
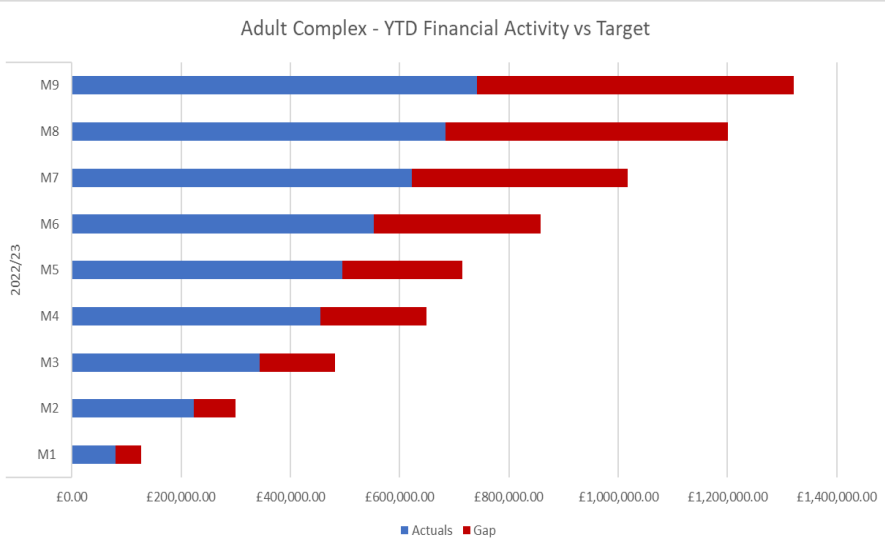
Complex Mental Health – All Age

- *NCL ICB (001 Camden Adult, 002 Barnet, 003 Enfield, 004 Haringey, 011 slington (excl. 010 Camden CAMHS)); NWL ICB (005 Ealing, 007 Central London, 013 Hammersmith & Fulham, 014 West London, 015 Brent); Hertfordshire and West Essex ICB (018 Hertfordshire)





- A proportion of finances covers areas in the Community and Integrated service line for 22/23. Part of nomenclature will be to align the finances with our contracts and targets for 23/24

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Carenotes Recovery for all Mental Health Services

- Recovery has been delayed due to a variety of reasons, including late agreement on clinical overtime arrangements.
- Position as at week commencing 16 January 2022:

Team / Service	Referrals Received	Referrals on Carenotes	% Compliant	Rag Status	No of clincians with appts to enter	No of clinicians whose appts have been entered	% compliant	RAG Status
Adolecent & Young Adult Service (AYAS)	Included in intake				38	1	3%	
Fostering, Adoption & Kinship Team (FAKT)	Included in intake				26	5	19%	
Family Mental Health (FMH)	Included in intake				54	12	22%	
Autism Spectrum Conditions & Learning Disabilities (ASC & LD)	Included in intake				26	0	0%	
Trauma	133	133	100%		119	25	22%	
Psychotherapy	148	148	100%					
Returning Families	Included in intake				7	0	0%	
The Portman	94	94	100%		19	2	11%	
FCAMHS	36	36	100%		8	0	0%	
FDAC			#DIV/0!				#DIV/0!	
North Camden CAMHS	Included in intake				60	10	17%	
South Camden CAMHS	Included in intake				46	0	0%	
Camden Adolecent Intensive Support Service (CAISS)	Included in intake				9	7	78%	
Camden Intake Team (CIT)	Included in intake				14	0	0%	
Whole Family Team (WFT) inc Perinatal	Included in intake				31	4	13%	
Looked After Children (LAC)	Included in intake				12	3	25%	
PCPCS	260	260	100%		16	4	25%	
First Step	80	0	0%		5	1	20%	
Gloucester House			#DIV/0!		17	0	0%	
Intake Admin	851	604	71%		0	0	#DIV/0!	One file per referral
TOTAL	1602	1275	80%		507	74	15%	

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Carenotes Recovery for all Mental Health Services

- Initial view of the data for validation shows:
  - Duplication of appointments
  - Duplications on referrals added
  - Referrals not added but patient on the system
  - Irregularities with referral dates
  - Irregularities on appointment dates
  - Gaps in some services
  - Contracts not coded to patients where files were added and discharged before the system could process
- Action taken: spoken to clinical managers meeting to highlight training and start mitigation.

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Community and Integrated

- Action plans highlighting key areas of improvement have been updated and monitored across the service line, completion rate at Appendix 2.
- The scale of work to be undertaken shown in the action plans means that there will need to be a process to prioritise areas, in line with strategic objectives.
- Initial Data shows an increase in average waiting times but this is likely due to not having the new referrals and their associated appointments on the system.
- Returning families Unit will be closing and there are significant issues with handover to new provider. Escalation around this has been done with the Home Office and HR.
- Gloucester House is not yet at capacity owing to clinical capacity.
- The following data should be taken in the context that there are a large number of unoutcomed appointments and this service line has a 4 week wait for camhs services, so where the referrals have not yet been uploaded to carenotes, there is also all of the appointments to be added too which will significantly impact the data.
- For the Portman service with an 18 week wait and referrals all added to the system, it doesn't look like we will meet targets for 22-23 (even if all 590 unoutcomed appointments were attended and not dna/cancelled)

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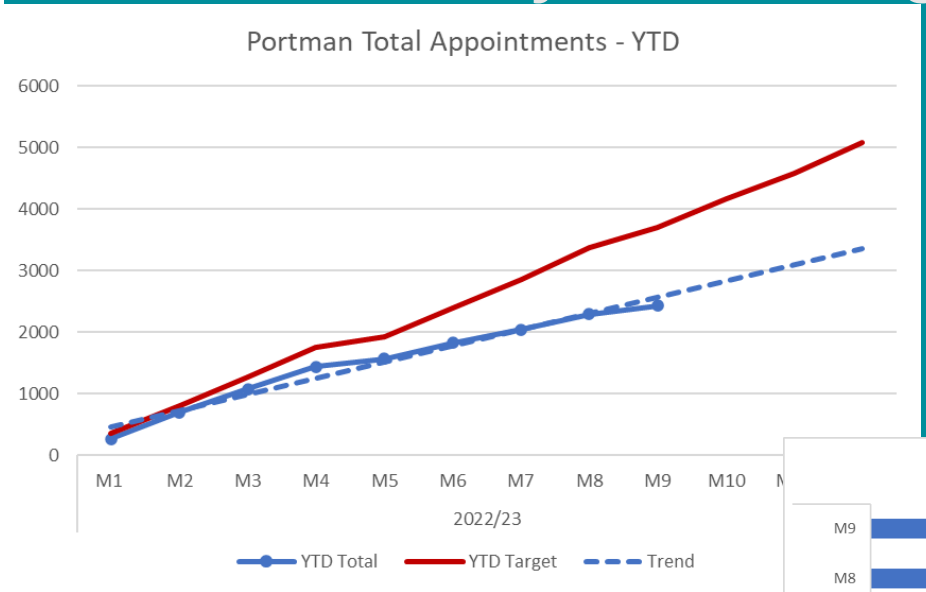
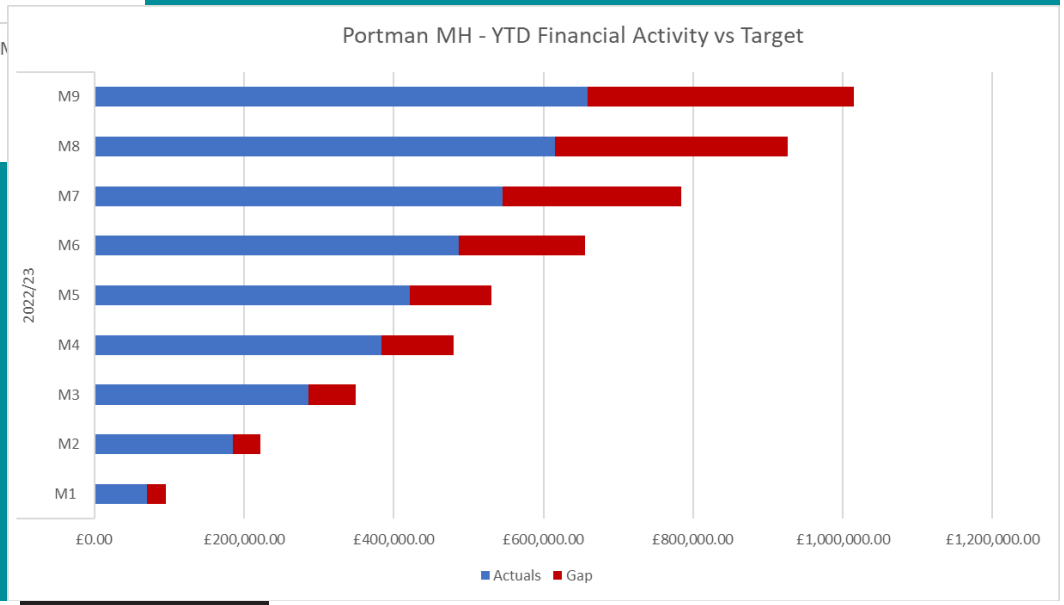
Community and Integrated - Portman





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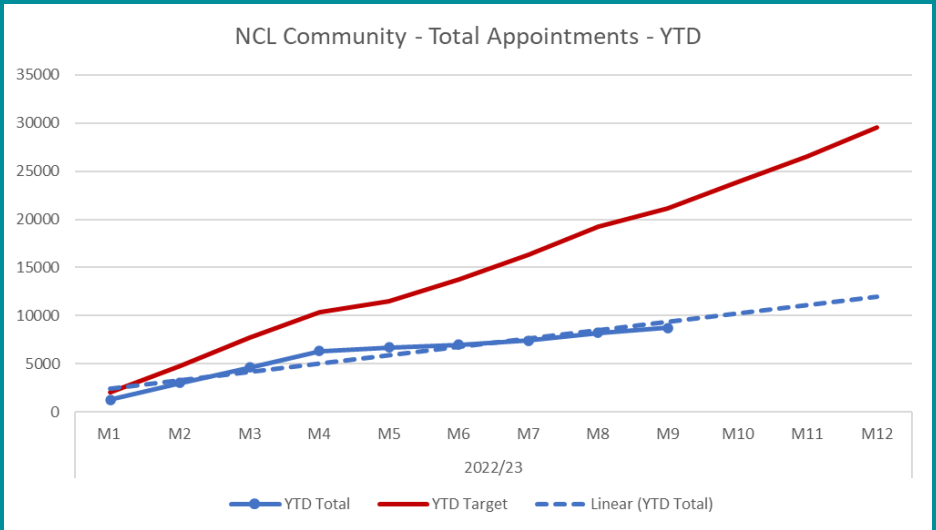
Community and Integrated – Core Mental Health Services



*NCL ICB (001 Camden Adult, 002 Barnet, 003 Enfield, 004 Haringey, 011 Islington (excl. 010 Camden CAMHS)); NWL ICB (005 Ealing, 007 Central London, 013 Hammersmith & Fulham, 014 West London, 015 Brent); Hertfordshire and West Essex ICB (018 Hertfordshire)

- 010 Camden CAMHS has activity targets but no financial targets by appointment

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GIC

- There are a number of performance issues that we are addressing with the service through targeted action plans.
- These include timely incident reviews for patients who have died on the waiting list and systematic risk assessments at the point of assessment.
- CMO, CNO and COO are working with the trust ops director to develop the management capacity in the service.
- This has included additional training for the GIC team and additional management support. Tor Jefferies from NHSE is providing additional support to the service.
- This week there is an inquest for a patient who died on the waiting list. Several issues have been identified that are likely to come up in the inquest including the process of transfer from the Irish GIC waiting list, hormone bridging arrangements and waiting list risk assessments.
- Senior leadership within the service have found the focus on the service and the expected service improvements difficult to reconcile with their historical ways of working and we suspect that there may be some further fall out from the changes being implemented.
- Action Plan at Appendix 3

