NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Wednesday 11th October 2023

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

Please refer to the agenda for timings.

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON WEDNESDAY, 11 OCTOBER 2023 AT 2.00PM – 5.10 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

23/	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		Limited ☐ Partial ☐ Adequate ☒ N/A ☐
004	Patient/ Service User Experience – Patient Experience Video	Discussion		V	2.05 (15)	
005	Minutes of the Previous Meeting held on 27 July 2023	Approval	Chair	E	2.20 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.25 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.30 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.40 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Annual Objectives and Strategic Priorities	Approval	Director of Strategy and Business Development	E	2.50 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
Comfort Break (10 minutes) 3.05pm – 3.15pm						
DELIVER HIGH QUALITY CLINICAL SERVICES which make a significant difference to the lives of the people & communities we serve.						

010	Quality Committee Assurance Report	Assurance	Quality Committee Chair	E	3.15 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☒
011	Annual Infection Prevention and Control Plan and Statement	Approval	Chief Nursing Officer	E	3.20 (5)	Limited ☐ Partial ☒ Adequate ☐ N/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						
012	Response to NHSE Letter about the Lucy Letby Case	Assurance	Chief Nursing Officer, Chief People Officer, Director of Corporate Governance	E	3.25 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
013	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	3.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☒
014	Education and Training Committee Assurance Report	Assurance	Education & Training Committee Chair	E	3.45 (10)	Limited ☐ Partial ☒ Adequate ☒ N/A ☐
015	Executive Appointment and Remuneration Committee Chair's Assurance Report	Assurance	Committee Chair	E	3.55 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
016	Annual Medical Revalidation Report	Approval	Chief Medical Officer	E	4.00 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
DEVELOP & DELIVER A STRATEGY & FINANCIAL PLAN that supports medium & long-term organisational sustainability & aligns with the ICS.						
017	Performance, Finance and Resources Committee Assurance Report	Assurance	PFR Committee Chair	E	4.05 (10)	Limited ☐ Partial ☒ Adequate ☒ N/A ☒
018	Finance Report – Month 5	Discussion	Chief Finance Officer	E	4.15 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
WELL-LED AND EFFECTIVELY GOVERNED						
019	Audit Committee Assurance Report	Assurance	Audit Committee Chair	E	4.20 (10)	Limited ☐ Partial ☒ Adequate ☒ N/A ☒

020	Board Assurance Framework (BAF)	Assurance	Director of Corporate Governance	E	4.30 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
021	Constitutional Changes on Board Members' Voting Status	Approval	Director of Corporate Governance	E	4.40 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
022	Review of Committee Terms of Reference	Approval	Chair	E	4.45 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CLOSING ITEMS						
023	Board Forward Planner	Information	Chair	E	4.50 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
024	Questions from the Governors	Discussion	Chair	V	4.55 (10)	
025	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
026	Questions from the Public	Discussion	Chair	V		
027	Reflections and Feedback from the meeting	Discussion	Chair	V	5.05 (5)	
DATE AND TIME OF NEXT MEETING						
028	Wednesday 13th December 2023 at 2.00 – 5.10 pm					

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Register of Directors' Interests 2023/24			**Agenda No. 003**
Report Author and Job Title:	Dorothy Otite, Governance Consultant	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Register of Directors' Interests 2023/24		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report and accompanying table in Appendix 1 set out the updated Register of Directors' Interests for 2023/24.		
Background:	The Trust is required to have a formal Register of Directors' Interests under the Constitution and the Health and Social Care Act 2012. In accordance with the Standing Orders provisions relating to the registers in Annex 5 of the Constitution: • The Trust shall have and maintain a register of interests of the Board of Directors ("the Register of Directors' Interests") (See Standing Orders 1.2); • The Register of Directors' Interests shall be kept up to date by means of a regular review by the Trust Secretary, during which, any changes of interest declared during the preceding period shall be incorporated (See Standing Orders 8); and • All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the Register of Directors' Interests. Any Directors appointed subsequently shall declare their relevant and material interests on appointment (See Standing Orders 9.1). In accordance with guidance from NHS England on 'Managing Conflicts of Interest in the NHS'; and the Trust's Gifts, Hospitality, and Interests Policy all decision-making staff (this includes Executive and Non-Executive Directors) are required to complete a declaration of interest form annually. Where there is no declaration to be made, a nil return is required. (See Paragraph 8.8).		
Assessment:	The Register of Directors' interests for 2023/24 has been refreshed to include the new Directors who have recently joined the Trust. The Register of Directors' interests for 2023/24 also forms part of the Public Board papers published on the Trust's website and will be publicly accessible in a section of the Trust's website for Registers of interests via this link .		
Key recommendation(s):	The Board of Directors is asked to **NOTE** the information contained in the Register of Board of Directors' Declaration of Interests 2023/24 (in Appendix 1) which was correct at 8 September 2023.		
Implications:			
Strategic Objectives:			

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

Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	There are no linked risks on the BAF/ CRR/ ORR associated with this report.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	NHS Foundation Trusts are required by statute to prepare annual reports and accounts that comply with the NHS Foundation Trust Annual Reporting Manual on an annual basis. As part of this, it is required to disclose in the Annual Report that it has published on its website a register of interests for all decision-making staff				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no EDI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	None				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

REGISTER OF DIRECTORS' INTERESTS - 2023/24 (LAST UPDATED 08/09/23)

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
NON-EXECUTIVE DIRECTORS						
ARUNA MEHTA	Non-Executive Director	01 November 2021 (1st Term)	Non-Executive Director, Epsom St Helier NHS Trust (1)	01/02/2016	Present	No perceived conflict as its an acute trust in a different area
			Governor, University of Greenwich (4)	01/09/2020	Present	No conflict
			Director, Dr A Mehta Limited (1)	01/04/2012	Present	Personal company – no conflict
			Associate, The Value Circle	01/04/2020	Present	Consultancy work for organisations outside of London- no conflict
			Closed Interests			
			Non-Executive Director, Clarion Housing (1)	01/11/2013	19/11/2022	No conflict
			Member, Kemnal Academy Trust	01/01/2020	01/12/2021	No conflict
CLAIRE JOHNSTON	Non-Executive Director	01 November 2022 (1st Term)	Registrant Council Member, Nursing and Midwifery Council	01/09/2018	Present	
			Chair, Our Time (3)	01/05/2018	Present	Charity supporting families with serious mental illness
			Member IFR panel NCL Intergrated Care Board (3)	05/04/2020	Present	
			Spouse is a journalist specialising in health and social care			
DAVID LEVENSON	Senior Independent Director and Non-Executive Director	01 September 2019 (2nd Term)	Non-Executive Director, Qualitas Housing CBS (1)	01/01/2022	Present	Housing provider for people with long term disabilities – no conflict
			Non-Executive Director, Industrial Dwelling Society (1)	01/01/2022	Present	Registered social housing provider – no conflict
			Director, The Executive Service Limited t/a Coaching Futures (1)	01/04/2016	Present	Personal Service Company – provides coaching and training services – no conflict
			Academy member, Institute of Chartered Accountants of England and Wales	01/10/2020	Present	Design and teach ICAEW Academy's courses on Corporate Governance, paid consultancy – no conflict
DEBORAH COLSON	Non-Executive Director and Vice Chair	01 October 2017 (2nd Term)	Member of the HRA SE Thames Research Ethics Committee (REC) (unpaid)	01/11/2018	22/03/2023	Resigned from being a member HRA SE Thames Research Ethics Committee (REC) on 22/03/23. No conflict
JANUSZ JANKOWSKI	Non-Executive Director	01 November 2022 (1st Term)	Non-Executive Director RDASH NHS Doncaster (1)	01/11/2022	Present	No conflict
			Consultant Advisor University of South Pacific	09/01/2023	Present	No conflict
			Clinical Consultant Placement Agency ad hoc (3)	01/10/2021	Present	No conflict
			Magistrate HMCTS (3)	01/11/2019	Present	No conflict
			Hon Professor University College of London	01/02/2020	Present	No conflict
			Chair EU Translational Cancer Panel (3)	01/08/2022	Present	No conflict
			Consultant Industry ad hoc	01/08/2021	Present	No conflict
JOHN LAWLOR, OBE	Trust Chair	06 June 2022 (1st Term)	Trustee of the national charity, Think Ahead, under contract to DHSC to provide postgraduate education in mental health social work. (3)	01/09/2019	Present	No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by Think Ahead and vice versa
			Wife is an Associate Director at Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) (1)	07/04/2019	Present	No perceived conflict - Will withdraw from relevant business in relation to CNTW discussed by the Tavistock and Portman
			Wife is a Trustee of Carers' Resource serving parts of West and North Yorkshire	01/07/2023	Present	No perceived conflict - Will withdraw from relevant business in relation to Carers' Resource discussed by the Tavistock and Portman
SABRINA PHILLIPS	Associate Non-Executive Director	01 November 2022 (1st Term)	Employed by the Lambeth Living Well Network Alliance as Service Director (The alliance is a partnership of 5 organisations SLaM, SEL ICS (Lambeth),Lambeth ASC,Certitude, Thamesreach) - I am seconded out to the Alliance from SLaM (4)	01/01/2020	Present	Full time employment - No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by the Alliance.
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	23/02/2023	Will withdraw from business decisions in competition with University of Westminster

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
SHALINI SEQUEIRA	Non-Executive Director	01 November 2021 (1st Term)	NIL RETURN			
EXECUTIVE DIRECTORS (VOTING)						
ELISA REYES-SIMPSON	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	16 June 2022	Company Secretary Simpson Practice Ltd (1)	19/11/2004	Present	No perceived conflict - Small psychotherapy private practice. As there are no direct referrals from the NHS and no lonk to Tavistock & Portman clinical services.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12 November 2016	NIL RETURN			
PETER O'NEILL	Interim Chief Finance Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ROD BOOTH	Director of Strategy and Business Development	26 June 2023	NIL RETURN			
EXECUTIVE DIRECTORS (NON-VOTING)						
GEM DAVIES	Chief People Officer	1 February 2022	NIL RETURN			
ADEWALE KADIRI	Director of Corporate Governance	7 August 2023	NIL RETURN			
JANE MEGGITT	Director of Communications and Marketing	24 April 2023	NIL RETURN			
Categories:						
1	Directorships including non-executive directorships, held in private companies or PLCs (with the exception of directorships of dormant companies)					
2	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS					
3	Position(s) of authority in a charity or voluntary organisation in the field of health and social care					
4	Any connection with a voluntary or other body contracting for NHS services					
5	Any connection with an organisation, entity or company considering entering into, or having entered into, a financial arrangement with the Trust, including but not limited to lenders or banks					

UNCONFIRMED MINUTES
OF A MEETING OF THE BOARD OF DIRECTORS

PART 2: MEETING HELD IN PUBLIC

THURSDAY, 27 July 2023
The Training Room, Garden Wing, Tavistock Clinic, London NW3
and virtually via Zoom

Present

Members

John Lawlor (JL)	Chair, Chair of the Trust
Deborah Colson (DC)	Vice Chair, Non-Executive Director
Aruna Mehta (AM)	Non-Executive Director, Chair of Performance, Finance and Resources Committee and Joint Chair of the Audit Committee
Claire Johnston (CJ)	Non-Executive Director, Chair of Quality Committee
David Levenson (DL)	Non-Executive Director, Joint Chair of the Audit Committee
Janusz Jankowski (JJ)	Non-Executive Director
Sal Jarvis (SJ)	Non-Executive Director, Chair of the Education and Training Committee
Michael Holland (MH)	Chief Executive Officer
Caroline McKenna (CMcK)	Interim Chief Medical Officer
Elisa Reyes-Simpson (ERS)	Interim Chief Education and Training Officer and Dean of Postgraduate Studies
Gem Davies (GD)	Chief People Officer
Clare Scott (CS)	Chief Nursing Officer
Peter O'Neill (PON)	Interim Chief Finance Officer
Sally Hodges (SH)	Chief Clinical Operating Officer
In Attendance:	
Sabrina Phillips (SP)	Associate Non-Executive Director
Jane Meggitt (JM)	Interim Director of Communications & Marketing
Rod Booth (RB)	Director of Strategy, Transformation & Business Development
Chris Abbott	Incoming Chief Medical Officer
Sarah Stenlake (SS)	Freedom to Speak Up Guardian
Amanda Hawke (AH)	Corporate Governance Manager
Reni Aina (RA)	Interim Corporate Governance Officer (Minutes)
Paul Dugmore (PD)	Associate Dean, Learning and Teaching
Kathy Elliott (KE)	Lead Governor
Nsimire Bisimwa (NB)	Family Psychotherapist and M6 Supervisor
Shila Rashid (SR)	Systemic Psychotherapist and M6 Course Lead
Sharon Evans (SE)	Family and Systemic Psychotherapist, M6 Supervisor
Baber Siddiqi (BS)	M6 Year 1 Student

Michael Rustin	Public Governor
Kenyah Nyameche	Public Governor
Paru Jeram	Staff Governor
Liz Searle	Caldicott Guardian
Sebastian Kraemar	Public Governor
Alisha Nurse	Communications Manager
Fran	Member of the Public
Apologies for absence:	
Shalini Sequeira	Non-Executive Director, Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee
Sheila Murphy	Interim Director of Corporate Governance
Jenny Goodridge	Interim Chief Nursing Officer

	Governance Matters
1.	**Chair's welcome, apologies and confirmation of a quorum**
	JL welcomed attendees to the Board meeting held in public. Apologies were received from Shalini Sequeira, Sheila Murphy and Jenny Goodridge. Following introductions, JL confirmed that the meeting was quorate.
2.	**Declarations of Interest**
	There were no declarations of interest that related to the business discussed at the meeting.
3.	**Patient/Service User Story**
	SR and NB presented the Patient/Service User Story providing information on the collaborative partnership between the Trust and Supervisors in providing systemic psychotherapy training (M6). The Board noted that 96 applicants had applied for 26 places, which had now increased to 36 places. It was also noted that on completion of the training most of the trainees would be eligible to register with the United Kingdom Council for Psychotherapy (UKCP). Trainees BS and SE who attended the meeting, shared their experience of the training programme. The feedback included: • The training provided a unique experience. It was of particular benefit to those from diverse backgrounds or for anyone who had challenges securing training. • A trainee gained experience of providing therapy to children and families. • The clinical supervision was enjoyable and they felt supported and the trainees worked in supervision groups.

	• It was a diverse team. • Families engaged well in the work with us and appreciated the work done. • As a result of feedback about the rooms, we added different items to the clinical rooms to make it look more welcoming. JL on behalf of the Board congratulated all the trainees and supervisors for their excellent work.
4.	**Minutes of the last meeting held on 14 June 2023**
	The minutes of the Board meeting (held in public) on 14 June 2023, were agreed as an accurate record of the meeting.
5.	**Matters arising and action log**
	The Board received and noted the updates to the Action Log. The information was taken as presented, subject to the inclusion of an additional action item from the Board meeting on 14 June 202 **Action point: JL advised that at the last Board meeting an action point to be included was the need for Non-Executive Directors to be assisted in accessing mandatory training.**
6.	**Chair's Update**
	JL provided the Board with the following updates: JL welcomed new starters to the meeting - Clare Scott, Chief Nursing Officer; Rod Booth, Director of Strategy, Transformation and Business Development and Reni Aina, Interim Corporate Governance Officer. The Board noted that Chris Abbott, the new Chief Medical Officer will be starting at the Trust very soon. The Board noted the following updates: • Jenny Goodridge, Interim Chief Nursing Officer; Caroline McKenna, Interim Chief Medical Officer and Sheila Murphy, Interim Director of Corporate Governance are leaving the Trust having completed their interim contracts. On behalf of the Board, JL expressed his thanks for their contribution during this transitional period. • Adewale Kadiri, the newly appointed Director of Corporate Governance will start on 7 August 2023.

	• On 5 July 2023, the Trust marked the 75th Anniversary of the NHS with a coffee morning. One of the highlights of that event was hearing from Isca Wittenberg, aged 100, who shared her experience of working in the NHS. • On 13 July 2023, the Staff at the Trust organised a summer event, which was attended by almost 200 people. • On 19 July 2023, JL and KE, Lead Governor attended a team meeting of the Looked After Children Team and Refugee team. • JL met with Peter Molyneux, Chair Barnet, Enfield and Haringey and Camden and Islington Mental Health Trusts to discuss the joint working on the mental health agenda. • JL advised that a meeting is planned in the coming weeks with him, MH and Peter Molyneux and Jinjer Kandola, CEO of Barnet Enfield and Haringey Mental Health Trust and Camden and Islington Trust.
7.	**Chief Executive's Report**
	MH, the Chief Executive Officer introduced the report which covered the period since the last Board meeting on 14 June 2023. The report was taken as read and points highlighted included: • The Gender Identity Development Service (GIDS) waiting list had transferred from the Trust to NHS Arden and GEM Commissioning Support Unit (CSU). • The appointment of the Chief Education and Training Officer had not been filled and the recruitment process will be starting again this Autumn. • The British Medical Association (BMA) announced further strike dates on 24 and 25 August 2023. The Board noted that the Trust is monitoring the impact that industrial action has on services. • The new oversight improvement plan will cover Finance, Service Performance, Care Quality, Leadership and Governance. • The NHS Long Term Workforce Plan has been published. Following discussions, it was further noted that in the short-to medium term, the Trust will be focusing on the current workforce challenges.
CORPORATE REPORTING	
8.	**Integrated Quality and Performance Report**
	SH, Chief Clinical Operations Officer introduced the report which had been discussed at the Performance, Finance and Resources Committee on 25 July 2023. The report was taken as read and points highlighted included:

	• The focus is on how to flow data more effectively across the Trust. Currently data is being flowed at a service line level. • The data demonstrates that there are improvements in activity, mandatory training and job planning compliance, but there are areas that continue to be a challenge and activity is still less than expected. • The Board noted that there were areas where compliance needs to improve, such as on the recording of supervision and outcomes. JL congratulated SH for providing a detailed report and suggested that the next report should be shorter so that the Board could focus on strategic risks.
DELIVER HIGH QUALITY CLINICAL SERVICES	
9.	**Quality Committee Chair's Assurance Report**
	CJ introduced the Quality Committee Chair's Assurance Report. The Board noted the key decisions and assurances provided at the Quality Committee meeting held on 6 July 2023. The report was taken as read points highlighted included: • The approval of the Clinical Audit Annual Programme 2023/24. • The Care Quality Commission (CQC) conducted a review of the Trust's approach and programmes to address Equality, Diversity and Inclusion. The CQC findings did not highlight anything unexpected. • Following the CQC review, the People Organisational Development & Equality, Diversity & Inclusion (POD EDI) Committee agreed to provide oversight for the work plan. • The Trust is still managing a backlog of complaints. • The validation process for case notes had been completed and a lessons learnt paper will be presented to the Quality Committee. • The Patient Safety Incident Response Framework (PSIRF) had made steady progress. The Board also noted that the new patient safety programme was in phase 2 (diagnostics and discovery) and phase 3 is to be explored.
10.	**Guardian of Safer Working Report**
	CMcK introduced the Guardian of Safer Working Report for Q1 period 2023/24. The report was taken as read and points highlighted included:

	The rate of exception reporting remained low. There had been two cases reported, both concerned login issues with the Doctors' Rostering System (DRS). The Trust will monitor the impact that the junior doctor strikes has on services.
DEVELOP & DELIVER A STRATEGY & FINANCIAL PLAN	
11.	**Performance, Finance & Resources Committee Chair's Assurance Report**
	The Performance, Finance & Resources Committee meeting was held on 25 July 2023. The Board received a verbal update and assurances. AM advised that: • Good progress has been made on job plans which now need to be embedded into clinical work. This will work towards delivery on contracts. • The cost improvement plans had provided more clarity and transparency. • The Trust now has budgets at Divisional level. • This month the Trust was over budget because of extra agency costs associated with GIDS. • IT projects were going well, and the Trust is now cyber-accredited. • The Electronic Staff Record (ESR) has been aligned to collect workforce data.
12.	**Finance Report – Month 3**
	PON introduced the Finance Report for Month 03, setting out the cumulative position to June 2023. The report was taken as read and points highlighted included: • Income & Expenditure. • Capital Expenditure. • The Cash Balance. The Board noted that excess agency costs associated with GIDS and one-off premises costs had an impact on the deficit in month 03. PON advised that forecasting for month 4 should result in the deficit being back on plan.

	It was noted that maintenance work on the Tavistock building is progressing. PON advised that capital funding for further work is limited.
Great & Safe Place to Work, Train & Learn	
13.	**People, Organisational Development, Equality, Diversity & inclusion Committee Chair's Assurance Report**
	GD introduced the People, Organisational Development, Equality, Diversity and Inclusion Committee (POD EDI Committee) Chair's Assurance report. The Board noted the key discussions and assurances provided at the meeting held on 6 July 2023. The points highlighted included: • Improvements had been seen in language, payroll, recruitment functions and the introduction of new processes and interventions. • GD reported that there were no errors in payroll last month. There had been a report of a network issue with one bank, however it had been resolved and all services were back to normal. • The Freedom to Speak Up Guardian will be attending the next POD EDI Committee. • The EDI, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) considerations were discussed. • The Associate Director of EDI on the WRES and WDES gave a presentation at the recent Board development seminar. **Action Point: The Board agreed that the Freedom to Speak up Guardian (FTSUG) should be invited to next year's Board meetings on two occasions to provide a six-month update.**
14.	**Education & Training Committee Chair's Assurance Report**
	The Education & Training Committee meeting was held on 20 July 2023. The Board received a verbal update and assurances. SJ and ERS highlighted the following points: • The survey indicated that there had been an increase in the overall level of student satisfaction. • Levels of staffing have improved in the department • Three different sources of data were used to decide which courses to expand.

	• The Workforce Innovation Unit advised that the budget needed to be linked to the workforce plans. • The report on marketing will be referred to the Board for discussion. • Professor Edward Harcourt the new Chair of the Tavistock and Portman Charity is to be invited to a future meeting to discuss bursaries for students. • Nominations for Honorary Doctorates to be discussed in part 1 of the Board of Directors. **Action Point: Nominations for Honorary Doctorates will be added to the forward planner to be considered at the next Board of Directors (part 1) meeting.** **Action Point: Chair of the Tavistock and Portman Charity to be invited to a future meeting to discuss bursaries for students**
15.	**Executive Appointment and Remuneration Committee Chairs's Assurance Report**
	GD introduced the report. The Board noted the key decisions and assurances provided at the Executive Appointment and Remuneration Committee meeting held on 8 June 2023. The highlights included: • The Committee had approved the starting salaries for new posts. • An annual Fit and Proper Person Test audit has been included in the Committee's Forward Planner for 2023/24. • The Committee approved the Chair's remuneration report statement for the 2022/23 Annual Report.
16.	**Gender Pay Gap Report**
	GD introduced the report which had been discussed at the POD EDI Committee on 6 July 2023. The Annual EDI Gender Pay Gap report was taken as read and the highlights included: • The Board approved the proposals to address the gender pay gap. • The pay gap for this year had shrunk by 3.02%, the Board noted that the national gap is 14.7%. • The Trust had completely eradicated the average bonus pay gap by sharing out the money available under the Clinical Excellence Awards scheme to all those eligible. • We are looking at fairer ways of recruiting and career progression

	under the Establishment Control Process (ECP) to ensure improvements are sustainable. **Action Point: A further report on the Gender Pay Gap will be considered by the Board later in the year.**
17.	**Equality, Diversity and Inclusion Annual Report 2022/23 (including the Department of Education & Training).**
	GD introduced the Equality, Diversity and Inclusion Annual Annual report which was taken as read. This report has been discussed at other forums in the Trust. GD advised that there had continued to be challenges and we were looking at fairer and more transparent career progression. Work was also underway around the Bullying and Harassment Policy. The Board noted the outcomes, the areas of progression and areas of work that needed further improvement. It was suggested that Non-Executive Directors are mentored by EDI representatives through the reciprocal mentoring programme. Following discussion, the Board approved the proposals and Action Plan set out in the report.
18.	**Freedom to Speak Up Guardian Report**
	The Freedom to Speak up Guardian (FTSUG) report was introduced by SS. The Board received and noted the contents of the Annual report. The Board considered the following recommendations: • To communicate clearly to all staff on the strategy and rationale behind mandatory leadership and management training for the whole Trust, including information and timescales for implementation of training for the most senior trust leaders. • Introduction of a reporting framework that allows for confidential and anonymous reporting of speaking up matters. • Closer and more transparent monitoring of formal investigations. • Internal review and action plans in relation to career progression opportunities. Following discussion, the Board supported the recommendations and noted that additional resources had been provided for an additional Freedom to Speak up Guardian. The Board noted that the FTSU arrangements will be discussed at the People, Organisational Development, Equality, Diversity and Inclusion (POD EDI) meeting on 7 September 2023.

	Action Point: The Board agreed that steps should be taken to promote awareness of the Freedom to Speak up Guardian to improve the FTSUG's visibility.
	Closing Items
19.	**Board Forward Planner**
	The Board received and noted the contents of the Forward Planner.
20.	**Questions from the Governors**
	KE noted that the FTSU arrangements will be discussed at the next meeting of the People, Organisational Development, Equality, Diversity and Inclusion (POD EDI) Committee and asked if this could also be discussed at the next meeting of the Council of Governors. **Action Point: The Board agreed that a report on the FTSU arrangements should be included at the next meeting of the Council of Governors.** KN asked about improving engagement with the Governors especially since the Governors no longer attend the Part 1 Board meetings. **Action Point: JL confirmed that Part 1 Board meetings should be held in private and that this is the case in most other Trusts. JL advised that this would be discussed at the next Council of Governors' meeting.** Paru Jeram noted that Professor Andrew Cooper who had worked for the Trust for many years had died recently. ERS confirmed that the Trust are planning to commemorate the work and achievements of Professor Cooper.
21.	**Any other business**
	Draft Annual Report and Accounts • An Extra-Ordinary Board of Directors meeting was held to approve the Annual Report and Accounts for 2022/23. Some issues over the statements made by Mazars were noted. The Well-Led Governance Review and the deadline for signing off the Annual Report and Accounts for 2022/23 were classified as having 'significant weakness'. This statement was challenged as we believe we have made improvements in these areas. Mazars advised that they are constrained by the wording they have to use in the report, but an alternative form of words has been agreed. In addition PON advised that: • There are still some audit queries from Mazars that are being addressed. This meant that the deadline to prepare the Annual Report and Accounts by 30 June 2023 had been missed.

	• This continued work on the Annual Report and Accounts has put pressures on the Finance Team. • The Integrated Governance Action Plan (IGAP) was progressing well; the intention is to complete this by the end of the year. • The tendering deadline to appoint new external Auditors has passed and no Auditors have come forward. NHS England will be approached for advice on how to proceed, then the Council of Governors will be involved in the appointment of new Auditors. • The Audit Committee approved and certified the Trust's NHS Provider Licence. There was no further other business.
22.	**Reflections and feedback from the meeting**
	On behalf of the Board, JL thanked all contributors and presenters. JL expressed the view that, overall, the time management for the meeting had been good. The Board noted that there will be an opportunity for further reflections and feedback on Board meetings once Adewale Kadiri, the new Director of Corporate Governance is in post.
23.	**Questions from the Public**
	There were no questions from the public.
24.	**Date And Time of Next Meetings**
	• Wednesday 13 September 2023 at 10am to 4pm Board Seminar • Wednesday 11 October 2023 at 10am to 12 noon: Board Development Session. • Wednesday 11 October 2023 at 2pm – to 4.30pm: Board Meeting in public. • Wednesday 15 November 2023 at 10am to 4pm Board Seminar • Wednesday 13 December 2023 at 10am to 12 noon: Board Development Session. • Wednesday 13 December 2023 at 2pm – to 4.30pm: Board Meeting in public.

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

				Actions are RAG rated as follows: ->	Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Action Ref.	**Meeting Date**	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
6.23	14..6.23	13	People, Organisational Development, Equality, Diversity & inclusion Committee Chair's Assurance Report	Future Directors Sessions with staff have now come to a close. Helpful feedback has been received from staff and a report on this will be produced. Communications with staff will be discussed with the Board.	27.7.23	Jane Meggitt, Interim Director of Communication and Marketing	To Close - propose for closure	A paper on Future Directors was discussed at the People Organisational Development, Equality, Diversity and Includion Committee on 7th September 2023
8.23	14.6.23	15	Audit Committee Chair's Assurance Report	Single Tender Waivers to be reported on at a future Board meeting.	11.10.23	Peter O'Neill, Financial Advisor	To Close - propose for closure	Single Tender Waiver review completed, with updated SFIs agreed.
9.23	14.6.23	15	Audit Committee Chair's Assurance Report	Discussion to be held with our Internal Auditors about progress on the Action Plan.	October	Peter O'Neill, Financial Advisor	To Close - propose for closure	CFO Met with Auditors on 3 October 2023. Agreed to review outstanding actions and take progress to November Audit Committee. ELT will receive montly progress reports.
10.23	14.6.23	16	Annual Self-Assessment of Committees' Effectiveness and Committee Annual Reports	Terms of Reference for Committees will be reviewed following this report.	1.9.23	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	All Committee Terms of Reference have been reviewed by relevant Committee.
11.23	27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	TBC	Adewale Kadiri, Director of Corporate Governance	Not yet due - Action still in date	Action still in date.
12.23	27.7.23	13	POD EDI Committee Chair's Assurance Report	The Board agreed that the Freedom to Speak up Guardian (FTSUG) should be invited to next year's Board meeting to provide a six-month update.	TBC 2024	Amanda Hawke (AH) Corporate Governance Manager	To close - propose for closure	Freedom to Speak Up Guardian 6 month review has been added to forward planner.
13.23	27.7.23	14	ETC Chair's Assurance Report	Nominations for Honorary Doctorates will be added to forward planner to be considered at the next Board of Directors (part 1) meeting.	11.10.23	Isabelle Bratte (IB)	To Close - propose for closure	On agenda for October Board, Part 1
14.23	27.7.23	14	ETC Chair's Assurance Report	Chair of the Tavistock and Portman Charity to be invited to a future meeting to discuss bursaries for students	13.12.23	Isabelle Bratte (IB)	Not yet due - Action still in date	to be added to the agenda for December Meeting
15.23	27.7.23	16	Gender Pay Gap Report	A further report on the Gender Pay Gap will be considered by the Board later in the year.	13.12.23	Gem Davies (GD) Chief People Officer	Not yet due - Action still in date	Action still in date.
16.23	27.7.23	18	The Freedom to Speak up Guardian (FTSUG) report	The Board agreed that steps should be taken to promote awareness of the Freedom to Speak up Guardian to improve the FTSUG's visibility.	September	Jane Meggitt (JM) Director Comms & Marketing	To Close - propose for closure	Working with FTSUG to design new materials to be displayed in the Trust
17.23	27.7.23	20	Questions from Governors	A report on the FTSU regime should be included at the next meeting of the Council of Governors	14.9.23	Amanda Hawke (AH) Corporate Governance Manager	To Close - propose for closure	Discussed at Council of Governors Meeting on 14 September 2023

Action Ref.	Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Action Due date	Action owner (Name and Job Title)	Status (pick from drop-down list)	Progress Note / Comments (to include the date of the meeting the action was closed)
18.23	27.7.23	20	Questions from Governors	Governors no longer attend BOD Part 1. Discussion on further engagement will be had at the next CoG meeting	14.9.23	JL(Chair), MH(CEO), Adewale Kadiri (AK) Director of Corporate Governance	To Close - propose for closure	Additional monthly meetings for Governors with the Chair have been scheduled and invites sent to all Governors.

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MEETING OF THE BOARD OF DIRECTORS PART II – PUBLIC – Wednesday, 11 October 2023			
Report Title: Chief Executive's Report			**Agenda No.: 07**
Report Author and Job Title:	Michael Holland, Chief Executive Officer	**Lead Executive Director:**	Michael Holland, Chief Executive Officer
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.		
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.		
Assessment:	This report covers the period since the meeting on 27 July 2023.		
Key recommendation(s):	The Board of Directors is asked to receive this report as **ASSURANCE** and progress update against leadership responsibilities within the CEO portfolio.		
Implications:			
Strategic Objectives:			
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☒ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☒ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☒ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.
Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All BAF Risks.				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no specific legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are resource implications associated with this report.				
	Yes ☒	No ☐			

Equality, Diversity and Inclusion (EDI) implications:	There are equality, diversity and inclusion implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	This is a regular report that is produced for every Board meeting			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Chief Executive's Report – 11 October 2023 Public Board

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

2. Senior management changes

All the newly appointed members of the Executive Team have now taken up their roles. The most recent additions are Chris Abbott, Chief Medical Director, who joins from South London and the Maudsley NHS Foundation Trust, and Ade Kadiri, Director of Corporate Governance, who was previously at the Royal United Hospitals Bath NHS Foundation Trust. As previously advised, the job description for the Chief Education and Training Officer role is being reviewed with a view to recommencing the recruitment process shortly.

3. 90th Anniversary of the Portman Clinic

The week of 18 September marked the 90th anniversary of the Portman Clinic seeing its first patient. During the week, I was pleased to visit the clinic with a birthday card and cake, and attend a presentation given by the Forensic CAMHS team. It was fascinating to hear how the Portman continues to be a pioneer in supporting people that some in society might not think deserving of help, working across the system with other health and social care partners to try to understand what might really be going on.

4. NHS Staff Survey 2022 and 2023

The Chief People Officer is in the process of consolidating the actions arising from the 2022 staff survey with the Inclusivity Action Plan, the CQC recommendations, the People Promise, and NHS England's High Impact actions for Equality, Diversity and Inclusion so that we have an overall stocktake of the actions we have planned and achieved in response to feedback on staff experience and culture within the trust.

We have also been communicating the positive actions that we have already taken in response to what staff told us last year, ahead of the next Staff Survey which launched on 2 October 2023. We are encouraging all staff to complete the survey to ensure that everyone's voice is heard.

Feedback on the 2023 survey will likely not be received by the organisation until January 2024.

5. Engagement on Vision, Mission, and Values

Throughout the summer, the People Team along with colleagues from the Communications team have held over 30 sessions with groups of staff, patients, service users and students to help in reshaping our vision, mission and values. We want to ensure our actions and decisions are guided by the common goals and behaviours that we have collectively chosen

as a Trust. The sessions held so far have been positive and participants have been energised by the discussions.

The Board seminar received an update on the emerging messages, and final recommendation will be brought to the meeting in November.

6. Industrial Action Update

In my last report I had indicated that the British Medical Association (BMA) announced a period of continuous strike action for consultants on 20 and 21 July and that further provisional strike dates had been announced for 24 and 25 August for its consultant members.

Since then, the BMA announced that hospital consultants would take part in strike action from 7am on Tuesday 19 September to 7am on Thursday 21 September, and junior doctors would strike from 7am on Wednesday 20 September to 7am on Saturday 23 September.

Both these strikes occurred, and further strikes were subsequently held by consultants and junior doctors from Monday 2 October to Thursday 5 October.

We support the right of any of our staff to take strike action and we will ensure our services are safe during this period.

7. Regulation and Effective Governance

The Care Quality Commission (CQC) carried out a planned inspection of the Gender Identity Development Service (GIDS) on 6 and 7 September. The focus of the visit was on assessing progress against the action plan following their previous inspection in January 2021. The inspection team spoke to a cross section of staff in the service as well as a number of service users. We expect to receive feedback from the team soon, and a formal report during the course of this month.

Preparation for a Trust-wide inspection against the CQC's Well Led domain is continuing. This is being led by the Chief Nursing Officer, and an experienced consultant has been recruited to provide expert support in this area. A virtual Trust wide event titled 'CQC Demystified' was held on the 2 October, with presentations from teams who have been inspected in recent months. The focus was on sharing learning from inspections, and hearing the various team approaches to embedding improvements.

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

The final accounts and external audit process was completed at the end of August, with a reported deficit of £3,418k. This was a slight improvement of £124k against the draft position previously reported, reflecting agreed adjustments as part of the outcome of the audit process.

The reported financial position at the 31 August (reporting month 5) was a deficit of £1,433k. This represents an adverse variance of £60k to plan for the period. This reduction in the adverse variance reflects the expected stabilisation of the position after the impact of some one-off non-pay costs in earlier months. Within this reported position, the expenditure on

agency staff remains an area of concern, with measures being taken to limit this spend to the year end.

The reconciliation between the base budgets and the Electronic Staff Record (ESR) continues, with input from the service leads being a key part of the work. This will then form a key component in enabling financial accountability at service line/team level and provide a further level of detail to the summary reports provided in the Integrated Quality Performance Reports.

The Medium-Term Financial Plan work has progressed, in line with the ICS-led process. The finance team continue to work with ICS colleagues to finesse the assumptions underlying the modelling work, including the impact of the loss of GIDS, FDAC and NWSDU income, plus any new income relating to service expansion or new commercial opportunities being pursued by the Trust. It is anticipated that this work will be accelerated in the coming weeks as part of the merger work being led by KPMG, with adjustments from updated ICS assumptions being reflected as the external process develops.

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9. Education and Training

I would like to congratulate the Department of Education and Training on hitting and surpassing the 1,000 applicant mark for our postgraduate courses, with 1,089 prospective students having now completed applications. This is a fantastic achievement in a difficult economic climate and demonstrates the value of our range of innovative courses. We held our Welcome Week for new and returning students during the week of 18 September the students have now started their courses. There will be further discussion of the work of DET when the Education and Training Committee Assurance Report is discussed later in the meeting.

National and Political Context

10. NHS England Letter re verdict in the trial of Lucy Letby

NHS England wrote to all NHS Trusts and Integrated Care Boards in response to the verdict in the trial of Lucy Letby. The letter set out steps that NHSE have taken and continue to take towards strengthening patient safety monitoring, including the national role out of medical examiners, the implementation of the Patient Safety Incident Response Framework and the strengthened Freedom to Speak Up policy.

They have acknowledged that that alone is not enough, and that good governance is essential, encouraging leaders and boards of individual organisations to ensure proper implementation and oversight. A paper has been drafted for discussion at this meeting on the steps that this Trust has taken or will be taking to ensure that we are able to learn and apply the lessons from this tragic case.