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GIDS

- The phase one meeting has not happened yet and the early adopters have sent us dates that we are reviewing at the next SMG to ensure there is sufficient critical mass to support their visit.
- Carenotes was released on the 12th December 2022 with the transfer of data from carenotes mini by 19th December 2022. Reporting services did not go live until 10/01/2023 as there were issues with the data transfer from Advanced Healthcare. First phase validation has been completed that all data has pulled across and now second phase validation is taking place to ensure that all data is pulling into the new reporting services (phoenix).
- Referrals for GIDS have all been uploaded and validated.
- The tracker on the next slide shows process against carenotes recovery:
- As of December 23rd 50 % of the admin staff have resigned, which is an additional risk. This includes the service GM. We have replaced leaving staff with agency and have as at January 3rd 2023 moved to a functional administrative delivery model. We have also ensured that the management structure straddles both gender services to bridge the gap of the GM leaving.
- As of December 23rd circa 19% of clinical staff have resigned. Plans are in place to ensure safe transition of open cases to remaining clinicians. Appropriate safeguards have been implemented to ensure patient safety and closure of patients ready for discharge.
- Harm reviews have continued for those who are on our waiting list who make contact with the service
- Action plan at Appendix 4

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GIDS Carenotes Recovery Tracker

	Item Type	Start Date	Due Date	Duration	Lead	% Progress to completion	RAG Status	Total number	Completion Estimate	Verifyers	VERIFICATION RAG Status	VERIFICATION % Checked	VERIFICATION % Not Correct of records checked	AUDIT RAG Status	AUDIT % Checked	AUDIT % Not Correct of records checked
1	Referrals accepted		20/01/2023		Aminata	100%	COMPLETE	116	N/A		RED			RED		
2	Non refrrals, returend to the GP		20/01/2023		Aminata	100%	COMPLETE	230	N/A		RED			RED		
3	Referrals sent to the RAG		20/01/2023		Aminata	100%	COMPLETE	45	N/A		RED			RED		
4	Referrals Received- not registered		20/01/2023		Aminata	100%	COMPLETE	179	N/A		RED			RED		
5	Paper Referrals to be Uploaded		20/01/2023		Aminata/Ibrahim	100%	GREEN	428	10/01/2023		RED			RED		
6	Appointments		20/01/2023		Biya, Graceson,Olamide	75%	GREEN	2262- 3 left to do	03/01/2023	Kamilah, Barbara, Rathusan, Roberto	RED	5%	17%	RED		
7	Enquires		20/01/2023			Not Started	RED				RED			RED		
8	Clincial note /Assesment summary		20/01/2023		needs to be discussed with clinicians first	Not Started	RED	2940			RED			RED		
9	Other correspondance (emails, GP, etc)- admin mitigation folder		20/01/2023		Adam / agency	75%	GREEN	5373- 5 to add	05/01/2023	Kamilah, Barbara, Rathusan, Roberto	RED			RED		
10	Deed polls		20/01/2023		Adam	100%	COMPLETE	36	N/A	Roberto	GREEN	100%	0%	RED		
11	Alerts		20/01/2023		Adam	100%	COMPLETE	38	N/A	Roberto	RED			RED		
12	CODs		20/01/2023		Adam	100%	COMPLETE	42	N/A	Roberto	RED			RED		
13	Questionnaire (Qualtrics)		20/01/2023		Adam	100%	COMPLETE	214	N/A	Roberto	RED			RED		
14	patient telephone records (admin/clinical note)		20/01/2023		Abbey	100%	COMPLETE	141	N/A	Roberto	GREEN	10%	0%	RED		
15	Patient Details Forms		20/01/2023		Graceson, Jaki, Biya	100%	GREEN	138	10/01/2023		RED			RED		
16	IC Forms		20/01/2023		Adam	100%	GREEN	48	10/01/2023	Roberto	RED			RED		
17	17+ Calls	##########	19/01/2023		Lucy/Sharleyne	25%	AMBER	397- 53 done so far	19/01/2023	TBC	RED			RED		

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Appendix 1

- Complex Mental Health Action Plan:

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Complex Mental Health – All Age

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE	pre planner 1
Activity and Throughput							
Intake Redesign		1	18	1		20%	
Draw up existing process and identify issues	FH/AH	1	1	1	1	100%	
Draft new process	FH/AH	1	1	1	1	100%	
Draft signed off my Clinical Director and AD	AH	1	1	1	1	100%	
Agree team for pilot of new process	AH	1	1	1	1	100%	
Introduce process to relevant team managers and make adjustments	AH	2	2	2	15	50%	
Complete detailed SOPs inc process for assessor allocation	AH	5	2			50%	
Share with pilot team, address issues	AH	14	2			0%	
Pilot	AH	16	4			0%	
Review feedback from pilot and adjust SOP	AH	20	2			0%	
Engagement with other teams to prep	AH	22	4			0%	
Expand pilot to other services	AH	24	6			0%	

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ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Job Plans		1	13	1		50
Complete first draft of job plans	AH	1	14	1		80%
Review all job plans to ensure follow supervision policy	AH	1	14	1		50%
Agree new meeting schedule	AH/TK	1	12	1		70%
Inform team of new schedule and give 6 weeks to adjust their schedules	AH/TK	12	12			
Update all job plans with new meeting schedule and send	AH	14	20			
Activity Monitoring		1				
Use job plan data to create activity targets for each team	AH/ALG	1	14			50%
Create report on reporting services/clinical dashboard to allow line managers to accuratly review activity for clinicians (including groups)	AH	1	14			50%
Communicate guidance to team and line managers about activity monitoring expectation in line management 1:1s	AH/TK	4	14			
Review activity at team business meetings and ops meetings and agree actions to address any issues	AH + Ops Managers	6	46			

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ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Treatment Waiting Lists on Carenotes		1				
Agree process with pilot teams	FH/AH	12	4			
Undertake pilot in FMH & Adult Complex	FH/AH	16	24			
Expand pilot to include AYAS & Portman	FH/AH	24	28			
Review pilots, make adjustments and roll out to all teams	FH/AH	28	30			
Review how working in practice and adjust action plan if necessary	FH/AH	30	52			
Reducing & Monitoring Waiting Times		1				
Establish Weekly PTL Meetings for all teams	AH/FH	1	3			90%
Create new Ops Managers KPI Meeting to review and agree action plans	AH/FH	1	3	12	2	80%
Review staffing structure, budgets & vacancies for teams with longest waiting lists to increase capacity where possible	AH/TK	1	8	12		20%
(Other actions covered in Job plan, activity and pathway sections)						
Pathway / Throughput Monitoring		1	22	1		10
Agree pathway expectations with each team & agree KPIs forums and regularity of complaince reviews	AH/TK	1	16			20%
Set up additional MDT/review panels as required	AH/TK	4	16			20%
Implement RAG process to under 18 teams	AH	11	4	11		20%
Monitor compliance of under 18s services	AH/TK	11	8	11		20%

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ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Outcome Measures						
Expand use of qualtrics for CORE & ESQ to Portman	AH	16	2			
Train Ops and Admin Leads to use Qualtrics	AH	16	2			
Roll Out Trauma Specific OMs	AH/IA	14	6			
Review reception processes to increase forms completed in waiting rooms	AH/FH	14	2	13		
Move to qualtrics for RCADS	FH	TBC				
Review process for GBM and CGAS with T&F	FH	TBC				
Roll out Dialog in all >18s teams (see separate project plan for detail)	AH/TK	TBC				
Consider need for CORE / moving to CORE 10 (see separate project plan for detail)	AH/TK	TBC				
Risk Management TBC						

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Appendix 2

- Community and Integrated Action Plan

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ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Intake Redesign		1	18	1		50%
Draw up existing process and identify issues	FH/AH	1	1	1	1	100%
Draft new process	FH/AH	1	1	1	1	100%
Draft signed off my Clinical Director and AD	FH	1	1	1	1	100%
Agree team for pilot of new process	FH	1	1	1	1	100%
Introduce process to relevant team managers and make adjustments	FH	2	2	2	4	100%
Complete detailed SOPs inc process for assessor allocation	FH	5	2	5	6	80%
Share with pilot team, address issues	FH	8	2	6	5	60%
Pilot	FH	10	4	12		
Review feedback from pilot and adjust SOP	FH	14	2	16		
Expand pilot to all under 18 services	FH	16	4	18		
Engagement with other teams to prep	FH	10	6	12		

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Job Plans		1	13	1		50
Complete first draft of job plans	FH	1	1	1		50%
Review all job plans to ensure follow supervision policy	FH	1	1	1		50%
Agree new meeting schedule	FH	1	4	1	5	100%
Inform team of new schedule and give 6 weeks to adjust their schedules	FH	4	6	6		20%
Update all job plans with new meeting schedule and send	FH	12	5	14		
Ensure dashboard contains all info managers need to measure activity against job plans	FH	5	8	10		20%
Treatment Waiting Lists on Carenotes	DATES TO BE ADDED WHEN CARENOTES BACK	1	32	1		5
Agree process with pilot teams	FH	1	1	1	1	100%
Undertake pilot in FMH	FH/AH	15	4			
Roll out across all pilot teams (NCCT/SCCT/FMH/AYAS)	FH/AH	19	2			
Review pilots, make adjustments and roll out to all teams	FH/AH	22	4			
Review how working in practice and adjust action plan if necessary	FH/AH	30	2			

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Pathway Monitoring		1	22	1		10
Redo priority and RAG rating doc (under 18) and get senior approval	FH	1	1	1	4	100%
Send above again for manager review of final version	FH	4	3	5	2	100%
Develop SOP and sign off	FH	5	4	9		
Implement process	FH	15	4			
Monitor compliance	FH	15	8			
Outcome Monitoring						
Establish task and finish group	FH	1	3	1	6	100%
Establish current OM use across all services	FH	11	3	10		10%
Redesign process for patient led measures to move to admin led process	FH	11	4			
Move to qualtrics for RCADS	FH	1	1	1		
Implement admin led process	FH	15	4			
Review process for GBM and CGAS with T&F	FH	11	4			
PCPCS Core plan TBC	FH					
Risk Management TBC						
Gloucester House Pupil Numbers TBC						
Surrey contract compliance TBC						

Innovation in mind

The Tavistock and Portman NHS Foundation Trust

Appendix 3

- GIC Action Plan

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
Intake Redesign						
Waiting List Management/Triaging/Harm Review /Audit	GIC Nurses	1	40	3	40	5%
Intake Process Mapping	MF/RI	1	6	2		
Patient pack Review and implementation	MF/RI	1	9	0	0	98%
Data cleansing	MF	1	19	3	10	10%
Job Planning						
Complete first draft of job plans for Core	MF	1	3	1	3	90%
Review job plans to ensure follow supervision policy	MF	1	3	1	3	90%
Final meeting to discuss JP and SLA	MF	1	3	1	3	70%
Ensure dashboard contains all info managers need to measure activity against job plans	MF	1	3	1	3	0%
Do overarching review of activty against new job plans and update action plans to reflect issues	MF	1	3	1	3	

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
PTL (Patient tracking list)						
Policy and TOR	MF	1	5	1	4	90%
Set up for meeting	MF	1	5	1	4	60%
chair meeting	AC	4	5	5		1%
Re-design Pathway Mapping						
Review current clinical pathway	RI/BK	1	3	1	3	80%
Develop and Re design proposed clinical pathway	RI/BK	1	6	1	6	20%
Create GIC staff Handbook						
Data gathering and interviewing	RI/BK/MF	1	8	1	8	50%
Drafting a main content	RI/BK/MF	1	8	1	8	30%
Review first Draft	RI/BK/MF	1	8	3	8	10%
Finanilsing with Comms Team	RI/BK/MF	1	8	4	8	0%

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Activity and Throughput						
SOPs						
Operational SOPS	MF/RI/BK	1	15	9		5%
Clinical SOPs	MF/RI/BK	1	15	9		5%
Governance						
Implementation of TOR	RI/MF/BK	1	10	1	8	70%
Record keeping	RI/HB/BK	10	18			0%

Innovation in mind

The Tavistock and Portman NHS Foundation Trust

Appendix 4

- GIDS Action Plan

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
Recruitment						
The service recruits admin roles via agencies to keep the minum level to run service	MF	1	59	1	59	
Maintain and Review the staff level tracker & escalate as approriate to GIDS issues and trust governance committies	MF /KA	1	59	1	59	
Job Planning						
Complete first draft Job planning for clinicans	HB	1	1	1	1	100%
meeting with consultants to refine 40% of the workforce that require resonable adjustment	HB	1	14	1	3	5%
Finalise JP and publish	HB	15	21	15		5%
Transfer Waiting Lists to new provider						
Uploading referrals into the CN	MF	1	1	1	1	100%
Validating referrals	MF	1	4	1	4	85%
17+ input data and trasfer	MF	1	5	1	5	50%
Validating 17+	MF	2	6	2	6	85%
prep data	ALG					0%
Informactics to transfer	Inf					0%