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Integrated Quality and Performance Report			**Agenda No.: 008**
Report Author and Job Title:	Amy LeGood, Commercial AD	**Lead Executive Director:**	Sally Hodges COO and Peter ONeill, CFO
Appendices:	Appendix 1: Trust-wide Integrated Quality & Performance Report October 2023		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	All four clinical service lines and DET review their local performance data on a monthly basis, in order to identify issues and trends, successes and challenges. This enables the service lines to direct focus to the most pressing areas and to develop recovery plans where needed. This report is an amalgamation of all the local IQPRs that have taken place across the Trust in September, with DET and quality data added. The report has been reviewed by the Performance, Finance and Resources committee. This committee made the following observations: • The report is going in the right direction, with better detail and thus it allows NEDS to triangulate data. • The report is still too fragmented and data heavy without enough direction for NEDS to know where to focus. We agreed to organise a seminar for the committee to work through together where the focus should be. • The plan on a page for the key strategic areas will also help, this will be visible in the reports in the next couple of months. The focus will be on waiting times. • Although waiting times are the key concern, a number of metrics, particularly in the GIC report raised questions for the committee and it was agreed that these would be shared with the board. • It was also agreed that a brief report on GIC issues with a summary on what actions we are taking will be brought back to the next PFRC. • The fire at our Bounds Green site and the Care Notes outage report raised questions about how well embedded our Business Continuity Plans are. Clare Scott, CNO reported that there is a training on this being rolled out. The committee asked for an update in 6 months post this training. • The contracts update highlighted significant risks to about 14 million of our income in 24-25. This will be escalated to board, and with the development of the IQR better link between contracts, activity and workforce. • Job Planning continues to be a challenge, and it was recognised that this is required for clarity on capacity across our services		

Background:	The Trust is moving towards a functional Trust wide IQP, however this is reliant on a number of data systems being able to flow data effectively. This work is being overseen by a project board. In the mean time the Trust is working at pace with KPMG to develop a plan on a page, that will focus on the key strategic areas, primarily waiting times.
Assessment:	See section on situation above
Key recommendation(s):	The board is asked to note the contents of this report

Implications:

Strategic Objectives: (tick)

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

Relevant CQC Domain: (tick)	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒

Link to the Risk Register: (tick)	BAF ☒	CRR ☐	ORR ☐
	Risk Ref and Title: 1. Delays to treatment, long waitlists/ Demand 2. Maturity of Data to support Transformation 10. sustainable income streams		

Legal and Regulatory Implications: (tick)	Yes ☐	No ☒
	There are no legal and/ or regulatory implications associated with this report.	
Resource Implications: (tick)	Yes ☐	No ☒
	There are no resource implications associated with this report.	
Equality, Diversity and Inclusion (EDI) implications: (tick)	Yes ☒	No ☐
	The report should enable the trust to identify inequalities in patient care as it becomes more refined	
Freedom of Information (FOI) status: (tick)	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:

Assurance Route - Previously Considered by:	Performance Finance and Resources committee 26th September 2023

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

Innovation in mind

NHS
The Tavistock and Portman
NHS Foundation Trust

Trust-wide Integrated Quality and Performance Report

October 2023

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1. DET Overview

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DET Successes

1074 prospective students have completed applications to our Postgraduate Courses surpassing the 1000 target

Current review of HESA Quality Rules have met "engaged with" and "action undertaken"

Full engagement with IQPR project and development with the SITS platform

42% increase in international student recruitment

D12, D4, D58 courses have all had significant rise in applications between 14 and 25%

Relaunch of the D59F Forensic training and the incorporation of the Executive Coaching Programme from Tavistock Consulting

DET Challenges

- Delays to the nomenclature changes in SITS (part of the IQPR project)
- Delayed start to the financial viability review of all courses
- Increased reporting and analysis without additional resources continues to be a challenge
- Delays to final HEE/NHSE contract signing due to the commissioning merger
- Student survey recommendations to be actioned and implemented

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The Tavistock and Portman NHS Foundation Trust

DET Improvement Programme

Date: 31/03/2023	Status	Delivery Lead
SETTING OUR FOUNDATIONS		
Assessment Boards	In flight	Lisa Harris
Student Admissions	In flight	Mike Whitcombe
Student Disability Support	In flight	Rebecca Bouckley
Trainee Clinical Governance	Scheduled	Isabelle Bratt
Extenuating Circumstances	To be scheduled	AQ Lead (vacant)
Intermission and Withdrawal	To be scheduled	Lisa Harris
SOP reviews and workflows - by each prof service team	To be scheduled	Heads of services
Growth targets/fee setting over 3 years, following course viability work	Behind schedule	Training Exec
SYSTEMS DEVELOPMENTS		
PowerBI student data phase 2	In flight	Will Fitzmaurice
SITS readiness for HESA Data Futures	In flight	Lisa Harris
Customer Relationship Management tool (CRM)	Requires approval	Rosalind Wright
Student Enquiry Management System	Requires approval	Will Fitzmaurice
SITS portfolio mapping and curriculum building	Requires approval	Lisa Harris
Moodle SITS integration	Scheduled	Matt Lingard
BAU PERFORMANCE REPORTING		
KPI setting for DET Prof Services teams	Scheduled	Will Fitzmaurice
Faculty KPIs and reporting (IQPR)	Requires approval	Elisa RS Paul D
Integration of Prof Services reporting into Trust IQPR	Requires approval	Will Fitzmaurice
Reporting financial performance against budgets - at service level (IQPR)	Requires approval	Heads of Service
STUDENT VOICE AND ENGAGEMENT PLAN		
Confirm governance arrangements for student voice	Scheduled	Will Fitzmaurice
Annual Student Survey - revise plan	In flight	Isabelle Bratt
Student voice plan for regular feedback loops throughout academic year	In flight	Isabelle Bratt
OPERATIONAL ENABLERS		
Budgets for 2023/24	In flight	
Course Financial Viability Review	Behind schedule	
Visiting Lecturer Framework - to include fee rates	To be scheduled	
Educational Governance Review	In flight	
Bursaries Review	To be scheduled	

Innovation in mind

Long Courses HEE 23/24 Q1 overview

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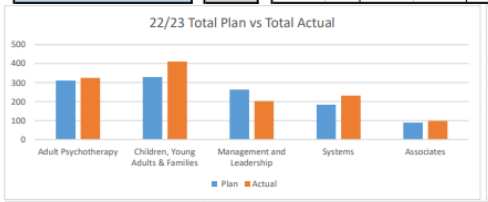
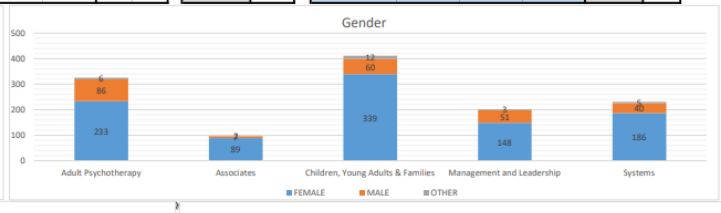
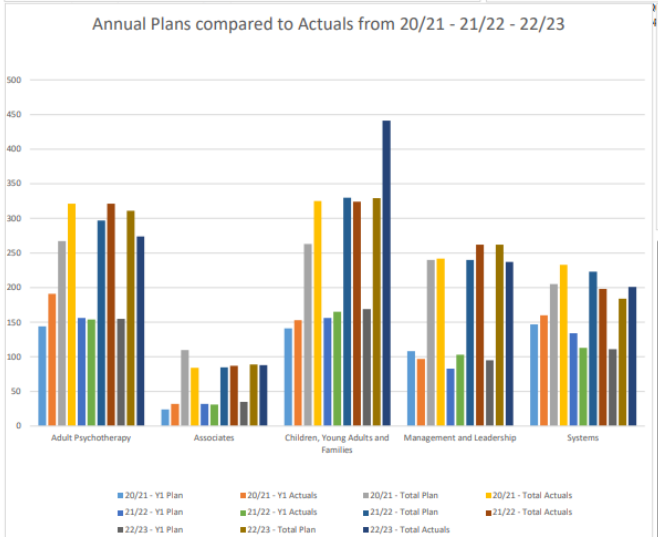
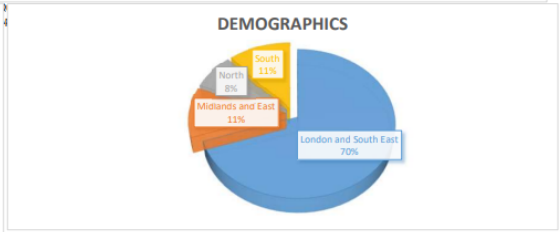
LONG COURSES

BRANCH	PLAN 2023/24	ACTIVITY (AY) 2022/23 Plan Year 1	2022/23 Plan Total	Actual Year 1	Actual Total	Variance Year 1	Variance Total	Variance (%) Year 1	Variance (%) Total	Intermitting Students	%	DEMOGRAPHICS (Actual) REGION London and South East	South	Midlands and East	North	Attrition	%
Adult Psychotherapy	286	155	311	163	325	8	14	105%	105%	16	5%	250	16	18	41	16	5%
Children, Young Adults and Families	342	169	329	190	411	21	82	112%	125%	39	9%	308	62	41	0	39	9%
Management and Leadership	253	95	262	68	202	(27)	(60)	72%	77%	8	4%	141	17	27	17	8	4%
Systems	217	111	184	150	231	39	47	135%	126%	11	5%	177	22	29	3	11	5%
Associates	88	35	89	29	98	(6)	9	83%	110%	6	6%	9	27	24	38	6	6%
Grand Total	**1186**	**565**	**1,175**	**600**	**1,267**	**35**	**92**	**106%**	**108%**	**80**	**6%**	**885**	**144**	**139**	**99**	**80**	**6%**









Q1 Narrative:

We are now coming to the end of the 22/23 academic year. The picture at the end of the year is that enrolments are above the planned numbers, with a 6% uplift for planned Yr1 students and 8% uplift overall. Areas that have performed particularly well have been Adult Psychotherapy (5% above planned Yr1 and overall), Children, Young Adults and Families (12% above planned for Yr1 and 25% above planned overall), and Systems (35% above planned for Yr1 and 26% above planned overall). Management and Leadership and Associates were both below the planned Yr1 numbers, but in total this was compensated for by the other areas exceeding their targets.

We had 80 students (6%) intermitting at the time of gathering the data.

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The Tavistock and Portman NHS Foundation Trust

HEE Short Courses 23/24 Q1 overview

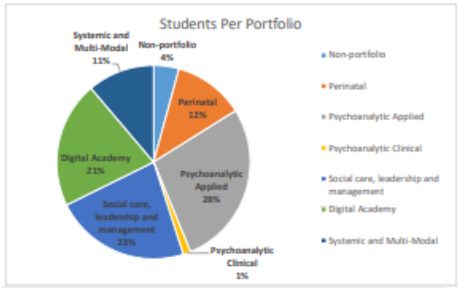
The 23-24 financial year will show, for the first time, combined student data from all of our short courses, both live and through the Digital Academy. We have trained 750 students in this quarter through our CPD, DA and bespoke courses. This number is slightly down, from 842, on the annual workplan for this period, although this can predominantly be explained by a change to delivery dates for a specific piece of bespoke training that we are running for Wolverhampton City Council on 'Working with Teenagers'. This will now be delivered later in the year, and the figures will therefore be represented in a later quarter (under the Social Care portfolio).

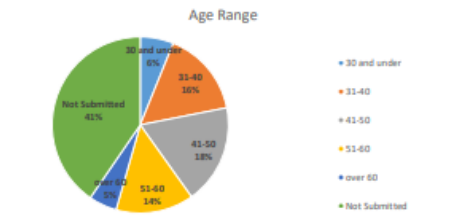
We are also showing slightly reduced numbers of students on our Digital Academy courses. The Q1 forecast is based on a quarter of the overall numbers of DA students expected over the year. We have fallen slightly short of this in this quarter, but anticipate an upturn in booking numbers later in the year. We currently have 3 new Digital Academy courses being developed, ready for launch in the autumn, and would therefore expect to see a substantial increase in DA student numbers being reported in Q3 and Q4. In this first quarter, we have maintained our geographical spread of students, with 69% coming from outside of the London area.

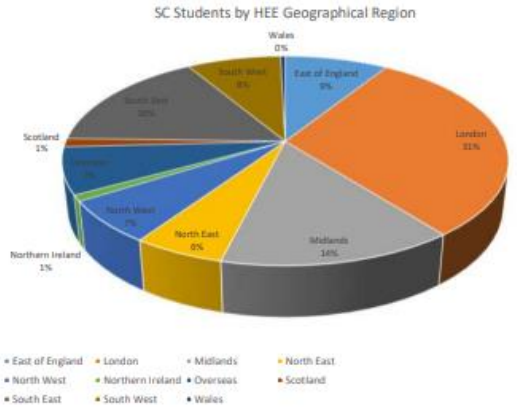
SHORT COURSES

QUARTER 1

PORTFOLIO	ANNUAL PLANs 2021/22	ANNUAL PLANs 2022/23	PLAN 2023/24	ACTIVITY (Q1) Q1 Plan	ACTIVITY (Q1) Q1 Actual	ACTIVITY (Q1) Variance
Perinatal	253	149	300	100	89	-11
Psychoanalytic Applied	924	559	530	157	207	50
Psychoanalytic Clinical(inc. Forensic)	88	36	33	10	10	0
Psychological Therapies	82	96	-	-	-	0
Social Care, Management and Leadership	580	1,111	693	220	170	-50
Systemic	289	141	299	95	84	-11
Non-Portfolio	452	550	842	36	32	-4
Digital Academy			896	224	158	-66
Grand Total	**2,668**	**2,642**	**3,593**	**842**	**750**	**-92**







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2. Clinical Overview

Successes, Challenges, Next Steps and Action Plans

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Clinical Successes

Safe 	Community and Integrated	• Clinical notes compliance has increased significantly in the PCPCS team following support from the operational teams, from 68% at the start of the year to 86%. In July 2023, Gloucester House Outreach and MHST teams reached 100% compliance.
	Complex Mental Health	• Following discussions with our commissioners, highlighting concerns, the Autism & LD Team have secured additional recurrent and some non-recurrent funds for service improvements and waiting list reduction. Programme delivery has started.
	GIDS	• All open case patients have been assessed and RAG rated with level of risk identified. Plans have been implemented for all "red" (high risk levels) patients.
	GIC	• Additional IG training undertaken across the GIC administrative team and an action plan and audit cycle has been implemented.
Effective 	Community and Integrated	• Camden Integrated Front door successfully launched at the end of July 2023, a complex collaborative piece of work with several partner organisations.
	Complex Mental Health	• An IQPR structure has been implemented at team level with the pilot being within the Child Complex Teams. There has been positive response from the teams to date and roll-out to the wider service line will begin before the end of the financial year. • Following successful recruitment campaign, the EDAS team is now fully staffed for the first time and this has had a significant positive impact on the waiting times.
	GIDS	• 97% of the 17+ waiting list have been transferred to adult GICs
	GIC	• Completion of clinician led PTL training sessions. • Full PTLs started in July 2023 and there has already been a positive impact on the number of dormant cases.

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Clinical Successes continued

Caring 	Community and Integrated	• There was a rapid and robust supportive response to patients and staff following the fire at Bounds Green, ensuring that staff and patients well-being was addressed first and foremost. The internal serious incident policy was enacted and followed through.
	Complex Mental Health	• Patient ESQ feedback consistently features positive references to care, listening and help.
	GIDS	• Using the PTL mechanism, all young people on the open caseload have been track and assurance has been provided on all care plans.
	GIC	• Implemented a successful cover rota for the clinical teams to reduce the number of cancellations by trust.
Responsive 	Community and Integrated	• Waiting times have significantly improved following the implementation of the PTLs.
	Complex Mental Health	• D59 Forensic course reinstated with 7 students offered and accepted onto the course, securing the provision within the Portman Clinic
	GIDS	• Coherent and rapid response to the CQC visits review of actions undertaken
	GIC	• Following the recovery of carenotes and the historical letter backlog, robust systems and process have been put in place to ensure a responsive service to our patients.

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Clinical Successes continued

Well-led 	Community and Integrated	• Monthly all staff drops-in sessions are now fully embedded. The feedback has been positive with an engaging group that has allowed positive changes to be made across our clinical and operational teams which included changing the language we use and the way we gather feedback around non-compliance with job plans.
	Complex Mental Health	• Improved recruitment process to reduce impact of vacancies on teams and waiting patients. • Implemented regular feedback loops and updates to teams and service leads on trustwide developments, SOF3 and organisational risks. • Undertook joint PPI project to bring in Lived experience advisors for ASC awareness raising work.
	GIDS	• Patient Tracking List meetings now fully operational and improvement rates are being tracked across the service line for Open Caseload activity.
	GIC	• GIC Clinical and Admin workshop took place in July 2023. The current clinical and admin processes were reviewed together. • Clinical notes reporting is now live for the GIC service.

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Clinical Challenges

Safe 	Community and Integrated	• NCL community managers do not feel they have enough time for all the management tasks. The roles and responsibilities are being reviewed in light of this.
	Complex Mental Health	• Autism assessment pathway, 100% increase in referrals from Herts in 2022 on track to be repeated this year. Demand outstripping capacity by 250%. Similar position with Haringey referrals.
	GIDS	• Competing demands on clinical capacity continues. • Long waiting lists at adult GICs has led to some delays in transfers. • Lack of key information on the new services is causing concern on about the affects on patient care.
	GIC	• The waiting list at the GIC continues to increase monthly with over 13500 patients waiting for first appointments. GIC receive on average 350 referrals per month. The Service Demand vs Capacity vs Activity is a challenge in reducing long wait times. • There is a high volume of staff sickness at the GIC. Staff wellbeing continues to be a challenge. The team are in the early stages of the QI Wellbeing Project to present ideas to boost morale and improve wellbeing.
Effective 	Community and Integrated	• Managers do not feel they have the information required to make decisions about resources because of the lack of a full budget and confidence issues with two different systems (ESR and Finance).
	Complex Mental Health	• Reduced resources has delayed progress on OM and pathway mapping projects.
	GIDS	• Retrospective data collection and data cleansing required due to increased requests from early adopters.
	GIC	• Job plans need to be full agreed. • PTL function is running however this is currently a manual process and has not yet been incorporated into CN which would provide accurate, up-to date, data.

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Clinical Challenges continued

Caring 	Community and Integrated	• Primary Care Psychotherapy Consultation Service and Mental Health Schools Team service reviews are underway to enhance their operational procedures and clinical oversight.
	Complex Mental Health	• We are working with NCL to ensure our services add best value to the care provided across NCL.
	GIDS	• There is uncertainty about future Gender services thus unable to share information with young people (YP) and their families. • Uncertainty about when and how caseloads will transfer to new services and if their care plan will be followed.
	GIC	• There have been increased levels of patient complaints for various reasons such as wait times, quality of clinic letters, transfer of care to other GICs and staff attitude which is being addressed
Responsive 	Community and Integrated	• Impact of the incident at bounds green on the First Step and FAK staff teams, while supporting patients.
	Complex Mental Health	• Higher turnover rate in Autism and LD team reducing capacity which in turn impacts patient waiting times and treatment pathways.
	GIDS	• Ad-hoc urgent requests and enquiries impacting the ability to support patients in the most responsive way.
	GIC	• The growing caseload (including the GIDS transfers) and the growing waiting list is increasing the administrative and clinical workload beyond job planned expectations.
Well-led 	Community and Integrated	• Delays in the training and development for Team Managers is impacting staff ability to deliver.
	Complex Mental Health	• Delays in the training and development for Team Managers is impacting staff ability to deliver.
	GIDS	• Holding the maintenance of quality and safety of patient care and patient experience as the key priority of the service.
	GIC	• Record keeping continues to be challenge. GIC are working on improved record keeping for Quality and Governance such as assessment summaries and supervision data.

Child Complex - Next Steps

- Implementation of Autism Assessment recovery plan for Haringey and Herts with anticipated reduction in waiting times
- Review of intake processes across the service line
- Development of Care of Waiters protocols for Autism pathway
- Review of supervision capacity across the service line
- Implementation of staff led QI improvement plan following staff survey
- Planned reduction in honorary posts with Trauma & development of training offer
- FDAC review report to go to councils highlighting the benefits of the service

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Community and Integrated Next Steps

- Admin have been trained in new assessment booking system. Clinicians have begun compiling their diary slots. Process due to be rolled out in September
- Job planning review and action plans to be further developed to highlight where further action is required
- Internal waiting list roll-out to all teams by the end of September following successful implementation in pilot teams
- Following the agreement on methodology for pathway mapping, the process will be used for the initial mapping of PCPCS and Camden Community teams.
- PCPCS – slow progress with QI approach and so an improvement plan has been developed and is being monitored and the IQPR meetings
- Staff survey action plan is complete, and implementation of actions is due to start
- PTL is due to be handed over to Ops Managers

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GIDS Next Steps

- Re-validate that all cases open to Endocrine are also open to GIDS
- Validate and record retrospective adult referral forms for Exeter
- Review of clinical notes missing or unrecorded on CN
- Analysis of activity for Clinicians in service from October 2022 to present to provide a benchmark for activity/expectations
- ➢Retrospective data collection to be completed for patients referred to Adult services ensuring the CN forms are completed

GIC Next Steps

- Prioritising waiting list management project by developing the patient pathway mapping, utilization of slots
- Focus on consecutive DNA's and Dormant cases as part of PTL (waiting list management)
- Further develop work on the transfer protocol, for waiting list transfers. Working collaboratively with NHSE and other Gender sites
- Continue to work on the implementation of CN Non-patient activity so that the service will be able to capture indirect clinical activity, enabling analysis of the demand and capacity for the clinical team
- Complete and clear the backlog of letters by September 2023 and introduce a robust process for the service to prevent reoccurrence

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General Managers - High Impact Actions Overview

The high impact actions are being managed within the Operational governance and processes but are impacted by the IQPR Project, please see slide for update on IQPR project

Priority No.	Deliverables	Start Date	Completion Date	Lead	Ops/ Clinical Support	PM Support (where applicable)	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1	PTL/ Activity Management	01/03/2023	30/06/2023	AH	NS	KA																
2	Pathway Mapping	01/04/2023	31/03/2024	FH	N/a	BK																
3	Clinical Service Delivery Model	01/04/2023	31/03/2024	FH	N/a	BK																
4	Waiting List Management	31/01/2023	31/09/2023	AH	FH	KA																
5	Key Performance Outcomes and Measures	01/01/2023	31/08/2023	HB/ALG	PP	RJ																
6	Booking System	01/06/2023	31/12/2023	MF	AC	TBC																
7	Monitoring management of ESR KPIs	01/04/2023	31/09/2023	DA/FH	RF/Sauo	N/a																
8	Integrated Quality and Performance Reporting (IQPR)	01/03/2023	Monthly	AH/HB	ALG	NB																

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3. Contracts Update

2023/24 Contracts Position

- Our NCL contract (which also includes NEL ICB and Hertfordshire) has now been agreed and we are awaiting the final contract for signature from NCL.
- We have received additional investment for a number of initiatives in North and South Camden, Mosaic and Haringey First Step.
- NHSE Have agreed to terms for the contract with negotiations around CQUIN to be finalised before signing.
- The NCL Staff well-being hub closed at the end of August 2023 and is accounted for in the current external NHSE Budget setting.
- We were due to review contracts by activity (albeit fixed value contracts) and ratify against job planning to ensure robust assessment of activity was been undertaken, however this has been pushed back to October due to delays outside of our control.

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ICB/generic contract position

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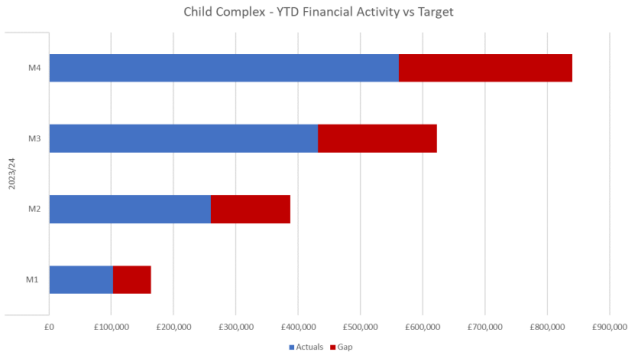
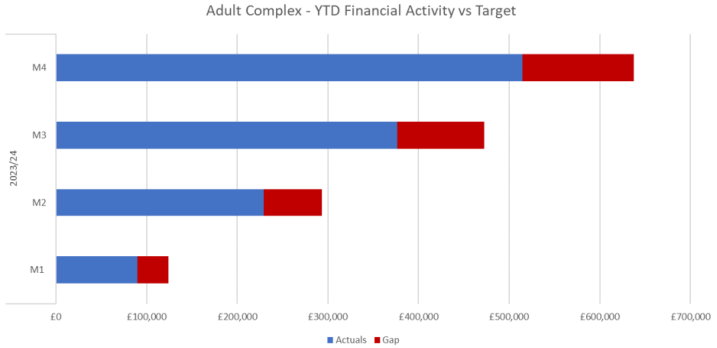
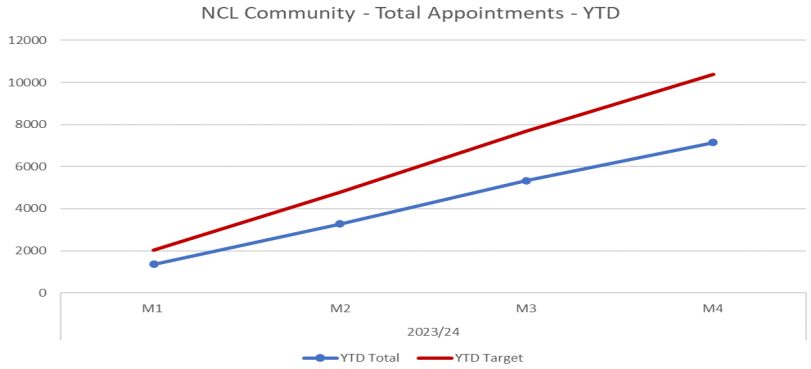




Our ICB contracts continue to underperform against targets which poses a potential risk in terms of our 2024/25 contract values.

Only a fraction of our ICB contract has explicit financial targets against it; the NCL Community element is subject to activity targets only. This helps mitigate the financial risk in terms of future contract values somewhat but does not complete remove it.



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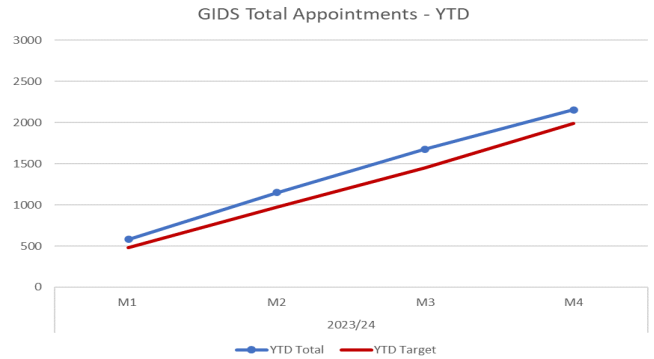
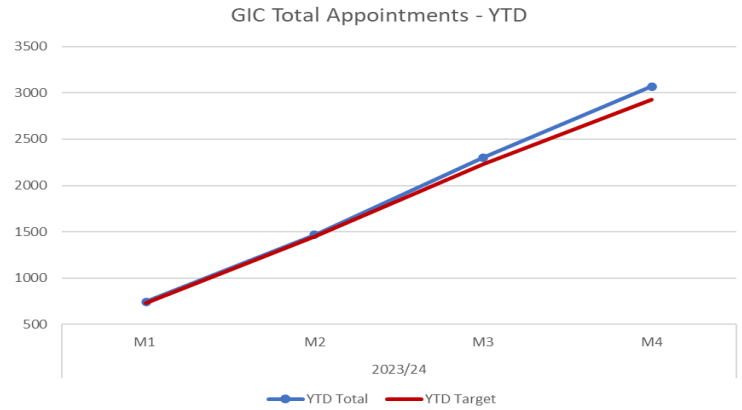
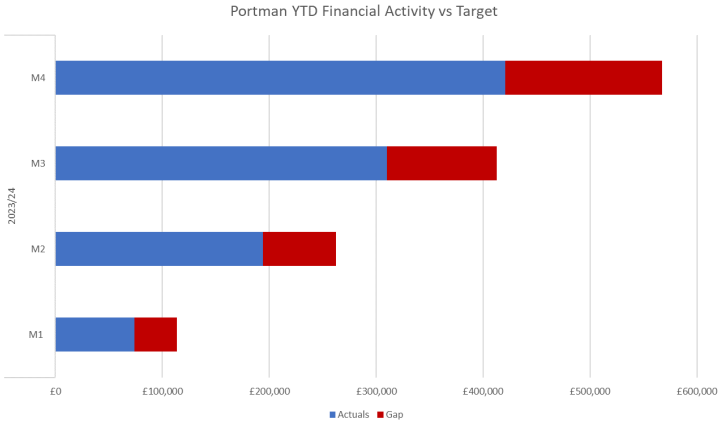
NHSE Contract Position





Activity targets for GIDS and GIC have been renegotiated to be more in line with actual staffing cohort levels and are no longer based on financial performance. As a result, the two services are currently meeting (and exceeding) their targets.

Portman's targets were not covered by the renegotiation process, and they are still bound by their 'traditional' financial/activity targets. The service is currently underperforming against these.



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4. Clinical Job Plan Analysis

CMH Appointments vs Job Plans

	YTD		April		May		June		July	
	Variance	Variance %	Variance	Variance %	Variance	Variance %	Variance	Variance %	Variance	Variance %
FMH	-463	-22%	-132	-28%	-102	-18%	-12	-2%	-218	-40%
FAKT	-804	-46%	-284	-65%	-153	-35%	-202	-46%	-167	-38%
AYAS	-222	-16%	-145	-42%	-20	-6%	-11	-3%	-47	-14%
EDAS	-165	-28%	-45	-30%	-72	-49%	-14	-9%	-35	-24%
Autism & LD	-201	-38%	-84	-63%	-37	-28%	-21	-16%	-49	-37%
Trauma	-630	-35%	-210	-47%	-133	-30%	-164	-37%	-123	-27%
Psychotherapy	-609	-29%	-273	-46%	-101	-17%	-119	-20%	-116	-19%
Portman	-337	-19%	-195	-43%	-29	-6%	-52	-11%	-72	-16%
FCAMHS										
Returning Families										

- The table shows a comparison of appointments against job planned capacity
- We have started monthly reviews of individual performance against job plans and are meeting individually with team managers to go through the report and agreeing plans to investigate any issues – this has to be carefully managed to not have a big impact on morale
- Performance in month has significant variation, which is expected to a degree due to peak leave periods. Teams with high levels of trainees and honorary staff experience this to a greater degree
- Work is still needed to complete consultant psychiatry job plans

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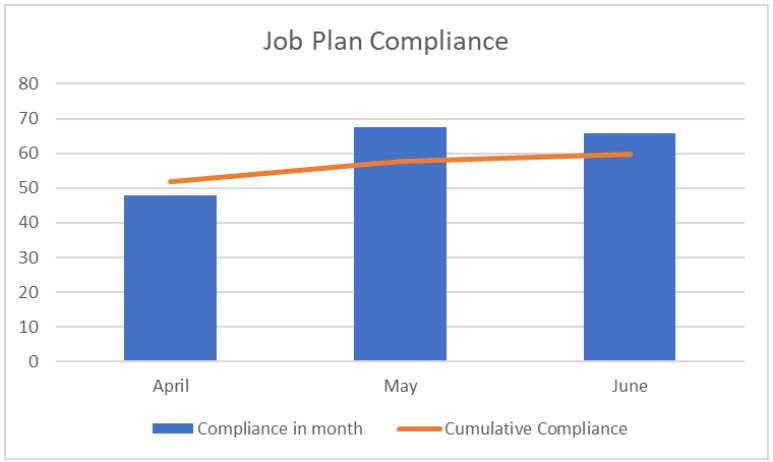
C&I Job Plan Analysis

- After a positive improvement in May there has been no change on job plan compliance in June.
- We have removed trainee totals from the compliance for the time being while we review expected activity for them.
- This month we have asked managers to complete action plans for all staff that have been less than 70% compliant in their job plan for the last 3 months. We will share learning from this in October 2023.

Team	Booked appts due	Booked appts actual	% compliance to plan
CAISS	338	126	37
Intake	0	0	0
CWP	428	352	82
LAC	182	138	76
MHST North	352	253	72
MHST South	423	202	48
North Camden	590	370	63
South Camden	408	323	79
WFT/WFTP	745	534	72
PCPCS	425	263	62
Total	3890	2561	66



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5. Clinical Workforce Updates

CMH and C&I Staffing Levels & Updates

- Detailed WTE establishment vs actuals to be provided in future report when data available
- Doing well overall in recruiting vacancies and the pre-employment checks are taking a lot less time
- Adult Complex Clinical Service Manager Role has been recruited to on trial basis
- The ongoing issue with ESR is impacting GMs ability to manage the staff groups and vacancies and impacts on MAST reports as well

GIDS Critical Staffing Levels – Clinical

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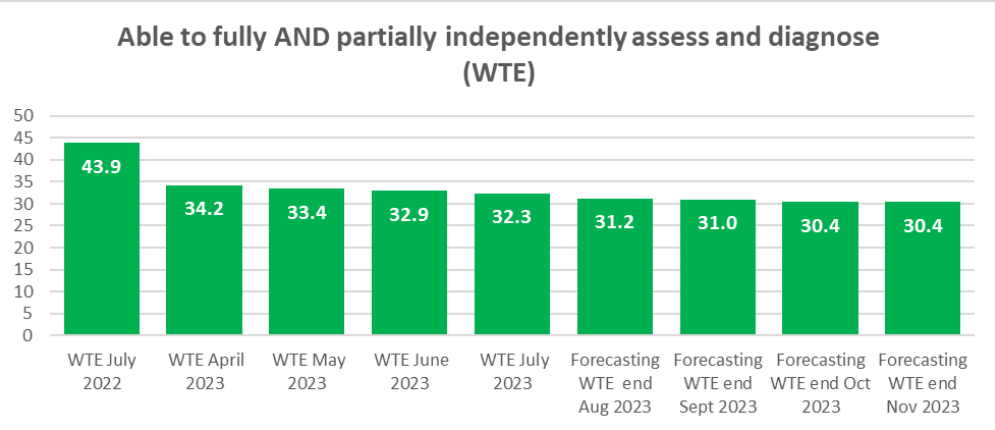

- In total, there are 879 open caseload that still open to the service.
- It has been agreed that Clinicians are to be categorised into two groups, “fully able to assess” and “partially able to assess”, depending on level of experience and length of service continuity.
- Recruitment for 2 x 8c fixed-term Consultant posts currently in progress.
- 0.2WTE reduction on B8a in Sept 2023 and further reduction of 0.6WTE in Oct 2023.

Clinicians able to fully and partially assess reviewed on 21/08/2023

Able to fully AND partially independently assess and diagnose - as of 21/08/2023									
Region	**WTE July 2022**	**WTE April 2023**	**WTE May 2023**	**WTE June 2023**	**WTE July 2023**	**Forecasting WTE end Aug 2023**	**Forecasting WTE end Sept 2023**	**Forecasting WTE end Oct 2023**	**Forecasting WTE end Nov 2023**
Leeds	12.1	9.3	8.5	9.4	9.4	8.7	8.5	8.5	8.5
Midlands	13.5	9.4	9.4	8.4	7.8	7.4	7.4	7.4	7.4
South East	9.2	7	7	6.6	6.6	6.6	6.6	6.0	6.0
South West	8.1	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5
Cross site	1	2	2	2	2	2	2	2	2
Total GIDS	**43.9**	**34.2**	**33.4**	**32.9**	**32.3**	**31.2**	**31.0**	**30.4**	**30.4**

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Oversight of Critical Staffing level reported weekly at Interim Management Board and Senior Management Group, and monthly at Clinical Governance Committee.

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GIDS Critical Staffing Levels – Admin

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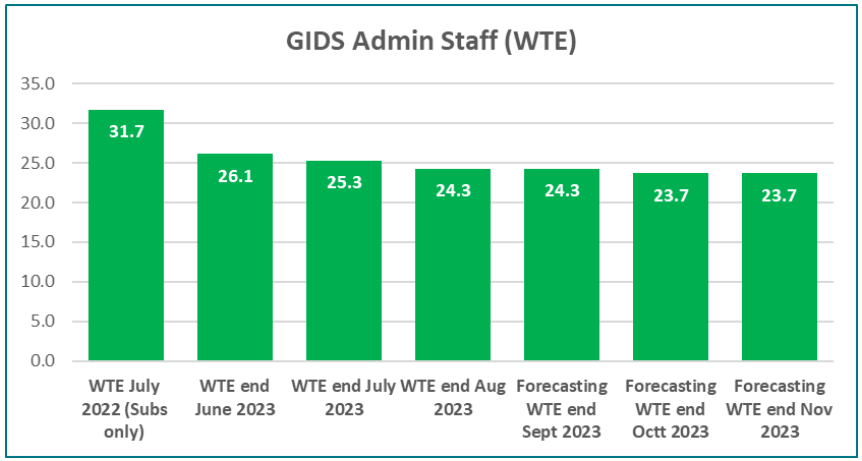
Admin Staff as of 21/08/2023							
Region	**WTE July 2022 (Subs only)**	**WTE end June 2023**	**WTE end July 2023**	**WTE end Aug 2023**	**Forecasting WTE end Sept 2023**	**Forecasting WTE end Oct 2023**	**Forecasting WTE end Nov 2023**
Leeds	6.0	6.0	7.0	7.0	7.0	6.4	6.4
Midlands	1.0	0.0	0.0	0.0	0.0	0.0	0.0
London / SE / Cross Service	23.7	20.1	18.3	17.3	17.3	17.3	17.3
Southwest	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Total GIDS Admin	**31.7**	**26.1**	**25.3**	**24.3**	**24.3**	**23.7**	**23.7**



Data as of 21/08/2023

6 x agency staff will move to fixed term contracts in Sept 2023, with the view of creating stability in the admin team and a reduction on agency cap

Admin staffing risks:

- London Admin Team now dealing with Bristol and Birmingham administration and still supporting on PTL tracking and any urgent priority requests (audits, data validation on CN).

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GIDS Sickness Levels

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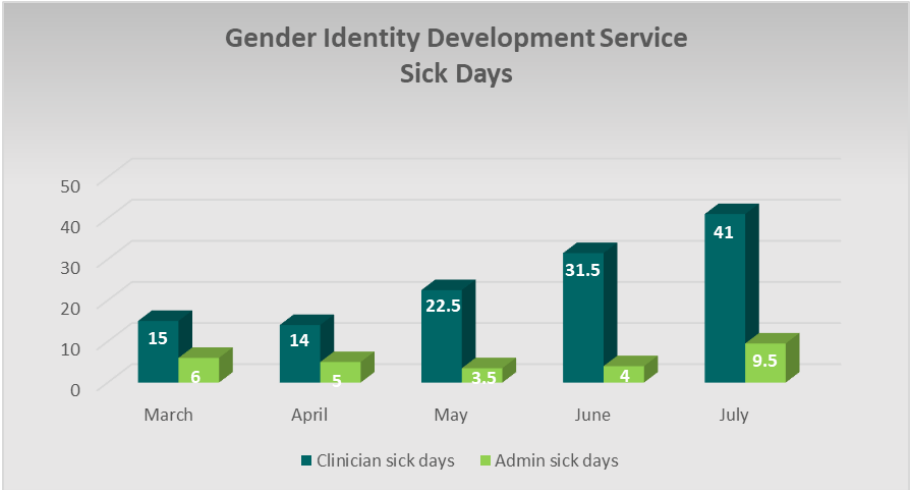
No. of Sick days / staff off sick				
Month	**Clinician sick days**	**No of Clinicians**	**Admin sick days**	**No of Admin**
March	15	10	6	5
April	14	5	5	1
May	22.5	10	3.5	3
June	31.5	11	4	2
July	41	12	9.5	5



Data correct as of 07/08/2023. Sickness records are sent to HR monthly whilst we await implementation of ESR.

- In July 2023, GIDS recorded 50.5 sickness days for all staff.
- Total number of sick days for all staff increased 30% from June 2023 to July 2023.
- Sickness absence reporting and recording (including Return to Work Meetings) was circulated in July 2023.
- ESR will capture and record sickness going forward.
- Further review of staff well-being is being undertaken

GIC Clinical Staffing Levels

The current Staff turnover in GIC 2.31%.

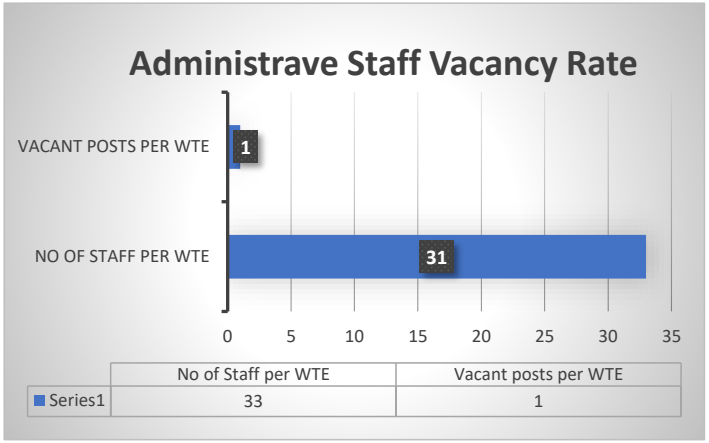
The service are currently recruiting into clinical posts as a priority. The service has recently recruited to 2 WTE Specialty Doctor who is anticipated to begin in October 2023.

Currently ongoing:

- 2x B7 clinical nurse specialists' vacancies have been advertised and is in the short-listing stage
- B8a clinical nurse specialists lead ‘is under review
- B8a Counselling psychology role is live on Trac
- B7 Counselling psychology role is live on Trac
- The Deputy Speech and Language Therapy 8a roles is under review.
- B7 SLT will shortly be out to vacancy

GIC Admin Staffing Levels

Department	Current Post WTE	Total Vacancy WTE
Management/Director/ Governance	6	1
Admin Leaders	3	0
Clinical admin	6	0
Endo Team	4	0
Referrals	4	0
Appointment	4	0
Assistants	4	0
Total	31WTE	1 vacancy



The service has completed recruitment in most substantive posts in admin. The service have started in reduction on agency staff by end of September 23 once historical backlog letter have been cleared.

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GIC Sickness Levels

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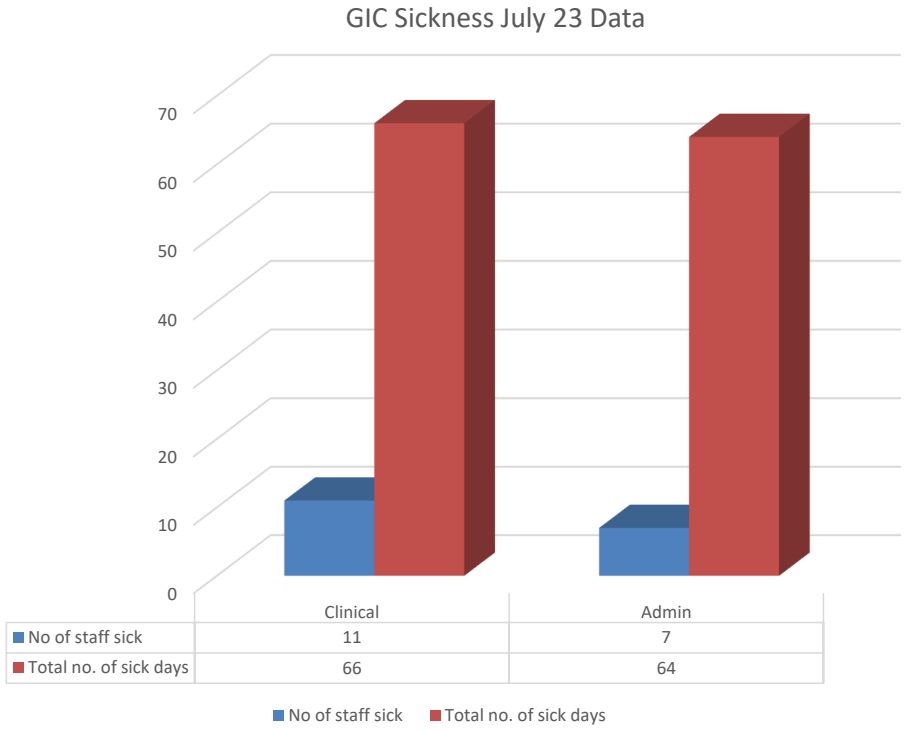
Staff sickness absence rate for June is 3.17% and we were 4.96% in July .

This translates to approximately 130 days of sickness reported in July 23.

All sickness is now being recorded to the ESR system.

Staff well being support is being reviewed across clinical and admin teams.



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CMH Mandatory Training & Appraisals

MAST compliance

Trust Target	95%

Directorate	Compliance %
Chief Clinical Operating Officer	86.35%
Division	**Compliance %**
Complex Mental Health	79.14%

- MAST compliance is down slightly, potentially due to new training requirements.
- Requested HR to sent team level compliance to help generate team competition and for increased team manager accountability
- Monthly reminders being sent to all with overdue training

Appraisal compliance

Directorate	Reviews Completed %
Chief Clinical Operating Officer	74.04
Division	**Reviews Completed %**
Complex Mental Health	64.65

- Appraisal compliance hasn't been updated since 18th July
- Each team manager has been sent a list of staff requesting an update and for this to be prioritised
- Almost all appraisals have taken place but the paperwork submission has been delayed
- Managers been sent a list of staff due pay increments for this year to ensure prioritised for completion

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C&I Mandatory Training and Appraisals

Note that MAST still has some small issues due to staff incorrectly being aligned to the service line.

	April Compliance %	May Compliance %	June Compliance %
Overall	85%	87%	88%
IG	82%	86%	89%
Safeguarding level 1 (children)	85%	88%	90%
Safeguarding level 3 (children)	94%	88%	88%* Note that sessions are still being cancelled
Appraisals		60%	75%

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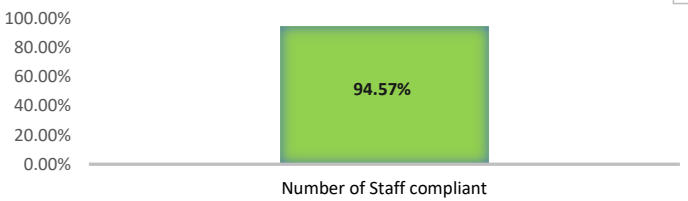
GIDS Mandatory Training

- Automatic reminders for training are sent out to all staff
- Level 3 Safeguarding for children's and adults has increased with full compliance for Adults safeguarding

MAST

(Data accurate as of 17/08/2023)

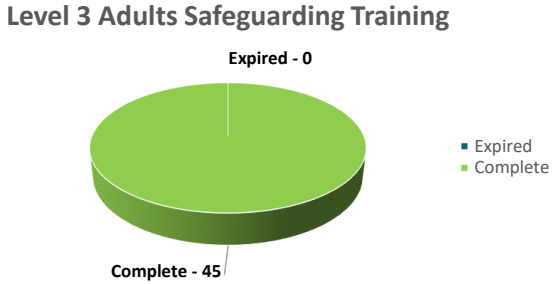


Mandatory & Statutory training (Compliance %)
Percentage of Staff compliant: 94.57%

Staff Annual Safeguarding Training

(Data accurate as of 17/08/2023)

Level 3 Children Safeguarding training	
Number of Staff requiring training	2
Number of staff expiring soon	2
Number of staff trained	41
Compliancy %	95.6%



Level 3 Adults Safeguarding Training	
Expired	0
Complete	45
Compliancy %	100%

37

GIC Mandatory Training

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GIC currently has 93% for MAST compliance rate. This has dropped by 2% since June 2023

Data accurate as of 17/08/2023 and includes all staffing disciplines in GIC

Division	Compliance %
GIC	92.92%

GIC Supervision Rate

(Data accurate as of 14/08/2023)

Number of eligible staff within ward/service site and by trust that are eligible for Clinical supervision within quarter	15
Number of eligible staff who have received Clinical Supervision as per Trust/organisation policy	5
% of eligible staff who have received Clinical Supervision as per Trust/organisation policy	33%

GIC Appraisal Data

(Data accurate as of 19/07/2023 and includes all staffing disciplines in GIC)

Division	Reviews Completed %
GIC	96.67%

Due to high sickness and annual leave in the team there has been a delay in receiving and recording supervision data.

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6. Clinical Activity including Referrals, Caseloads and Waiting-times

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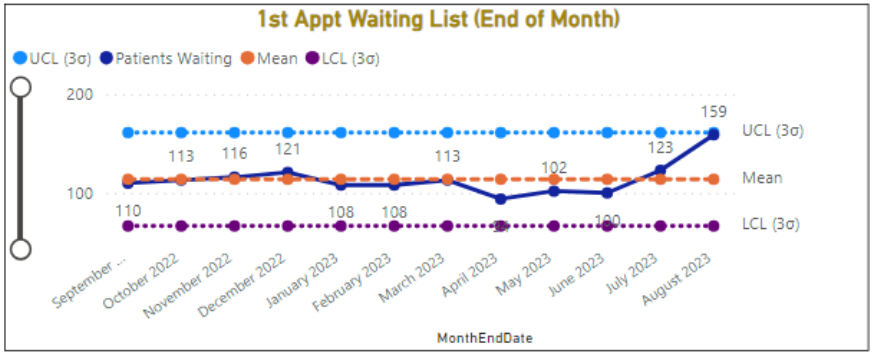
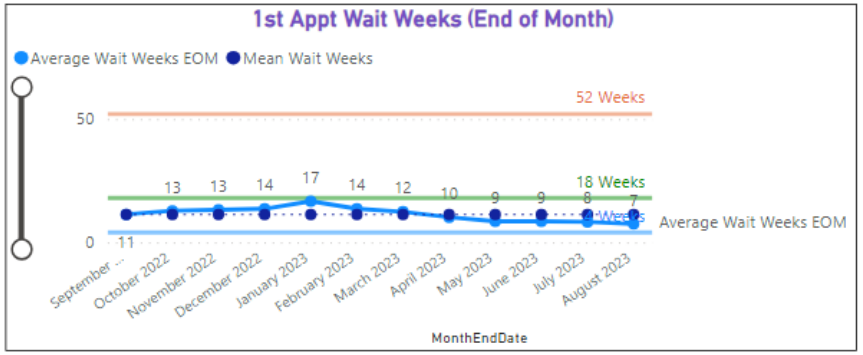
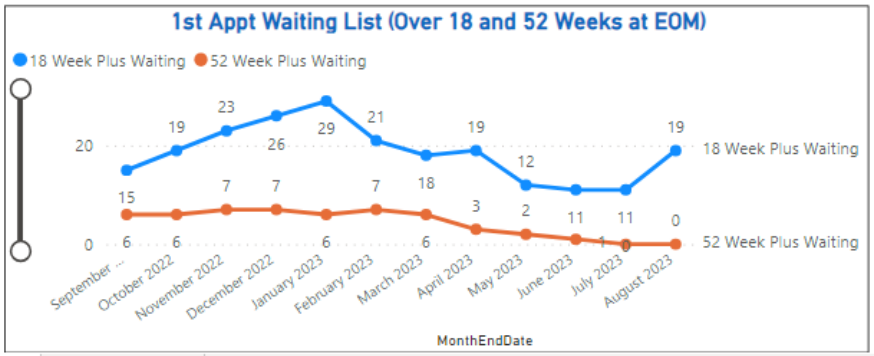
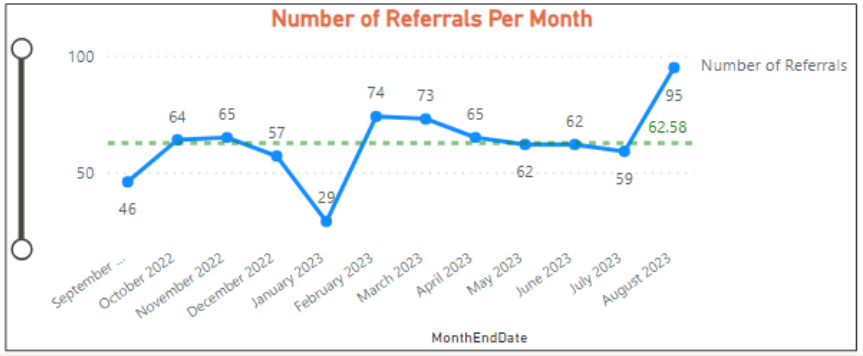
Moving To SPC Reports – Child Complex

- With Waiting Times being a key strategic objective, dashboards have started to be developed to meet SPC requirements. Further developments will follow to ensure easier read across of the data.









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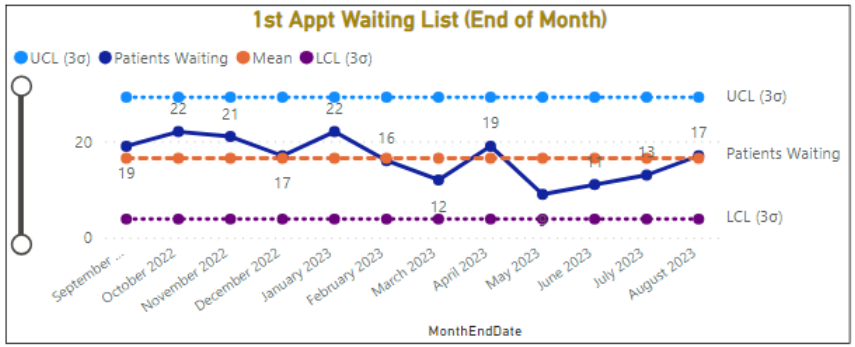
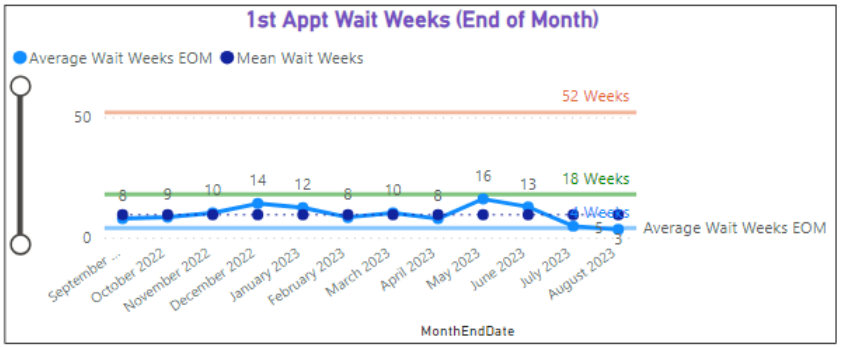
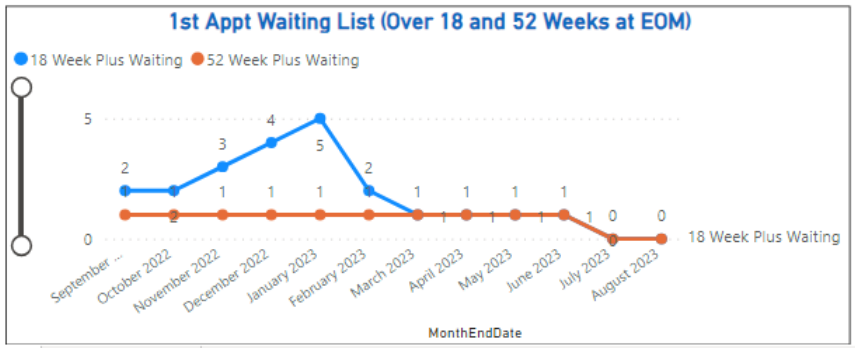
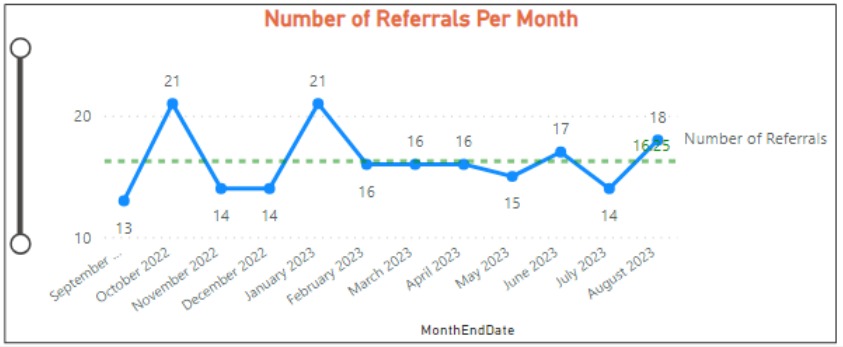
Moving To SPC Reports – Adolescents

- With Waiting Times being a key strategic objective, dashboards have started to be developed to meet SPC requirements. Further developments will follow to ensure easier read across of the data.









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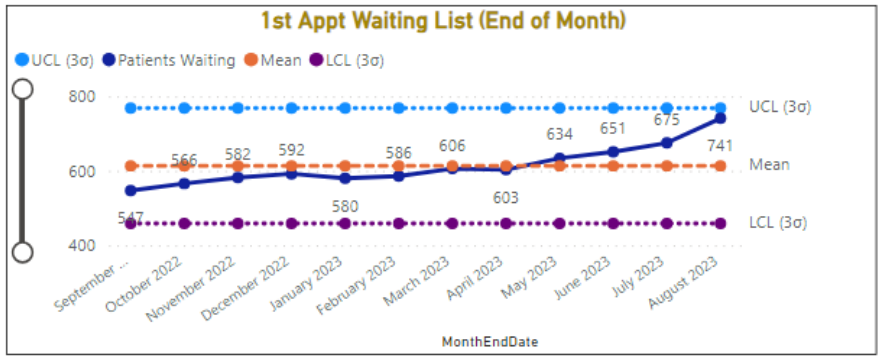
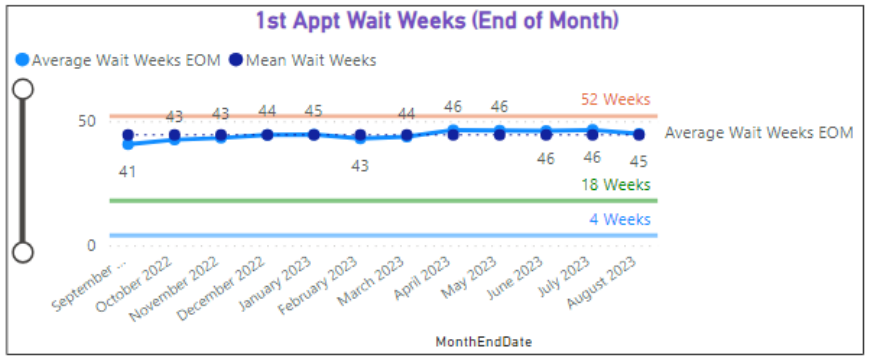
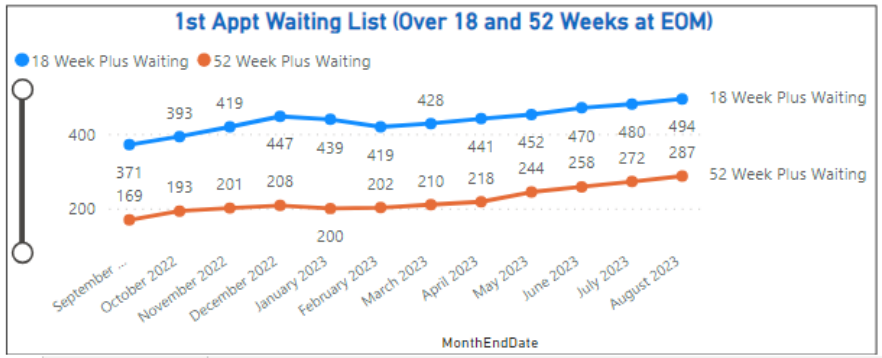
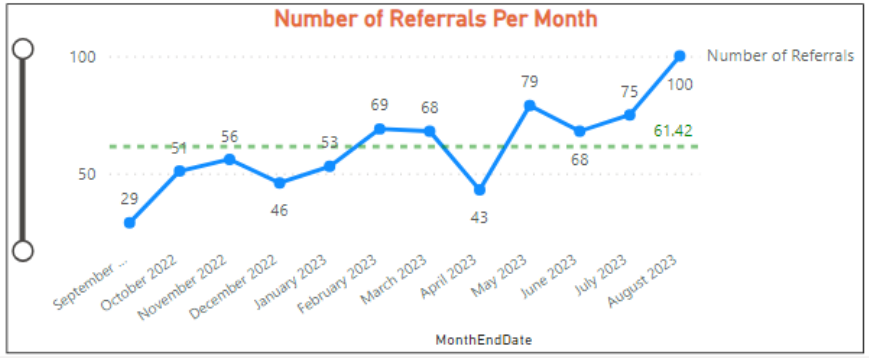
Moving To SPC Reports – Adult Complex

- With Waiting Times being a key strategic objective, dashboards have started to be developed to meet SPC requirements. Further developments will follow to ensure easier read across of the data.









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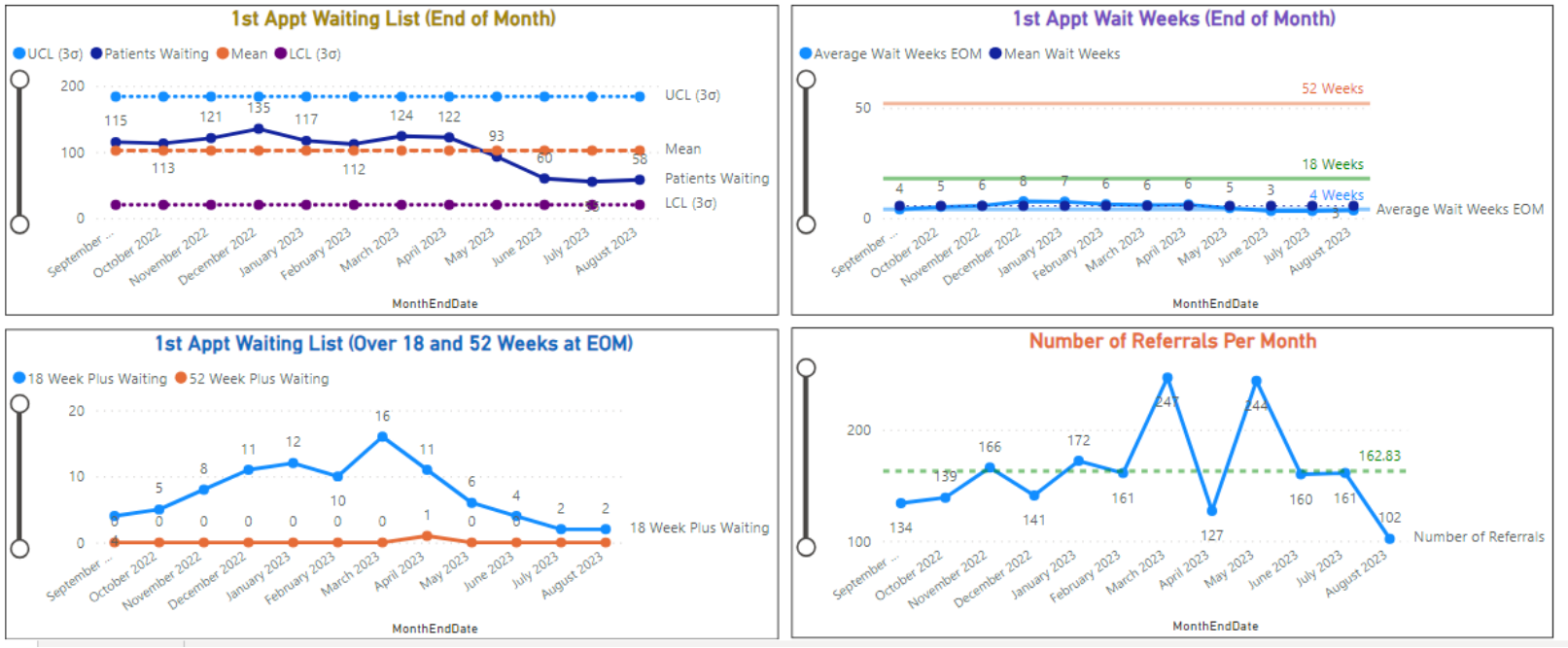
Moving To SPC Reports – NCL Community

- With Waiting Times being a key strategic objective, dashboards have started to be developed to meet SPC requirements. Further developments will follow to ensure easier read across of the data.



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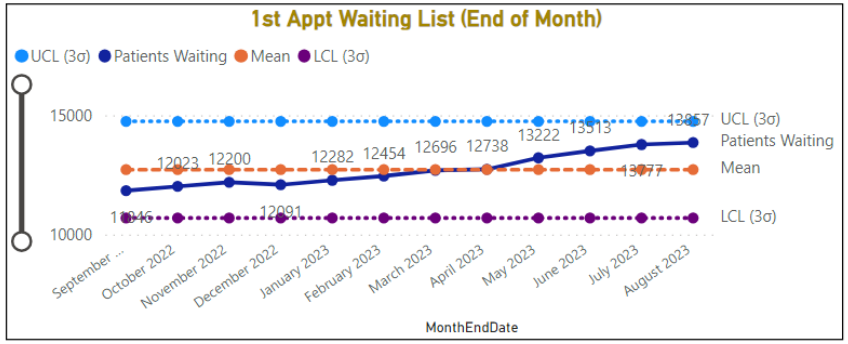
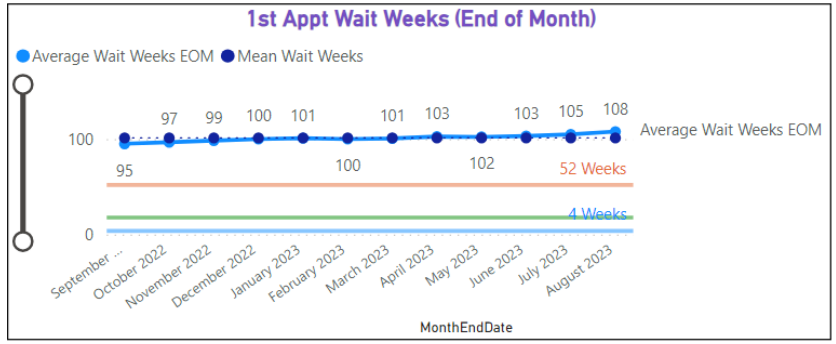
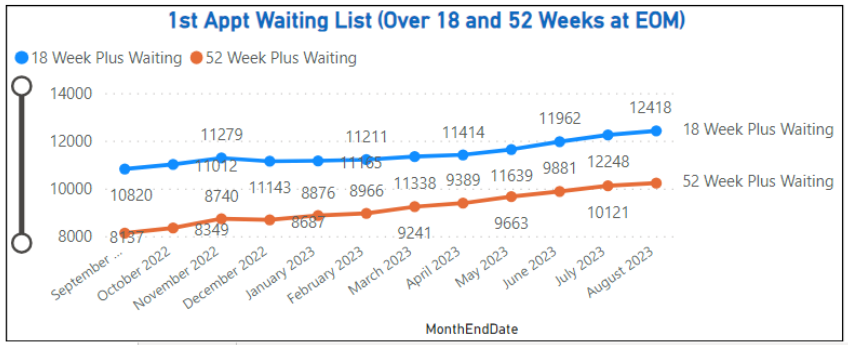
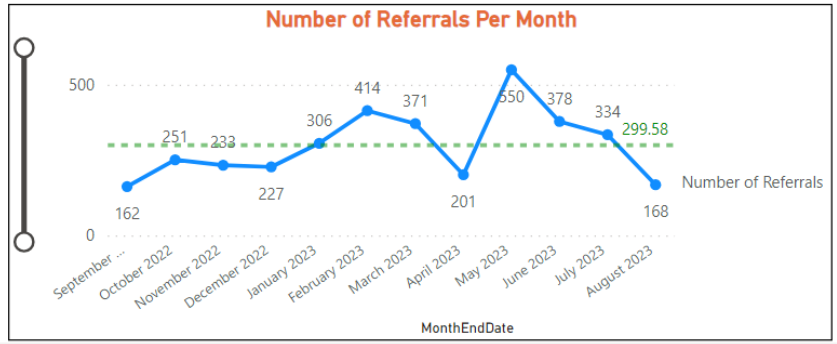
Moving To SPC Reports – GIC

- With Waiting Times being a key strategic objective, dashboards have started to be developed to meet SPC requirements. Further developments will follow to ensure easier read across of the data.









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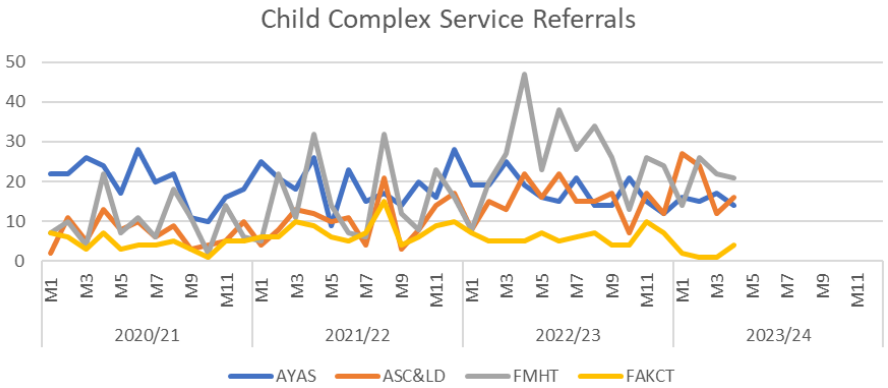
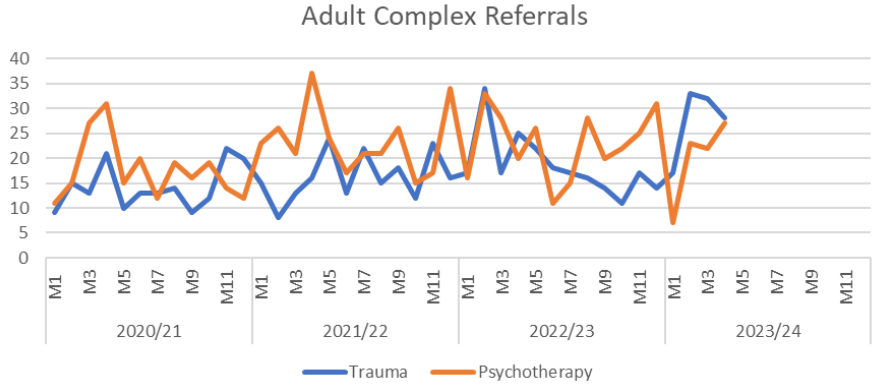
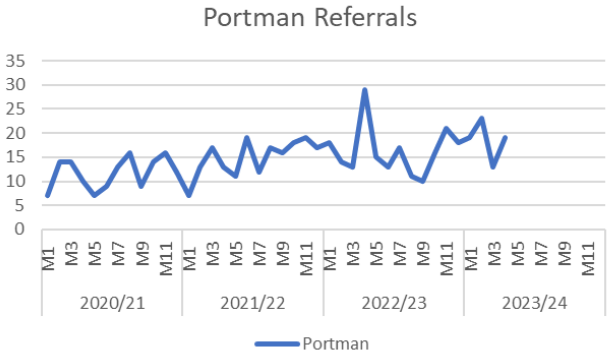
Complex Mental Health Referrals







Monthly Average			
	21-22	22-23	23-24
Trauma	16	19	28
Psychotherapy	24	23	20
Portman	15	16	19
FCAMHS			
FDAC			
Returning Families			
AYAS	19	18	16
ASC & LD	10	15	20
FMHT	16	26	21
FAKCT	8	6	2
Total	108	123	126

Data taken from internal monitoring dashboard

- Autism referrals continue to increase. Funding secured for backlog reduction. Developing a proposal for local, increased offer for Herts
- Trauma demand remains high and remains priority for pathway and commissioning review
- FAKT referrals very low in Q4 after a peak in Q4 – need to promote ASF work

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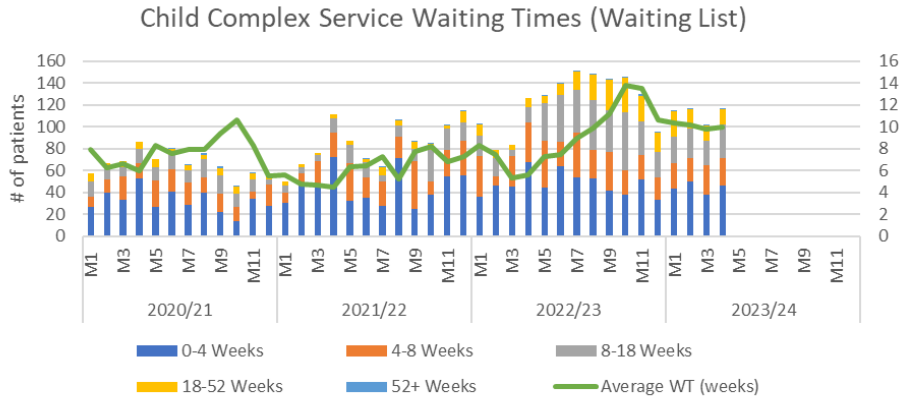
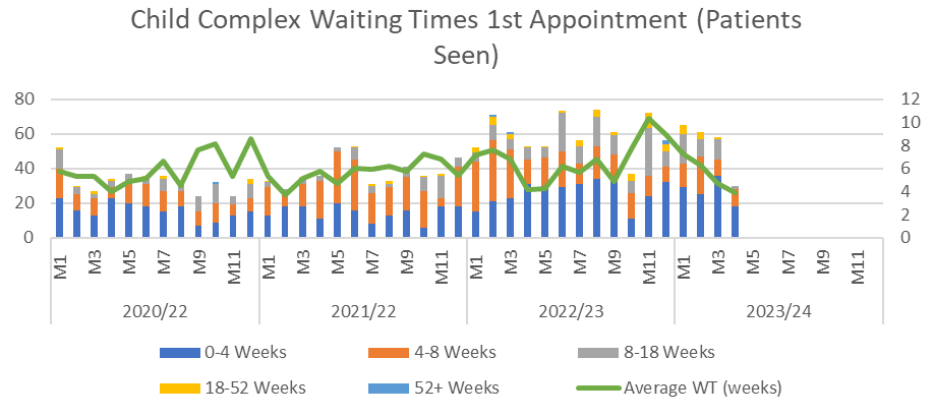
First Appointment Waits – Child Complex





- The number of patient waiting has reduced for most teams over the past 6 months, as has the average waiting times for those still waiting and those seen
- FMH's clinic model and PTL focus has continued to reduce waits, reducing from 50 waiting in January to 16 in July. The average waits also fell from 19 weeks to just 3.6 over the same period
- FAKT has reduced from 16 waiting in Feb to 5 in July
- AYAS waits are stable with the average wait for July being 5 weeks
- EDAS has increase from 4 to 14 waiting over the past month but will clear the backlog with the 2 new starters (waits in July were <1 week for those seen)
- ASC & LD team have stopped triage called for patients with lower risk ratings to redirect the capacity to assessments. This has increased the number waiting doubling from 29 to 63 since March
- PTL meeting focus has shifted to ASC & LD and we are working to reduce the longest waiters

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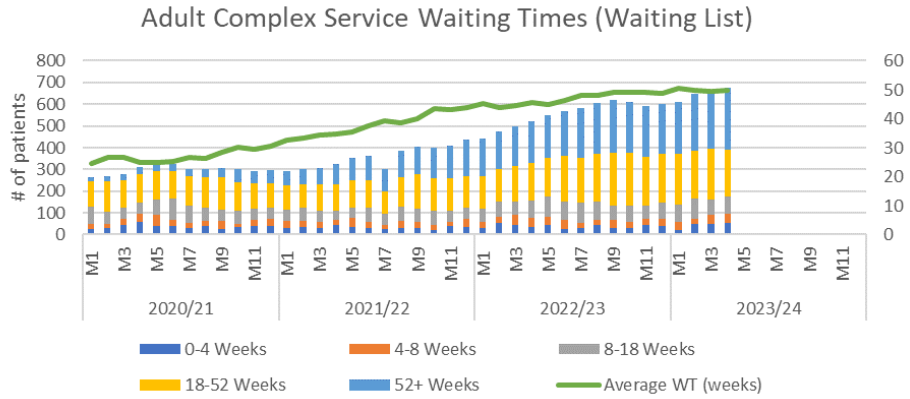
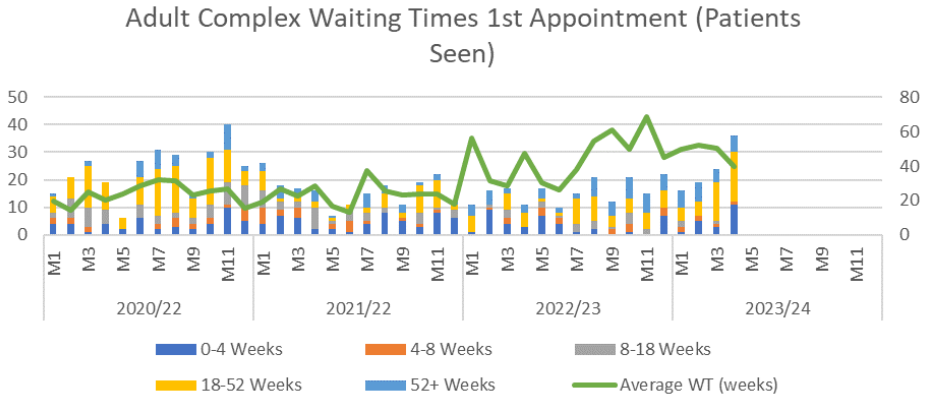
First Appointment Waits – Adult Complex





- The Adult Complex had stabilised but is now starting to increase again
- Psychotherapy Team only used 40% of 1st appt capacity in 2022/33 which has prompted the 2 QI projects to be agreed
- QI projects to start in September with half the team adopting a clinical model and the other being given a monthly quota of allocations.
- A new 0.4 WTE FTC has been approved and is being shortlisted to focus on assessment backlog in Psychotherapy
- Trauma processes will be reviewed as part of pathway project – **Project management support needed**