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

ACTIVITY	Responsible	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION	PERCENT COMPLETE
PTL meeting						
complete and finilise the the guidelines for Open cases and doremant cases	Tor	1	16			50%
re-run PTL meeting		17	59			50%
Dormant cases						
TOR to be match for a single meeting	TOR	1	16			50%
Dormant cases - alighed with PTL meeting	LK	17	59			50%
Opencase load						
Reviw and update all key patient record in anticipation of open caseload transfer using the CN hygine document developed by PC and HB	Clinical staff	1	59			

The Tavistock and Portman
NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)

Committee:	Meeting Date	Chair	Report Author	Quorate	
People, Organisational Development, Equality, Diversity and Inclusion Committee	12 January 2023	Shalini Sequeira, NED	Alison Kingscott, Interim Chief People Officer	**Yes**	~~**No**~~
Appendices:	None		**Agenda Item:**	**16**	

Assurance ratings used in the report are set out below:

Assurance rating	Colour to use in 'Assurance rating' colour below
Limited Assurance	Red: There are significant gaps in assurance or action plans
Partial Assurance	Amber: There are gaps in assurance
Assurance	Green: There are no gaps in assurance
Not Applicable	White: No assurance is required

The key discussion items being highlighted to the Board for Assurance are noted below:

Key headline	Assurance rating
1. Board Assurance Framework – Review of risks assigned to the POD EDI Committee: • Discussion to continue, as mitigations to the three risks identified need to be developed and shared with POD EDI in order to comment on the ratings.	Red ☒ Amber ☐ Green ☐ White ☐
2. Implementation of the Equality and Diversity and Inclusion Action Plan: • EDI and Race Equality Action Plan to be actioned through programme management approach and further progress on activity to be reported at next POD EDI meeting.	Red ☐ Amber ☒ Green ☐ White ☐
3. North Central London Recruitment Shared Service – Recovery Plan Update: • Recruitment Shared Service recovery plan is on target and improvements are being seen in provision. A further report on progress will come back to the committee in 6 months.	Red ☐ Amber ☒ Green ☐ White ☐
4. Workforce Performance Report (including metrics dashboard): • Appraisal compliance levels are low and there is concern that with 11 weeks to go before end of financial year target levels will be a challenge to achieve.	Red ☒ Amber ☐ Green ☐ White ☐

Decisions made by the Committee:

The Committee did not approve or make any key decisions at this meeting. The only item for approval on the agenda was the Board Assurance Framework and discussions around this item is ongoing.
Further Risks Identified:
There was no new risk identified by the Committee during this meeting.
Items to come back to the Committee outside its routine business cycle:
There was no specific item over those planned within its cycle that it asked to return.
Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
None	N/A	N/A

BOARD OF DIRECTORS – 7th February 2023			
2022/23 Board Assurance Framework Quart 3 Review			**AGENDA ITEM: 17**
Report Author and Job Title:	Julie Dawes, Interim Director of Corporate Governance Frazer Tams, Interim Risk and Assurance Manager	**Responsible Director:**	Michael Holland, Chief Executive Officer
Action Required	Approve ☒ Discuss ☒ Inform ☐		
Situation	Following the Board's approval of the Trust's revised Strategic Objectives in December 2022, the first iteration of the refreshed Board Assurance Framework (BAF) document for Quarter 3 2022/23 is presented for consideration and approval. The revised BAF is presented in a new format with principal risks linked to the achievement of the new objectives.		
Background	The Trust approved a revised set of strategic objectives at the Board development session on 15th December 2022. Following on from this a process has been completed to agree a set of principal strategic risks linked to these objectives. These were initially developed by the Executive Leadership Team and then considered by each of the relevant Board sub committees through January. The development process will continue throughout Quarter 4 to further enhance the quality of the controls and assurance data contained within the BAF. The intention is that a fully populated BAF will be presented for further consideration by the Board in April for the required formal year-end approval. This version of the BAF will also inform the Trust's Annual Governance Statement and the Head of Internal Audit Opinion for 2022/23.		
Assessment	The refreshed BAF demonstrates a significant improvement on the previous version and reflects the key risks linked to the revised strategic objectives. The BAF remains a work in progress even though initial population of the risks has been completed. Further work to enhance the quality of assurance information presented and the strategic deliverables will continue during Quarter 4 and this will be agreed through the Board Sub-Committees during March 2023. The BAF will then be included on the agenda for the April Board meeting where the comprehensive assurance position for each objective will be agreed.		

Recommendation	Members of the Board are asked to: 1)Consider the first iteration of the fully refreshed BAF and its coverage of key risks linked to the revised strategic objectives 2) Agree the approach to further enhancing the BAF content during Quarter 4 with the view to approving the comprehensive BAF document at the April 2023 Board meeting.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report includes all risks on the BAF and their current control and assurance status.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve ☒	Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration. ☒
	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS. ☒	Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities. ☒
	Ensure we are well-led & effectively governed ☒	

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Quarter 3 Board Assurance Framework Review

Overview
The Quarter 3 BAF document as presented represents a change in approach to BAF reporting based on feedback received from the Board and sub-Committee. Following the agreement of a revised set of strategic objectives the BAF has been completely reworked to link key risks to the new objectives. This is the first iteration of the revised BAF presented to the Board.

BAF Development Process
The revised set of strategic objectives were developed and agreed at the Board development session on 15th December 2022. This gave the springboard to commence development of a refreshed BAF during December and January.

Initial process involved consideration of three elements, firstly information included in the previous version of the BAF, secondly other key information and risks documented within the Trust and thirdly consideration of the wider risk position across the North Central London Integrated Care System. This gave a strong platform to identify key risks that needed to be reflected within the BAF.

An initial set of strategic risks were drafted out of this process and then discussed with the Executive Directors to confirm the wording an initial indicative scoring. In addition, Non-Executive Directors were asked to provide their thoughts on the key organisational risks mapped against each strategic objective.

Outline risks were then presented to the relevant Board Sub-Committees during January to provide further input from members. Following this work has taken place to populate the detail behind each risk which has lead us to the first full iteration of the BAF being presented to the Board.

Quarter 4 Development
Following the Board meeting, the process to further work up the BAF detail will continue during February and will specifically focus on enhanced detail around actual assurances received and their conclusion whilst also mapping out the strategic deliverables around each objective and their link to the risks included.

Once complete the BAF will be received and considered at the representative Sub Committees for agreement prior to coming back to the April 19th Board meeting for approval.

The timeline for the BAF during Quarter 4 is as follows:

Review Stage	Date of Meeting
Executive Director Review	w/e 23rd February 2023
Executive Leadership Team Review	27th February 2023
Quality Committee	2nd March 2023
Education and Training Committee	23rd March 2023
POD EDI Committee	23rd March 2023

Performance, Finance & Resources Committee	28th March 2023
Audit Committee	30th March 2023
Trust Board Open Meeting	19th April 2023

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BOARD ASSURANCE FRAMEWORK

Likelihood	
1	Very Unlikely to occur
2	Unlikely to occur
3	Could occur
4	Likely to occur
5	Almost certain to occur

Risk Appetite		
1	Negligible	Avoidance of risk and uncertainty
2	Low	Preference for ultra-safe delivery options that have a low degree of inherent risk and limited reward potential
3	Moderate	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
4	High	Willing to consider all potential delivery options and choose while also providing an acceptable level of rewards (and VfM)
5	Significant	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

*Risk Appetite levels as agreed at November 2021 Board meeting. These are currently under review.

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

Risk Ref	Risk Title	Risk Description (cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
1. Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve						

Risk Ref	Risk Title	Risk Description (cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
1	Delays to treatment, long Wait times/demand	Continued pressures resulting from limitations to Trust capacity and unwarranted variation in care pathways, is resulting in waiting lists and demand for some services continuing to increase. This could result in a deterioration of the quality and safety of services and impact on the service user experience.	20 (4 x 5)	16 (4 x 4)	9 (3 x 3)	L
2	Maturity of Data quality to support transformation	A lack of maturity towards the collection and use of data within the Trust restricts innovation, limits the ability to implement evidence-based improvements and meet the requirements of the transformational information sharing agenda.	16 (4 x 4)	12 (3 x 4)	8 (2 x 4)	M
3	Quality of service provision	If standards of care to service users and students are not consistently met it could lead to poor clinical and educational outcomes and breaches of statutory and contractual obligations.	20 (5 x 4)	16 (4 x 4)	8 (2 x 4)	M
4	Quality Assurance	A prolonged inability to have oversight, or understanding, of key quality indicators could lead to the organisation not being aware of patient safety, clinical effectiveness and/or patient experience concerns.	20 (45x 4)	16 (4 x 4)	8 (2 x 4)	M
2. Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.						
5	Workforce development, retention, recruitment	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce through its education, training and development plan, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered.	16 (4 x 4)	12 (4 x 3)	6 3 x 2	M
6	Lack of inclusive and open culture	The failure to instil an Inclusive and open organisational culture in line with our priority commitment around EDI, including sufficient staff support and commitment to health and wellbeing, will lead to reduced levels of staff morale and engagement and quality of patient care delivered.	20 (5 x 4)	12 (4 x 3)	9 3 x 3	M

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Risk Ref	Risk Title	Risk Description (cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
7	Lack of management capability and capacity to manage People issues	If people issues are not managed effectively there is a direct impact on staff morale, engagement and wellbeing. This impacts the resilience of our workforce and quality of patient care that we can deliver.	20 (4 x 5)	9 (3 x 3)	6 2 x 3	M
3. Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.						
8	Delivering financial sustainability targets	A failure to deliver the Trust's 2022/23 financial plan and demonstrate a trajectory towards break-even, may result in medium term ICB financial obligations not being met. This will lead to further scrutiny, additional control measures and further restrict investment opportunities required to deliver sustainable services.	20 (5 x 4)	16 (4 x 4)	8 (2 x 4)	M
9	Maintaining an effective estate function	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	16 (4 x 4)	12 (4 x 3)	8 (2 x 4)	M
10	Sustainable income streams	The result of changes in the commissioning environment, alongside the impact of the pandemic on funding and delivery models may prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration. This could render the Trust's service provision unsustainable.	16 (4 x 4)	16 (4 x 4)	8 (4 x 2)	M
11	IT infrastructure and cyber security	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	20 (5 x 4)	12 (4 x 3)	9 (3 x 3)	L
4. Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.						

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Risk Ref	Risk Title	Risk Description (cause, Event, Consequence)	Inherent Risk LxC (Pre mitigation)	Current Risk LxC (Post mitigation)	Target Risk	Appetite Level
12	Developing Partnerships	A failure to develop and maintain effective system partnerships could prevent a clear understanding of the population health needs, diluting the specialist mental health voice and potentially lead to the Trust missing opportunities to improve patient care within the ICS.	16 (4 x 4)	12 (3 x 4)	9 (3 x 3)	M
5. Ensure we are well-led & effectively governed.						
13	Compliance with Information Governance requirements	A failure to comply with the Data protection and security toolkit could lead to a serious breach of data security resulting in service user harm, a loss of Trust reputation and potential ICO financial penalties.	15 (5 x 3)	9 (3 x 3)	6 (3 x 2)	M
14	Effective Performance and Risk management arrangements	If effective performance and risk management processes are not embedded within the Trust it could reduce the effectiveness of senior management decision making whilst also impacting on the level of confidence over our systems of internal control.	15 (5 x 3)	12 (4 x 3)	6 (3 x 2)	M
15	Effectiveness of senior leadership	A prolonged period of instability across the Trust Executive and senior management could impact on the effectiveness of governance, performance and engagement across the Trust, resulting in poor outcomes, levels of compliance, and staff performance.	15 (5 x 3)	12 (4 x 3)	6 (2 x 3)	M
16	Reputational Management & Stakeholder Engagement	A failure to demonstrate and effectively communicate strong regulatory performance to the public and engage key stakeholders in Trust development plans, will result in a sustained loss of public confidence and long-term reputational damage to the Trust.	20 (5 x 4)	20 (5 x 4)	8 (2 x 4)	M

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Principal Risk 1	**Delays to treatment, long Wait times/demand**		
Description	Continued pressures resulting from limitations to Trust capacity and unwarranted variation in care pathways, is resulting in waiting lists and demand for some services continuing to increase. This could result in a deterioration of the quality and safety of services and impact on the service user experience.	**Strategic Objective**	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.