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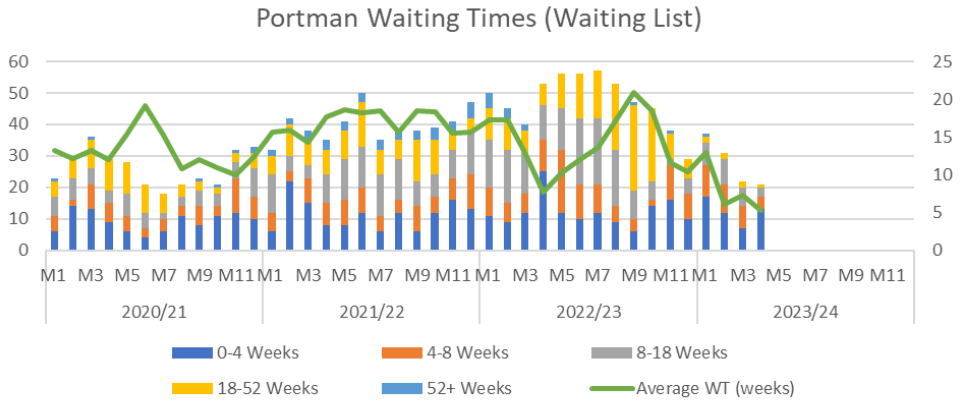
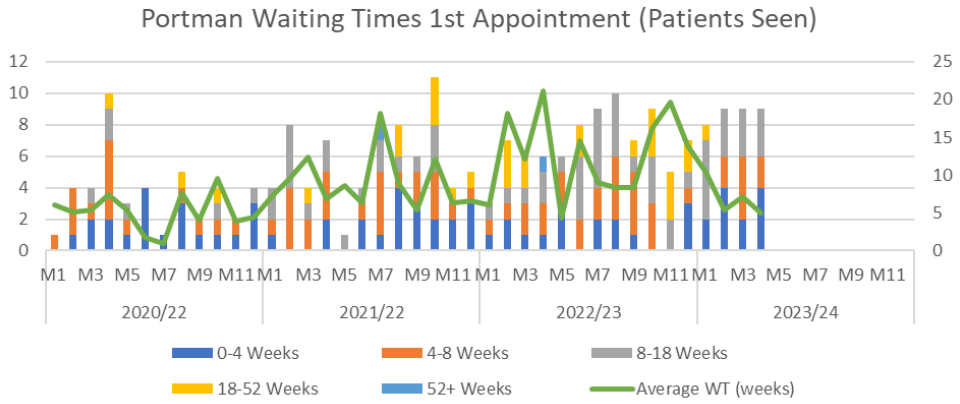
First Appointment Waits - Portman





- The Portman waiting list and waiting times have been reducing month on month since November despite a sustained increase in referrals
- All patients have had their first appointment within 18 weeks since May with the average wait being just 5 weeks
- This change is due to improved intake processes, weekly review in the PTL meetings and reminding clinicians about waiting targets once they have been allocated an assessment case

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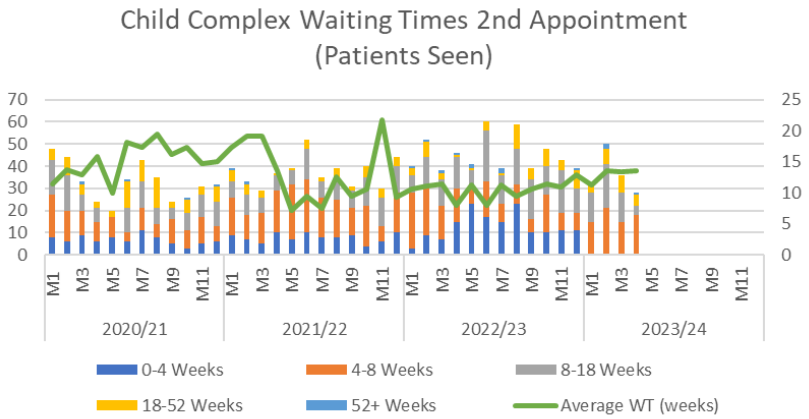
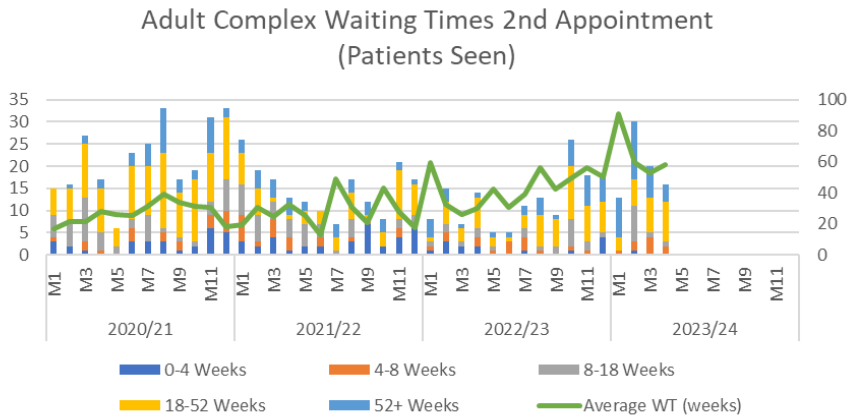
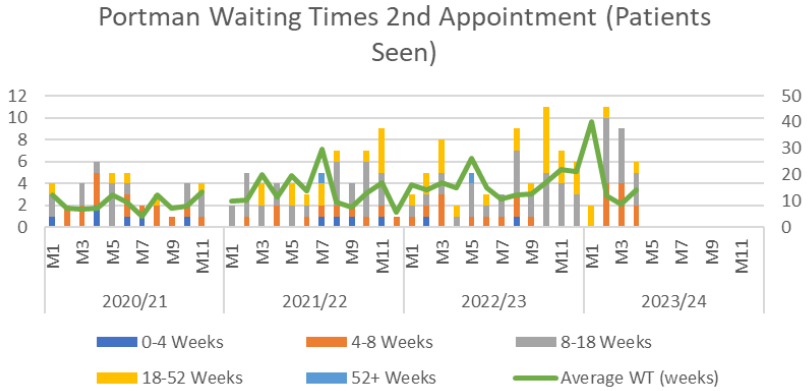
Second Appointment Waits







- The waiting times for 2nd appointment in Child Complex has been gradually increasing.
- Adult Complex waits continue to grow
- Focus has been on 1st appt waits but PTLs will include greater focus on 2nd appt waiting times from September
- Portman average waits had been increasing as the backlog was being cleared but has now reduced considerably in May, June & July and is regularly reviewed in their PTL

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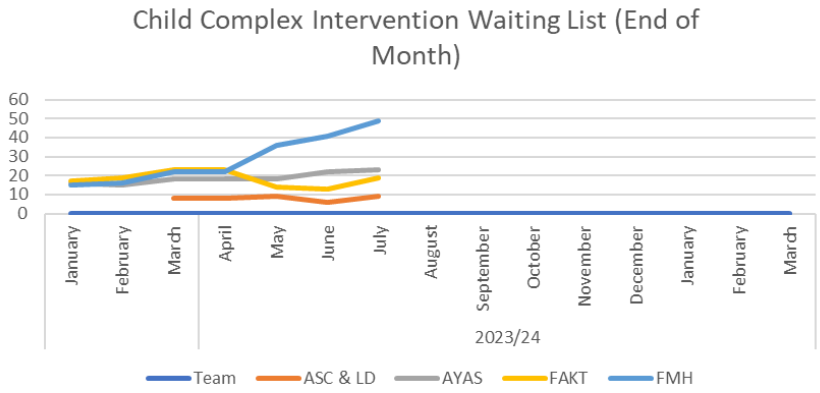
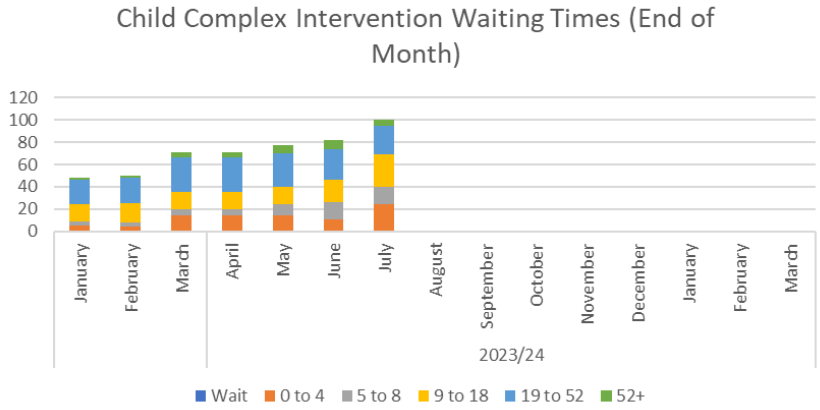
Intervention Waits





- Child Complex waiting lists are relatively stable except for FMH which has more than doubled since April. This increase will partially be due to the increased number of assessments. However, further analysis and discussion is needed with the team to understand the increase and to agree a plan to address.
- The average waits for those waiting is 16 weeks, down from 23 in June. This decrease is a result of the number of patients who have been recently added to the waiting list and a reduction in the longest waiting patients, with 2 and 3 less waiting in the 19-52 and 52+ brackets respectively.
- Adult Complex and Portman data will be available in this detail when we move to managing waiting lists on Carenotes (by end September).

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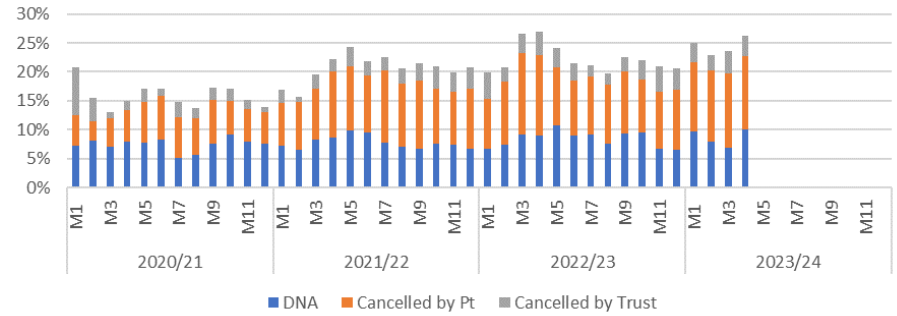
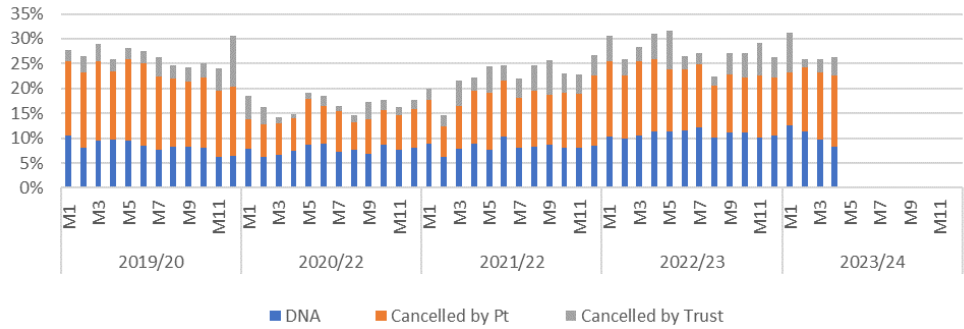
DNAs and Cancellations

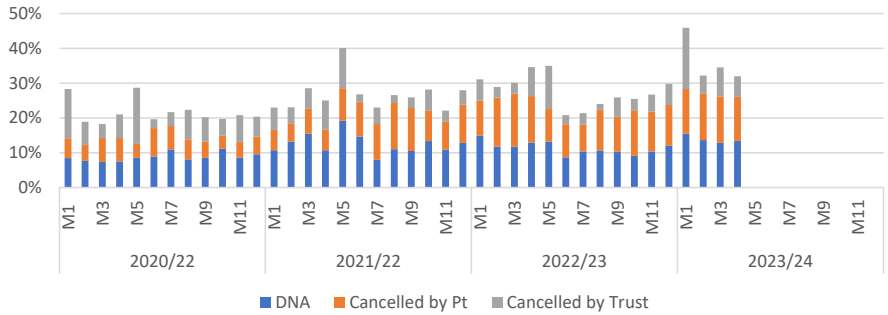
Child Complex DNA & Cancellation Rates



Adult Complex DNA & Cancellation Rates



Portman DNA & Cancellation Rates



- The Portman team reported April cancellations by trust surge was due to leave for staff undertaking groups
- Adult Complex moving to negotiating all assessment bookings over the phone with stricter rules on cancellations and DNAs as part of QI in September

Data taken from internal monitoring & power BI dashboard - Based on the percentage of booked appointments

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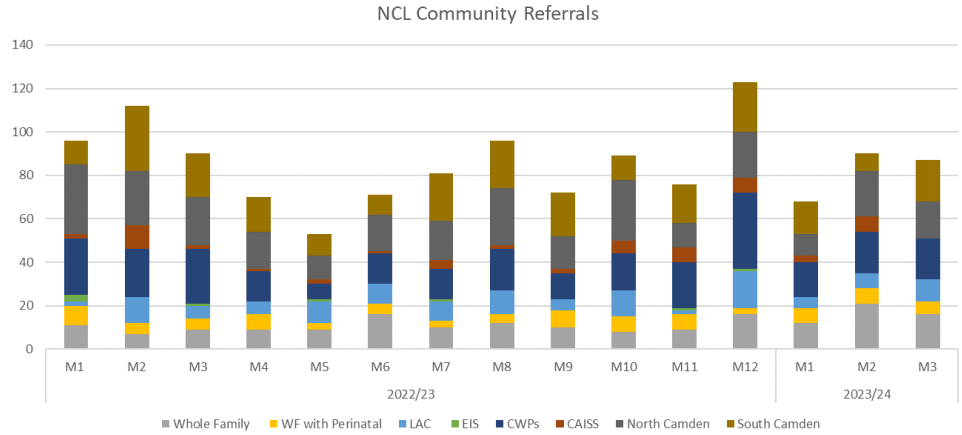
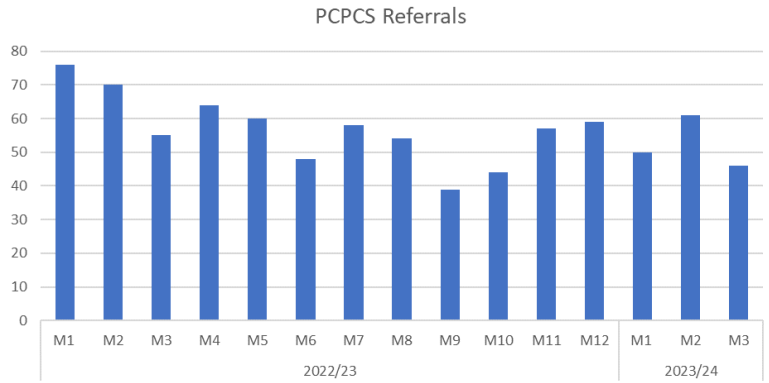
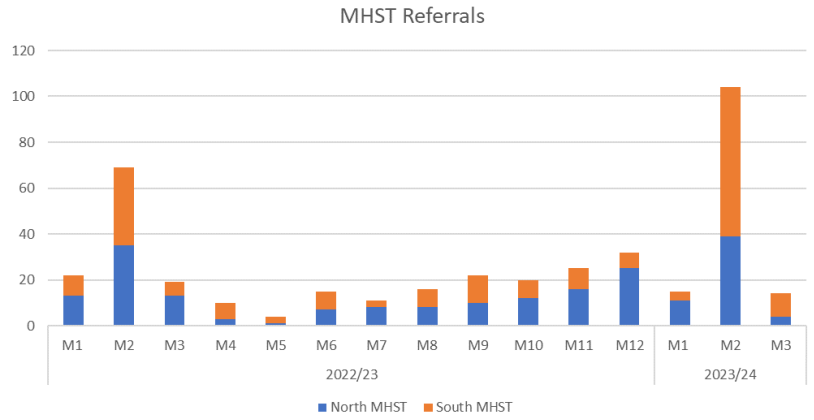
Community and Integrated Referrals







Unit/Service	Cumulative refs 22/23 (April - June)	Cumulative refs 23/24 (April - June)	% change
NCL Community	298	245	-18%*
PCPCS	201	157	-22%**
MHST	110	132	+20%***

* 25% in May **31% in May ***30% in May

Data taken from internal monitoring dashboard

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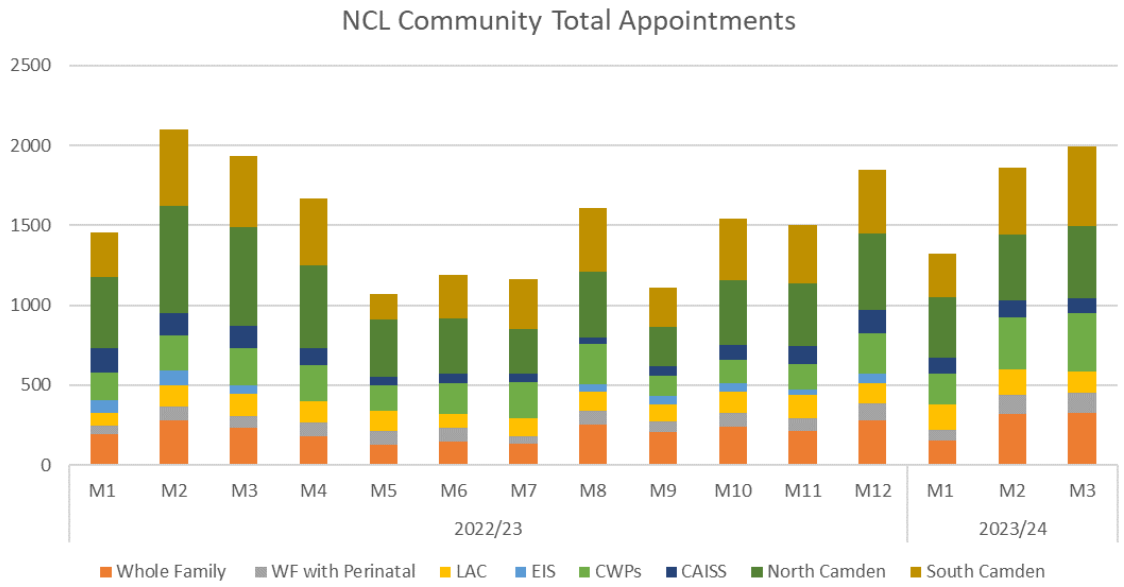
Appointments – NCL Community



- 1.5% fewer appointments were booked in the first 3 months of 23/24 as compared to 22/23. Last month we were at 4%
- We are pleased to see a steady increase in appointments since April, while there is still a gap to last year it is narrowing, and the trend is positive.
- We note that this report does not include NPA. This means that it does not accurately reflect all our clinical activity. It is acknowledged that the number of NPAs delivered has not changed year on year (28/29 in period)

Data taken from internal monitoring & power BI dashboard

Innovation in mind

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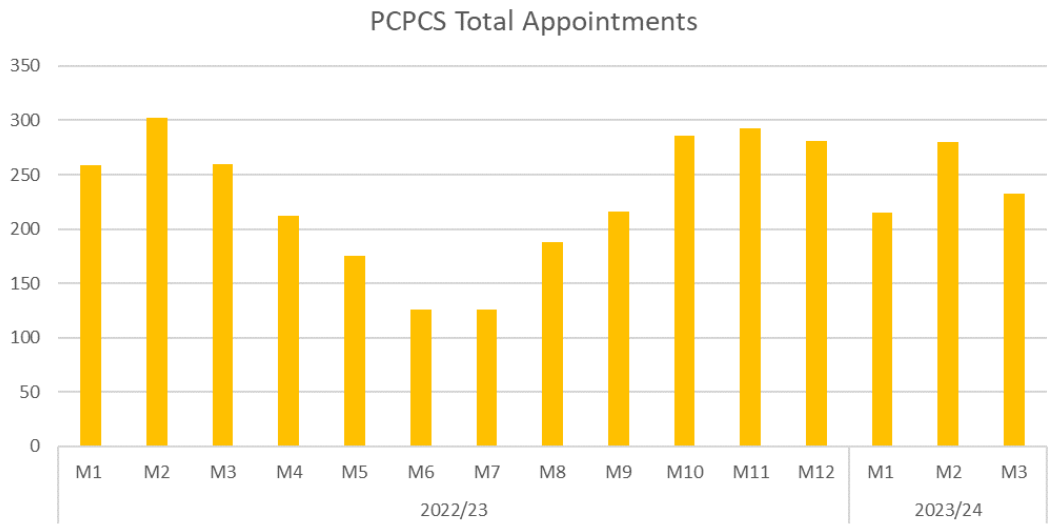
Appointments – PCPCS



- 11% reduction in cumulative appointments in 23/24 compared to 22/23. This has not changed since May.
- A service improvement plan is being developed with the team as the current approach was not seeing results.
- We are aiming for a rapid turnaround with weekly meetings with the senior team and clear roles, expectations and accountability,

Data taken from internal monitoring & power BI dashboard

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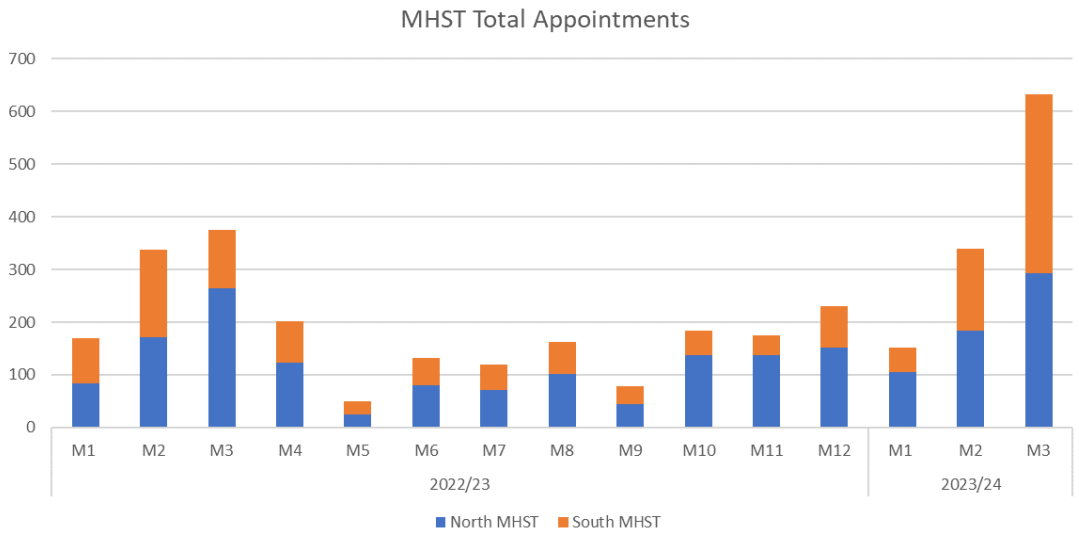
Appointments – MHST



- 27% increase in cumulative appointments in 23/24 compared to 22/23. This is from being 10% under last month.
- The team have made great efforts to get their activity on the system and have received support from the Ops Manager to ensure all contacts are correctly attached.
- In addition, they have delivered 15 NPA this year compared to 10 in the same period last year.
- We would like to include other metrics for MHST to reflect their reporting and the aims of their work

Data taken from internal monitoring & power BI dashboard

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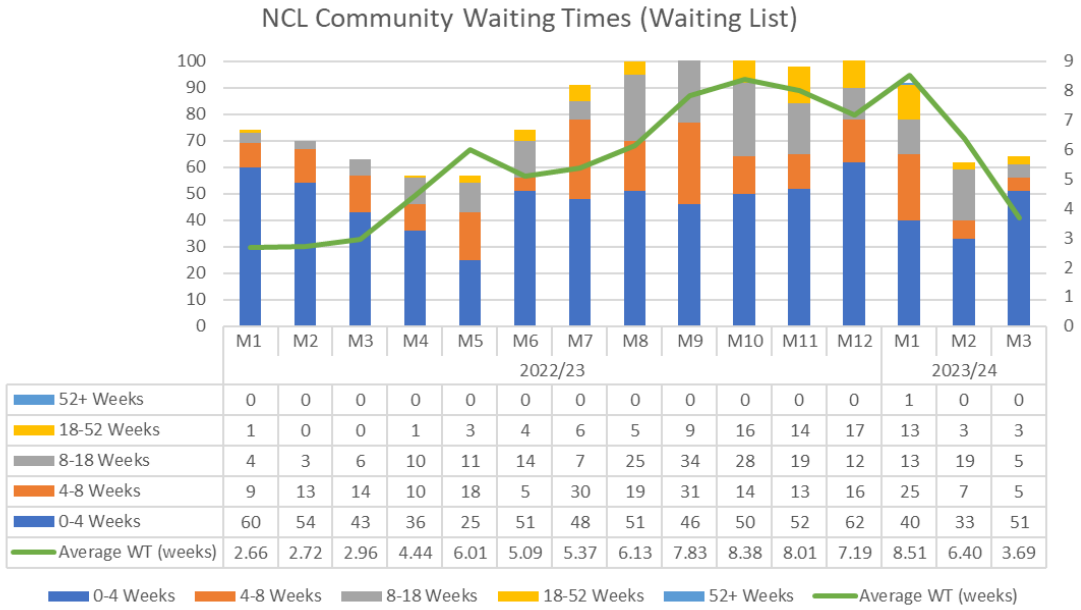
First Appointment Waits at end of each month – NCL Community



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
18-52 Weeks	1	0	0	1	3	4	6	5	9	16	14	17	13	3	3
8-18 Weeks	4	3	6	10	11	14	7	25	34	28	19	12	13	19	5
4-8 Weeks	9	13	14	10	18	5	30	19	31	14	13	16	25	7	5
0-4 Weeks	60	54	43	36	25	51	48	51	46	50	52	62	40	33	51
Average WT (weeks)	2.66	2.72	2.96	4.44	6.01	5.09	5.37	6.13	7.83	8.38	8.01	7.19	8.51	6.40	3.69

- We continue to see a reduction in how long those still waiting for contact have been waiting and this month this was below 4 weeks for the first time in a year.
- The majority are in the 0–4 week bracket.
- We hope this will be sustained and would like to acknowledge the engagement of the teams in PTL and the intake redesign which has, we believe, led to this.

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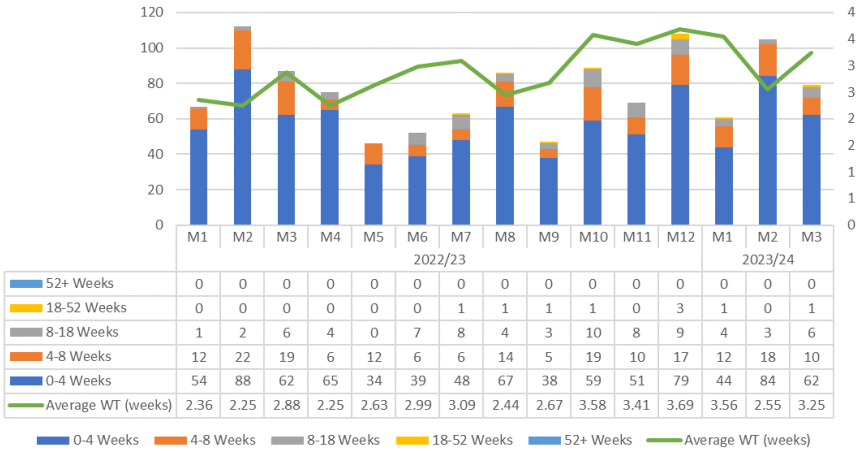
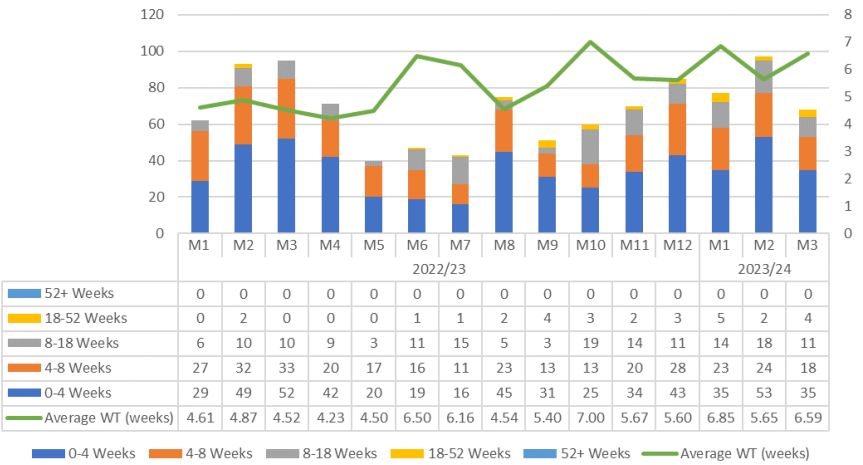
First and Second Appointment Waits for Patients Seen – NCL Community

NCL CommunityWaiting Times 1st Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-52 Weeks	0	0	0	0	0	0	1	1	1	1	0	3	1	0	1
8-18 Weeks	1	2	6	4	0	7	8	4	3	10	8	9	4	3	6
4-8 Weeks	12	22	19	6	12	6	6	14	5	19	10	17	12	18	10
0-4 Weeks	54	88	62	65	34	39	48	67	38	59	51	79	44	84	62
Average WT (weeks)	2.36	2.25	2.88	2.25	2.63	2.99	3.09	2.44	2.67	3.58	3.41	3.69	3.56	2.55	3.25

NCL Community Waiting Times 2nd Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-52 Weeks	0	2	0	0	0	1	1	2	4	3	2	3	5	2	4
8-18 Weeks	6	10	10	9	3	11	15	5	3	19	14	11	14	18	11
4-8 Weeks	27	32	33	20	17	16	11	23	13	13	20	28	23	24	18
0-4 Weeks	29	49	52	42	20	19	16	45	31	25	34	43	35	53	35
Average WT (weeks)	4.61	4.87	4.52	4.23	4.50	6.50	6.16	4.54	5.40	7.00	5.67	5.60	6.85	5.65	6.59

- There was a slight upturn in waiting times in June thought for first appointments we remain within our target.
- In the coming once as we move to a system of appointment 1 and 2 happening on the same day in NCCT and SCCT we hope to see significant improvement in 2nd appointment waiting times

Innovation in mind

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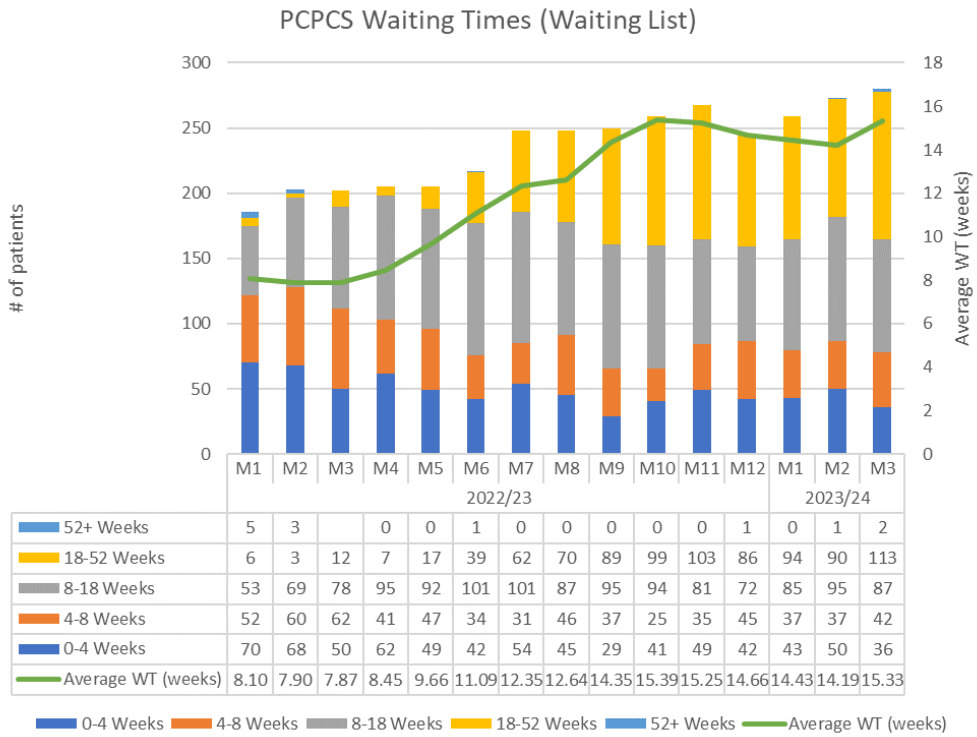
First Appointment Waits at end of each month – PCPCS



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	5	3		0	0	1	0	0	0	0	0	1	0	1	2
18-52 Weeks	6	3	12	7	17	39	62	70	89	99	103	86	94	90	113
8-18 Weeks	53	69	78	95	92	101	101	87	95	94	81	72	85	95	87
4-8 Weeks	52	60	62	41	47	34	31	46	37	25	35	45	37	37	42
0-4 Weeks	70	68	50	62	49	42	54	45	29	41	49	42	43	50	36
Average WT (weeks)	8.10	7.90	7.87	8.45	9.66	11.09	12.35	12.64	14.35	15.39	15.25	14.66	14.43	14.19	15.33

- After a minor reduction we saw an increase in waiting times in June.
- As set out above a service improvement plan is being developed with waiting times being a key priority.

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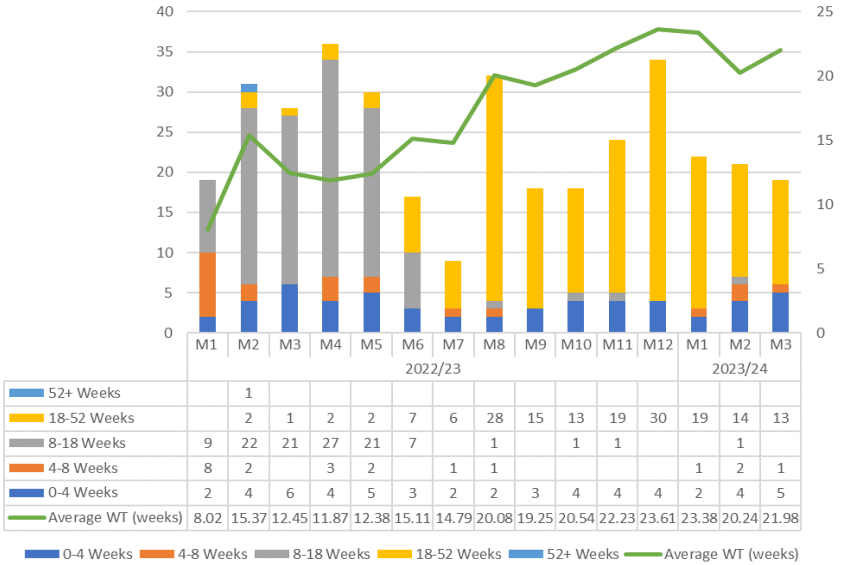
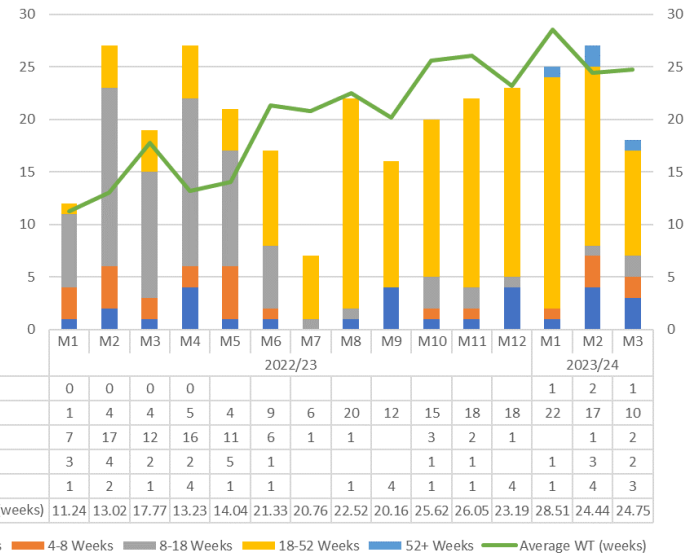
First and Second Appointment Waits for Patients Seen – PCPCS

PCPCS Waiting Times 1st Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks		1													
18-52 Weeks		2	1	2	2	7	6	28	15	13	19	30	19	14	13
8-18 Weeks	9	22	21	27	21	7		1		1	1			1	
4-8 Weeks	8	2		3	2		1	1					1	2	1
0-4 Weeks	2	4	6	4	5	3	2	2	3	4	4	4	2	4	5
Average WT (weeks)	8.02	15.37	12.45	11.87	12.38	15.11	14.79	20.08	19.25	20.54	22.23	23.61	23.38	20.24	21.98

PCPCS Waiting Times 2nd Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0									1	2	1
18-52 Weeks	1	4	4	5	4	9	6	20	12	15	18	18	22	17	10
8-18 Weeks	7	17	12	16	11	6	1	1		3	2	1		1	2
4-8 Weeks	3	4	2	2	5	1				1	1		1	3	2
0-4 Weeks	1	2	1	4	1	1		1	4	1	1	4	1	4	3
Average WT (weeks)	11.24	13.02	17.77	13.23	14.04	21.33	20.76	22.52	20.16	25.62	26.05	23.19	28.51	24.44	24.75

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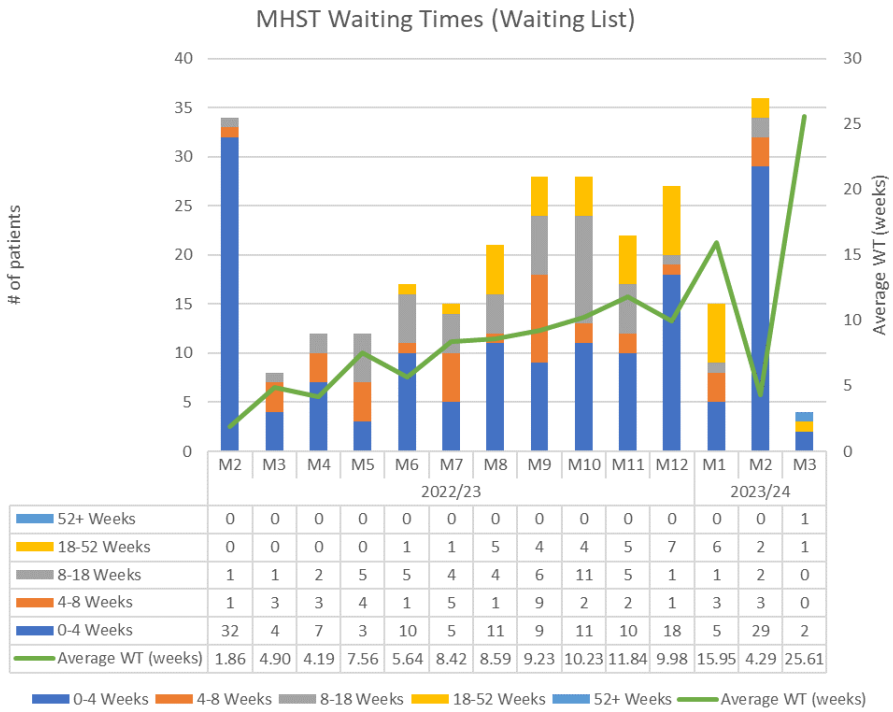
First Appointment Waits at end of each month – MHST



	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23											2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	1
18-52 Weeks	0	0	0	0	1	1	5	4	4	5	7	6	2	1
8-18 Weeks	1	1	2	5	5	4	4	6	11	5	1	1	2	0
4-8 Weeks	1	3	3	4	1	5	1	9	2	2	1	3	3	0
0-4 Weeks	32	4	7	3	10	5	11	9	11	10	18	5	29	2
Average WT (weeks)	1.86	4.90	4.19	7.56	5.64	8.42	8.59	9.23	10.23	11.84	9.98	15.95	4.29	25.61

- The team started several groups in May which significantly reduced the number waiting.
- The case waiting over 52 weeks is a data error that has now being corrected. As of 17.07.2023 the average waiting time in the team is 1.5 weeks.
- The team have just 7 people waiting for a first contact, the majority of whom have waiting less than 2 weeks. They have been very responsive to the PTL

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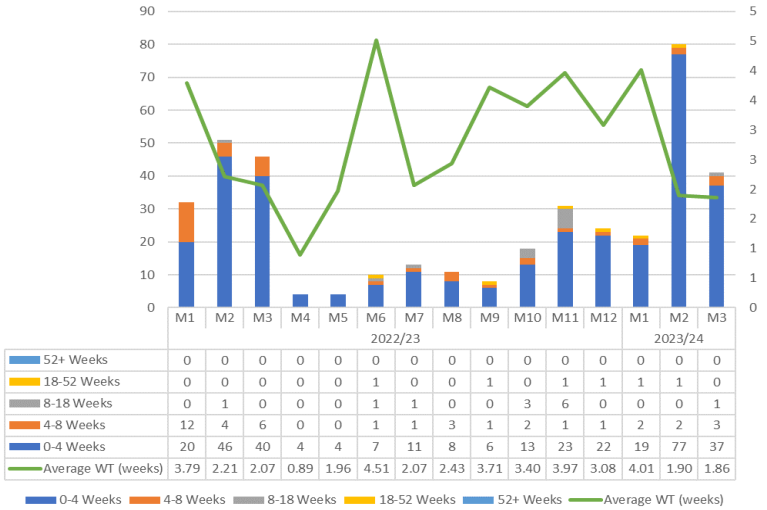
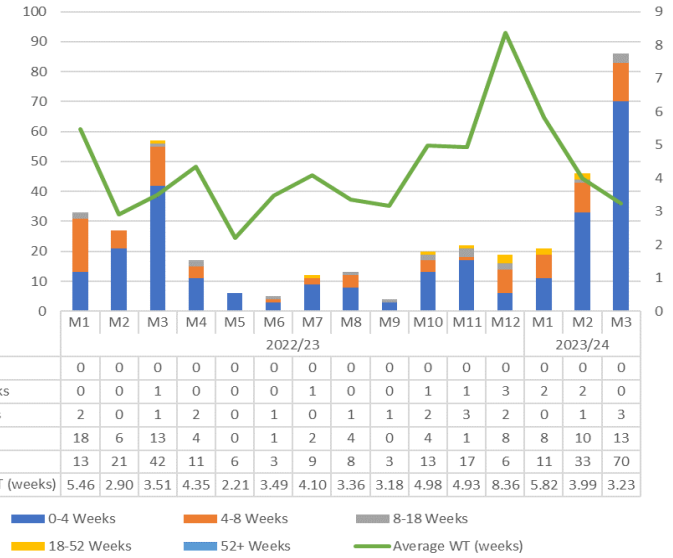
First and Second Appointment Waits for Patients Seen – MHST

MHST Waiting Times 1st Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-52 Weeks	0	0	0	0	0	1	0	0	1	0	1	1	1	1	0
8-18 Weeks	0	1	0	0	0	1	1	0	0	3	6	0	0	0	1
4-8 Weeks	12	4	6	0	0	1	1	3	1	2	1	1	2	2	3
0-4 Weeks	20	46	40	4	4	7	11	8	6	13	23	22	19	77	37
Average WT (weeks)	3.79	2.21	2.07	0.89	1.96	4.51	2.07	2.43	3.71	3.40	3.97	3.08	4.01	1.90	1.86

MHST Waiting Times 2nd Appointment (Patients Seen)



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
52+ Weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-52 Weeks	0	0	1	0	0	0	1	0	0	1	1	3	2	2	0
8-18 Weeks	2	0	1	2	0	1	0	1	1	2	3	2	0	1	3
4-8 Weeks	18	6	13	4	0	1	2	4	0	4	1	8	8	10	13
0-4 Weeks	13	21	42	11	6	3	9	8	3	13	17	6	11	33	70
Average WT (weeks)	5.46	2.90	3.51	4.35	2.21	3.49	4.10	3.36	3.18	4.98	4.93	8.36	5.82	3.99	3.23

- We continue to see reductions in waiting times in MHST with them meeting the target for both first and second appointments now.

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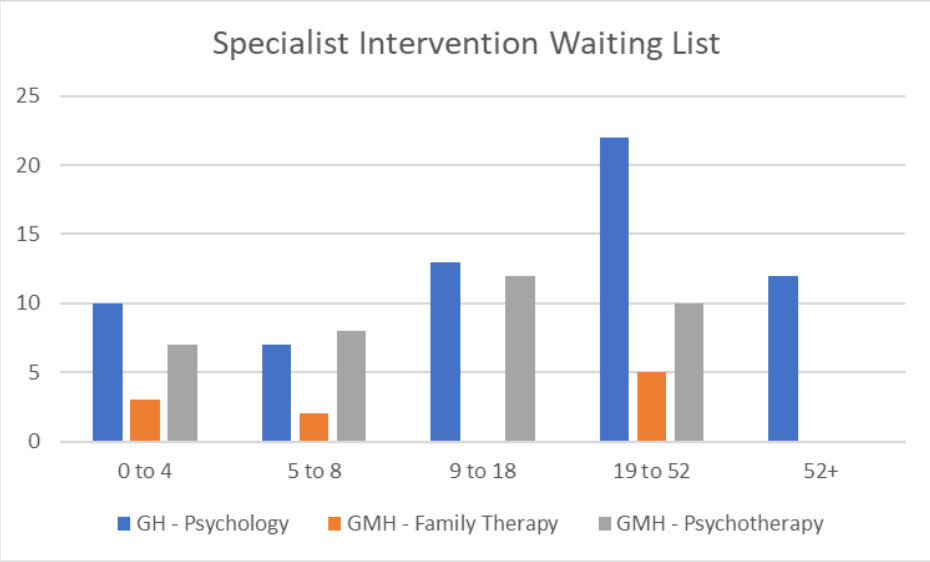
Intervention Waits



- From September we will use Carenotes reporting for this so will be able to provide figures over time.
- In June we saw an increase in the number of cases waiting over a year for treatment.
- We have had some challenges in training staff to use the new system.
- The Family Therapy lead for NCCT and SCCT has been proactively reaching out to leads for psychology and psychotherapy to try are redistribute some of the load where appropriate

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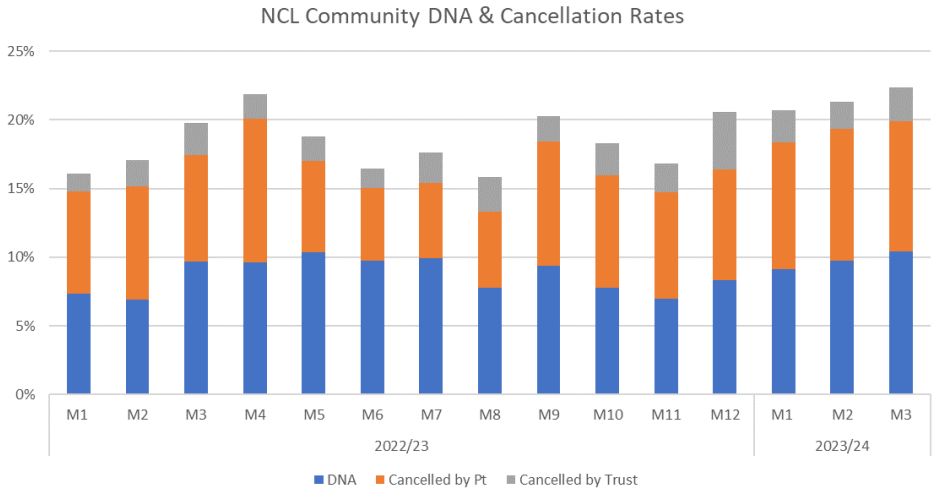
DNAs and Cancellations – NCL Community

- DNA rate in NCL community has just exceeded 10%.
- As agreed, we will not be taking targeted action on DNA's or cancellations in this financial year but will continue to monitor figures given this development.



Data taken from internal monitoring & power BI dashboard

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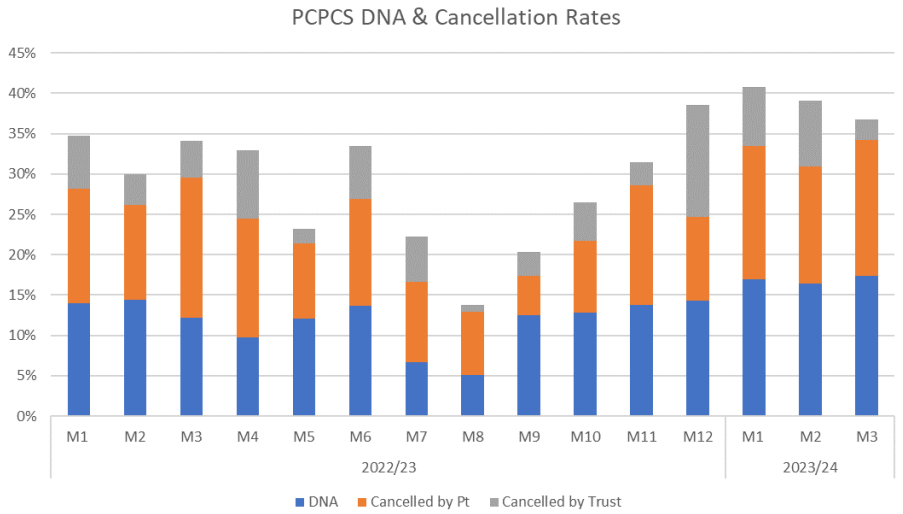
DNAs and Cancellations – PCPCS

DNA's

- The DNA rate in Hackney has consistently been high.
- The service remit is to try and engage hard to reach populations however we could do more to evidence that we have done all we can to ensure attendance.
- We will consider this as part of the service improvement plan

Cancellations

- It would be helpful to ID if there is a target cancellation rate and think about what we can do to address this in line with the above.



Data taken from internal monitoring & power BI dashboard

Numbers based on the percentage of booked appointments. Number of appointments booked do not reflect clinicians resource in the service, which we know is decreasing.

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The Tavistock and Portman NHS Foundation Trust

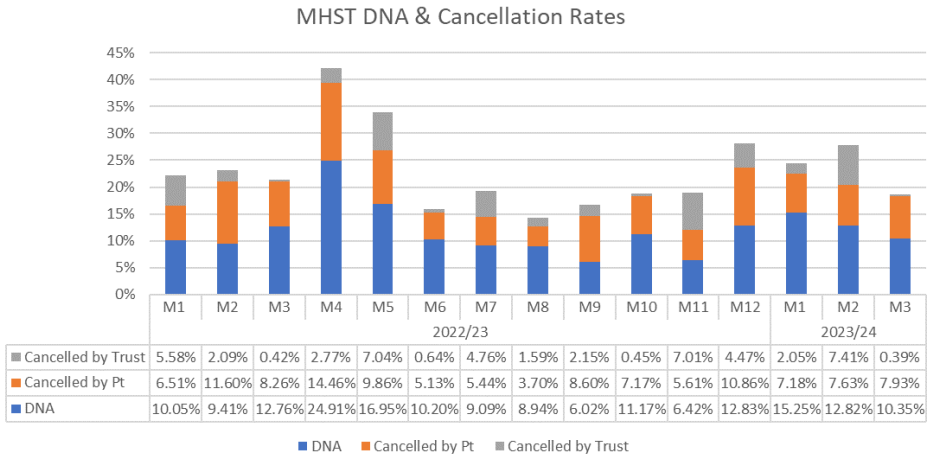
DNAs and Cancellations – MHST

DNA's

- The DNA rate in MHST has fallen over the last 3 months and is now within the target range.

Cancellations

- There has been a small increase in cancellations but this likely reflects a change from DNA to cancellation which is positive



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3
	2022/23												2023/24		
Cancelled by Trust	5.58%	2.09%	0.42%	2.77%	7.04%	0.64%	4.76%	1.59%	2.15%	0.45%	7.01%	4.47%	2.05%	7.41%	0.39%
Cancelled by Pt	6.51%	11.60%	8.26%	14.46%	9.86%	5.13%	5.44%	3.70%	8.60%	7.17%	5.61%	10.86%	7.18%	7.63%	7.93%
DNA	10.05%	9.41%	12.76%	24.91%	16.95%	10.20%	9.09%	8.94%	6.02%	11.17%	6.42%	12.83%	15.25%	12.82%	10.35%

Data taken from internal monitoring & power BI dashboard

Numbers based on the percentage of booked appointments. Number of appointments booked do not reflect clinicians' resource in the service, which we know is decreasing.

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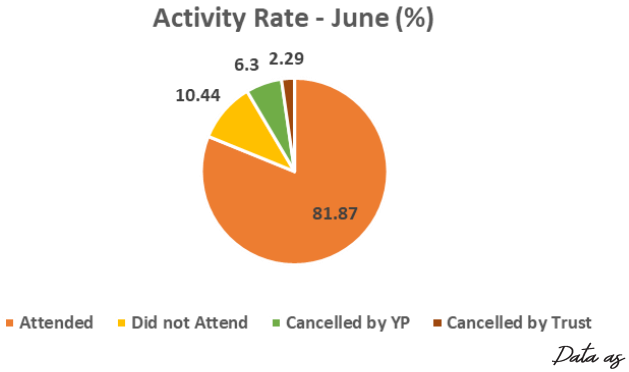
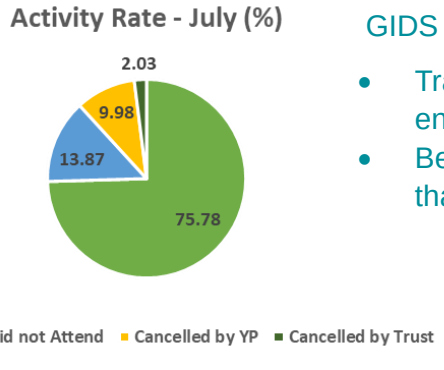
GIDS Appointments, DNAs and Cancellations

GIDS	June		July	
	Activity	Rate (%)	Activity	Rate (%)
Attended	429	81.87	410	75.78
Did not Attend	50	10.44	66	13.87
Cancelled by YP	33	6.3	54	9.98
Cancelled by Trust	12	2.29	11	2.03





There was a 6% drop in the number of attended appointments between June 2023 and July 2023. This slight reduction in activity correlates to the departure of key senior staff as well as other factors such as high level of Clinician staff sickness.

There is an ongoing review of the Cancellation and DNA Policy in order to effectively support DNA processes and procedures to remain within the DNA national target, which GIDS breached in July 2023.

GIDS will actively continue to:

- Track patients on PTL meeting on weekly basis to ensure that patients will be seen.
- Benchmark activity vs Job planning template to ensure that activity target for Clinicians are met.

Data as of 17/08/23

Data taken from internal monitoring & power BI dashboard

Numbers based on the percentage of booked appointments. Number of appointments booked do not reflect clinicians' resource in the service, which we know is decreasing.

66

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GIDS First and Second Appointment Waits

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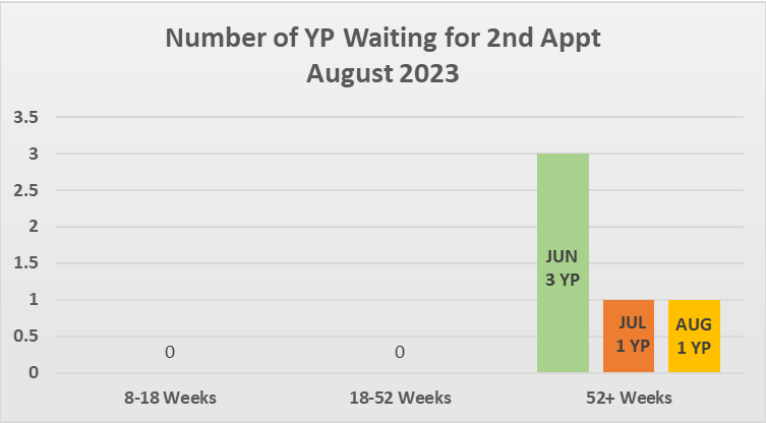
First Appointment Waits

There are no 1st Appointments waits

Second Appointment Waits



	No. of YP		
Waiting Time	**June**	**July**	**August**
8-18 Weeks	0	0	0
18-52 Weeks	0	0	0
52+ Weeks	3	1	1

Data correct as at 17/08/2023

- There is one YP waiting over 52 weeks for a 2nd appointment. Clinician has been contacted to allocate appointment.

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17+ Waiting List Transfer Progress

	GIDS Transfer of the Care - 17+	Total number of referrals	Start Date	Due Date	Number completed	Comments	% Progress to completion	RAG Status
Region								
1	Wales	122	Mar-23	Apr-23	118	Complete	100%	COMPLETE
2	London GIC	364	Apr-23	May-23	364	Complete	100%	COMPLETE
3	Leeds GIC	86	May-23	Jul-23	86	Complete	100%	COMPLETE
4	C-Magic GIC	79	May-23	Jul-23	79	Complete	100%	COMPLETE
5	Northampton GIC	89	May-23	Jul-23	89	Complete	100%	COMPLETE
6	Sheffield GIC	45	May-23	Jul-23	45	Complete	100%	COMPLETE
7	***Newcastle GIC**	66	May-23	Jul-23	66	Complete	100%	COMPLETE
8	Nottingham GIC	64	May-23	Jul-23	64	Complete	100%	COMPLETE
9	Indigo GIC	78	May-23	Jul-23	78	Complete	100%	COMPLETE
10	Exeter GIC	49	May-23	Jul-23	49	Complete	100%	COMPLETE
11	Ireland/N Ireland GIC	31	Jul-23	Sep-23	0	Outstanding	Pending	RED
12	Guernsey	1	Jul-23	Sep-23	0	In progress	25%	AMBER
13	Isle of Man	1	Jul-23	Sep-23	0	In progress	25%	AMBER

97% of transfers to adult GICs are complete.

The remaining 3% are referrals sat outside of the UK. **Isle of Man** and **Guernsey** transfers are in progress, and separate arrangements have been agreed for **Ireland**.

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18+ Open Case Load Template

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18+ GIDS New adult referral template	Total number of referrals	Start Date	Due Date	% Progress to completion	RAG Status
Total No of cases	202				
Referral form for 18+ transfers enacted but may not be accepted by adult GICs (on CN report; 58 on PC s/s)	172	Jun-23	Sep-23	100%	COMPLETE
Referral form for 18+ transfers enacted but may not be accepted by adult GICs (on CN report stating no form & on PC report)	1	Jun-23	Sep-23	100%	COMPLETE
Referral form for 18+ transfers enacted but may not be accepted by adult GICs (not on CN report; have status as 'Closed' on PC report)	35	Jun-23	Sep-23	100%	COMPLETE
Total no. of cases without forms (on CN report & not PC report)	13	Jun-23	Sep-23	75%	GREEN
Total no. of cases with no referral form undergoing clinical and admin actions (on CN report and PC report)	16	Jun-23	Sep-23	75%	GREEN
Total no. of cases without forms undergoing clinical and admin actions (not on CN report)	7	Jun-23	Sep-23	75%	GREEN

In total, 85% 18+ patients that have completed referral forms. The remaining 15% do not have completed referral form because of various reasons such as YP still in train and not yet referred to adult service.

The new adult template form is now on Carenotes to enable tracking of cases and productions of reports to measure outcomes.

GIC Referrals

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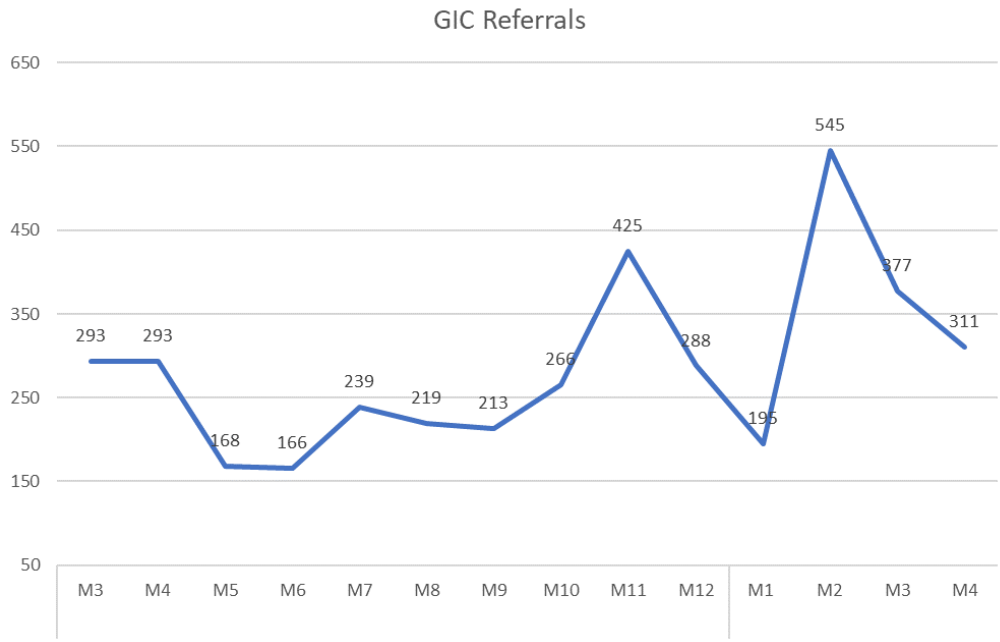
The number of referrals received has slightly decreased in Q1 compared to the last quarter. All referrals are now being managed via the Electronic Referral System. On receipt of referrals, non-complex patients are being screened and referred to their local GIC however the patient is given a choice whether they are seen within this or their local service.



Data taken from internal monitoring dashboard

GIC Appointments

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Attended Appointments

We have an attendance rate of 64% for the month of July, a drop from 69% reported in June. One of the main reasons being due to sickness in the team. Activity targets will be monitored to effectively manage waiting lists and throughput.

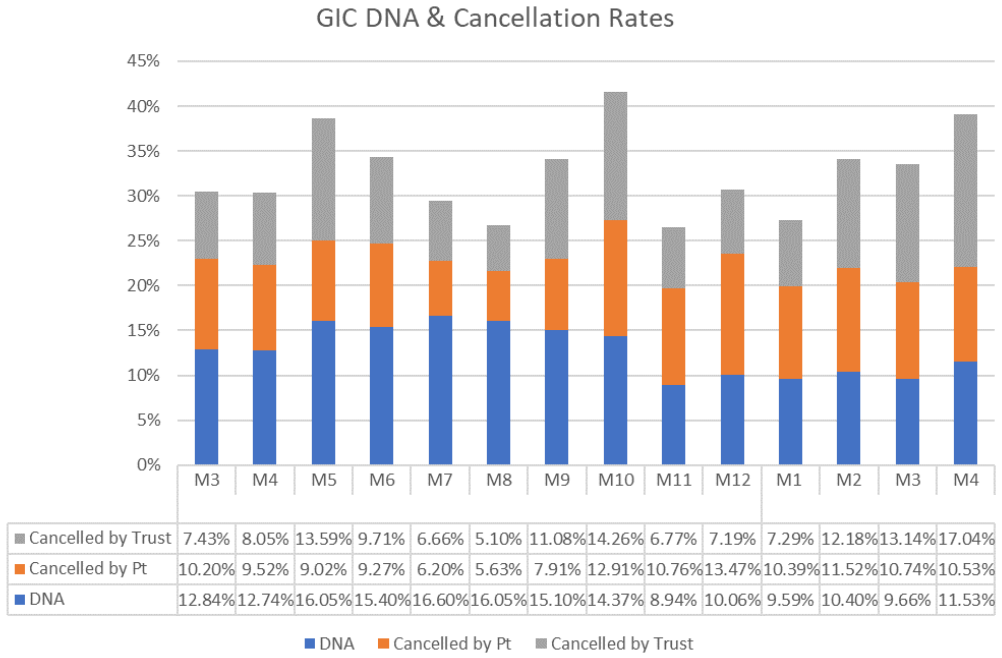
DNA's

The services DNA rate is reported at 11.53% which is above the national target. GIC will continue to actively monitor DNA's and apply the principles in the service DNA policy. Although enacting the DNA policy has reduced the number of DNA's in the service, some clinicians have raised concerns and presented challenge regarding its application.

The Clinical Director is currently reviewing the process, following which this will be discussed at the Clinical Governance Meeting. The operational team will continue to monitor trends to measure the impact of the policy changes on DNA's.

Cancellations

There are high number of appointments are cancelled by Trust staff. This is related to a high volume of sickness for clinicians in June and July however there is also a system issue that does not allow for rescheduling on Care Notes that does result in a higher number of cancellation captured (patients moved by an hour can show up in the reports as cancelled by trust even though it is a rescheduled time..



	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4
Cancelled by Trust	7.43%	8.05%	13.59%	9.71%	6.66%	5.10%	11.08%	14.26%	6.77%	7.19%	7.29%	12.18%	13.14%	17.04%
Cancelled by Pt	10.20%	9.52%	9.02%	9.27%	6.20%	5.63%	7.91%	12.91%	10.76%	13.47%	10.39%	11.52%	10.74%	10.53%
DNA	12.84%	12.74%	16.05%	15.40%	16.60%	16.05%	15.10%	14.37%	8.94%	10.06%	9.59%	10.40%	9.66%	11.53%

Data taken from internal monitoring & power BI dashboard

Numbers based on the percentage of booked appointments. Number of appointments booked do not reflect clinicians' resource in the service.

GIC First Appointment Waits at end of each month

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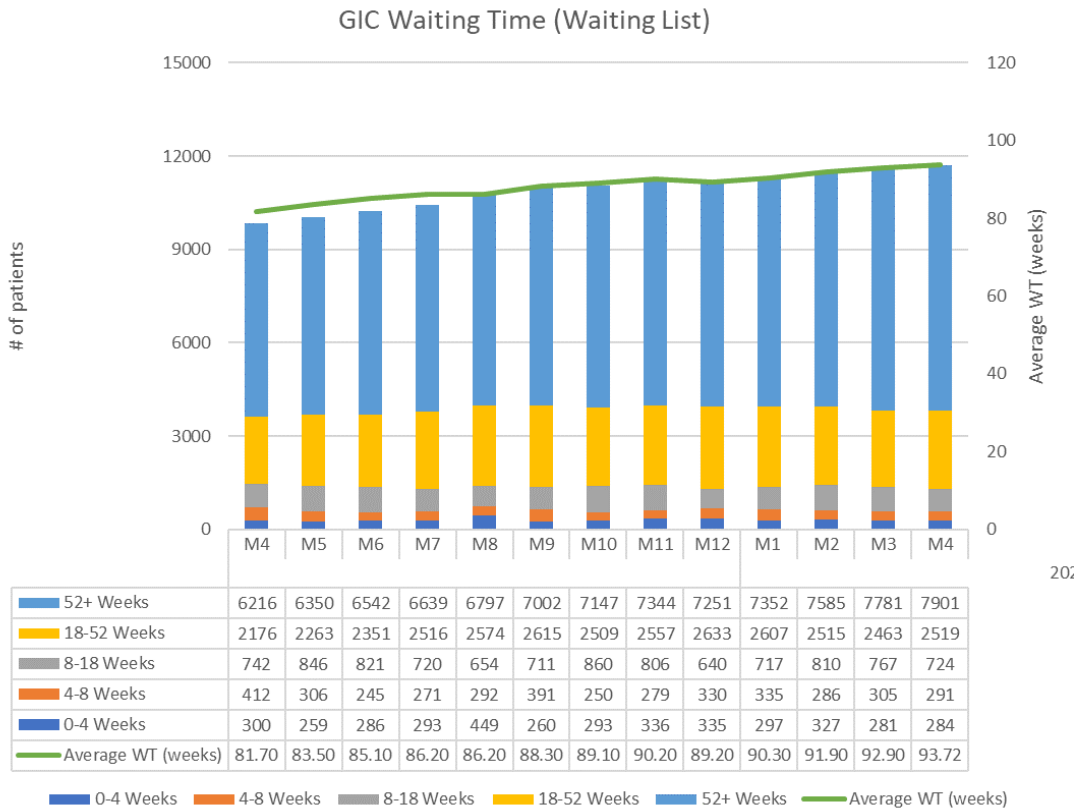
GIC are actively recruiting additional medical staff which we anticipate will increase our productivity and ability to see more patients.

- The service continues to fall significantly below the 18-week waiting time target due to significant rise in referrals over the past 4 years combined with a high active caseload. Internally, the Trust have agreed a Waiting list reduction quality priority with a related action plan.

- The service is going out to procurement of the digital platform for the CX Clinic, which will streamline patient access and improve preparedness for assessment and completing the pathway.

- The service is working with NHSE and the Adult Gender pilot sites to transfer some patients, in bulk, to their local services. Patients will be asked to opt out of transfer if they wish to remain with the service. There are several interdependencies and potential risk of inequitable access which we hope to resolve through a shared patient transfer protocol.



	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4
52+ Weeks	6216	6350	6542	6639	6797	7002	7147	7344	7251	7352	7585	7781	7901
18-52 Weeks	2176	2263	2351	2516	2574	2615	2509	2557	2633	2607	2515	2463	2519
8-18 Weeks	742	846	821	720	654	711	860	806	640	717	810	767	724
4-8 Weeks	412	306	245	271	292	391	250	279	330	335	286	305	291
0-4 Weeks	300	259	286	293	449	260	293	336	335	297	327	281	284
Average WT (weeks)	81.70	83.50	85.10	86.20	86.20	88.30	89.10	90.20	89.20	90.30	91.90	92.90	93.72

GIC First and Second Appointment Waits for Patients Seen

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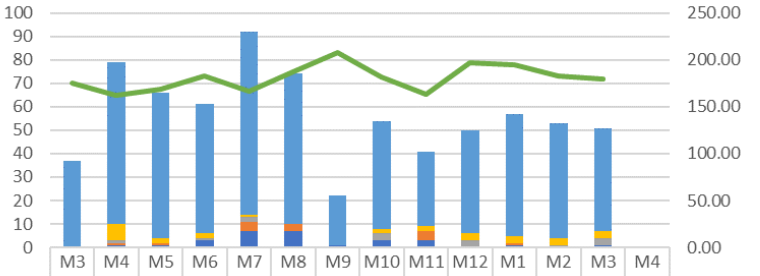
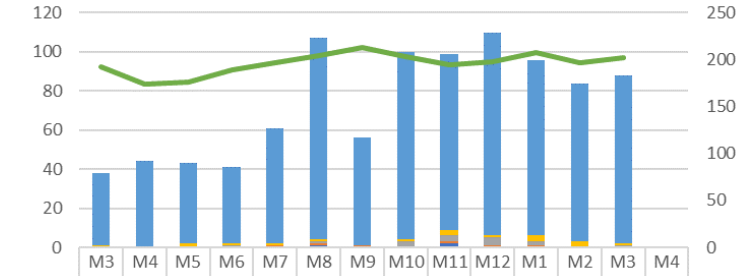
GIC Waiting Times 1st Appointment (Patients Seen)



	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4
52+ Weeks	37	69	62	55	78	64	21	46	32	44	52	49	44	
18-52 Weeks		7	2	2	1			2	2	3	3	3	3	
8-18 Weeks		1		1	2			3		3		1	3	
4-8 Weeks		1	1		4	3			4		1			
0-4 Weeks		1	1	3	7	7	1	3	3		1		1	
Average WT (weeks)	174.7	162.4	169.0	183.0	166.7	187.0	207.7	181.9	163.7	196.9	194.8	183.1	179.2	

0-4 Weeks 4-8 Weeks 8-18 Weeks
18-52 Weeks 52+ Weeks Average WT (weeks)

GIC Waiting Times 2nd Appointment (Patients Seen)

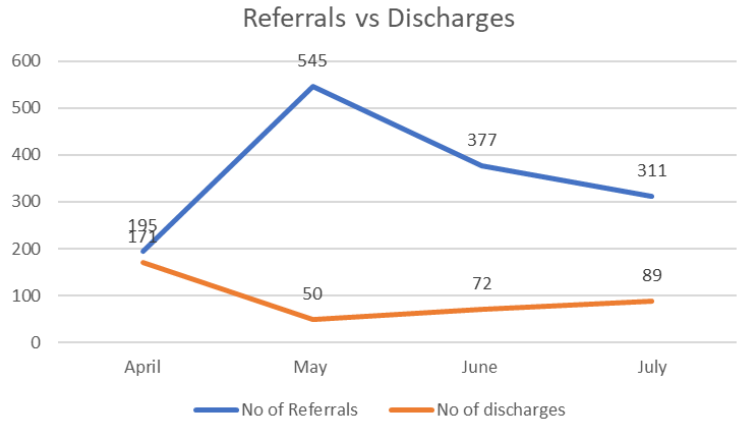


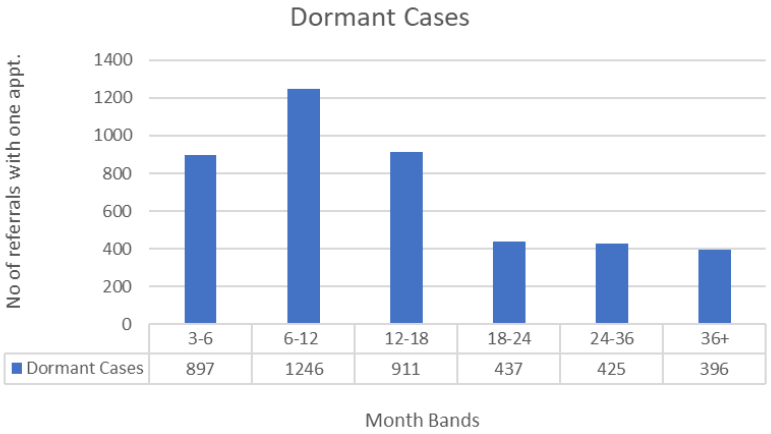
	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4
52+ Weeks	37	44	41	39	59	103	55	96	90	104	90	81	86	
18-52 Weeks	1		2	1	1	1		1	3	1	3	3	1	
8-18 Weeks				1		1		3	3	4	2		1	
4-8 Weeks					1	1	1		1	1	1			
0-4 Weeks						1			2					
Average WT (weeks)	192.0	174.5	176.1	189.7	196.4	204.7	212.6	202.8	194.0	198.0	207.2	197.2	201.6	

0-4 Weeks 4-8 Weeks 8-18 Weeks
18-52 Weeks 52+ Weeks Average WT (weeks)

- GIC has continued to increase clinical activity from March 2023
- Two Speciality Doctor vacancy posts have been filled and due to start Oct in 2023.
- The service remains below the 2nd appointment waiting time target. The service intends to resolve this by prioritising consecutive DNA's and Dormant cases in PTL meetings to create capacity for 2nd appointments.

GIC Discharges and Dormant cases





- As of the 30th August 2023 there are 4294 Dormant Cases.
- The PTL are working with clinicians weekly to review dormant patients and discharging where clinically appropriate.
- A Total of 161 patient were discharged in June and July.

Data taken from internal monitoring & power BI dashboard

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7. Quality and Patient Safety

- Clinical Outcome Measures
- Clinical Notes and Care Plan Compliance
- Incidents
- Compliments
- Complaints
- PPI

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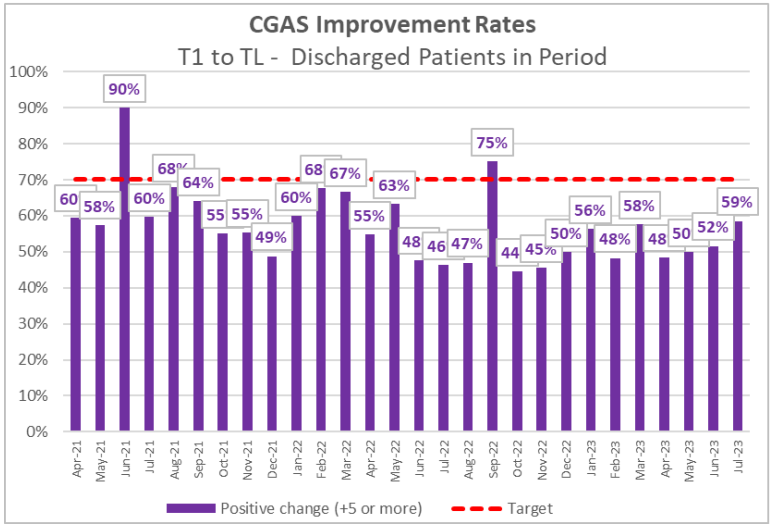
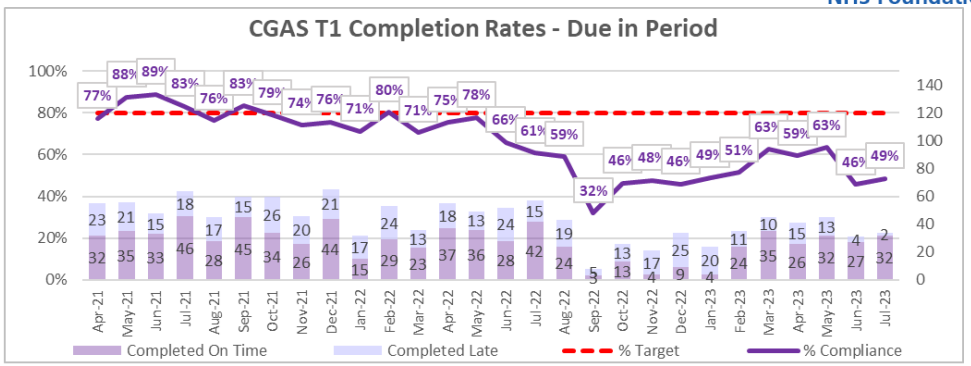
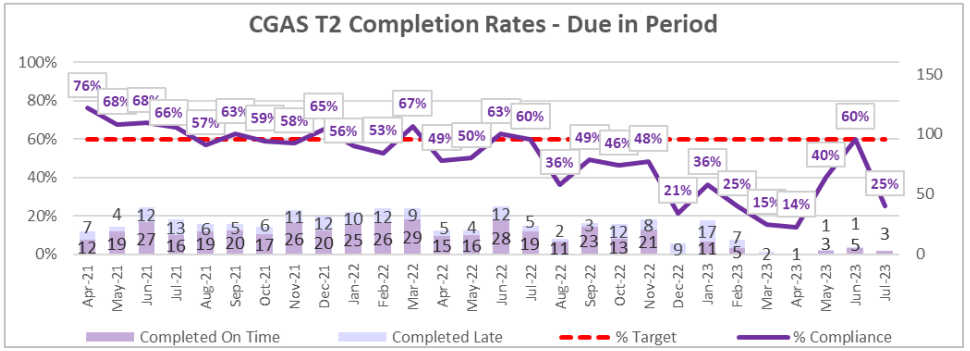
Outcomes – CGAS







- Completion rates continue to be much lower than pre-Carenotes outage and work is required to re-engage the clinical teams
- Requested to be shown as match pairs and for improvement % to be included in future months

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Clinical Outcomes – GIDS CGAS Completion

CGAS report for Q1: 1st April – 30th June 2023

The CGAS is one of the reported outcome measures agreed by Commissioners.