Executive Lead	Sally Hodges Chief Clinical Operating Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	31st January 2023
Lead Committee	Quality Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	31st January 2023
Risk Appetite	**Low**	5	4	**20**	4	4	**16**	3	3	**9**	**Date of Next Review**	28th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Activity monitoring across the service		Trust activity dashboard and GIDS activity monthly submission	Internal	
CQC must do action plan		Tracked through the transformation workstream & Monthly reporting	Internal	
Gender Executive Oversight		GIDS waiting times report & CQC action plan implementation	Internal	
GIDS waitlist action plan	Data on impact of initiatives being taken and planned to address issues.	Reports on implementation to GIDS Oversight Committee	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Commencement of further data analysis work by service to understand referral trends, and initiation of relevant Quality Improvement work.	Hector Bayayi		
Implementation of CQC Action Plan	Hector Bayayi		

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
To be agreed			

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Principal Risk 2	**Maturity of Data quality to support transformation**		
Description	A lack of maturity towards the collection and use of data within the Trust restricts innovation, limits the ability to implement evidence-based improvements and meet the requirements of the transformational information sharing agenda.	**Strategic Objective**	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.

Executive Lead	Terry Noys Chief Finance Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	4	**16**	3	4	**12**	2	4	**8**	**Date of Next Review**	19th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Ensure data is collected at source to consistent quality standards	Specific areas of data collection are not consistently maintained or mature e.g. OM collection	Trust has robust performance and quality teams assessing data and providing assurance.	Internal	
Deliver a comprehensive data warehouse for both clinical and educational purposes	Data warehouses are in place but in early versions and will become more mature with new requirements	Data Warehouse is managed and secured by the trust Informatics team ensuring data is safe.	Internal	
Ensure data is uploaded to the data warehouse from core systems such as CareNotes and SITS	Additional data stores should be integrated into the data warehouse	Assurance to be determined	N/A	
Implement sophisticated tools to analyse the stored data flexibly	Expertise in the analytical tools is increasing but still at early stages of maturity	Assurance to be determined	N/A	
Create multiple levels of user facing data provision for performance management and proactive operational output	Targeted deliveries have been completed in performance, clinical and educational areas. Further widening on scope is now required.	Multiple reporting options are available both via the data warehouse and the core systems	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Improve maturity of infrastructure to support data provision	Director of Infrastructure		
Improve data collection processes where gaps identified	Director of Infrastructure		
Create a wider suite of information assets to enable a “data – led” organisation	Director of Infrastructure		

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 3	**Quality of service provision**	**Strategic Objective**	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.
Description	If standards of care to service users and students are not consistently met it could lead to poor clinical and educational outcomes and breaches of statutory and contractual obligations.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Sally Hodges Chief Clinical Operating Officer Jenny Goodridge Chief Nurse Officer										**Original Assessment Date**	1st February 2023
Lead Committee	Quality Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	1st February 2023
Risk Appetite	**Moderate**	4	5	**20**	4	4	**16**	2	4	**8**	**Date of Next Review**	1st March 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Job planning				
Mandatory training	IG training shortfall still a concern	Mandatory training compliance reported through the POD EDI Committee bi-monthly	Internal	
Supervision/clinical safeguarding Process	CareNotes access issues has prevented reporting around this			
Quality assurance tools and methodology				
Quality Framework Improvement Plan in place		Quality Framework monitoring report to Quality Committee	Internal	
Strategic review on structures	Professional leadership recruitment			
Quality Committee in place with approved terms of reference	Sub structure that feeds the committee lacks structure and co-ordination	Quality Committee terms of reference and meeting papers	Internal	
Learning from deaths process		Highlight report from the Risk and Safety Group presented to Quality Committee	Internal	
Senior Clinical Management structure has been agreed	Chief Nurse Officer and Chief Medical Officer posts to be filled substantively			
Clinical Audit Schedule agreed		Presented to Quality Committee	Internal	
Complaints Process	Lessons learnt process from complaints		Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Review Quality Governance processes including patient safety.			
Review sub structure of Quality Committee to align and co-ordinate reporting			

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 4	Quality Assurance		
Description	A prolonged inability to have oversight, or understanding, of key quality indicators could lead to the organisation not being aware of patient safety, clinical effectiveness and/or patient experience concerns.	Strategic Objective	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.

Executive Lead	Jenny Goodridge Chief Nurse	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	Quality Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	19th December 2022
Risk Appetite	Moderate	4	5	20	4	4	16	2	4	8	Date of Next Review	19th January 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Quality Portal for Incident reporting and Risk Management	Not fit for purpose	Incident reporting data from the Quality Portal is presented to the Quality Committee bi-monthly	Internal	
Key quality Policies, Procedures & Guidelines in place for all key aspects of quality governance	Policies not up to date	Bi-monthly Quality committee report	Internal	
Nationally prescribed KPIs along with Locally agreed Quality Indicators	CareNotes access has prevented reporting against some key indicators. Consistency of recording of indicator data requires further control.	Quality committee bi-monthly, quality dashboard (mandatory training)	Internal	
Quality governance structure	Sub structure that feeds the Quality Committee doesn't flow and requires work co-ordination.	Terms of reference, agenda, and minutes from the Quality Committee	Internal	
Quality improvement Plan		Report on implementation progress presented to SoF3 meetings	Internal	
SoF3 oversight meetings		SoF3 oversight Meeting minutes and papers	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Implementation of Quality Improvement Plan actions	Jenny Goodridge, Chief Nurse Officer	31st March 2023	
Review of key policies	All Executives	Programme for all Trust policies set over next 12 months	
Upload core records to CareNotes system	Jenny Goodridge, Chief Nurse Officer	31st January 2023	
Review Quality Portal effectiveness with view to consideration of alternative arrangements	Caroline McKenna, Chief Medical Officer	31st January 2023	
SOF3 action plan implementation	Jenny Goodridge, Chief Nurse Officer		

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance

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Principal Risk 5	**Workforce resilience, retention, recruitment**		
Description	If the Trust is unable to effectively plan and recruit to critical vacancies and improve the resilience of its workforce, the ongoing sustainability of quality services and activity volume will be impacted. This will lead to enhanced levels of turnover, sickness and future recruitment issues as well as potentially leading to reduced contract income for services delivered.	**Strategic Objective**	**Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.**

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Chief People Officer										**Original Assessment Date**	19th December 2022
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	4	**16**	4	3	**12**	3	2	**6**	**Date of Next Review**	19th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
People plan includes 5 year action plan for the Trust		POD EDI bi-monthly progress reports including developments with the people plan which covers all areas including recruitment, retention, and resilience.	Internal	
Recruitment and approval group approval of roles for recruitment		Output spreadsheet for all approved posts from meeting although meetings are not formally minuted	Internal	
NLPSS Operations meetings weekly		Verbal feedback only not record of meetings held.	Internal	
Chief People Officer meeting with NLPSS fortnightly		Chief People Officer meeting pack with update from previous meeting includes plans for recruitment.	Internal	
Trust Recruitment and selection Policy and Procedures	Doesn't reference NLPSS involvement ESR limitations in reporting recruitment data No current performance pack for directorate on compliance	No formal assurance on adherence to procedures without performance information pack from ESR.	Internal	
Some KPIs in place for time to hire	Not all recruitment processes have KPIs currently			

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
NLPSS workshop to refine end to end process	Head of HR	31st January 2023	
NLPSS agreeing KPIs across NCL	Chief People Officer	31st March 2023	
Camburg updating RAG terms of reference formalising routes for approval/standardised process	Chief People Officer		
Align ESR and Oracle information to improve reporting capability	Head of HR	31st March 2023	
Performance pack to be developed	Head of HR	31st March 2023	

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Upscaling managers to the recruitment process			
Review of productivity, establishment, finance	Process has started with the Clinical division and will then move to Corporate followed by DET.		

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Principal Risk 6	**Lack of inclusive and open culture**		
Description	The failure to instil an Inclusive and open organisational culture in line with our priority commitment around EDI, including sufficient staff support and commitment to health and wellbeing, will lead to reduced levels of staff morale and engagement and quality of patient care delivered.	**Strategic Objective**	**Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.**

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Chief People Officer										**Original Assessment Date**	19th December 2022
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	5	4	**20**	4	3	**12**	3	3	**9**	**Date of Next Review**	19th January 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Engagement sessions hosted by CEO and Director of Strategy		Records of sessions held	Internal	
Health & Wellbeing group (includes review of cost of living issues)		Key issues fed back to POD EDI Committee through the Associate Director of EDI	Internal	
Occupational Health and employee assistance programme			Internal	
Action plan in place resulting from external review	Lack of clarity around Recruitment process / internal promotion	POD EDI receive update and feedback on status of delivery against the action.	Internal	
	No central planning process for interview panel involving BAME candidates			
Staff Networks feed to EDI team who escalate key outcomes through POD EDI	Lack of clarity around Bullying & harassment process being followed	EDI reporting through the POD EDI includes key outcomes/concerns from network forum meetings.	Internal	
	Process to ensure equity for BAME candidates for senior roles (band 8 and above)			
	Improved process around recruitment and treatment of disabled candidates.			
Chief Clinical Operating Officer sponsoring EDI programme and providing link with the Board		Feedback through EMT	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Race Action plan (63 points)	CEO/Execs		Progress to POD EDI

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 7	**Lack of management capability and capacity to manage People issues**	**Strategic Objective**	**Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.**
Description	If people issues are not managed effectively there is a direct impact on staff morale, engagement and wellbeing. This impacts the resilience of our workforce and quality of patient care that we can deliver.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Chief People Officer										**Original Assessment Date**	19th December 2022
Lead Committee	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	5	**20**	3	4	**12**	2	3	**6**	**Date of Next Review**	19th January 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Full suite of Trust HR policies in place	These policies are currently due for review and some require a refresh	Sickness, Grievance, disciplinary levels reported to the POD EDI through the Chief People Officer report. Bi-monthly	Internal	
Management structure in place with revised job descriptions clarifying line management responsibilities	Manager leadership training required	Strategic review paper to EMT approving structure.	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme to be rolled out across the Trust	Head of HR	April 2023	Ongoing, currently on target to meet implementation date.
All HR Policies to be reviewed over next 12 months (priority to be given to Recruitment & Selection, disciplinary, capability, grievance and flexible working policies)	Head of HR	April 2023 (initial top 6) March 2024 completion for all policies	Ongoing, currently on target to meet implementation date.
KPIs to be formalised and reported	Chief People Officer	31st March 2023	In process of being formally agreed.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 8	**Delivering financial sustainability targets**		
Description	A failure to deliver the Trust's 2022/23 financial plan and demonstrate a trajectory towards break-even, may result in medium term ICB financial obligations not being met. This will lead to further scrutiny, additional control measures and further restrict investment opportunities required to deliver sustainable services.	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**

Executive Lead	Terry Noys Chief Finance Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	5	4	**20**	4	4	**16**	2	4	**8**	**Date of Next Review**	19th January 2023

Key Risk Controls (1st line of defence)	**Gaps in Control** (what are we missing)	**Sources of Assurance** (2nd and 3rd lines of defence)	**Type of Assurance** (Internal / External)	**Assurance Rating** (RAG)
Long term financial plan	Requires updating	EMT review status with delivery PFRC review delivery status Board approval long term plan and receive updates from PFRC	Internal	
Annual Budget agreed	Required for 23/24	EMT review, PFRC review and agree in principle, Board formal approval of budget	Internal	
In Year Reforecasts	Updated reforecast required	EMT review, PFRC review, Board approval	Internal	
Monthly Finance Reports	None	EMT monthly review of progress paper PFRC bi-monthly review of progress	Internal	
	CIP Programme is required to support financial improvement but is not currently in place	EMT paper reviewed on a monthly basis and minuted PFRC paper reviewed each committee and formal minutes held Board approval of CIP programme	Internal	

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Updated Long Term Financial Plan	CFO	TBC	Will need to be based on revised Trust strategy
Agree 2023/24 Budget	CFO	March 2023	Planning in progress
Detailed in year reforecast	Deputy CFO	January 2023	In progress
Detailed CIP programme	CFO	March 2023	Planning in progress