GIDS CGAS KPI Data: 2023/24 Quarter 1 Update		
Total number of cases discharged		**136**
	First CGAS	**Last CGAS**
Total no. CGAS completed	**132**	**135**
% completion rate	**97.1%**	**99.3%**
Mean CGAS score	64.0	67.8
From all GIDS patients discharged between 1st April – 30th June 2023:		
97.1% completed a CGAS at assessment		
99.3% completed a CGAS at close		

CGAS completion for Q1 at rate of 99.3%

- *CGAS data is reported quarterly.*
- *Carenotes has assistant panel function which prompts clinicians to complete CGAS. This is embedded as part of the clinical assessment process.*
- *Informatics has worked with GIDS in creating alerts for CGAS outcome measures.*

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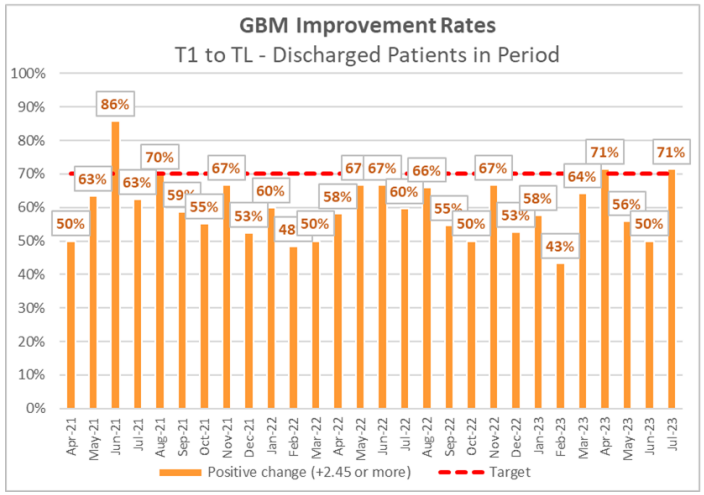
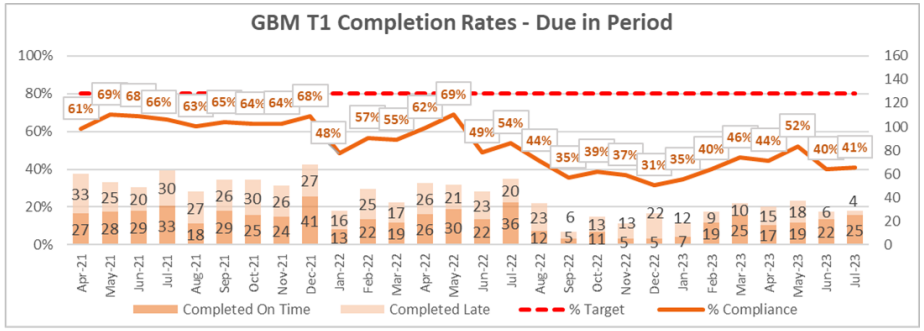
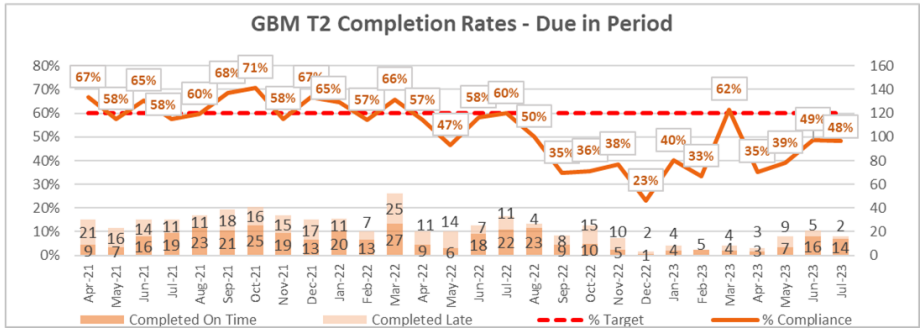
Outcomes – GBM







- Completion rates continue to be much lower than pre-Carenotes outage and work is required to re-engage the clinical teams
- Requested performance to be shown as match pairs and for improvement % to be included in future months

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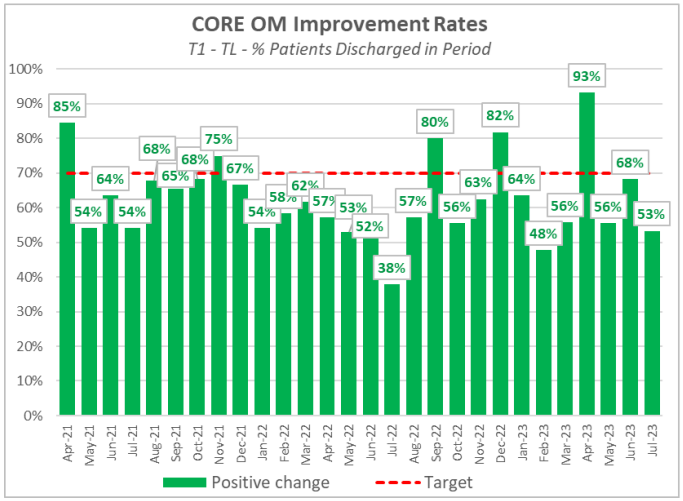
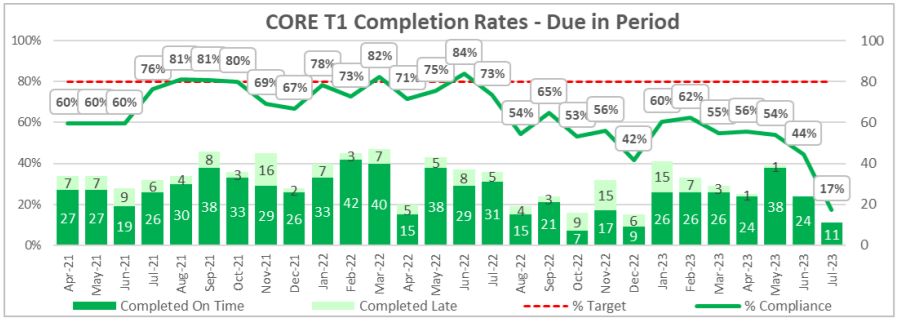
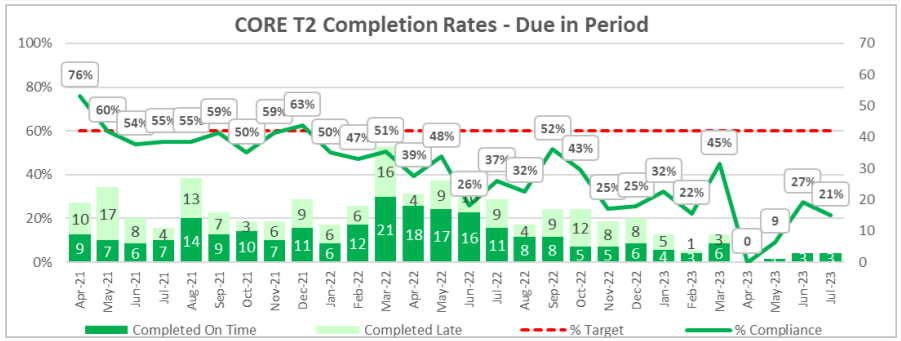
Outcomes – CORE







- Service specific data and data on performance not available this month but has been requested to be provided monthly going forward
- Qualtrics has restarted restarted for Adult Complex & being implemented at The Portman and improvements are being seen

Innovation in mind

Complex Mental Health Clinical Notes

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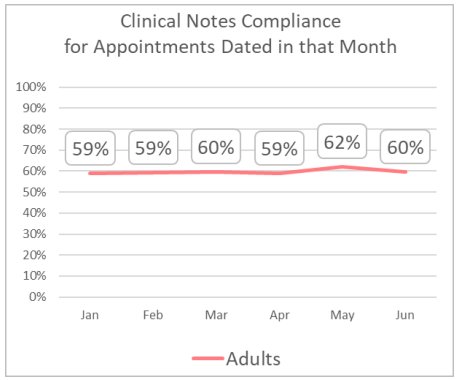

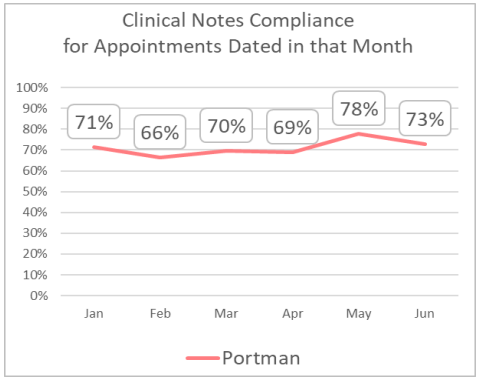

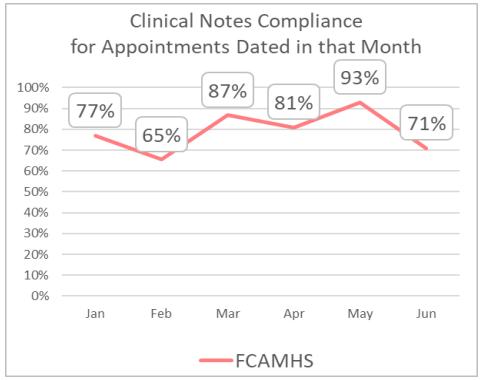

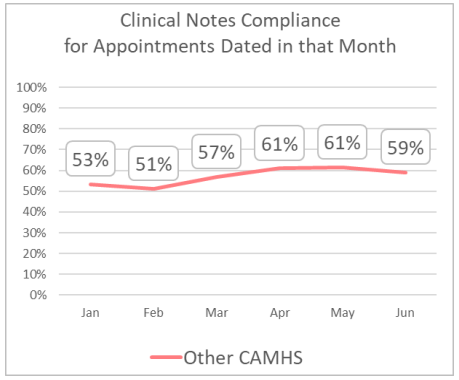

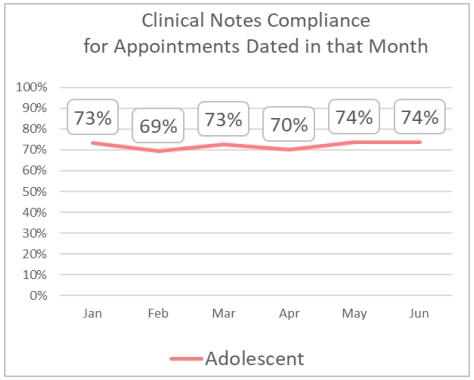

- Performance still varies by team & requires ongoing review to understand how to support staff to improve capture
- The Portman team focused on note completion in May, which resulted in a 9% improvement and are now sending regular reminders for missing notes
- CMH governance meeting considering suggestion for admin to add clinical notes for cancellations

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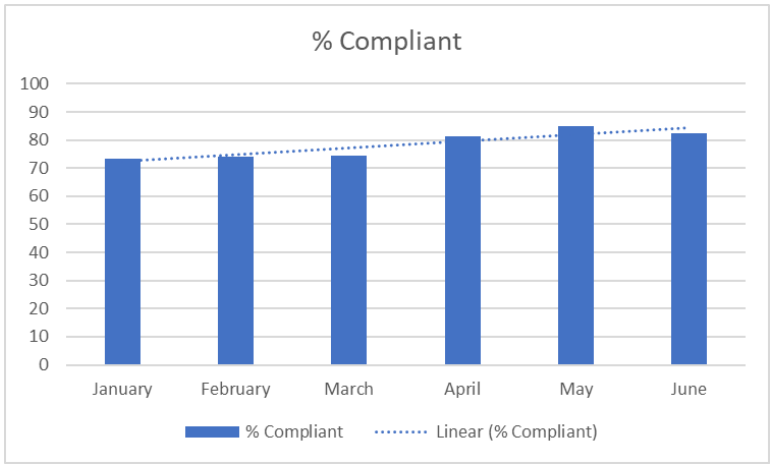
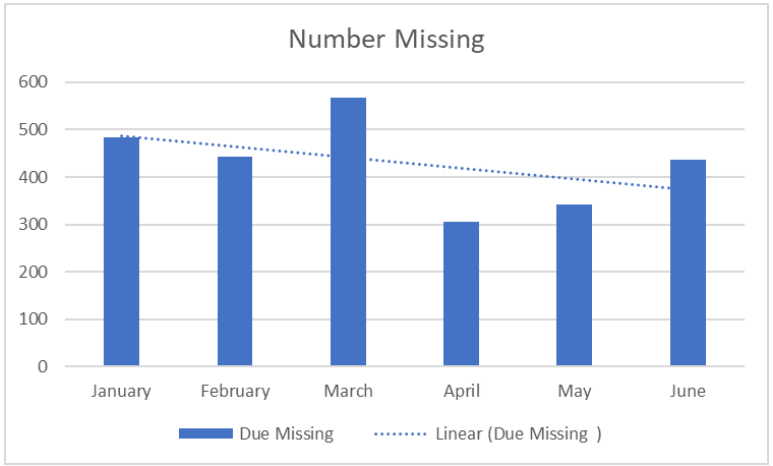
Clinical Notes – NCL Community





- While there were more missing in June, this is in the context of more appointments so the % compliance remains around 80%.
- We will this month ID if some teams are having more of an issue than others and focus on training for them

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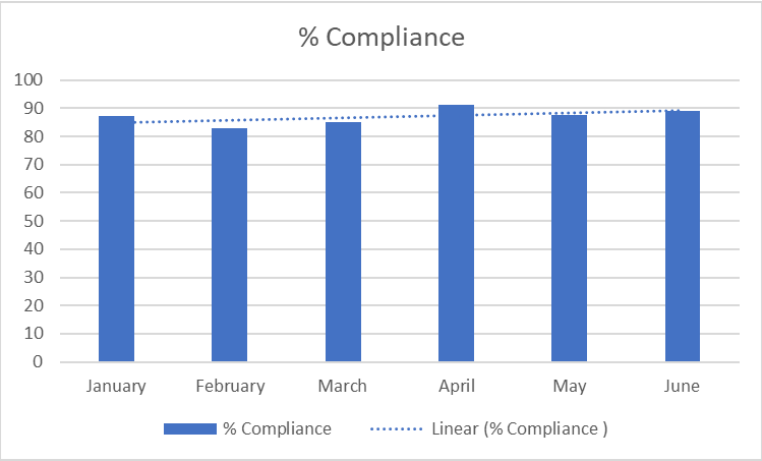
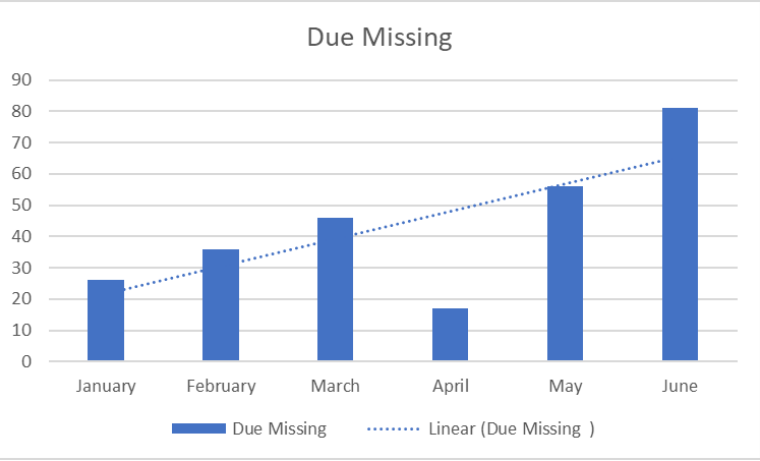
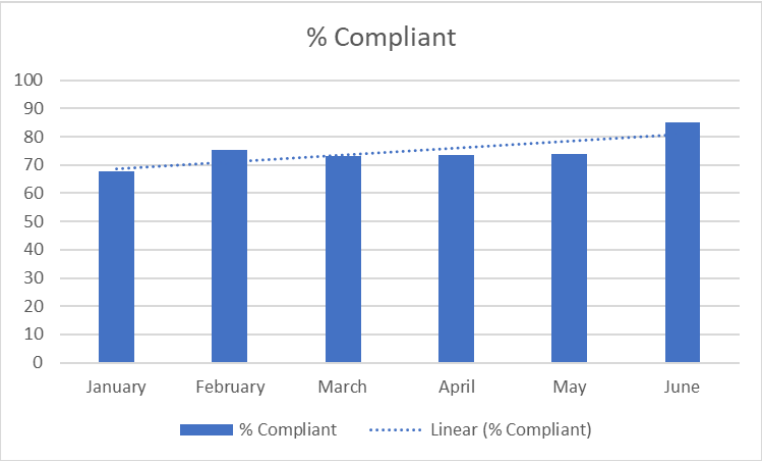
Clinical Notes – MHST

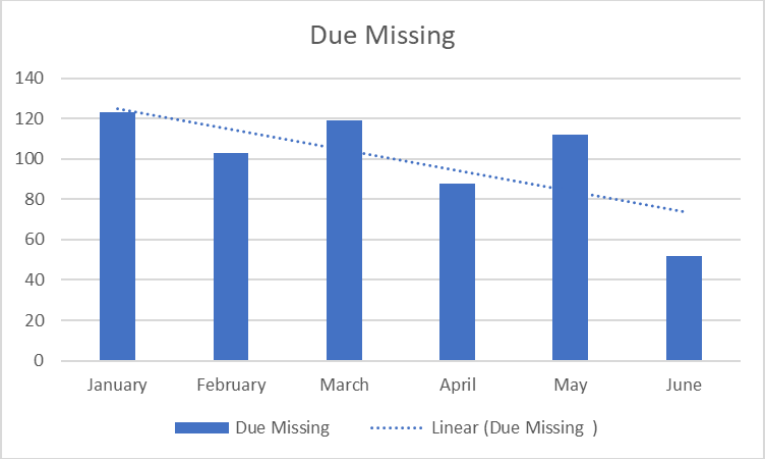




- While the number missing in MHST is increasing, they remain our best performing team at 90% compliance. The higher number reflects a significant increase in recorded activity in the period

Clinical Notes – PCPCS





- PCPCS have made real improvement in the last month with the % compliance increasing and number of missing notes falling significantly.
- We will discuss any lessons learned that they could share with the wider service line

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GIDS Clinical Notes

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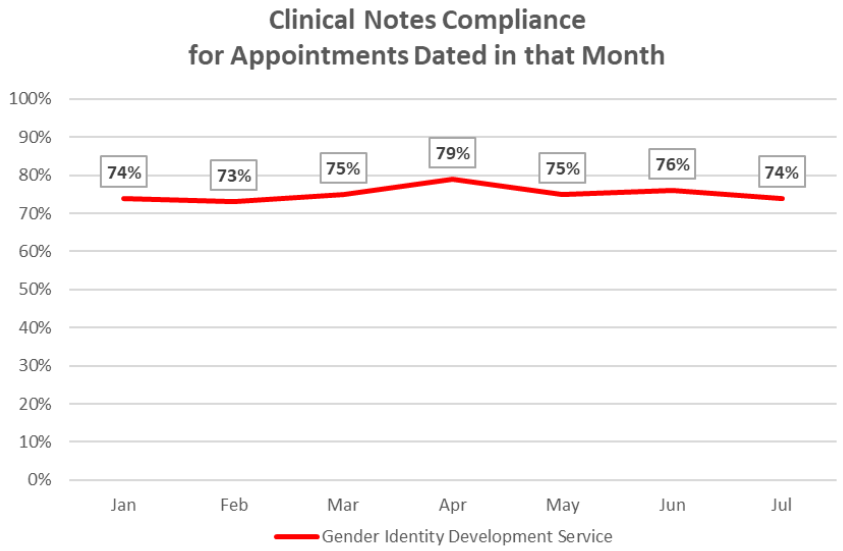

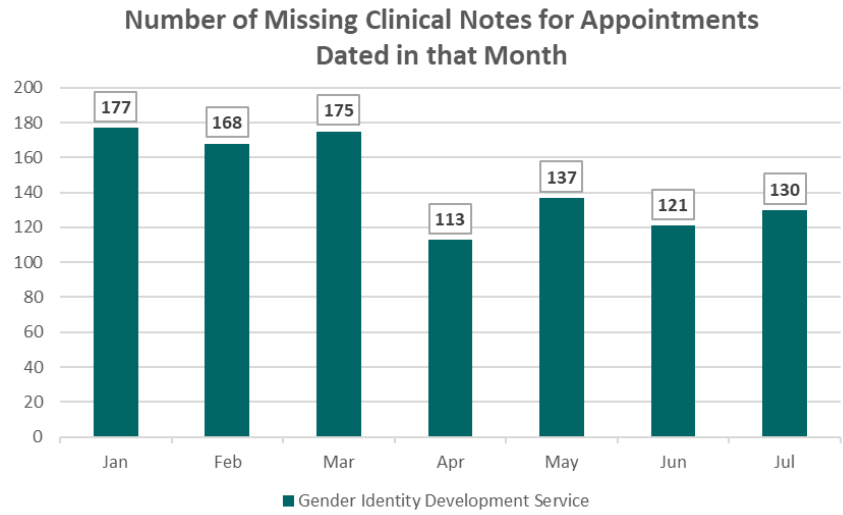

GIDS Completion Rates YTD (from Jan to Jun) 75%

Data ran on 17/08/23

GIDS Total Number Missing Notes YTD (from Jan to Jun) 1021

Year to date number of forms missing is 1021.

The Ops Team have escalated this to the regional leads who are in the process of disseminating across teams for action. To help compliance, via the PTL meeting, the admin team will escalate to clinicians any missing clinical notes from cases that are tracked.

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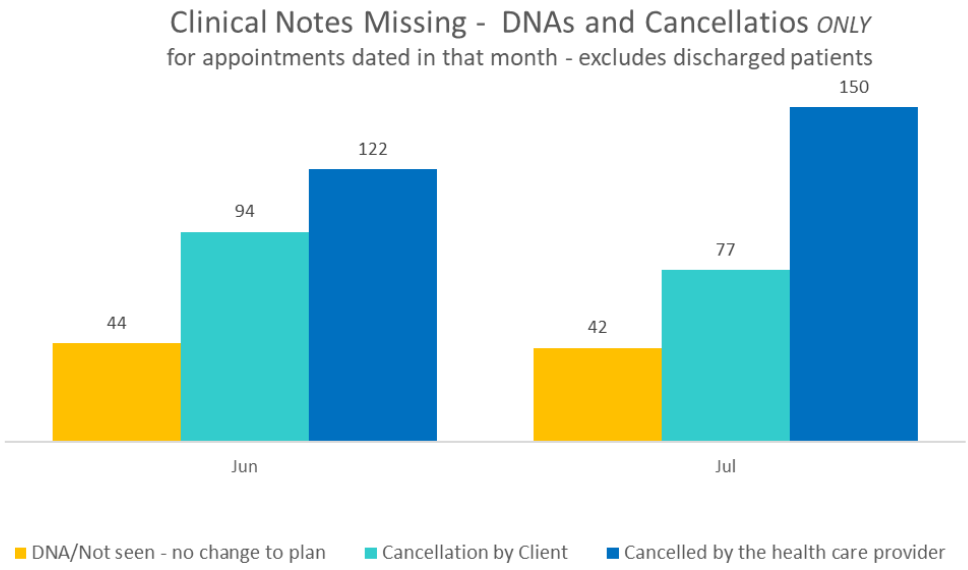
GIC Missing Clinical Notes

GIC are now able to share data on missing clinical notes. As per Trust policy, the clinical notes should be linked/attached to an appointment. Staff are being offered training to ensure the service are following the correct process.

The administrative team will be responsible for attaching all cancelled appointment clinical notes to the correct encounters on CN.

The Clinicians are responsible for ensuring all DNA's appointment clinical notes are attached to the appropriate encounters on CN.



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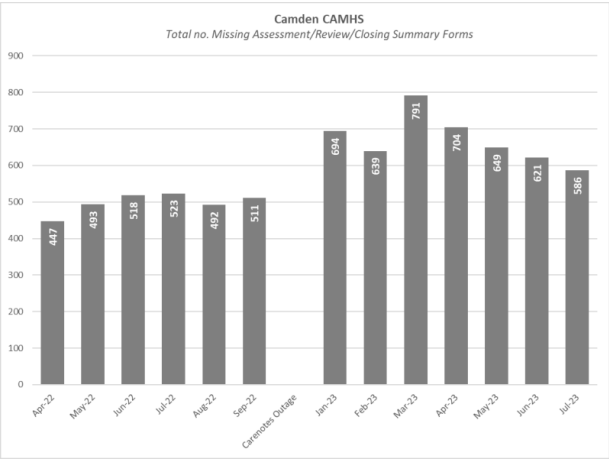
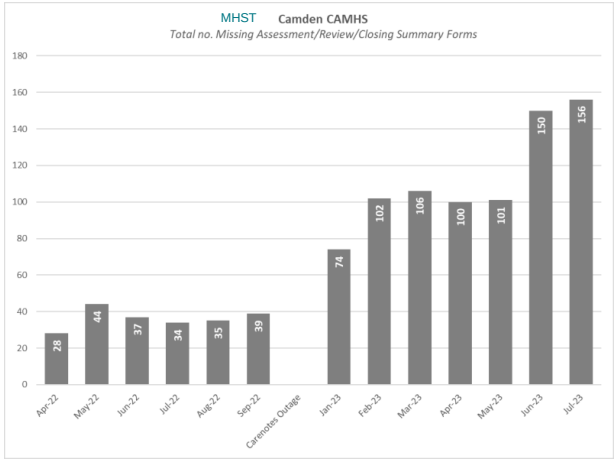
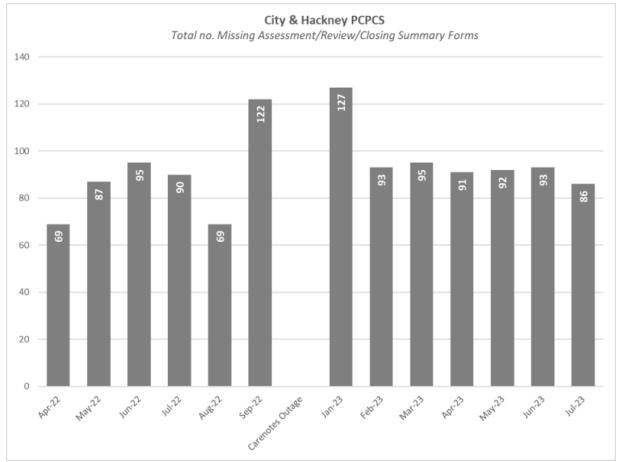
Assessment & Review Summaries Community and Integrated

Missing Assessment and Review Summaries - Mini







- Carenotes recovery is now largely complete and so this data is now accurate enough to be followed up.
- Addressing this is not part our service improvement plans and so while reminders will continue to be sent this will not be prioritised this financial year.

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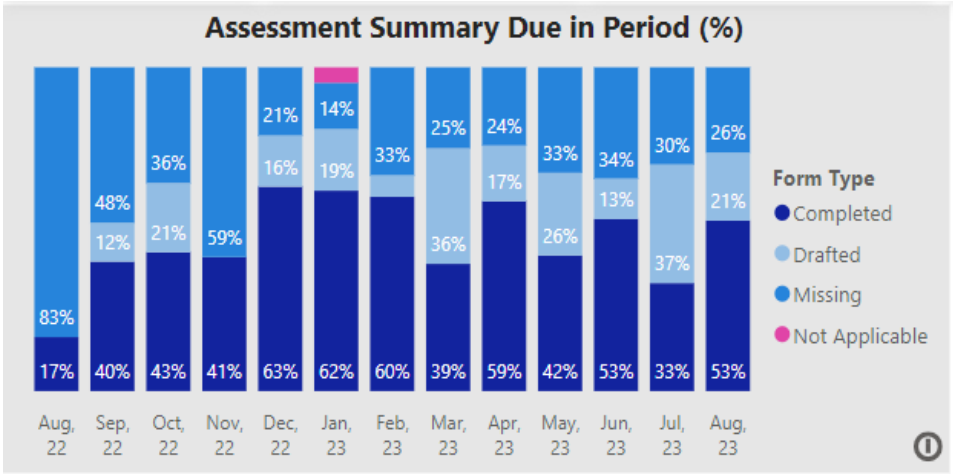
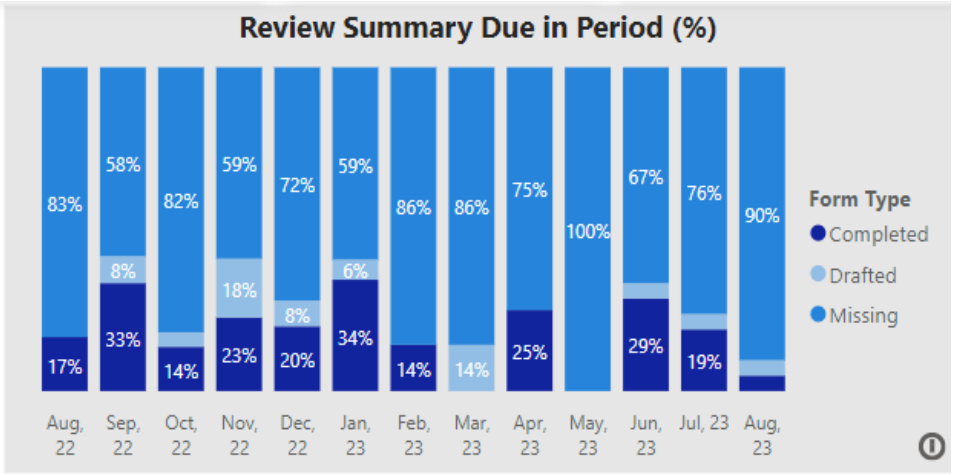
Assessment & Review Summaries – Child Complex





- The above graphs show completion by month due which makes it hard to measure improvements made to forms due in previous months. We have requested data be shown by end of month performance for open cases to solve this issue
- Monthly reminders have started again and this will be one of the KPIs reviewed in the new team performance meeting structure for Child Complex

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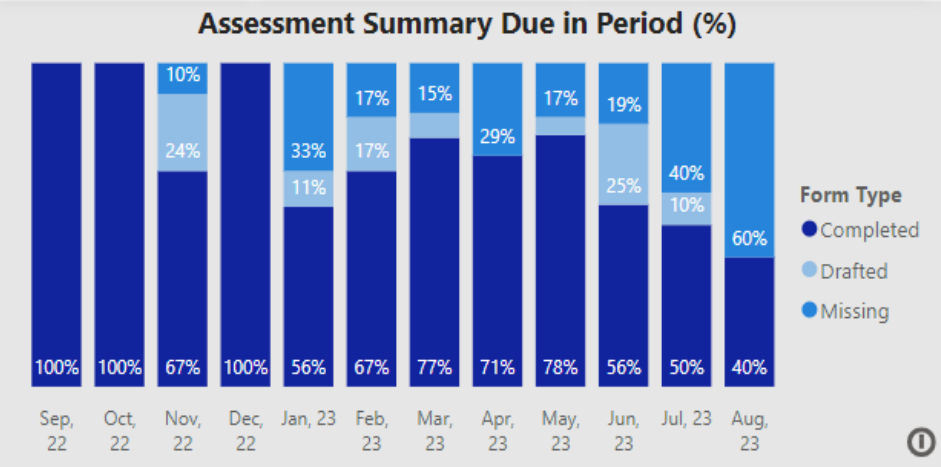
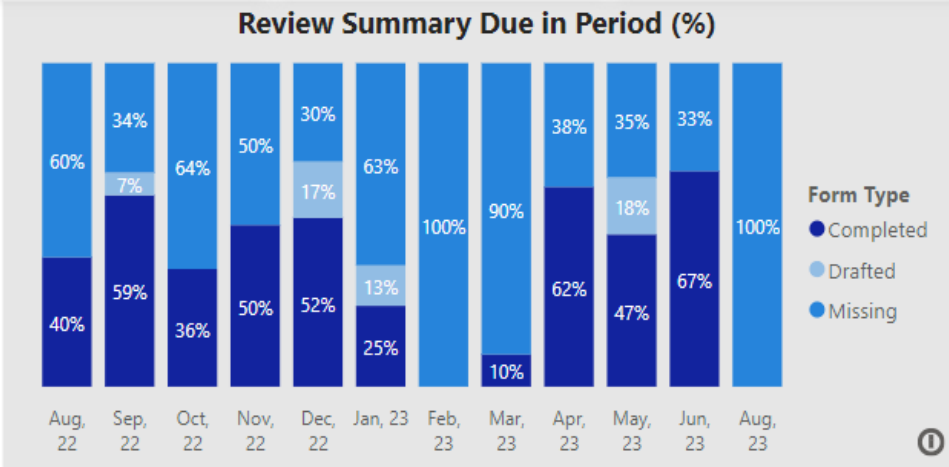
Assessment & Review Summaries – Adult Complex





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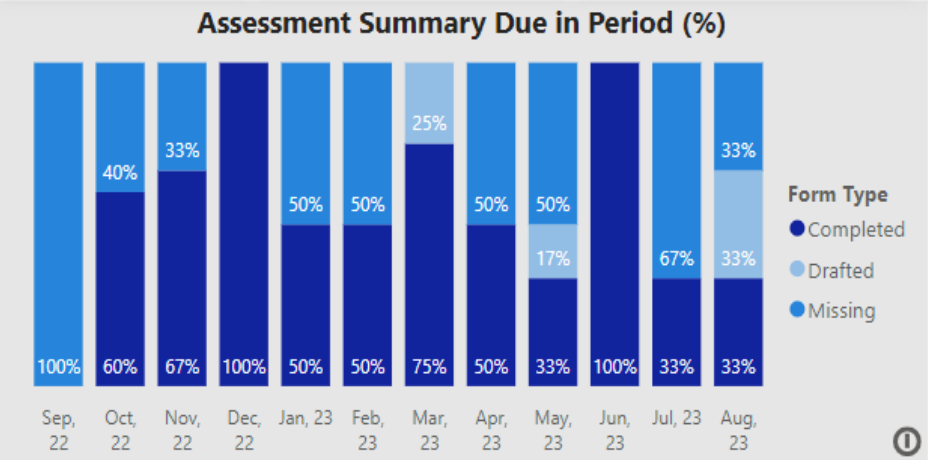
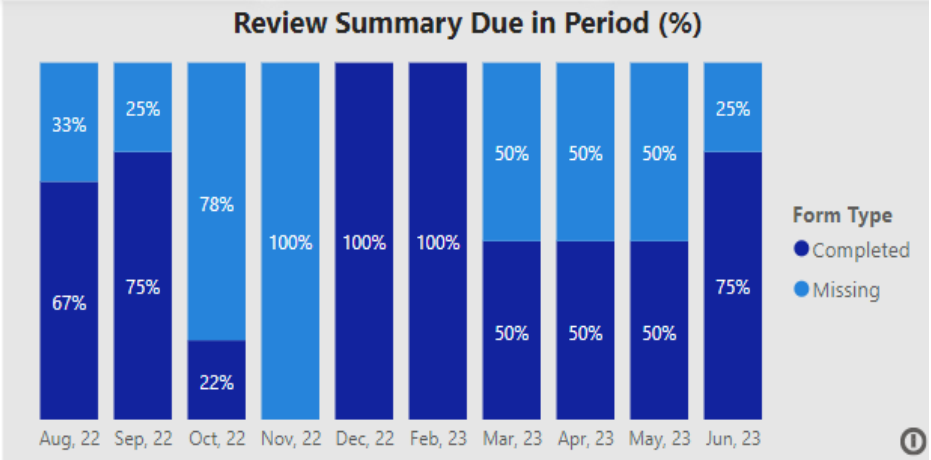
Assessment & Review Summaries – Portman





- The above graphs show completion by month due which makes it hard to measure improvements made to forms due in previous months. We have requested data be shown by end of month performance for open cases to solve this issue

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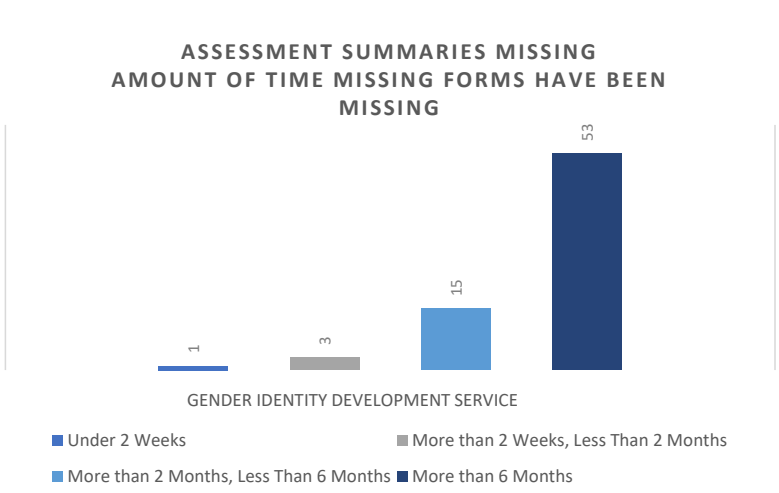
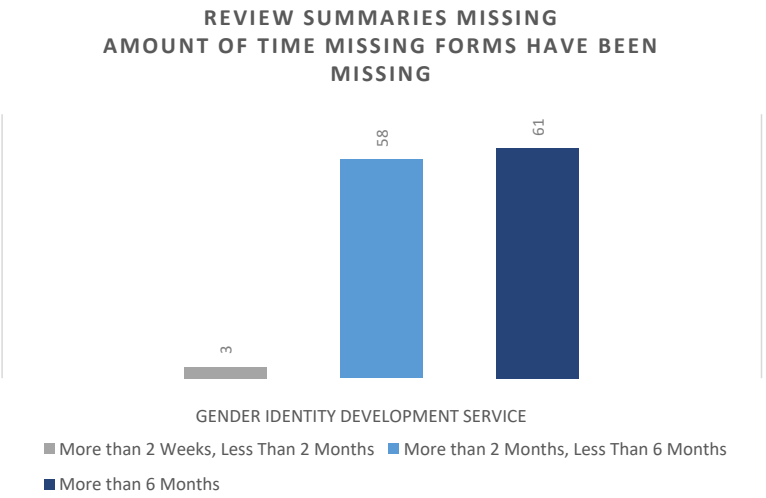
GIDS Assessment & Review Summaries Missing

Missing Assessment and Review Summaries - Mini

72 Missing GIDS Initial Consultation Report And Care Plans



122 Missing GIDS Updated Report And Care Plans



Data ran on 19/06/23

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Incidents

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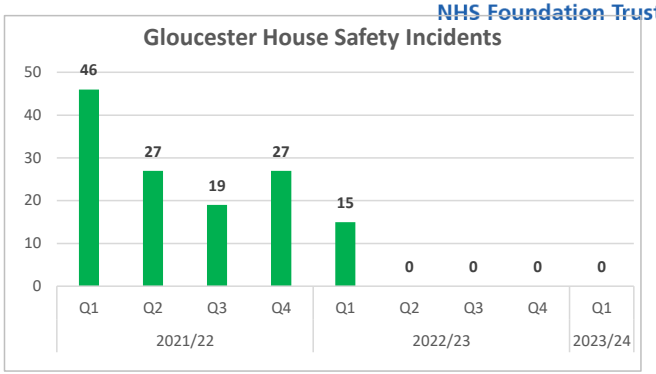
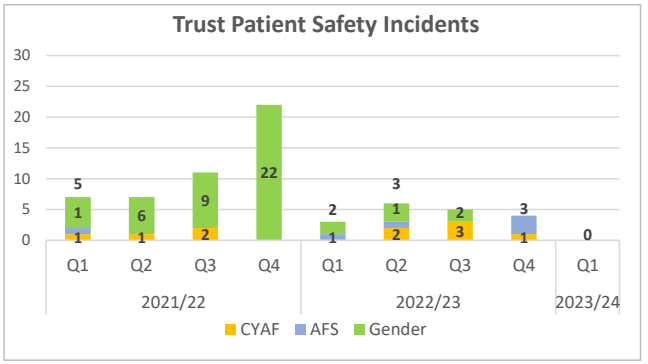
Incidents Reported by Risk Level – Trust wide	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Apr 2023	2023/24 May 2023	2023/24 June 2023
1-4	64	40	30	36	26	30	33	43	7	15	19
5-8	42	69	29	24	35	32	23	39	7	8	12
9-12	11	5	16	4	16	16	9	17	2	3	7
15+	1	1	1	2	2	1	3	2	0	1	0
Total	**118**	**115**	**76**	**66**	**79**	**79**	**68**	**101**	**16**	**27**	**38**



No PSI from the school due to earlier intervention by staff preventing children hurting themselves and other pupils, and no reports of children being hurt by staff.



No PSIs reported from Mental Health and Gender services

Patient Safety Incidents (PSI)

The majority of the PSIs are usually reported from Gloucester House (GH) and Gender Identity Clinic (GIC) – GH have had no reportable PSIs for the last 12 months due to changes in the early intervention of staff via de escalation and holds.

81 Incidents reported for Q1

Adult Forensic Service (AFS) = 15, Children Young People and Adolescent Service(CYAS) = 20 ,GH = 19, GIC = 16, GIDS= 5 and Corporate and Trust wide reported 6.

Themes and trends of Incidents

- Gender have reported the majority of the IG incidents, 12 out of 21. IG training for the GIC had been provided in July.
- Physical and Verbal abuse for GH, 6 out of 8 reports.

Changes to Incident reporting system to NRLS and PSIRF changes for Q2/ Q3

The Trust is in the final stages of replacing its Local Risk Management System (LRMS). Once a supplier has been appointed, a timeline for implementation will be confirmed.

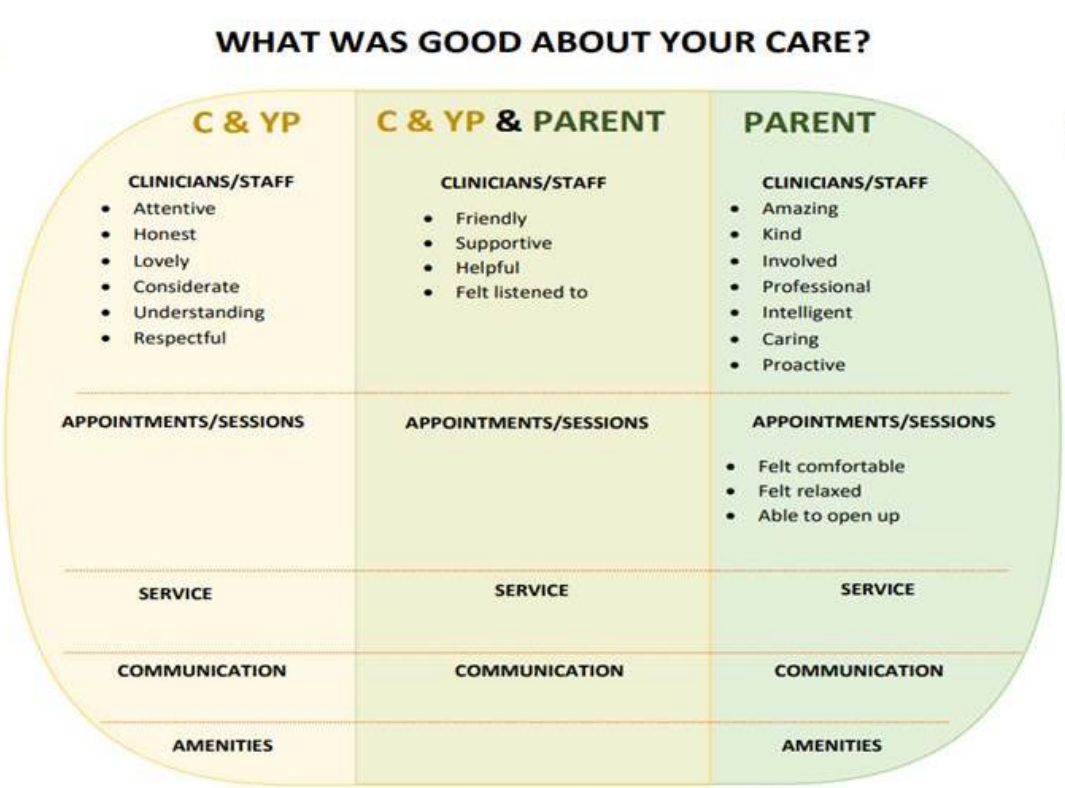
Data & commentary source: Q1 data run by Health & Safety and Safeguarding Departments 11/08/2023.
Previous data as reported in relevant earlier reports.

GIDS Patient Feedback and Engagement

'My worker was really attentive and helpful throughout my sessions and makes me feel like no question is a dumb question, they are honest and helpful and genuinely lovely.'
-Young Person

'Both the people I saw were lovely- very considerate, friendly and I felt listened to by them.'
-Young Person

'Everybody I saw was very good at listening and letting you go at your own pace. Very understanding too.'
-Young Person



'Our clinicians were amazing, we felt very relaxed and comfortable to open up to them during our virtual appointments.'
-Caregiver

'We felt we had become friends with the team and felt that they always wanted the best for us.'
-Caregiver

'Our clinician was BRILLIANT - they had a very professional, intelligent, caring, and proactive approach to my child's care.'
-Caregiver

4

The categories included here are the most frequently occurring themes that were recorded from the ESQs.

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GIC Complaints, Compliments & PALS

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COMPLIMENTS	COMPLAINTS	PALS*
4 service compliments received in June **1** service compliment received in July/	**June** Received: **8** Acknowledged: **8** Investigating: **3** Awaiting Information: **2** Report Submitted/waiting for approval: **25** **July** Received: **9** Acknowledged: **9** Investigating: **2** Awaiting Information: **1** Report Submitted/waiting for approval: **7**	**June** Received (QP and PPALS): QP: **7** PPALS: **64** Closed: **71** Open: **0** **July** Received (QP and PPALS): QP: **19** PPALS: **48** Closed: **67** Open: **0**
All staff have been reminded to send compliments to ppalsgic@tavi-port.nhs.uk	Delays in letters, Discharge without being informed, approach of clinician during assessment, waiting times, multiple errors in clinical letter, patient unhappy that they did not start Hormones, conduct of switchboard telephonist	Referral Queries, Appointment Queries, Change of Details, Discharge query, Queries from non-GIC; typos in clinical letter, waiting times.
		* PALS-all responded to within 24 hours and maximum 48 hours

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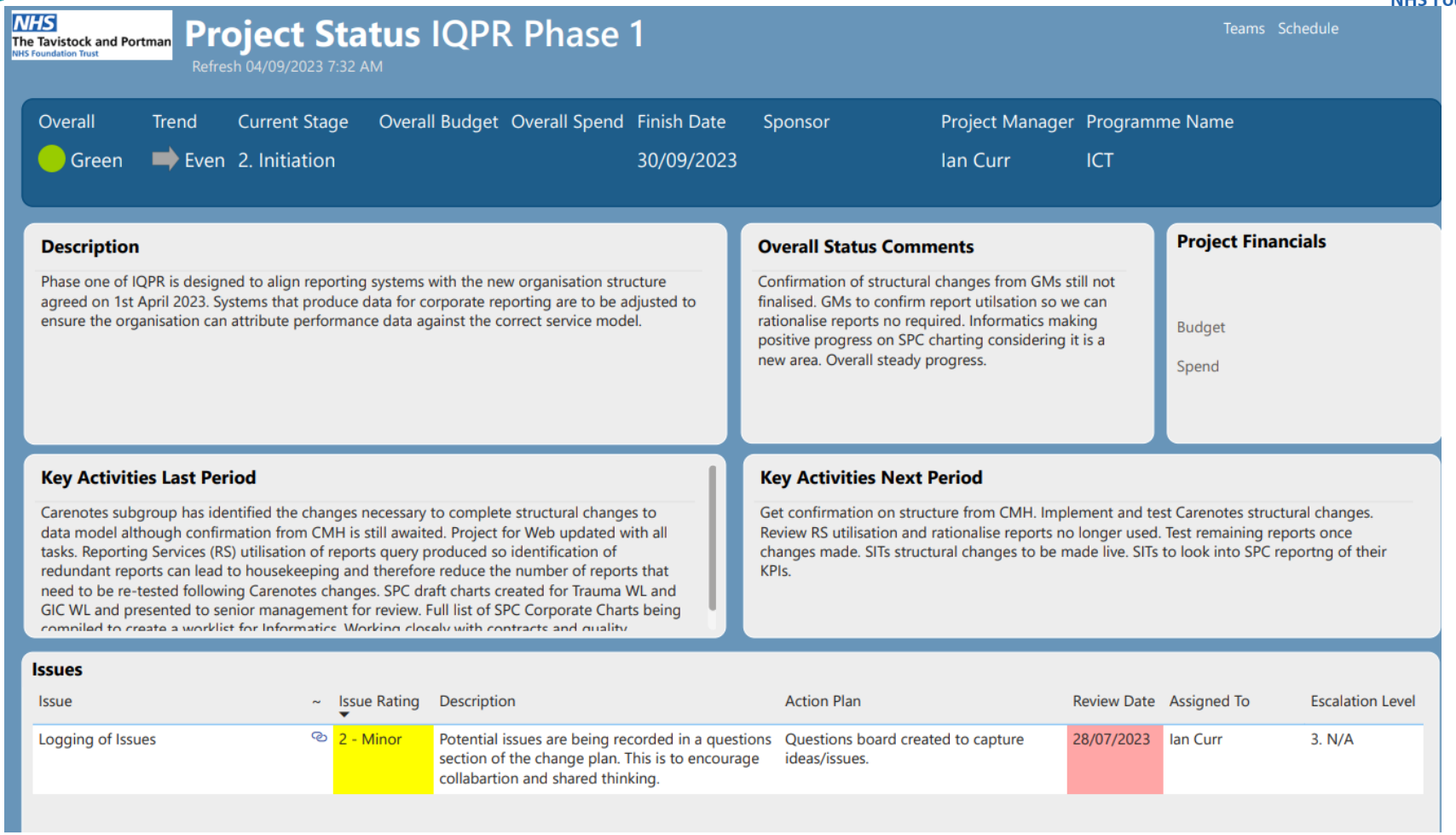
8. IQPR Project Update



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Project Status IQPR Phase 1

Refresh 04/09/2023 7:32 AM

Teams Schedule

Overall	Trend	Current Stage	Overall Budget	Overall Spend	Finish Date	Sponsor	Project Manager	Programme Name
Green	Even	2. Initiation			30/09/2023		Ian Curr	ICT

Description

Phase one of IQPR is designed to align reporting systems with the new organisation structure agreed on 1st April 2023. Systems that produce data for corporate reporting are to be adjusted to ensure the organisation can attribute performance data against the correct service model.

Overall Status Comments

Confirmation of structural changes from GMs still not finalised. GMs to confirm report utilsation so we can rationalise reports no required. Informatics making positive progress on SPC charting considering it is a new area. Overall steady progress.

Project Financials

Budget

Spend

Key Activities Last Period

Carenotes subgroup has identified the changes necessary to complete structural changes to data model although confirmation from CMH is still awaited. Project for Web updated with all tasks. Reporting Services (RS) utilisation of reports query produced so identification of redundant reports can lead to housekeeping and therefore reduce the number of reports that need to be re-tested following Carenotes changes. SPC draft charts created for Trauma WL and GIC WL and presented to senior management for review. Full list of SPC Corporate Charts being compiled to create a worklist for Informatics. Working closely with contracts and quality

Key Activities Next Period

Get confirmation on structure from CMH. Implement and test Carenotes structural changes. Review RS utilisation and rationalise reports no longer used. Test remaining reports once changes made. SITs structural changes to be made live. SITs to look into SPC reportng of their KPIs.

Issues

Issue	~	Issue Rating	Description	Action Plan	Review Date	Assigned To	Escalation Level
Logging of Issues		2 - Minor	Potential issues are being recorded in a questions section of the change plan. This is to encourage collabartion and shared thinking.	Questions board created to capture ideas/issues.	28/07/2023	Ian Curr	3. N/A

Risks

Risk	Risk Rating	Description	Mitigation Plan	Review Date	Escalation Level
Technical Skills	12 - High	IF the right technical skills are not available THEN there is potential for the changes to be delayed or not take place at all.	Ensure we have carefully considered all changes, approve changes and ensure before making changes that we have all the necessary skills available. Produce training skills analysis document.	08/08/2023	3. N/A
No Project Licenses	9 - High	IF there are not enough Project for Web Licenses, THEN those who are assigned project tasks will not be able to interact directly with the project which will cause delays and possible inaccurate information	Request a pool or O365 P3 licenses for those involved in projects.	08/08/2023	3. N/A
Unexpected consequences to system changes (CN)	9 - High	IF changes are made to the Carenotes application/ database THEN there is a risk of unexpected consequences particularly for performance reporting.	Ensure all proposed changes are reviewed by all project team members before approval given to make the change. Document fully in the change plan. Follow methodology.	28/07/2023	3. N/A

		Year	2023						
		Quarter	Qtr 2				Qtr 3		
		Month	May	June			July	August	
Project Name	Milestone Title	Milestone Type	22/05/2023	05/06/2023	23/06/2023	30/06/2023	28/07/2023	07/08/2023	31/08/2023
IQPR Phase 1	Establish Project Board	Key Deliverable	◆						
	Create ToR	Key Deliverable		◆					
	Create PID	Key Deliverable		◆					
	Establish Project Teams CN and SITs	Key Deliverable			◆				
	Sign Off Service Model	Key Deliverable				◆			
	Establish Change Methodology (CN)	Key Deliverable				◆			
	Identify Report Change Requirements	Key Deliverable					◆		
	Complete Change Model for Board Sign off	Decision Point						◆	
	Effect Change in Change Model	Key Deliverable							◆

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Detailed Project Plan

The detailed project plan is embedded here which shows up to date completion rates on tasks:

Microsoft Excel Worksheet

MEETING OF THE BOARD OF DIRECTORS PART II – PUBLIC - 11th October 2023			
Report Title: Annual Objectives and Strategic Priorities			**Agenda No:** 009
Report Author and Job Title:	Rod Booth, Executive Director of Strategy and Business Development Fred Peel, Head of Strategy	**Lead Executive Director:**	All Executive Directors
Appendices:	Appendix 1: Executive Leadership Team Priorities and Delivery Plan		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	To support delivery of Trust strategic ambitions, Executive Team colleagues have spent time together during September to consider objectives, priorities and ways of collective working in line with NHS constitutional values (working together for patients, respect and dignity, commitment to quality of care, compassion, improving lives and everyone counts).		
Background:	Planning is underway to deliver a new 3-year strategic plan for the Trust. This will deliver a new Strategy that builds on best of the 100-year history of the Tavistock and Portman and secures a shared service user, carer, student, staff and system partner vision. To enable this vision, the Executive Team participated in three independently facilitated planning days in September followed by a Board Seminar discussion to develop objectives and priorities for the next twelve months (as set out in Appendix 1). These objectives and priorities are targeted at supporting delivery of our five strategic ambitions: 1. Providing outstanding patient care. 2. Enhancing our reputation and grow as a leading local, regional, national and international provider of training and education. 3. Developing partnerships to improve population health and build on our reputation for innovation and research in this area. 4. Developing a culture where everyone thrives with a focus on equality, diversity and inclusion. 5. Improving value, productivity, financial and environmental sustainability. Delivery of actions will be tracked weekly via a Strategy Delivery Room with Microsoft Teams used to map progress against each individual action to enable a focussed discussion each week. For the remaining **3 months** of 2023/24 we have defined **88 key actions** across **45 key priorities** each linked and contributing to at least one of our **5 strategic ambitions.**  More than 50% of the actions are underway and several already completed.		

	Each action has a clear definition, agreed acceptance criteria, linked strategic ambitions, due date and a named owner and the approach allows for curation of key documents and notes against each action, as well as automated monitoring and reminders to action owners. In addition to weekly monitoring of all due and upcoming actions we will be focussing on actions and priorities by undertaking **2 deep dives each week**. So far these have looked at Gender Identity Clinic (GIC) Waiting Times and the Medium-Term Financial Plan (MTFP), with the Gender Identity Development Service (GIDS) Handover Plan and Patient and Public (PPI) Involvement Strategy scheduled next.
Assessment:	Planning by the new Executive Team and consideration by Non-Executive Directors during September has put in place an enabling delivery plan for the Trust to deliver its strategic ambitions. The plan will be tracked weekly via a Strategy Delivery Room (SDR) to support progress and planning for shared mitigations on risk areas.
Key recommendation(s):	The Board of Directors is asked to consider Appendix 1 – Executive Team Objectives and Priorities for approval.

Implications:

Strategic Objectives:

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

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

Link to the Risk Register:	BAF ☒	CRR ☒	ORR ☒
	The objectives and priorities will impact in supporting the mitigation of all current risks as it will set out the direction of travel for service improvement, financial sustainability, student and staff wellbeing over the next three years.		
Legal and Regulatory Implications:	Yes ☒	No ☐	
	There may be implications linked to the future direction of travel for the Trust.		
Resource Implications:	Yes ☒	No ☐	
	To deliver the Strategy we will need to think differently about how we use existing resources to deliver care improvements whilst also seeking to deliver new income via our Training and Education offer.		
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐	
	DEI considerations are a key pillar of our strategy to ensure we are an organisation that offers equity of access to care and career opportunities.		

Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Board Seminar: 13th September			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Appendix 1

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009a Appendix 1 - Executive Team Delivery Plan

Executive Leadership Team
Priorities and Delivery Plan

Board Meeting – 11th October 2023

Michael – Chief Executive

Why have we chosen these priority areas

The Tavistock and Portman NHS Foundation Trust

1. Clear about sustainable future of organisation
2. Not good at evidencing the value of our services that we deliver
3. Culture within organisation both relating to morale and delivery needs improvement
4. Organisation that currently doesn't represent local communities or wider populations in both how and what it does
5. Previously lack of collaboration at leadership level and not modelling consistent behaviours for the organisation

How we intend to work together to deliver the priorities

The Tavistock and Portman NHS Foundation Trust

1. A single Exec voice – “we” and “I”
2. Working collaboratively across portfolios
3. Clear accountability for programmes - starting with the Exec
4. Set aside ego and have transparent, high challenge conversations
5. Whole organisation T&P & DET together.
6. Time for strategic reflection

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Where we will be in a year

An organisation that:

1. Demonstrates we value, engage, listen and empower our staff
2. Shows our ability to improve and demonstrate outcomes
3. Builds a new reputation externally
4. Is fit for the future and has a clear roadmap to sustainability

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My CEO Priorities

1. OD programme to build clear and coherent culture across the organisation

2. Future of the organisation

3. Operational and Financial Improvement

4. EDI improvement

Rod – Director of Strategy and Business Development

Reminder of our Strategy Ambitions

The Tavistock and Portman NHS Foundation Trust

1:

Providing outstanding patient care

2:

To enhance our reputation and grow as a leading local, regional, national & international provider of training & education

3.

Developing partnerships to improve population health and building on our reputation for innovation and research in this area

4.

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

5.

Improving value, productivity, financial and environmental sustainability

My Objectives:

1. Leading on delivery of a new 3-year Trust Strategy
2. Leading on behalf of the Executive, delivery of a 'future state' proposal for Board consideration
3. Leading on roll out of a new Quality Improvement system and reconfiguring resources to deliver this
4. Co-leading with the Chief Operating Officer delivery of a new Integrated Quality and Performance report based on the plan on a page (A3 approach)
5. Leading on delivery of our Equalities, Diversity and Inclusion ambition
6. Co-Leading with the Chief Finance Officer, delivery of a robust annual plan that triangulates activity, finance and workforce
7. Leading on building a positive reputation for the Trust in support of income generation by building strategic partnerships locally, regionally, nationally and internationally across all education, training and care services.

My priorities:

1. Stakeholder engagement on Strategy content for sign-off by Board and defining improvement metrics with delivery to be reviewed each Monday in our 'Strategy Delivery Room'
2. Phase 2 Merger Planning: options assessed with Board consideration of viable partners for further exploration and preferred merger partner selected
3. Taking a lead role in strengthening and developing staff networks by supporting Network Chairs in shared planning for development and delivery of strategic ambitions
4. Training in A3 and linked QI methodology to be rolled out in support of IQPR improvements with Board and Committee reports redesigned in line with this
5. Delivery of an Annual Plan for 2024/25 (linked to NHSE Operating Plan Guidance for MH Trusts)
6. Commercial strategic partnership with an international service provider in place building on our Educational links

Chris – Chief Medical Officer

My Objectives:

1. **Lead** a review on clinical and medical leadership structure
2. **Develop** leadership skills within the medical workforce both internal and external to the Trust
3. **Lead** on Trust wide improvement exercise ensuring outcome measures are used by all services
4. **Build** our external profile to showcase our unique services with use of outcome data
5. **Support** a safe and timely transfer of GIDS to new providers
6. **Lead** on the use of data to look at equality of access to services and outcomes within our EDI agenda
7. **Lead** the delivery of the strategic objectives within the organisation
8. **Build** effective relationships with key stakeholders, (NCL ICB, local NHS providers, Camden and other Local Authorities and NHSE)
9. **Develop** a population health strategy and develop partnerships for funding and delivery

My priorities:

1. Map the clinical/medical leadership structure identifying gaps
2. Set expectations/targets for the use of outcome measures across all services
3. Lead on development of EDI service user data for equality of access, wait times and outcomes
4. Development of a Population Health strategy and plan for Trust

Sally – Chief Operating Officer & Deputy CEO

My Objectives:

1. Providing leadership as deputy CEO on supporting and delivering on trust strategy by supporting the CEO objectives.
2. Lead on the Integrated quality and performance report, building on the evidence to drive operational improvement with a golden thread narrative from floor to board,
3. Lead on continuously improving performance in the trust through a range of approaches eg QI, IQPR, data fidelity and use.
4. Working closely with the CMO and CNO creating an effective clinical services triumvirate
5. Supporting the implementation of the 'plan on a page' for reducing wait times and improving collation of OM measures.
6. Lead on the operational transfer of GIDS, whilst ensuring its safety in the meantime.
7. Lead on the operational transformation of the GIC service.
8. Engage in reciprocal mentoring that challenges my understanding of the experiences of staff from the global majority, using this understanding to improve staff experience in clinical services.
9. As DCEO to lead on building a strong, cohesive and engaged workforce across the organisation.

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My Priorities:

1. To deliver improved waiting times across the organisation through the use of QI methodology
2. Ensuring staff understand and use data effectively to improve services.
3. Roll out the IQP methodology to teams so that there is floor to board impact of the IQPR.
4. Ensure a safe handover of GIDS
5. Lead on the development of our GIC service implementing any recommended changes.
6. Ensure services are doing what they need to, implementing performance process if appropriate.
7. Ensuring that effective structures and processes are in place to reduce the likelihood of differential treatment of staff and patients from backgrounds with protected characteristics

Clare – Chief Nursing Officer

My Objectives:

1. Physical health strategy in partnership with current and previous service users, include plans for groups who experience poorer outcomes (LD, SMI, certain ethnic backgrounds)
2. Develop quality data that reports throughout the organisation (triangulates QP, CQUIN, relevant quality data).
3. Review patient and carer experience, complaints/feedback and engagement and involvement strategy.
4. Re- establish ICS role in lead for learning disability & autism training
5. Review teams and structures in the CNO portfolio; develop structure and recruit to all roles substantively. Creating development plans to enable teams to deliver the priorities.
6. Develop Quality and Safety structure sub-groups reporting into QSC (to form part of accountability framework)
7. Develop a collaborative coordinated professional leadership group to work with DET to develop short courses and CPD
8. Supporting to embed QI methodology
9. Review Patient & public involvement work, patient representation and patient safety partner presence at all levels on Quality & Safety groups; with focus on diversity of the group. Develop plan for year 2 to take to Service Users Experience to next level
11. Develop framework for new roles, PSW, NA, ACPs.
12. Introduce new roles following team led QI approach to team requirements
13. Review progress against priorities, communicate progress to staff, service users, students.

My priorities:

1. Lead on ensuring service users have access to physical health care enabling holistic person centred care and improved outcomes.
2. Lead on the development of quality and safety governance, including quality and safety data
3. Improve learning from service user and carer feedback and work with a diverse group of service users to improve services
4. Establish relationships and leadership in ICS, particularly for LD & A
5. Develop and lead effective corporate teams and professional leads to deliver the priorities.
6. Lead on ensuring a diverse and modern workforce through Introduction of new lived experience and nursing roles to the workforce.

Elisa – Interim Chief Education and Training Officer and Dean of Postgraduate Studies

My Objectives:

1. Increase the level of growth in DET
2. Contribute to the financial sustainability of the Trust
3. Enhance student engagement to ensure high quality student experience
4. Increase accessibility, reach, and relevance of DET to underrepresented populations
5. Enhance performance through data informed practice
6. Embed a robust system of governance in DET
7. Introduce a planned and sustainable system to enhance student placements

My priorities:

1. Widen and diversify DET provision to meet the current education-workforce landscape and clinical service needs
2. Promote commercial opportunities including international
3. Identify underrepresented populations and address existing obstacles to engagement
4. Improve and implement new systems of data collection and management to inform DET development.

Gem – Chief People Officer

My Objectives:

1. To facilitate the delivery of a culture where everyone thrives.
2. To deliver an improvement in staff engagement and satisfaction across the organisation, demonstrating improvement in equity, diversity and inclusion across the organisation.
3. To support the CEO to develop a highly effective and cohesive executive leadership team.
4. To support executive colleagues to plan and deliver highly effective staffing structures which underpin safe, quality care and training.
5. To enact continuous improvement in business-as-usual processes, practices, and services in order to deliver a high-quality people function.

My priorities:

1. EDI
2. OD and Learning
3. Staff engagement and satisfaction
4. Workforce Composition
5. Continuous improvement in BAU

Peter – Interim Chief Financial Officer

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My Objectives:

1. Appointment of External Auditor
2. Assessment of Audit issues to inform planning and management next year
3. Progress on Payroll and other Financial Control weaknesses highlighted by Internal Audit.
4. Complete Action plan from HFMA self assessment
5. Recurrent CIP development for 24/25 delivery.
6. Mid Year Review of 23/24 Financial Plan – inform in year reporting, budget maintenance and MTFP.
7. GIDS financial exit plan
8. Financial Modelling to support 'Future State' work with KPMG
9. Development of Estates options - MTFP
10. Budget Maintenance and consistency with ESR/SR
11. Financial reporting improvement to feed into IQP, including a consistency of approach.
12. Draft 24/25 Financial Plan, fed by draft base budgets.
13. Base budgets available to services before the new year.
14. Care Notes system learning implemented, and cyber security solutions in place

My Priorities:

1. Improved External Audit Process
2. Development of Medium-Term Financial Plan
3. Financial Modelling Future State Work
4. Better Financial Planning
5. Better Financial Reporting
6. Maximising use of key digital systems and ensuring adequate Cyber Security
7. Ensure adequate Financial Controls in place

Ade – Director of Corporate Governance

My Objectives:

1. Lead a review of the effectiveness of the structures, governance and approach to the delivery of EDI
2. Responsibility for the Trust's secretatiat function
3. Complete the work to fulfill the actions agreed in the Integrated Governance Action Plan
4. Develop, agree and implement a Board Development Plan
5. Ensure effective support to the Council of Governors to enable them fulfill their statutory roles.
6. Take on the leadership of, enhance access and the reactivity of the Freedom to Speak Up service
7. Work with colleagues to develop effective Member and public engagement approach
8. Develop a cost-effective and consistent approach to the management of legal risk
9. Improve the approach to clinical and non-clinical risk assessment across the organisation

My priorities:

1. Completion of the EDI review
2. Completion of the IGAP
3. Legal services review
4. Develop and run the Board Development Programme
5. Take on leadership of the FTSU service

Jane – Interim Director of Communications and Marketing

My Objectives:

1. Reputation management:

- Leadership of campaign with key stakeholders to ensure a greater understanding of who we are and what we do
- Management of consistent, strong and timely response to potentially negative media - GIDS /GIC

2. Leadership of **strategic communications and engagement** to support to delivery of the **Future Direction Programme**

3. Leadership of strategic and operational **communications** to support to delivery of the **Improvement Strategy and annual plan**.

4. Leadership of communications support to the People Team to **embed the People Promise, the new vision, mission and values and improve staff engagement**

5. **Review and strengthen the Communications and Marketing team** to ensure it is fit for purpose

6. Support the Chief Nurse to develop and delivery a new **Patient and Public Engagement Strategy** to ensure strategic and operational decisions are informed by patient and service user experience and feedback.

7. Active participation in the reciprocal mentoring scheme

My priorities:

The Tavistock and Portman NHS Foundation Trust

1. Reputation management:

2. Strategic communications and engagement support to delivery of the Future Direction Programme, the Improvement Strategy and annual plan.

3. Embed People Promise, new vision, mission and values, improve staff engagement and strengthen equality, diversity and inclusion

4. 'Fit for Purpose' communications and marketing team

5. Support development and delivery of a new Patient and Public Engagement Strategy

Agreed ways of working?

- Prioritise time together (Mon + Tues)
- Spend 3 days p/week in the office, sharing the load of Friday
- Disagree, challenge and debate in ELT and Informal Exec
- Commit to the same, single messages everywhere else
- Drive clarity on who the decision maker is for each priority / agenda item / next step
- Practice clarity on what we need from each other (even from agenda items)
- Challenge and hold account quickly by conversation - tough by integrity
- Practice bringing things back to the team because we act as one
- Start and end meetings on time
- Arrive prepared and be present
- Allocate a 'challenge' role to each meeting
- Adopt a decision and action recap agenda practice
- Embed a culture of strategic reflection

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC
Wednesday, 11 October 2023

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

Committee:	Meeting Date	Chair	Report Author	Quorate	
Quality Committee	7 September 2023	Dr Janusz Jakowski Deputy Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 010**		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Complaints The Committee received an update in relation to the Complaints improvement plan, plus a summary of complaints received in Quarter 1 2023/24. The Committee noted the proposed trajectory for addressing the current backlog and the following key actions to be taken between now and the next Committee meeting in November; • Continue to work through open complaints and contact investigation leads where report is outstanding • First draft of refreshed policy and procedure to be completed incorporating elements as outlined in the improvement plan • Analysis of Complaints & PALS data over previous 24 months to be completed to inform structure and resourcing discussions	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Flu Plan for 23/24 The Committee received an update on the plan for 23/24 vaccinations. Following last year's flu campaign, an after action review (AAR) was undertaken to understand possible reasons for low uptake. This has informed the strategy for this year's flu campaign which includes; • Refreshed communications in place including information around the voucher system for staff • Vaccinations to be made available earlier for front line staff	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

• Establishment of a robust data set for eligible staff. Currently all staff including honorary contracts are included in the data set which is not appropriate	
3. Infection Prevention & Control (IPC) Annual Report The Committee received an update in relation to the IPC Annual Report which will be presented to the Trust Board at its next meeting in October 2023. Due to scheduling challenges, this was not presented to the Quality Committee in advance of Board. Challenges and risks that would be included in the report were highlighted and assurance was given that forward plans to address these have been discussed with the Committee's Chair.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Safeguarding Annual Reports (Children and Adults) Two separate annual reports were presented at Quality Committee. Both reports provided a comprehensive summary of the work undertaken by the named safeguarding leads during 2022-23. The reports highlighted a need to review the safeguarding service and resource following the Strategic Review and move from Chief Medical Officer to Chief Nursing Officer portfolio. The differential progress between children and adults safeguarding progress reflects to greater resource available for the former. A review of safeguarding will be led by CNO.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Risk & Safety System Update The Committee received an update about the procurement of the Trust's Risk & Safety system (currently called the Quality Portal). The tender process for a new system has now been completed and a provider has been appointed. This remains subject to final contract award and so will remain confidential until that point. It has been noted and discussed that the system may require an incremental install and implementation. The Trust's Informatics team will continue to work with the CNO team and wider Trust departments to configure this product. The Committee requested to be kept updated on the timeline for implementation.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
6. PSIRP The Committee reviewed and approved the high level Patient Safety Incident Response Plan (PSIRP). This PSIRP sets out how the Trust intends to implement the Patient Safety Incident Response Framework (PSIRF) which transforms the systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The plan was previously agreed and reviewed by the PSIRF Transformation Board following engagements with internal and external colleagues. Going forward, a quality improvement approach will be used to implement the framework.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
7. Terms of Reference The Committee approved a refreshed version of its Terms of Reference. The main change is the Committees' name to Quality and Safety Committee.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

8. Urgent matters discussed The Committee received an update on a number of urgent items that had not be submitted in papers due to the timing of publication. This included; • Focused inspection of the GIDS service by the CQC (6th and 7th September) • A draft paper and response to NHS England's letter regarding the Lucy Letby case will be presented to the next Board meeting • Annual IPC report as above	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- The Committee APPROVED the Trust's Patient Safety Incident Response Plan (PSIRP)
- The Committee APPROVED its updated Terms of Reference v 0.2

Risks Identified by the Committee during the meeting:

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

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

None.

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

Item	Purpose	Date
N/A		

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Infection Prevention and Control Annual Report 2022–2023			**Agenda No.: 011**
Report Author and Job Title:	Clare Scott – Chief Nursing Officer and DIPC	**Lead Executive Director:**	Clare Scott – Chief Nursing Officer
Appendices:	Appendix 1: National Infection Prevention and Control Board Assurance Framework		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This is the 2022-2023 annual report for Infection Prevention & Control (IPC) to the Trust Board. The report includes a summary of the gaps identified through the National Infection Prevention Control Board Assurance Framework (NIPC BAF) which was completed in the current financial year.		
Background:	It is a Trust requirement to deliver the required standards of IPC and environmental cleanliness, to reduce, as far as possible, the risk of Healthcare Associated Infections (HCAIs) The Tavistock and Portman has a duty to ensure that patients are cared for, and staff work in, a safe and clean environment. This report outlines the work carried out and highlights any gaps against criterion areas relevant to the Trust of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015). The Tavistock and Portman continued to recover from the Covid-19 Pandemic during 2022-23 and did not have an annual plan. To provide a framework of our current position, a self-assessment in the form of the NIPC BAF was carried out.		
Assessment:	The report demonstrates that IPC related risk and gaps in assurance have been identified. The Tavistock and Portman does not provide inpatient services, and as such, much of the Criterion from the H&SC Act as well as the NIPC BAF are not applicable. Despite this there is still a requirement for IPC expertise, along with an IPC audit programme. This gap is the main risk identified; the report makes recommendations for a proposed plan to review the Trust requirements.		
Key recommendation(s):	The Board is asked to note the content of the report, including gaps highlighted and proposed plan for the Trust as identified through the National Infection Prevention and Control (NIPC) Board Assurance Framework.		

Implications:					
Strategic Objectives:					
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☐ Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: e.g., BAF 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. BAF 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.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust is required to ensure that all services are compliant with the Care Quality Commission's regulatory framework.				
Resource Implications:	Yes ☒	No ☐			
	Potential investment or redirection of resource required for specialist advice or role.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	Fully compliant with equality and diversity standards.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Verbal summary to Quality Committee 07.09.2023				

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

Contents

Infection Prevention and Control Annual Report 2022–2023

Purpose of the report

This report covers the period of 01.04.22 -31.03.23.

The purpose of the report is to demonstrate the Trust's commitment to achieving and maintaining the standards required by The Health & Social Care Act (H&SC) (2008) Regulation 12, detailed in the Code of Practice for the Prevention & Control of Infections**.** It provides details of the infection prevention and control (IPC) arrangements in place and the Trust's compliance with IPC related legislation. It also identifies risks and gaps in assurance and the mitigations and plans in place around these issues.

The key risks and gaps in assurance relate to:

- Lack of IPC expertise in the Trust, although it is acknowledged that the requirements for Tavistock and Portman Foundation trust (TPFT) are different to any other mental health Trust.
- Standards of cleaning
- Management of water, including drinking water
- Management of air-conditioning units
- A number of clinical areas need remedial work; the latter affects the ability to clean to the required standards.

There are mitigations and plans in place to reduce or remove the risks and gaps in assurance, which includes collaboration with the appropriate department in the Trust and external contractors.