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Develop a medium-term financial plan that supports the Trust's strategy & which aligns with ICS plans.	No progress, as awaiting a Trust strategy	Lack of Trust strategy	n/a
Deliver the 2022/23 Out-Turn within Plan	As at Month 8 Trust deficit slightly positive to Plan	Plan expected to be delivered, unless GIDS TUPE does not apply and Trust is faced with redundancy costs	October Finance Report (November PFRC) November Finance Report
Develop and deliver the Action Plan following the HFMA review	Action plan developed. Delivery against plan on-going	Ability to deliver given other demands on Finance	Self Assessment (October Audit Committee)

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Principal Risk 9	**Maintaining an effective estate function**		
Description	If the Trust fails to deliver affordable and appropriate estates solutions, there may be a significant negative impact on patient, staff and student experience, resulting in the possible need to reduce Trust activities potentially resulting in a loss of organisational autonomy.	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**

Executive Lead	Terry Noys Chief Finance Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	4	**16**	4	3	**12**	2	4	**8**	**Date of Next Review**	19th January 2023

Key Risk Controls (1st line of defence)	**Gaps in Control** (what are we missing)	**Sources of Assurance** (2nd and 3rd lines of defence)	**Type of Assurance** (Internal / External)	**Assurance Rating** (RAG)
Develop a hybrid/ face to face model with clinical and education team, as this will determine the space requirement	Outcome based approach to clinical and educational delivery models	Ensure existing estate fulfils statutory compliant – with support from Authorising Engineers and aligned to HTM, EMT review, PFRC review	Internal	

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Develop a detailed Estate revenue model to support finance model	Estates lead	March 2023	Planning in progress

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
10-year capital plan based on the 6 facet survey	Requires a more detailed survey of system assets, that have not been upgraded in 22/23 or planned for 23/24	Aging estate, will require upgrades over	April Estates report EMT
Derive a space efficiency model with increased desk sharing/ hot desks	Will develop an approach that will enable a reduced leased property	The Trust strategy would be a useful enabler	February Estates report EMT
Develop a soft FM strategy	Consolidate fragmented contracts, and staffing model, in line with service operating hours	Ability to deliver as team is in transition	March Estates report EMT

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Principal Risk 10	**Sustainable income streams**	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**
Description	The result of changes in the commissioning environment, alongside the impact of the pandemic on funding and delivery models may prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration. This could render the Trust's service provision unsustainable.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Alistair Hughes Director of Strategy & Transformation										**Original Assessment Date**	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	4	**20**	4	4	**20**	4	2	**8**	**Date of Next Review**	19th January 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Internal Monitoring Reporting on current clinical services to ensure meeting current contractual objectives	Key HR staffing data	Clinical Leadership Meeting, PFRC Review	Internal	
External Reporting on commissioned services in DET and Clinical	Commissioned services do not align with new structures / not all commissioners have maintained contact	Clinical Leadership Meeting, PFRC Review, DET Exec, Commissioner Review Meetings	Internal / External	
Development of Internal Reporting for DET Services	To be scoped / implemented	DET Exec, PFRC Review	Internal	
External Financial Audits	none	EMT, Board	External	
Attendance at ICB level Meetings to be able to address system needs and address growth areas	Attendees at meetings not scoped and clear	Clinical Leadership Meeting	Internal	
Commercial Strategy	Current market assessment across all services	EMT, PFRC Review,	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Data between SBS / ESR and Team Managers to be monitored and establish control mechanism to maintain united systems	Deputy CFO / HR AD	March 2023	Scoping started on how to address the gaps
Address service specifications with commissioners during contracting round	Commercial Director	April 2023	Issues discussed with commissioner to align and re-cost services
Market assessment to be undertaken	Head of Business Development	February 2023	Work started look at education sector

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Deliver Medium and Long term commercial Strategy for growth	Initial plan has been developed to review the missed opportunities and the current open opportunities	Need to ensure strategy aligns to trustwide strategy	EMT sign off of strategy

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Principal Risk 11	IT infrastructure and cyber security		
Description	The failure to implement comprehensive security measure to protect the Trust from Cyber-attack could result in a sustained period where critical IT systems are unavailable, reducing the capacity to provide some services and leaving service users at risk of harm.	Strategic Objective	Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.

Executive Lead	Terry Noys Chief Finance Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	19th December 2022
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	19th December 2022
Risk Appetite	Moderate	5	4	20	4	3	12	3	3	9	Date of Next Review	19th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Implementation of security software on all endpoints	None	Usage of leading industry standard products maintained in accordance with best practice	External	
Implementation of security software on all servers	None	Usage of leading industry standard products maintained in accordance with best practice	External	
Successful completion of IG Toolkit annually	Full compliance with mandatory IG training	NHS IG toolkit annual submission. External validation of submission	External	
Compliance with industry standard Cyber Security Accreditations	None presently. However each year adds additional controls.	External validation with independent agencies e.g. Cyber Essentials	External	
Implementation of email security infrastructure	None	Secure data tools on email send and receive at a trust level e.g Mimecast. Additional individual email security management via Egress email security software.	Internal/External	
Subscription to NHSX cyber threat service	None	NHS issues threat warnings and remedial actions with timescales. These are called CareCerts and we comply with the actions required in the timescales advised where appropriate.	External	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Increased communication and monitoring of IG mandatory compliance	Data Protection Officer	By June 2023 and annually thereafter.	In progress

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance
Increase external Cyber Essentials accreditation to plus level	Project is underway and in final stages of delivery before completion of underlying work by end of 22/23 FY. External accreditation process will commence in early 23/24 FY	New requirements added to the standard in mid 22/23 FY for mobile device management necessitated additional software selection and implementation.	External Cyber Essentials accreditation organisation.

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Principal Risk 12	**Developing Partnerships**		
Description	A failure to develop and maintain effective system partnerships could prevent a clear understanding of the population health needs, diluting the specialist mental health voice and potentially lead to the Trust missing opportunities to improve patient care within the ICS.	**Strategic Objective**	**Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.**

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Sally Hodges , Chief Clinical Operations Officer										**Original Assessment Date**	19th December 2022
Lead Committee	Executive Management Team	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	4	4	**16**	3	4	**12**	3	3	**9**	**Date of Next Review**	19th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Development of a matrix of key relationships and allocated relationship managers	Ensuring that these are being enacted	Reporting back through relevant committees eg ELT, CLG etc Minutes from meetings SOF3	Internal Internal and external External	
New business development	BD team under resourced	Growth in new business	Internal and external	
Professional leadership forums		Reports back that we are engaged, contributing and leading new developments	External	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 13	**Compliance with Information Governance requirements**		
Description	A failure to comply with the Data protection and security toolkit could lead to a serious breach of data security resulting in service user harm, a loss of Trust reputation and potential ICO financial penalties.	**Strategic Objective**	**Ensure we are well-led & effectively governed.**

Executive Lead	Julie Dawes Director of Corporate Governance	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Audit Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	5	3	**15**	3	3	**9**	3	2	**6**	**Date of Next Review**	19th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
External Data Protection Officer (DPO) and IG Service appointed from April 2022.		Report to PFRC demonstrate effectiveness of existing arrangements	Internal	
Key policies on Information Security, Information Management, GDPR		IG Progress Report to PFRC provides update on current compliance	Internal	
Formal procedures for recording, reporting and responding to GDPR requests (FOI, SARs)	Current compliance is below the 90% set by the ICO for FOI response times (69% Q1)	IG Progress Report to PFRC provides update on current compliance	Internal	
DSP Toolkit annual submission	DSPT standard "not met" due to 95% staff mandatory training not achieved	DSPT outcome report from NHS Digital. Internal Audit of DSP Toolkit compliance set for January 2023	External External	
Plan for achieving compliance with DSPT approved by NHS Digital July 2022		IG Progress Report to PFRC provides update on current compliance	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Implementation of improvement plan to achieve 95% mandatory training compliance	IG & Data Protection Officer	31st March 2023	
Work with teams and improve guidance for completion of SARs	IG & Data Protection Officer		
Working with Teams to support and provide guidance to improve compliance with FOI request timeframes.	IG & Data Protection Officer		

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

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Principal Risk 14	**Effective Performance and Risk management arrangements**											
Description	If effective performance and risk management processes are not embedded within the Trust it could reduce the effectiveness of senior management decision making whilst also impacting on the level of confidence over our systems of internal control.									**Strategic Objective**	**Ensure we are well-led & effectively governed.**	
Executive Lead	Julie Dawes Director of Corporate Governance	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Executive Management Team	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	18th January 2023
Risk Appetite	**Moderate**	5	3	**15**	4	3	**12**	3	2	**6**	**Date of Next Review**	18th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
Quality Portal system for recording and reporting all risks	Not all risks managed through the Quality Portal Limited reporting capabilities from the Quality Portal system	Quality portal download shows latest risk scores and last review date for each live risk.	Internal	
Approved risk management strategy and policy	Need to update for the BAF process	Compliance with policy will be reported through sub-committees, audit committee and EMT as part of regular reporting once risk policy has been revised. Internal audit annual review of risk	Internal External	
Committee terms of reference include reporting and scrutiny of key risks	Processes for ensuring risks are included on agendas are not robust	Committee papers and minutes will provide confirmation of risk discussions once process relaunched.		
Risk reviewed by Board sub-committee	Consistent reporting needs to be reinstated	Bi-monthly meeting papers and minutes of sub-committees will provide confirmation of agreement and discussion over key risks. Internal audit annual review of risk.	Internal External	
12+risks escalated through EMT	Risk registers not routinely being reviewed by EMT	EMT monthly report of key risks and minutes will provide assurance over the management of key risks once reinstated.	Internal	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
New BAF risks to be agreed with Executives and reported through Audit Committee for discussion/scrutiny.	Risk and Assurance Lead	19th January 2023	Included in papers for Audit Committee on 19th January
Full BAF to be considered by March Board Sub-committees and Audit Committee and fully approved by the Board in April.	Director of Corporate Governance	4th April 2023	Currently 10 of 15 risks fully populated, agreement for population of other 5 in place.
All directorate operational and strategic risks to be reviewed and up to date risk registers produced for reporting through committee framework	Risk and Assurance Lead	28th February 2023	Meeting commenced with directorate leads and review of Quality portal effectiveness in progress.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Implement a refreshed "fit for purpose" BAF framework based around new Trust strategic objectives	Timetable has been agreed that will see a fully populated BAF signed off by the Board on 4th April 2023	Challenging timeframe for completion. Risks to be agreed through sub committee and Audit Committee prior to Board.	EMT papers and minutes Audit Committee minutes and papers Sub Committee papers and minutes
Embed risk management within the Directorate structure and committee reporting framework	Ongoing	Work needed to restructure risk in line with new directorate structure and reassign risks from managers who have left.	Risk register reporting through sub-committee meetings from February/March
Instil a Trust wide risk appetite framework	To be drafted for consideration by EMT initially in February	Change in approach may need time to agree	EMT papers and discussions
Deliver risk management awareness training across all levels of the Trust	Programme to be agreed for delivery by end of Q1 2023/24	Scheduling of training g may be difficult in some areas. Requires buy in to ensure well attended.	Record of attendance to be retained and training pack.

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Principal Risk 15	**Effectiveness of senior leadership**		
Description	A prolonged period of instability across the Trust Executive and senior management could impact on the effectiveness of governance, performance and engagement across the Trust, resulting in poor outcomes, levels of compliance, and staff performance.	**Strategic Objective**	**Ensure we are well-led & effectively governed.**

Executive Lead	Michael Holland Chief Executive Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19th December 2022
Lead Committee	Trust Board	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	19th December 2022
Risk Appetite	**Moderate**	5	4	**20**	4	3	**12**	2	3	**6**	**Date of Next Review**	19th February 2023

Key Risk Controls (1st line of defence)	**Gaps in Control** (what are we missing)	**Sources of Assurance** (2nd and 3rd lines of defence)	**Type of Assurance** (Internal / External)	**Assurance Rating** (RAG)
Revised organisational structure agreed	Gaps in governance support due to Key Board positions currently without substantive post holder (CPO, CMO,CNO)	Structure agreed at Trust Board July 2022	Internal	
New CEO in post		N/A		
Revised EMT structure and agenda based on accountability	Structured Board development programme required to improve Board impact	In place from January 2023 meeting agenda and packs	Internal	
OMG Well led Governance review Action Plan and Strategic Oversight Framework (SOF3) actions	Staffing structures below the Executive level may not be adequate to deliver the governance agenda	NHSE regular meetings Updates on progress through EMT and to Board	External Internal	
	Lack of performance reporting and accountability across all levels			
	Loss of corporate and organisational knowledge and history when staff leave			

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Implementation of Governance Action Plan	Director of Corporate Governance		
Recruitment to substantive Board level positions	Chief Executive Officer		

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**

12a Board Assurance Framework 070223 document.docx

Principal Risk 16	Reputational Management & Stakeholder Engagement		
Description	A failure to promote effective performance to the public and engage key stakeholders in Trust development plans, will result in a sustained loss of public confidence and long-term reputational damage to the Trust.	Strategic Objective	Ensure we are well-led & effectively governed.

Executive Lead	Michael Holland Chief Executive Officer	Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)			Original Assessment Date	27th January 2023
Lead Committee	Performance, Finance and Resources Committee	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Likelihood	Consequence	Risk Score	Date of Last Review	27th January 2023
Risk Appetite	Moderate	5	4	20	5	4	20	2	4	8	Date of Next Review	28th February 2023

Key Risk Controls (1st line of defence)	Gaps in Control (what are we missing)	Sources of Assurance (2nd and 3rd lines of defence)	Type of Assurance (Internal / External)	Assurance Rating (RAG)
New CEO in post and resultant changed culture at the top of the organisation	Create advocates & ambassadors	New Chief People Officer appointed. EMT weekly meeting structure revised from January 2023 to enhance accountability.	Internal	
	Assignment of NEDs as champions for each service area.		Internal	
Quarterly campaigns programme for 2023 based on topics of expertise led by the communications team		Detail within Communication and engagement plan to be rolled out from Q1 2023/24	Internal	
Enhanced GIDS website for patient and family facing owned channel		Website in place	Internal	
Communications performance reporting	Ongoing issues around the effectiveness of complaints process and delayed responses to complainants.	EMT reports on communication activity and performance	Internal	
	Control over the use of different communication channels within the Trust		Internal	
	Improved staff engagement required to enhance our external reputation	Existing press coverage around the closure of GIDS and ongoing legal case current impacting on current level of reputational risk.	External	

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
External Communications and Engagement Plan to be approved by Board	Laure Thomas	4th April 2023	Going to EMT end of February and then April Board
Internal Communications and Engagement Strategy to be approved at POD EDI	Laure Thomas	31st March 2023	Initial version went to POD EDI in September 2022.
Review of existing complaints process		31st March 2023	

Strategic Delivery Metrics			
Key Strategic deliverables	Progress to date	What are the current challenges/risks to progress?	Sources of Assurance

MEETING OF THE PUBLIC TRUST BOARD OF DIRECTORS – 07/02/2023			
Our Future Direction – Update & Next Steps			**AGENDA ITEM: 18**
Report Author and Job Title:	Alastair Hughes, Director of Strategy & Transformation (Interim)	**Responsible Director:**	Alastair Hughes, Director of Strategy & Transformation (Interim)
Action Required	Approve ☐ Discuss ☒ Inform ☐		
Situation	The purpose of this paper is to update the Board regarding development of our Trust Strategy.		
Background	Trust strategy development is underway with the last Board engagement in Dec 15. At this time, we also received the final outcome of the independent financial resilience review commissioned by NHSE London with the NCL ICB. This identified a number of strategic options for the organisational future of the Trust which are expected to be addressed through the development of our strategy and our subsequent work programme.		
Assessment	This paper provides an update to the Board on development of our Trust strategy ("Our Future Direction").		
Recommendation	Members of the Trust Board are asked to: 1. Note the scale and nature of the challenge that the Trust is facing. 2. Note the direction and progress. 3. Note and discuss next steps. 4. Note the timeframes and the potential for further development beyond April Board.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	There are no immediate risk implications associated with this paper.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Excellence in patient outcomes and experience ☒	Excellence in employee experience ☒	
	Drive operational performance ☒	Long term financial sustainability ☒	
	Develop clinical and commercial strategies ☒		

Board Update

07/02/2023

The Tavistock and Portman
NHS Foundation Trust

Our Future Direction

Update & Next Steps

What this covers

The Tavistock and Portman
NHS Foundation Trust

1. **What we are seeking to achieve**
2. **Plan**
3. **Progress Update**
4. **Next Steps**

Our strategy should set out the following

The Tavistock and Portman NHS Foundation Trust

Section					
1	**Our Context**				
	Our Challenges	**The Changing Landscape**	**Changing Need**		
2	**Our Organisation**				
	Our USP / Our Role in the System	**Our Vision**	**Our Purpose, Mission & Values**		
	And Our Organisational Form That Best Enables Delivery				
3	**Our Services**				
	Commercial Plans	**Improvement Plans**	**Workforce Development**	**Service Plans**	
	And New Services / New Markets / New Capabilities / New Partnerships				
4	**Our Enabling Functions**				
	People	**Estate**	**IM&T**	**Finance**	**Marketing & Comms**
	Aligned With Our Plans for Organisational Form				

Our strategy must be a highly effective response to a very challenging situation

The Tavistock and Portman NHS Foundation Trust

Our Context

Our Challenges	The Changing Landscape	Changing Need
• We must address the significant challenges that the Trust faces that impact our medium and long-term sustainability, including the outcomes of the financial sustainability review.	• We must reflect the changing landscape: the national strategy (Long-Term Plan, MH strategy & implementation plan, the focus on prevention (& the importance of setting), the developing strategy for Adult Mental Health, local population and place-based approaches and the impact of system change (ICSs, Spec Comm, HEE, Higher Education).	• We must reflect changing patterns of need in society - and understand what this means as a Trust operating in different systems (local, national) and sectors.

We must, within this context, set out the Trust's ambitions and role in the Mental Health sector which respects our unique role, history and contribution, but also acknowledges the honest reality of where we – and respond accordingly.

We need a more fundamental response to our situation

The Tavistock and Portman NHS Foundation Trust

Our strategy needs to bring together the following:

A collaborative approach

The Tavistock and Portman NHS Foundation Trust

Our strategy should also set out how we are engaging

- With staff
- With patients, students and the communities we serve
- With our strategic and system partners

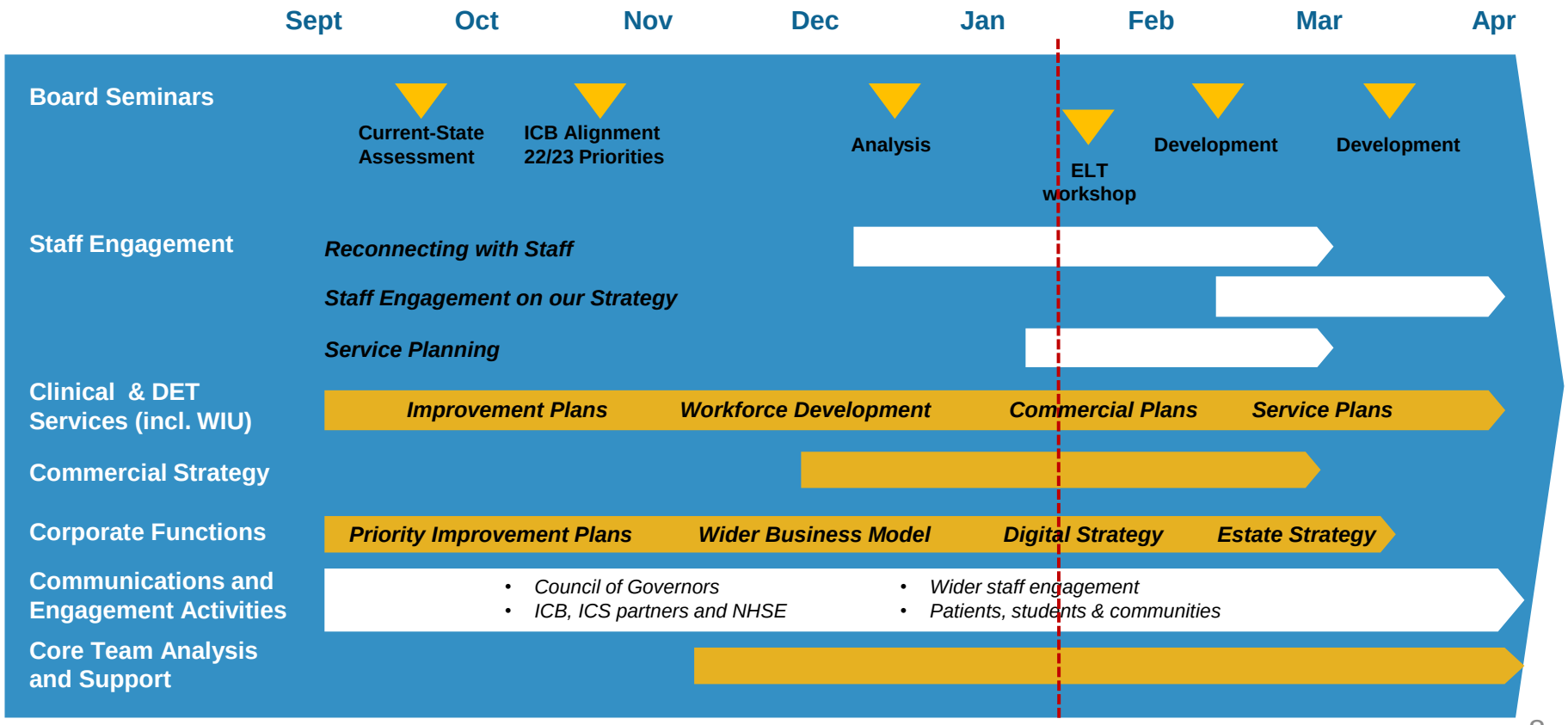
Board Update

The Tavistock and Portman
NHS Foundation Trust

Plan

Strategy development timeline

Timeline



Board Update

The Tavistock and Portman
NHS Foundation Trust

Progress Update

Progress update covers

The Tavistock and Portman NHS Foundation Trust

1. **Board Seminar (15 Dec)**
2. **Commercial Strategy Development**
3. **Service Planning**
4. **Staff Engagement**

1. Board Seminar (15 Dec)

The Tavistock and Portman NHS Foundation Trust

Outcomes

1. The development of our commercial strategy: commercial and contracts analysis:
   - Contracts analysis
   - Margin analysis
   - Growth analysis

   ➡ The need for further analysis (markets, services)
2. DET update
   - Including the draft commercial strategy of the Workforce Innovation Unit
3. Financial requirements
   - Including an update following the independent financial resilience review
4. Estate
   - A presentation of the current state of our estate to enable future options development

2. Commercial Strategy Development

The Tavistock and Portman NHS Foundation Trust

Development of our commercial strategy is a critical part of our overall Trust strategy to achieve medium and long-term sustainability.

It will set out the following:

- Our strategy for income growth* across our markets and services,
- Our strategy for growing our contribution / margin across our services portfolio, and
- Our strategy to manage commercial risk across our portfolio

*Please note that a growth strategy (vs a managed response to a maintaining or reducing income) is our working assumption.

2. Commercial Strategy Development

The Tavistock and Portman NHS Foundation Trust

- At our last Board seminar (Dec 15), we reviewed initial commercial analyses* across our clinical services portfolio and DET services (including our Workforce Innovation Unit).
- Subsequent conversations with the Executive have confirmed that:
  - We need immediate work to identify growth opportunities (further markets and services analysis) including priorities for next financial year (2023/24).
  - The results of this analysis and plan should be expected by the Board in March.
- In order to do this, we need additional immediate external capacity.
  - We are currently seeking to rapidly identify and confirm appropriate consultancy support with the objective of mobilising this work as soon as possible. We indicatively expect this work to take 6-7 weeks based on a proposal received from one consultancy.
  - There are benefits of an external, objective, evidence-based approach that helps us think in a broad and open-minded way, that challenges us and helps us to think beyond our current boundaries.

* Commercial and contracts analysis included in Appendix A

3. Service Planning

The Tavistock and Portman NHS Foundation Trust

Service planning process fits alongside 23/24 budgeting process (& would ideally precede this)

- 23/24 budgeting process timeline is through Jan and Feb 23
- Clinical Services and DET plans/needs will inform Corporate Services
- Assumes SR outcome (structure)

Service planning must align with strategy development

- Developing Trust strategy
- Commercial strategy (growth, contribution improvement)
- Contracting requirements
- Performance improvement priorities
- Efficiency improvement
- Workforce development

3. How service planning fits in

The Tavistock and Portman NHS Foundation Trust

Outcomes:

By end Feb

1. Completed service plans for all services
2. Refreshed and aligned commercial strategy

By end Apr

1. Updated commercial strategy aligned with wider strategy analysis
2. Updated service plans as required

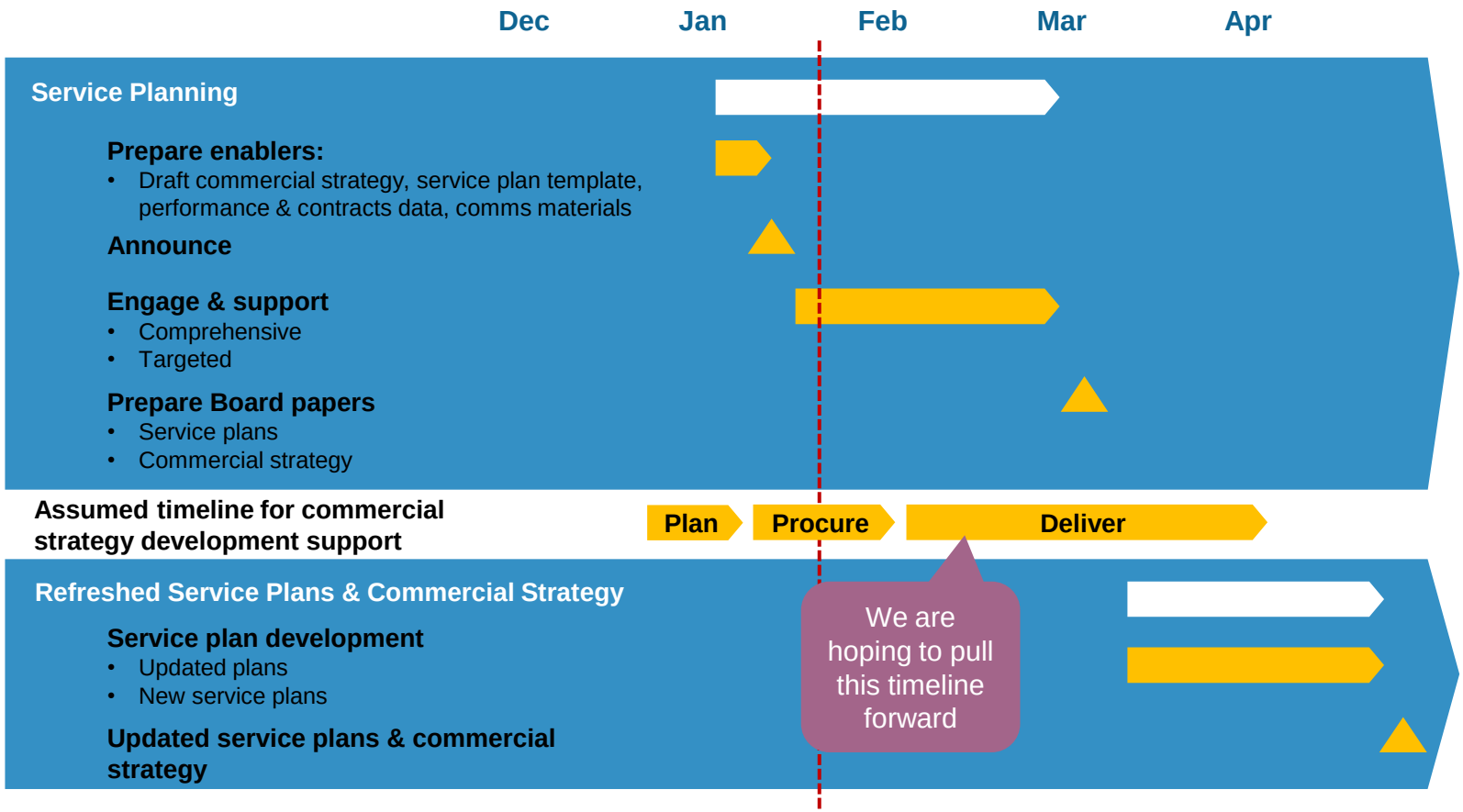
Enablers:

1. Draft commercial strategy (Appx. A)
2. Common service plan template (Appx. B)
3. Information on current service performance and contracting
4. Clear communications, engagement and support (Appx. C)
    1. Comprehensive
    2. Targeted

3. Service Planning Process

The Tavistock and Portman NHS Foundation Trust

Timeline



3. Service Planning
Appendices

The Tavistock and Portman NHS Foundation Trust

A. Draft Commercial Strategy

Microsoft
werPoint Presentat

B. Service Plan Template

Microsoft Word
Document

C. Staff Communications: this covers targeted comms to teams and service leads, all staff comms (intranet) and the highlight in the CEO weekly roundup

Microsoft Word
Document

4. Staff Engagement Priorities

The Tavistock and Portman NHS Foundation Trust

Priorities

Leadership reaching out to all staff

- On-going

Re-connect

with Staff, Students, Patients, Communities

MH: How we are engaging should set out how we want to work across the organisation

- We need to demonstrate that we're listening to staff, the process both of learning from staff & how we're acting on their ideas
- We need this to overlap with the quality improvement strategy as I see the engagement & improvement approach overlapping & becoming the way we work across the organisation

Service line planning

- Strategy alignment
- Supported
- Consistent quality

Re-think

our services

Re-define

our role as an organisation & what makes us distinctive

Staff engagement on our strategy

- Our USP
- Our role in the MH system

Board Update

The Tavistock and Portman
NHS Foundation Trust

Next Steps

Next Steps

The Tavistock and Portman NHS Foundation Trust

1. **Exec Workshop (24 Jan) and Board Development Workshop (7 Feb)**
    1. The Landscape
    2. Our USP
    3. Our Vision
2. **Staff Engagement**
3. **Service Planning**
4. **Commercial Strategy Development**
5. **Executive Objectives (strategic objectives for improvement and development)**
6. **Other strategy development**
    1. Estate Strategy
    2. Digital Strategy (alongside IM&T plans)

The Tavistock and Portman
NHS Foundation Trust

Trust Board Seminar

Commercial & Contracts Analysis

Amy LeGood
Alastair Hughes

Dec 2022

Context

The Tavistock and Portman NHS Foundation Trust

We will use this slide pack at the Board away-day

Please gather any thoughts ahead of this. We look forward to the discussion.

Objectives of this session

The Tavistock and Portman NHS Foundation Trust

To seek the Board's direction on the following:

1. The development of our commercial strategy
2. Priority areas of further investigation and research (markets, services)

Contents

The Tavistock and Portman NHS Foundation Trust

1. Introduction

The Tavistock and Portman NHS Foundation Trust

Our commercial strategy must align with our wider organisational strategy for medium and long-term sustainability and cover:

1. **Our strategy for revenue growth***
   - Services
   - Markets
2. **Our strategy for growing our contribution / margin**
3. **Our strategy to manage commercial risk across our portfolio**

*Please note that a growth strategy (vs a managed response to a maintaining or reducing income) is our working assumption

1. How does our commercial strategy form part of our wider organisational strategy?

The Tavistock and Portman NHS Foundation Trust

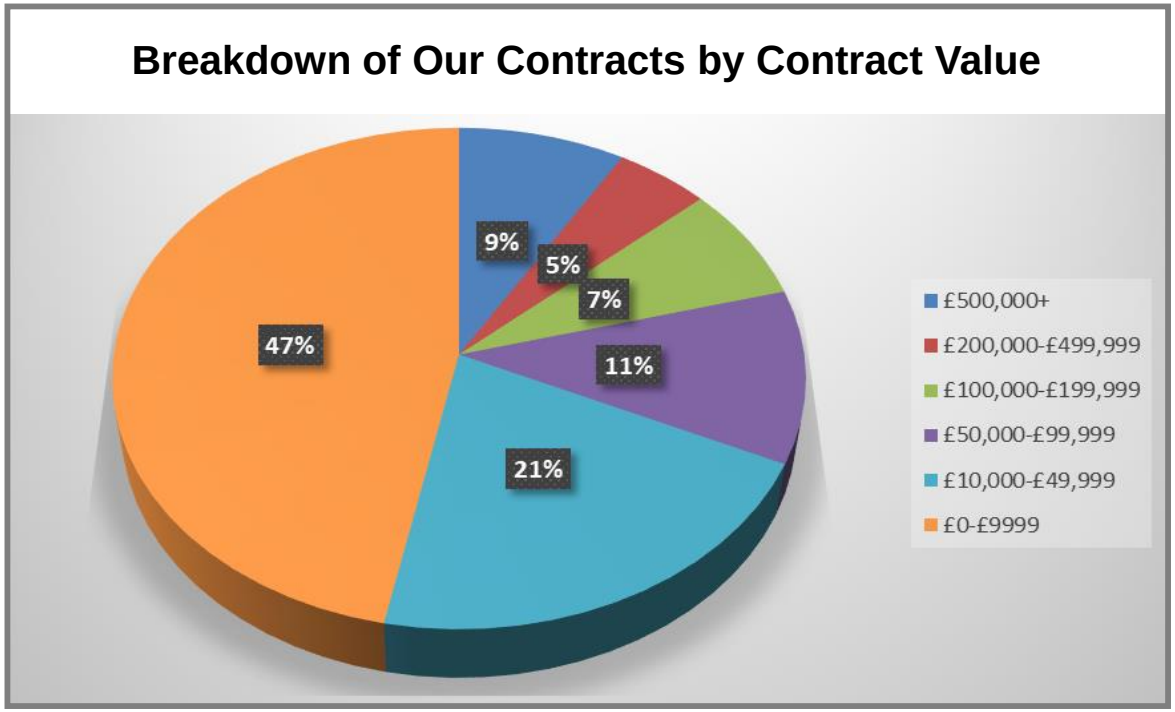
Our strategy needs to bring together the following:

2. Contracts Analysis

The Tavistock and Portman NHS Foundation Trust

Over that last 5 years we have pursued a strategy of diversification, through a scattered approach.

This has translated into a large portfolio, including a significant proportion of small value contracts as shown:



We have approx. 300 contracts including 40 sub-contracts which we manage.

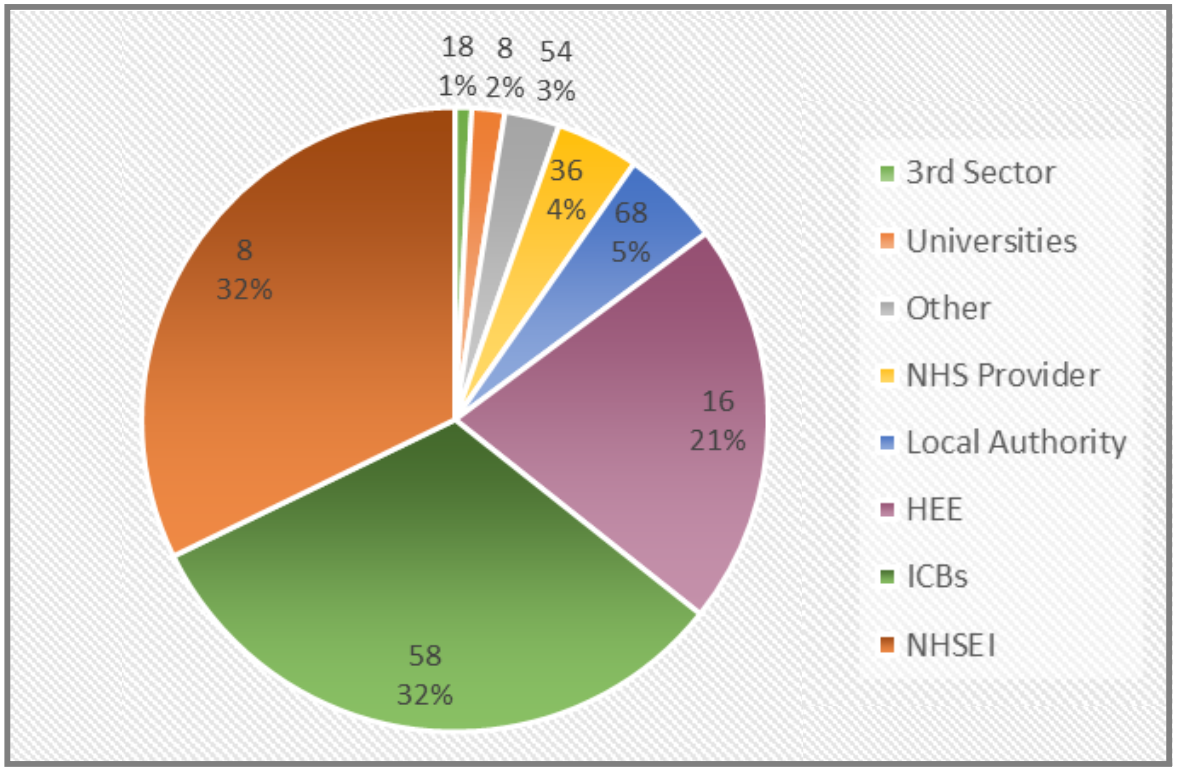
In FY 22/23 we have taken on (net) 81 new contracts with a value of £1.25m. This is a standard recurring annual pattern.

In addition, we manage approx. a thousand LVAs.

2. Our contract revenue by main source (commissioner) is shown below

The Tavistock and Portman NHS Foundation Trust

Trust Income Breakdown (%) by Commissioner, and the associated number of contracts



*This revenue split does not account for student fees or individual LVAs

A small number of contracts with a few commissioners (NHSE/I, ICBs, HEE) delivers the highest revenue value for the trust.

Disproportionate number of commissioning arrangements with multiple commissioners.

Key Income Risk Exposure:

- NHSE/I
- HEE
- NCL ICB

2. This portfolio represents high short/medium-term risk in a number of ways

The Tavistock and Portman NHS Foundation Trust

1. Immediate commercial risk exposure (excluding GIDS and associated LVAs (£8.8m) due to a range of current service delivery performance and risk issues. The largest of these are:
   - NCL ICB Core contracts (£2m)
2. There are also major chunks of additional risky revenue streams within our portfolio for a range of reasons. The largest of these are:
   - PCPCS (£1.5m), Well-being Hub (£1.4m), Surrey Mindworks (£1.3m), Returning Families(£0.5m)
   - Additional risk from the NHSE GIC contract, due to the nature of the contract, NHSE can recoup funds. We are working through the detail with NHSE currently.
3. Contract duration – overdependency on annual contract renewal cycles which have risks associated (Q3/Q4 contracting round)
4. A huge long-tail of contracts which require disproportionate effort
   - Huge knock-on impact regarding ability to focus on high-value contract management and business development
   - Significant impact on complexity of corporate management (e.g. Finance, HR, Estates)

2. In order to respond to these risks, our commercial strategy should include:

The Tavistock and Portman NHS Foundation Trust

1. A stabilisation strategy
   - Currently underway in clinical services and planned for DET
   - Priorities are: Job Planning / Activity Monitoring / Waiting Times Reduction / Pathway Mapping and Monitoring / Outcome Measures
2. Growing our number of larger contracts
   - Focused development and strategic diversification across markets and services (covered next)
3. Development of larger contract duration cycles
   - Market-specific approaches
4. Reducing the proportion of small, short-term contracts
5. Development of our model of performance management, contract management and business development
   - Our use of **data** and monitoring of outcomes
   - Improving Board-level performance reporting
   - A much greater focus on supporting business development

3. Margin Analysis

The Tavistock and Portman NHS Foundation Trust

Analysis of Current Services

	Low Margin	High Margin
High Growth Potential (at scale)	Digital training Long courses Research *Services which we should develop to improve return*	FDAC (family drug & alcohol court) *Priority focus for development and marketing*
Low Growth Potential	Trauma ASD (autistic spectrum disorders) CAMHS (core) Schools Services Tavistock Consulting Adult MH (core and PCPCS) *Services we should review and challenge*	Short Courses GIC Surrey Mind-works *Services for which we should maximise short-term return*

This is for workshop-based discussion during the away-day.

Areas we highlight here are what we think we need to be discussing as a minimum.

Please note, it might be helpful to think of different levels of scale:

- Local (borough-specific or NCL-wide)
- Regional (London)
- National

4. Growth Analysis

The Tavistock and Portman NHS Foundation Trust

Analysis of Growth Opportunities

	Current Markets	New Markets
New Services	IAPT New long courses	New university partnerships Integrated Schools Service • Schools holiday camps • Hub & spoke specialist service model • Care & respite • Social, emotional, mental health for schools units
Current Services	FDAC (family drug & alcohol court) Digital training Long courses Research	Large Corporate Employment Assistance Offer Private Medical Insurance Companies • Adult MH • CAMHS Private MH Offer

This contains the '**high growth potential (at scale)**' items from the previous slide

This is for workshop-based discussion during the away-day.

Areas we highlight here are what we think we need to be discussing as a minimum.

Other ideas mentioned recently include:

- University market
- International market (such as the approach of Health UK)
- Continuing Professional Development - DET
- Nursing training - DET

Where would these sit?

Key questions

The Tavistock and Portman NHS Foundation Trust

Have we made any decisions?

What should be our priority areas of further investigation and research (markets, services) for decision-making next time?

Immediate priorities?

Service Plan 2023-2026 (*insert service name)*

Current State SWOT Analysis – Q4 2022/2023

To cover service performance, quality, reputation, margin, revenue, staffing and infrastructure

Strengths:

Weaknesses:

Opportunities:

Threats:

Needs assessment:

- Demand for the service – *e.g., referral rates, waiting list, waiting time*
- Service user needs and changing profile – *how are needs developing, is the profile changing – i.e., socioeconomic background, demographic, vulnerability, comorbidities, complexity - what does the data say? What do service users tell us they need?*
- How the local and wider system is changing - *i.e., commissioning landscape, service spec*

STRATEGIC DIRECTION

1. The overall vision and strategy for the service
2. Plans for performance improvement including use of data
    - *Immediate plans for performance stabilisation where required*
    - *Aligned with Trust-wide approach to performance improvement*
3. Commercial strategy including plans for contribution improvement and revenue growth - market development
    - *Plans for services/offer development (including digital)*
    - *Plans for market development – e.g., reaching new areas and people*
    - *Plans for improving level of contribution*
4. Enablers:
    - *New business models and partnering*
    - *Workforce development priorities*
    - *Infrastructure requirements (estate and IM&T)*

Key Priorities for 2023/2024:

Short term objectives and targets (*ensure these are aligned with your 23/24 annual budget plan)*

- *Performance*
- *Commercial*
- *Workforce*

Service planning comms 20.01.2023.

1. Targeted comms to team and service leads:

Dear colleagues,

We are writing to you directly as team and service managers to introduce you to a service planning exercise following on to Michael Holland's message to all Trust staff at the end of last week. This exercise will use a standard format across all Trust services.

Over the next 4-5 weeks we will be working with you to listen, understand and capture your plans for your service. These should set our your ambitions . for the next 2-3 years and priority objectives for delivery over the next financial year (2023/2024). Our goal is to develop a deeper understanding of your vision for your service and to align Trust-wide strategy development with your views through an inclusive approach.

We are running this in parallel with the 2023/2024 budget planning process so that any planning assumptions can be discussed and joined-up.

The objectives of this exercise are to:

- *Facilitate an ongoing dialogue between services and Trust leadership*
- *Involve all Clinical and DET Services*
- *Develop short-term (12 months) and medium-term (3 years) service plans by the end of February*
- *To do this in a consistent way for each service area to facilitate cross-Trust collaboration and learning.*

What happens next?

- *You will receive an email with more detailed information, a service plan template with accompanying guidance and an invitation to a workshop lead by members of the Strategy and Transformation Team.*
- *There will be an opportunity to discuss your plans with the Strategy & Transformation Team before the workshop, as well as access to support from your service's Contracts and Performance Manager drawing on commissioner reports or performance data to inform thinking.*

We understand that you will have practical constraints around your availability and will be flexible and responsive in finding a time for discussion that works for you. Please expect to receive our email next week. We look forward to working with you on this.

Kind regards,
Alastair Hughes and the Strategy and Transformation Team

2. Comms for all staff on the intranet:

Service planning
Over the next 4-5 weeks the Strategy and Transformation Team will be working with each service to understand and capture their ambitions and plans for their services. Work will look at medium term

ambitions (2-3 years) and set priority objectives for delivery over the next financial year (2023/2024). Our goal is to develop a deeper understanding of the vision for each service and to align Trust-wide strategy development with service level views through an inclusive approach.

This will be run in parallel with the 2023/2024 budget planning process so that any planning assumptions can be discussed and joined-up.

The objectives of the exercise are to:

- *Facilitate an ongoing dialogue between Services and Trust leadership*
- *Involve all Clinical and DET Services*
- *Develop short-term (12 months) and medium-term (3 years) service plans by the end of February 2023*
- *To do this in a consistent way for each service area to facilitate cross-Trust collaboration and learning.*

What happens next?

- *Service and team leads will receive further information, including a service plan template with accompanying guidance and an invitation to a workshop led by members of the Strategy and Transformation Team.*
- *There will also be opportunities to discuss plans with the Strategy & Transformation Team before the workshop, as well as support from Contracts and Performance drawing on commissioner reports or performance data to inform thinking.*

3. Highlight messaging for Michael's weekly roundup (with link to intranet):

Over the coming weeks the Strategy and Transformation Team will be working with each service to listen, understand and capture ambitions and plans. We want to understand each service's plans over the next 2-3 years and capture a set of priority objectives for delivery over the next financial year (2023/2024). Our goal is to develop a deeper understanding of the vision for each service and to align Trust-wide strategy development with service level views through an inclusive approach.

We are running this in parallel with the 2023/2024 budget planning process so that any planning assumptions can be discussed and joined-up. More information can be found here on the intranet.

4. Distribution list for targeted comms:

Sally Hodges
Rachel James
Hector Bayayi
Tim Kent
Steve Bamborough
Fiona Hartnett
Aaron Horner
Mona Fathollahi
Rakiya Ibrahim
Jenny Goodridge
Antonia Carding
Caroline McKenna

Liz Searle
Amy Le Good
Pia Pedersen
Will Fitzmaurice
Elisa Reyes-Simpson
Esther Usiskin Cohen
Katie Argent
Anne Hurley
Helen Shaw
Jessica Yakely
Sophie Marshall
Katie Walker
Lottie Laverty
Jess Elmer
Nell Nicholson
Kirsty Brant
Nimisha Deakin
James Barrett
Dean Flanagan
Claire Vaughan
Dexter Benjamin
Milos Djordjevic
Amy O'Gorman
Tracy Laroya
Patricia Pemberton
Nancy Sheppard
Wendy Lobatto
Rafeek Baksh
Siobhan Netherwood
Zoe Given-Wilson
Hiroshi Amino

Meeting of the Board of Directors:			**7 February 2023**
Board meetings dates 2023/24			**AGENDA ITEM:** 19
Report Author and Job Title:	Julie Dawes, Interim Director of Corporate Governance	**Responsible Director:**	Julie Dawes, Interim Director of Corporate Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒		
Summary	The purpose of this report is to confirm the following dates for board meetings to be held in public during 2023/24: • Wednesday 19th April 2023 • Wednesday 23rd May 2023 • Wednesday 14th June 2023 • Thursday 27th July 2023 • July 2023 – Annual General Meeting (provisional) • September 2023 - Annual General Meeting (provisional) • Wednesday 11th October 2023 • Wednesday 13th December 2023 • Wednesday 17th January 2024 • Wednesday 21st February 2024 For the purpose of planning, the provisional public board meeting dates for 2024/25 are as follows. These will be confirmed in July/August 2023: • Wednesday 17th April 2024 • Wednesday 12th June 2024 • Wednesday 10th July 2024 • Thursday 25th July 2024 *(provisional)* • Thursday 25th July 2024 - Annual General Meeting (provisional) • Wednesday 14th August 2024 *(provisional)* • Wednesday 11th September 2024 - Annual General Meeting (provisional) • Wednesday 9th October 2024 • Wednesday 11th December 2024 • Wednesday 12th February 2025 We are in the process of updating the Board Cycle of Business (forward planner) for 2023/24 and this will be presented at the next meeting in April 2023 consideration.		
Recommendation	The Board of Directors is asked to note the agreed meeting dates for 2023/24 and provisional dated for 2024/25.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The report supports the risks in the BAF associated with achieving he Well - Led and effective governance strategic objective.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		

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