Background

This is the 2022-2023 annual report for Infection Prevention & Control to the Trust Board. The report is due to be presented at Quality and Safety Committee in November, although it was noted at the Committee in October but not reviewed due to scheduling issues which have since been addressed.

Introduction

It is a Trust priority to deliver the required standards of IPC and environmental cleanliness, to reduce, as far as possible, the risk of Healthcare Associated Infections (HCAIs)

The Trust's objective is to ensure that patients are cared for, and staff work in, a safe and clean environment in which the risk of HCAIs are minimised.

The prevention and management of infection is the responsibility of all staff working at Tavistock and Portman Foundation Trust and is integral to day-to-day practice.

The Trust is a mental health Trust that is fairly unique in the services it provides, it does not inpatient services. The Trust aims to adhere to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015); as well **as o**ther National Guidance: National Institute for Clinical Excellence (NICE); Infection & Prevention Control Quality Statement 61 (2014). Although the completion of the national Infection Prevention and Control Board Assurance Framework (NiPC BAF – Appendix 1) identified that many of the areas, such as tackling antimicrobial prescribing, are not applicable.

This report highlights any risk IPC in the Trust, this is recorded on the Trust Risk Register

Infection Prevention and Control Arrangements in Place:

- The Chief Nurse is the Director of Infection Prevention and Control (DIPC) and reports directly to the Chief Executive Officer.
- The Associate Director of Nursing supports the Chief Nurse with any operational IPC matters.
- There is currently no IPC resource in place within the Trust and as such there has been no annual IPC plan or audit process. The Trust Health and safety Lead has attended all system wide IPC forums and disseminated any relevant information to trust staff via communications team.
- Due to the nature of the services, staff are not required to carry out blood tests and access to a microbiologist or IPC Doctor is not required.

The flu vaccination campaign was led by the People and Organisational Directorate, the final uptake published by NHSE was 22.2% at end of March 2023. An After-Action review was carried out by the Chief Nursing Officer and lessons learned will be taken forward for the 2023/24 campaign.

As the Trust does not provide inpatient services, there is no requirement to report on patient outbreaks or hospital acquired infections.

IPC Risks on the Risk Register:

A risk was not recorded during this period. A risk has been recorded in the current year 2023/24

- If Infection, Prevention and Control (IPC) clinical expertise is not in place, the Trust may not adhere to its regulatory compliance around IPC, potentially resulting in poor clinical environments for patients and staff with potential negative effect on health.

Mitigation/Plan:

- 1. CNO Review of requirements for the Trust
- 2. Noted at Quality and Safety Committee in September 2023 and paper will return to this committee in November 2023 for assurance.

IPC progress against Health & Social Care Act 10 criterion:

Criterion 2- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention of infections.

- The cleaning services are managed by Estates and facilities, all are in house.
- Cleanliness audits were not carried out in outpatient departments or clinics during this period, usual frequency monthly.
- Audits were not completed in non-clinical areas; usual planned frequency is dictated by risk category (3 to 6 monthly).
- The National Standards of Healthcare Cleanliness were reviewed by Estates and Facilities and introduced.

Gaps in Assurance:

- There is no current audit programme in place with IPC involvement, this should be carried out jointly with the domestic supervisor to provide assurance on cleanliness.
- Lack of assurance that the Clinical staff are aware of the required minimum standards of cleanliness.

Mitigation / Plan:

- CNO/DIPC to work with Director of Estates and facilities to introduce a cleanliness audit.
- CNO/DIPC to review IPC requirements for the Trust.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection:

- All staff receive IPC training on induction and are required to update the training as per the Trust's competencies.
- The IPC Induction training is delivered via e-learning.
- Mandatory IPC e-learning training is renewed every 3 years.
- Current compliance is at 90.69%

Table 1: IPC Mandatory Training compliance

Competence Name	Compliance %
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	90.69%

Gaps in Assurance:

None identified.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections:

- An IPC policy is available to all staff on the Trust intranet.

Gaps in Assurance:

- A brief review of the current policy has identified that it is overdue for review.

Mitigation/Plan:

- CNO/DIPC to review the policy in consultation with NCL IPC expertise.

Criterion 10: Providers have a system in place to manage the occupational health (OH) needs and obligations of staff in relation to infection.

- The workforce directorate manages the Trust's OH service, which is a contracted service.
- The service provides employment screening for all new staff, checks on immunisation status (childhood immunisations and immunisations required due to the nature of the healthcare role) and supports staff in updating or accessing missing vaccines.

Gaps in Assurance

- The OH service does not provide support with the flu or covid vaccination campaigns.

Mitigation/Plan:

- There is a plan to signpost staff to alternative vaccination sites outside of the Trust.

Additional Activity

COVID-19:

The Covid-19 intranet page has been reviewed and cleansed, with updated publications from the government available.

Wall Mounted Disinfectant Wipes and Alcohol Foam:

Wall mounted disinfection is available in toilet areas and some corridors**.**

Influenza Vaccination Campaign 2022-2023:

TPFT campaign was for an all staff offer but with patient facing staff data.

Progress of uptake:

- Most of the flu vaccines were administered early in the campaign.
- Uptake for the Trust at the end of the campaign was 12.8%, TPFT were recorded as having the lowest uptake in the country.
- This decrease was thought in part due to staff prioritising their Covid vaccinations, concerns about being double vaccinated and side effects, as well as staff being aware there was a low level of flu circulating in the community.
- It was also identified that the denominator for patient facing staff was not accurate, reflecting a significantly larger number than that employed by the Trust.

Table 2: Uptake of Flu Vaccine for Patient Facing Staff Across the Trust 2022-2023

Number of HCWs involved with direct patient care	Numbers vaccinated with flu vaccine	Flu percentage vaccine uptake
1430	183	12.8%

- The London average was 42% and the National average was 49.9%.
- An After-Action Review (AAR) was carried out at the end of the campaign with identified points of learning to be taken forward for the next campaign in 2023-2024 led by the Associate Director of Nursing. This will include a comprehensive communication plan and a focus on data to ensure that the denominator is correct.

National Infection Prevention and Control Board Assurance Framework

The IPC BAF (appendix 1) highlights where gaps in assurance are. The gaps in assurance relate to delay in implementing National Cleanliness standards and gaps in auditing standards; the other significant gap is the lack of dedicated IPC resource and expertise.
Four of the domains are not applicable due to the nature of the services provided by the Trust, i.e., no inpatient services.

Conclusion and Recommendations

Over this year, the absence of a dedicated resource with expertise in IPC has been noted in the report. This has been emphasised by the identified gaps in assurance relating to cleaning standards, water safety and expert advice to relevant estates and facilities functions, staff and other support services. The NIPC BAF has provided a framework to identify gaps and to implement plans and mitigations. Some of these gaps will take time and potential resource to rectify and will require collaboration with other teams.

The Chief Nursing Officer/DIPC will review the resource required for the Tavistock and Portman and develop a proposal accordingly.

The Nursing Directorate will work in partnership with Director of Estates and Facilities to develop a governance structure for reporting water safety, air safety relating to maintenance of air conditioning units and ensure implementation of cleaning standards and a cleaning audit programme.

Appendix 1 – MS Excel Spreadsheet nipc – board assurance framework Sept 2023

1. Board Assurance Fra
2. Summary Plots
3. Overall

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART II – PUBLIC – Wednesday, 11 October 2023			
Report Title: Response to NHS England Letter about the Lucy Letby Case			**Agenda No.: 12**
Report Author and Job Title:	Chris Abbott - CMO Ade Kadiri – Director of Corporate Governance Clare Scott – Chief Nursing Officer Gem Davies – Chief People Officer	**Lead Executive Director:**	Clare Scott – Chief Nursing Officer
Appendices:	Appendix 1: Letter from NHSE		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	To provide the Board with assurance around the points raised in the letter from NHSE in regard to the Lucy Letby case.		
Background:	On 18th August 2023, the CEO, COO, CNO, CMO of NHSE wrote to NHS Trusts and Integrated Care Boards in response to the verdict in the trial of Lucy Letby.		
Assessment:	The letter asked Boards to assure themselves of the strength of the speaking up cultures in their organisations, and that their governance arrangements enable disclosures to be received and acted on appropriately. The letter also reminded trusts of their obligations under the Fit and Proper Person requirements, which have recently been strengthened through the provision of additional background checks and the introduction of a new board member reference template. The purpose of this paper is to update the Board of the actions that have been and are being taken to ensure that the lessons from some of the circumstances that contributed to these appalling crimes are learnt and embedded here.		
Key recommendation(s):	The Board is asked to: Note and discuss the paper, and to identify areas where they think further assurance may be needed.		

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

Relevant CQC Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 6: Lack of inclusive and open culture.				
Legal and Regulatory Implications:	Yes ☒		No ☐		
	Having effective Freedom to Speak Up and Fit and Proper Person arrangements are essential elements within the Well Led domain. Failure to demonstrate that these are working properly could have negative regulatory implications.				
Resource Implications:	Yes ☐		No ☒		
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐		
	There is evidence nationally and at this Trust that people with protected characteristics, especially those from a global majority background, are less likely to speak up. The Trust is keen to ensure that this issue is addressed and is taking steps in this regard.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.		
Assurance:					
Assurance Route - Previously Considered by:					
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Response to NHS England Letter about the Lucy Letby Case

1. Purpose of the report

To provide the Board with assurance that the points outlined in the letter from NHS England (NHSE) in regard to the Lucy Letby (LL) case.

2. Background

On 18th August 2023, the CEO, COO, CNO, CMO of NHSE wrote to NHS Trusts and Integrated Care Boards in response to the verdict in the trial of Lucy Letby. They set out the steps that they have taken and continue to take towards strengthening patient safety monitoring, including the national role out of medical examiners, the implementation of the Patient Safety Incident Response Framework and the strengthened Freedom to Speak Up policy. NHSE have however acknowledged that that alone is not enough; good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight.

3. Freedom To Speak Up

NHSE asked boards to ensure that systems and processes are in place ad effective across a number of areas. In response, a high-level gap analysis was carried out by the Chief People Officer, Chief Medical Officer, Director of Corporate Governance and Chief Nursing Officer. This paper provides a review and response to each area, identifies gaps and sets out plans to address these.

1. *All staff have easy access to information on how to speak up.*

   Information on the Freedom to Speak Up Guardian (FTSUG) service is on the Trust intranet and displayed on posters in communal areas across the Trust.

   A gap identified is information for staff providing guidance on what it is like raising concerns, what the process is once they have raised concerns and what support is in place. A resource pack will be developed to provide this information.

2. *Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.*

   We will refresh and strengthen the knowledge of our teams in this regard, ensuring that all staff in every department know the correct escalation routes for raising concerns.

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

The Trust has reviewed its guardianship resource and will shortly be advertising for a second FTSUG, seeking to provide a total resource of three days per week (from the current one day). The Trust will actively encourage non-white, non-clinical staff to become the second FTSUG and/or become FTSU ambassadors.

The current FTSUG has access to CEO, NED, CPO, EDI lead, and the exec lead for FTSU.

The creation of additional resource is pivotal to our culture improvement work across the organisation. Creating a just and fair culture of no blame, which encourages all staff to raise concerns, will enhance our ability to make safe decisions and continuously improve our services.

We identified that where particular members of staff are known to raise a number of concerns, it is important to listen to every concern and assume that they are genuine. Every concern should be investigated on its merits, and timeliness should be tracked to ensure that a response is received within a reasonable time.

Discussions on national Chief Nurse meetings raised the issues around racial bias, asking the question of whether LL would have been treated differently had she not been a white female.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

There is log in place to record where people have spoken up. It is confirmed that all concerns that have been raised are either in the process of being addressed or have been addressed.

However, there is a question as to whether concerns raised with the FTSUG are triangulated with issues, complaints, incidents and any soft intelligence. It is recommended that the Executive Leadership Team have an agenda item at each of their weekly meetings to review this.

5. Boards are regularly reporting, reviewing and acting upon available data.

The review included a triangulation of data and the identification of themes across the following:

- Serious incidents
- Complaints, any other service user, and carer feedback
- Safeguarding referrals or concerns raised
- Incidents or disciplinaries relating to staff misconduct
- Concerns raised with the Freedom to Speak up Guardian Service
- Scrutiny of advocacy services and how they are used

Data is reported in the integrated performance and quality report. Work is ongoing to refine this, to be completed by December 2023.

4. Fit and Proper Person Test

In the letter of 18 August, NHSE also reminded NHS organisations of their obligations under the Fit and Proper Person requirements, not to appoint any individual as a Board director unless they fully satisfy all the FPP requirements. It is confirmed that all current Board directors have passed the FPP Test under the current rules. The new rules will apply to the future Chief Education and Training Officer and substantive Chief Finance Officer upon their appointment. A new policy is being drafted to take account of the updated framework, and to meet the requirements of the new test. This is due for approval during this month.
At the Board Seminar in September, a number of areas where there were gaps were highlighted, and required improvements identified. These are being addressed.

5. The Tavistock and Portman context

To support efforts to maintain patient safety across the NHS, it is important that patient safety incidents continue to be reported at a national level; trust leaders must proceed on the basis that what they are seeing in their organisations could be happening elsewhere.

Taking this approach, the Executive Team has asked itself the following questions:

- Could this happen here, and how would we know?
- How robust is the assessment of services and the culture of services?
- Are we visible enough as a team, and do we hear enough from patients, their families, and all staff on a ward e.g., the porter, cleaner, HCAs?

We acknowledged that TPFT provides very different services from those at the trust where LL worked, so we asked what it might look like in our Trust. In that regard, we reflected that an equivalent event would most likely be the direct or indirect abuse of a patient, or the death of a patient in any of our services.

We asked how we would know that it was happening and identified a few areas:

- Anything that is seen to be unusual in our services or data
- FTSU concerns
- Spike in DNAs and cancellations relating to one service
- An unusual pattern in SIs, complaints or safeguarding referrals

6. Leadership

There are new structures in place across the organisation to ensure visible leadership from Board to floor, including reinstating planned Executive and Non-Executive team visits and a Senior Leadership Forum. We know that organisations that place the voice of people and families at the heart of their governance, service design and delivery are those most likely to identify and prevent cultures where concerns are ignored. At TPFT, feedback from staff, service users, carers, commissioners, advocacy services, CQC, the Freedom to Speak up Guardians and other stakeholders is sought, although a gap has been identified and work is progressing to scope where we seek feedback from and how we engage with external stakeholders such as Healthwatch.

7. Recommendations

The Board is asked to note and discuss the paper, and to identify areas where they think further assurance may be needed.

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC Wednesday, 11 October 2023					
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	7 September 2023	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 013**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Leadership and management development training • It was noted several times throughout the committee and at previous meetings that the leadership and management development training is expected to provide pivotal mitigation to several issue areas within the work of the People Plan. As such, the committee will receive updates going forward as to the uptake of and feedback on the training programme.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
2. Purple circle network plans and challenges • The committee welcomed Lisa Tucker and Patience Akande to the committee. They are the newly elected chairs of the Disability and Long Term Health Condition network, now renamed as Purple Circle. They spoke about the challenges for staff within the organisation and the ongoing perceived stigma attached to having a long term condition. The Purple Circle want to celebrate and educate moving forward, commencing with training for staff on Neurodiversity in September.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. EDI WRES and WDES considerations • The chair heard from the AD of EDI that as part of the commitment to addressing issues around workforce composition highlighted by our WRES and WDES reports, we have embarked on a journey towards embedding an inclusive ethos to our recruitment and selection process. Recommendations were proposed to both increase the number and improve the experience of inclusive recruitment reps, to train recruiting managers in inclusive recruitment, and to create a comprehensive debiasing toolkit/ checklist that will cover pre-interview, interview and post-interview. The recommendations were accepted.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

The Committee approved the revised terms of reference document.

Risks Identified by the Committee during the meeting:

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

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

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

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

Item	Purpose	Date
None		

The Tavistock and Portman
NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Education and Training Committee	21 September 2023	Sal Jarvis, Non-Executive Director	Elisa Reyes-Simpson, Interim Chief Education & Training Officer/Dean	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 014**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Finance & Business: CETO Budget 23/24 • The Committee requested a full discussion regarding the 2023/24 budget but, at the time of the meeting there were no income figures. • The combination of NCL ICS reporting requirements and aligning budget to the post-strategic review structure have presented a challenge, exacerbated by key finance staff leaving the Trust just prior to year-end and the prolonged audit process. • Work is ongoing between Finance, HR and the directorate to ensure that the budget reflects the Electronic Staff Record (ESR) status, and that ESR accurately reflects the post strategic review position, but this has been challenging. • It is hoped that the budget position will soon be stabilised so that work can commence on the forecast out-turn. • Within the next two months, there will be a clearer indication of new academic year student numbers and income. This will help inform an up to date forecast position, from which the next budget setting process will be commenced.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. CETO/Dean's Report • We have been further developing the Staff Survey Action Plan for DET following a directorate away day. • Space management continues to be a challenge at times, with the focus on locating staff without (a) creating silos between teams, or (b) making student-facing staff less accessible to students – with colleagues mindful of the adverse impact on student experience and satisfaction. • At the date of the Committee, applications across long courses have reached 1089, compared to 1090 at the equivalent point last year, several courses having been heavily oversubscribed. • Cohort diversity has improved, with a 3% increase in applicants to long courses identifying as a category other than White and with a 4% increase in applicants who do not identify as heterosexual.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

International applicants have seen a 54% rise this year. Our top-recruiting countries are China, India, Iran, Nigeria, and Turkey. • Our first in-house Digital Academic course development is underway (Talking to children about difficult things). The Digital Academy is approaching it's 2,000th student since launch in September 2020.	
3. Annual Student Survey Action Plan Progress/Overview Report: • The Student Survey for 22/23 had an increased response rate (35%). It is very pleasing that student overall satisfaction increased to 85% (from 76%). Specific areas of concern include Student Support and Engagement, Assessment, Organisation and Management, and EDI. Enhancement work is underway.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. DET Development Update: • The Trust was invited to a health trade mission in Vietnam and Thailand in September. • Our partnerships with Chinese organisations continue to progress. • Oxleas are now looking to commission a further year of the Trust's two-year commission to develop and deliver a leadership and management programme to Oxeas nursing workforce. • There continue to be opportunities either through established commissioning relationships or through the development of new ones and through submitting bids for tenders.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Psychoanalytic Applied Portfolio Update: • The committee received an update. Despite financial difficulty faced by applicants and current students, the courses continue to recruit well. However, there are risks in relation to the increasing need for student support, and the recruitment of visiting lecturers, which place considerable demands on course teams.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
6. Digital Education Strategy Update: • We have put an appropriate structure in place to shape and oversee action plans to implement the Digital Education Strategy. • Linking up with our university partner, a working group has been set up to consider the use of AI and guidance for staff and students. • The directorate is holding its first Skills Fest in November 2023.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. HECoS Code Changes for the purposes of Data Futures & Reporting: • University of Essex validated courses need to be classified by subject area for regulatory reporting purposes. We currently classify all courses under a single subject (Psychology). Going forward the Trust needs to report these course classifications more accurately and on a more granular level, to meet our regulatory requirements. The Committee approved the changes.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
8. Board Assurance Framework and Risk Register (EYC Risks): • The Committee was assured as to the maintenance of an operational risk register within the directorate and the effective reduction and mitigation of risk. • The Committee noted the identification of where focus should be going forward to ensure risk status and management actions align with the Trust's risk appetite and target risk scores.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Revised Terms of Reference: • The Committee discussed and agreed the proposed revisions to the Terms of Reference, including the updated membership, and are recommending these for approval by the Board of Directors.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee **APPROVED** the recommendations from the Annual Student Survey 2022-23
- The Committee **APPROVED** the change to HECoS codes for the University of Essex validated courses.
- The Committee **AGREED** the proposed revisions to the ET Committee Terms of Reference and **RECOMMEND** these to the Board of Directors for approval.

Risks Identified by the Committee during the meeting:

The Committee identified the following risks for escalation to the Board of Directors:

- The risk of a lack of joined up approach to estates works and communication, impacting on student experience (in particular for disabled students) and staff morale.
- The need for a full budget and financial viability work to be able to move forward in planning and growth.
- Freedom to Speak Up page on the Trust website does not include details of how to contact the Freedom to Speak Up Guardian.

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

The Committee asked the Senior Finance Business Partner and Director of Education (Operations) to review and report back on what student debt looks like, and how the future process should work.

The Committee requested the first draft of the financial forecast to see the end of year position at the next meeting (November).

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

Item	Purpose	Date
Revised Terms of Reference	Approval	11.10.2023
Management of the Estate(s) and links to reasonable adjustments and broader education and training delivery to be raised at Finance, Performance and Resource Committee	Action	

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC
Wednesday, 11 October 2023

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

Committee:	Meeting Date	Chair	Report Author	Quorate	
Remuneration Committee	13th September 2023	John Lawlor, Chair	Amanda Hawke, Corporate Governance Manager	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 15**		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Proposed Changes to the Trust Constitution – voting Executive Directors: • Changes to the Trust Constitution to add further voting members of the Board were suggested to provide clarity should a vote be required. • It was noted that as we have increased the number of Non-Executive Directors to eight we can increase the number of voting Executive Directors to seven. • Proposed voting members are:- ➢ Chief Executive Officer ➢ Chief Finance Officer ➢ Chief Clinical Operating Officer ➢ Chief Medical Officer ➢ Chief Nursing Officer ➢ Chief Education and Training Officer ➢ Director of Strategy and Business Development • The non-voting members of the Board are:- ➢ Chief People Officer ➢ Director of Communications and Marketing ➢ Director of Corporate Governance • The updates to the Trust Constitution on voting members was agreed subject to the approval of the Council of Governors and the Members at the Annual Members Meeting on 11th October 2023.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Recruitment of Chief Education and Training Officer:	Limited ☐

• It was noted that we were not able to make an appointment to this post following the recent recruitment process. • A different recruitment consultant, Society, has been engaged. This organisation is from within the Framework and has come recommended. • The recruitment process will proceed in line with the education calendar.	Partial ☐ Adequate ☒ N/A ☐
3. Chief Finance Officer - Update: • It was decided not to recruit to this post at present. • Once the contract for the Interim Chief Financial Officer comes to an end a secondment to this post will be arranged.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Review of Terms of Reference: • The revised Terms of Reference were agreed. • Succession planning to be discussed further at the next meeting. • All individuals on local pay awards have now been moved to Agenda for Change rates. • Clinical Excellence Awards are now shared out among all Doctors • Pay for Very Senior Managers is agreed at Remuneration Committees.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee **APPROVED** Changes to the Trust Constitution
- The Committee APPROVED the appointment of a secondment to the post of Chief Financial Officer at the conclusion of the current Interim Chief Financial Officer's contract

- The Committee **AGREED** to discuss Succession Planning at the next meeting

Risks Identified by the Committee during the meeting:

The Committee identified the following risk for escalation to the Board:

Lack of succession planning for Executive Directors

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
Changes to the Trust Constitution	Approval	To Board on 11th October 2023

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC Wednesday, 11 October 2023			
Report Title: Annual Medical Revalidation Report			**Agenda No.:16**
Report Author and Job Title:	Chris Abbott, CMO	**Lead Executive Director:**	Chris Abbott, CMO
Appendices:			
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	The purpose of this report is to assure the Board about the fitness to practice of medical staff in the Trust.		
Background:	Doctors require revalidation or renewal of their licence to practice once every five years and as a part of this must engage fully in the cycle of appraisal and CPD. Revalidation ensures that all practicing doctors are fit to engage in clinical work. This report outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.		
Assessment:	The General Medical Council (GMC) continues to support the Trust in its role as the regulatory body and all doctors have been given a date for revalidation. None of the doctors for whom the Tavistock and Portman NHS FT is the designated body is currently subject to any GMC fitness to practice procedures or any imposed conditions or undertakings and all doctors are engaging fully in the revalidation process.		
Key recommendation(s):	The Board is asked to approve the report.		
Implications:			
Strategic Objectives:			
☒ Improve delivery of high-quality clinical services	☐ Be a great & safe place to work, train & learn for	☐ Develop & deliver a strategy & financial plan that	☐ Be an effective, integrated partner within the ICS &	☐ Ensure we are well-led &

which make a significant difference to the lives of the people & communities we serve.	everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	supports medium & long-term organisational sustainability & aligns with the ICS.	nationally, supporting improvements in population health & care & reducing health inequalities.	effectively governed.

Relevant CQC Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☐
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	No current linked risks				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no equality, diversity and inclusion implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	ROAG 28/09/2023				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are	☐ Partial Assurance:	☒ Adequate Assurance: There are no	☐ Not applicable: No assurance is required	

	significant gaps in assurance or action plans	There are gaps in assurance	gaps in assurance	

Report Title: Annual Medical Revalidation Report

1. Purpose of the report

1.1. The purpose of this report is to assure the Board about the fitness to practice of medical staff in the Trust.

2. Background

2.1. Doctors require revalidation or renewal of their licence to practice once every five years and as a part of this must engage fully in the cycle of appraisal and CPD.

2.2. Revalidation ensures that all practicing doctors are fit to engage in clinical work. This report outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.

3. Appraisals and Revalidation

3.1. The Appraisal Lead, Dr Caroline McKenna, and Dr Chris Abbott, RO, email regular updates on revalidation to all doctors in the Trust.

3.2. All medical staff in the Trust have been informed that revalidation requires them to have a full appraisal which has to be recorded on the electronic system of SARD (Strengthened Appraisal and Revalidation Database). The Trust cannot allow medical staff who are not revalidated to continue to work with patients and that failure to have up to date appraisals, properly recorded, can impede incremental progression.

3.3. The RO (as of August 2023, Dr Abbott) meets on a bi annual basis with the Trust GMC employment advisor who informs him of any doctors who have been referred to the GMC.

3.4. The Trust continues to invest in training of all appraisers so that medical appraisals are of a high standard, in keeping with the needs of the revalidation process.

3.5. There are currently 39 doctors undertaking internal appraisals within the Trust.

3.6. Dr Abbott and Dr McKenna have begun a review alongside HR of appraisals within the Trust of external doctors providing services to the organisation but not on substantive, locum or honorary contracts. The review will look at the appropriateness of this and look at alternative arrangements.

3.7. Of these 39, 6 missed appraisals have been due to extended sick leave and career breaks. These have all now had their dates adjusted to reflect this.

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2023 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 12-14 for assistance completing this table**	Number of Prescribed	1 Completed Appraisal (1)	1a (Optional) Completed Appraisal	2 Approved incomplete or missed appraisal (2)	3 Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	33	27	6	4	2	33
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	2	1	0	0	1	2
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0

2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0

2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	0	0	0	0	0	0
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	4	4	0	0	0	4
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	39	32	6	4	3	39

	Indicator	2022/2023 Q1(01 Apr 22 to 30 Jun 22)	Q2(01 Jul 22 to 30 Sep 22)	Q3(01 Oct 22 to 31 Dec 22)	Q4(01 Jan 23 to 31 Mar 23)
1	**Name of designated body (or NHS England geography)** Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	Tavistock and Portman NHS Foundation Trust			
2	The number of doctors with whom the designated body has a prescribed connection	42	42	39	38
3	The number of doctors **due** to hold an appraisal meeting in the reporting period	8	17	20	19
4	The number of doctors within question 3 above, who **had an appraisal meeting** in the reporting period	1	6	13	12
5	The number of doctors within question 3 above, who **did not have an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	7	11	7	7
6	The number of doctors in question 5 above, for whom the RO accepts the postponement is reasonable	2	2	4	4
7	The number of doctors in question 5 above, for whom the RO does not accept the postponement is reasonable	5	9	3	3

4. Recommendations

4.1 There are no areas of concern that need to be flagged at this time and all doctors within the Trust are engaging with the revalidation process.

4.2 External contracted doctors who are receiving their appraisal within the Trust will be reviewed with a view to moving responsibility to their primary employer or the independent doctor appraisal group.

4.3 The 7 doctors with missed appraisals have now all had dates adjusted and meetings arranged to bring them back in line with expected appraisal guidelines.

5. Conclusion

5.1 The Trust is fully committed to revalidating medical staff in keeping with GMC guidelines and all doctors have up to date appraisals or delayed dates that have now been formally approved and dates adjusted.

5.2 No doctors within the Trust have restrictions on their practice and no doctors are undergoing formal fitness to practice investigations.

5.3 Dr Abbott who has taken over as RO from August 2023 is currently undergoing formal RO training and Dr McKenna continues in her role as appraisal lead for the Trust.

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC
Wednesday, 11 October 2023

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

Committee:	Meeting Date	Chair	Report Author	Quorate	
Performance Finance and Resources Committee	26th September 2023	Aruna Mehta, Non-Executive Director	Sally Hodges COO and Peter ONeill CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 017**		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Integrated Quality and Performance report: • Report is going in the right direction, with better detail and thus allowing NEDS to triangulate data • Report is still too fragmented and data heavy without enough direction for NEDS to know where to focus. We agreed to organise a seminar for the committee to work through together where the focus should be. • The plan on a page for the key strategic areas will also help, this will be visible in the reports in the next couple of months. The focus will be on waiting times. • Although waiting times are the key concern, a number of metrics, particularly in the GIC report raised questions for the committee and it was agreed that these would be shared with the board. • It was also agreed that a brief report on GIC issues with a summary on what actions we are taking will be brought back to the next PFRC. • The fire and the Carenotes outage report raised questions about how well embedded our Business Continuity Plans are. Clare Scott, CNO reported that there is a training being rolled out. The committee asked for an update in 6 months post this training. • Contract update highlighted significant risk of c.£14m to our income in 24-25, £10m of which is GIDS. This will be escalated to board, and with the development of the IQR establishing a better link between contracts, activity and workforce. • Job Planning continues to be a challenge, and it was recognised that this is required for clarity on capacity across our services. • ESR issues raised in the Committee highlighted in the IQPR to be clarified and reported to PODEDI if required.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

2. Finance report : • Finance Report was presented to the Committee with no issues raised. • Committee noted that IQP level summaries to be added from M06.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. IMT projects including Carenotes outage lessons learned: • The Committee thanked Jon for the clarity of the report and accepted that all reasonable mitigations are now in place.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. BAF and Operational Risks: • The GIC operational risks (including waiting times) were agreed to be separated out as a specific set of new risks on the Risk Register.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

- The Committee wasn't required to make any decisions

Risks Identified by the Committee during the meeting:

The committee highlighted two significant issues for escalation to board, issues with GIC staffing and morale, as well as the finance risks to contracts in 2024-2025.

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
Staffing and ESR development progress	Action	To PODEDI on

BOARD OF DIRECTORS PART 2 (PUBLIC) – 11th October 2023			
Report Title: Finance Report - As at 31st August 23 (Reporting Month 05)			**Agenda No. 018**
Report Author and Job Title:	Udey Chowdhury, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim CFO
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 05 (cumulative position to August 23) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £1,433k in the period, against a planned deficit of £1,373k i.e., an adverse variance of £60k. This is an improvement from the previous month's negative variance of £117k against plan. This improvement reflects the expected stabilisation of the expenditure position from the adverse variances experienced in previous months. **Capital Expenditure** To date capital spend totals £578k, versus the plan total of £970k. Anticipated expenditure at the year being on plan at £2.4m. **Cash** The cash balance at the end of the period is £6.0m against the planned M05 figure of £8.7m. The negative variance reflects the impact of the deficit and a continued lower income receivables figure from NHS sources. It is anticipated that this position will move closer to plan in the coming months.		
Background:	The Trust has a plan for a revenue deficit for 2023/24 of £2.5m, with Capital Expenditure of £2.4m and a year-end cash position of £3.1m.		
Assessment:	**Income and Expenditure** The Trusts planned deficit of £2.5m requires the delivery of a £3m efficiency to achieve this. This is to be delivered by £2m of non-recurrent income and identified non-pay schemes of £1m. The Trust will in addition establish a process for planning and delivering recurrent efficiency opportunities to run alongside the current non-recurrent program to support the financial performance in future periods as part of the development of medium-term financial plans designed to get the Trust back further towards a balanced financial position. **Capital Expenditure** The agreed capital spend for the year is £2.4m, is a reduction from the previous year of £0.9m and will require robust management to ensure the Trust stays within plan. **Cash** The agreed plan includes a reduction in cash over the year to an outturn of £3.1m, which reflects the expected deficit position.		
Key recommendation(s):	The Board is asked to **NOTE** the position outlined in the report.		
Implications:			

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 8: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 10: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.		

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

Assurance:				
Assurance Route - Previously Considered by:	ELT and PFRC			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no	☐ Not applicable: No assurance is required

	in assurance or action plans		gaps in assurance	

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Audit Committee	28th September 23	David Levenson, Non-Executive Director	Peter O'Neill, Interim Chief Financial Officer	☒ **Yes**	☐ **No**
Appendices:	Appendix 1: Updated SFI's		**Agenda Item: 19**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline. The main issue to highlight to the Board of Directors are issues relating to the assessment of the Effectiveness of External Audit.	**Assurance rating**

1. Effectiveness of External Audit
• Agreed that additional fees of £41k should be challenged.
• Email to Audit Partner to be produced, describing the key issues we believe contributed to the delays in the audit process, including supporting evidence. Key concerns being:
  ○ Unplanned nature of the work, including significant increases in sample sizes.
  ○ Mazars staff churn during the audit
  ○ Number of queries generated that were answered but responded to by Mazars in a timely manner.
  ○ Repeat of queries already answered.
  ○ Timing of queries generated (towards the end of the process) from samples sent earlier in the process.
  ○ May Audit meeting feedback indicated that there were a handful of queries left to resolve – this position changed within days based on new samples that weren't mentioned as required at the meeting.
• Next steps to be agreed once a response from the Audit Partner is received, with the option of pursuing the firm's internal complaints process being the expected next step, should there not be a satisfactory resolution on the additional fees.
• The intention is that the process be concluded as quickly as possible, so as to not hinder the appointment and initial engagement with new External Auditors.
	Limited ☐
	Partial ☐
	Adequate ☐
	N/A ☒

2. Local Counter Fraud • No significant issues raised by RSM, with the CFO requesting a follow up meeting with RSM to discuss the agency control actions agreed with Trust management. To ensure recommendations are then embedded in internal processes.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. Internal Audit Update • Security Data Toolkit - ELT support to embed change in Trust behaviours internally.	Limited ☐ Partial ☒

• Payroll action plan – 12 outstanding management actions to be followed up to ensure progress on this key control weakness.	Adequate ☐ N/A ☐
4. Terms of Reference • New set agreed with the addition of NHS Counter Fraud Authority requirements added.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Aged Debtor Report • Agreed that the write off of debts over 180 days (£224k) not be approved until the causes and process issues were fully understood and assurance that appropriate mitigations are in place.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
6. Single Tender Waivers • Analysis of the 22/23 STWs indicated that all bar 11 were due to contract extensions so should have been classified as STWs. • Updated SFIs to reflect this are included in appendices for Board agreement. • No evidence of potential fraud was found	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. Effectiveness of Internal Audit • No significant issues raised. • Agreed that KPIs for IA to be included in future years' contracts to improve the assessment of services received.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- Challenge and not pay additional fees to Mazars at this point.
- Updated to SFIs

Risks Identified by the Committee during the meeting:

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

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

The age debtor report is to come back to the next committee.

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

Item	Purpose	Date
Updated SFIs	Approval	To Board on 11th October 23

Appendix 1

Updated Extract from Tendering and Contract Procedure section of SFI's

5. WAIVERS / EXCEPTIONS

Tender Waiver Form

5.1. If a contract is above £10,000 and there are exceptional circumstances to award the contract to one supplier, a Tender Waiver Form (TWF) needs to be completed.

5.2. The reasons for requesting a TWF will normally be one of the following:

a. where the timescale genuinely precludes competitive tendering (failure to plan the work properly may not be regarded as a justification for a single tender);

b. where specialist expertise is required and can be demonstrated to be available from only one source; or

Note. The following is not a Single Tender Waiver. An extension of an existing contract with an external supplier that is essential to complete a project or is an associated additional requirement that is linked to the current contract and engaging different consultants for the new task would be impracticable. Any extension or addition that adds additional cost will however need a new Purchase Order raising.

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Board Assurance Framework Report			**Agenda No.: 020**
Report Author and Job Title:	Frazer Tams, Risk and Assurance Contractor	**Lead Executive Director:**	Ade Kadiri, Director of Corporate Governance
Appendices:	Appendix 1: Board Assurance Framework		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	The Board Assurance Framework is a mandatory assurance requirement for Foundation Trusts and is seen as the key tool for the management and assessment of assurances relating to the control of the key strategic risks most likely to impact on our achievement of strategic objectives.		
Background:	The BAF is a key assurance tool for the Trust and has been completely redeveloped over the past 8 months redesigned around the agreed strategic objectives agreed in December 2022.		
Assessment:	The paper represents the latest position of Trust's Board Assurance Framework for scrutiny and comment. The paper highlights key messages for the Board in respect of controls, assurances, and the identification of gaps. It also sets out progress with actions with the aim to move the strategic risks towards their target scores.		
Key recommendation(s):	The Board is asked to: receive this report for assurance, having considered the latest iteration of the Board Assurance Framework, the proposed next steps and confirming the continued acceptance and appropriateness of the strategic risks for 2023/24.		

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

Relevant CQC Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: This report includes the Board Assurance Framework				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	None				

Resource Implications:	Yes ☐	No ☒
	None	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒
	There are no specific implications for EDI from the BAF report although it should be noted that the BAF includes the following risk: **BAF risk 6** The failure to instill 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.	
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.
Assurance:		
Assurance Route - Previously Considered by:	• Executive Leadership Team – received the full BAF on 18th September along with the 12+ corporate risk register. • Quality Committee – received details of BAF risks 1,3 & 4 assigned to them for scrutiny on 7th September 2023 • POD EDI Committee – received BAF risks 5, 6 & 7 assigned to them for scrutiny on 7th September 2023 • Education & Training Committee – received a report on operational risk along with the full BAF for information at their meeting on 21st September 2023 • Performance, Finance and Resources Committee – received BAF risks 2, 8, 9, 10 & 11 assigned to them for scrutiny and comment on 26th September 2023 • Audit Committee – received the full BAF as part of a comprehensive risk report at its meeting on 28th September 2023	
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance
	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Report Title: Board Assurance Framework report

1. Introduction

1.1. The strategic risk management process for the Trust is underpinned by the Board Assurance Framework which provides a structured means of identifying and mapping key sources of assurance that support the achievement of our core strategic objectives. This in turn provides the Board with a level of confidence over what is happening in practice specifically in respect of the control environment around the management of key strategic risks. In addition, it also enables the Board to:

- Consider the types of assurance currently received and whether they are effective and provide comprehensive cover of key controls.
- Identify and understand where controls are failing or are not yet fully operational and their impact on the likelihood of risks occurring.
- Identify and consider where assurance arrangements don't currently exist, are insufficient or may be duplicated.

1.2 The Board Assurance Framework plays a key part in informing the Annual Governance Statement which is a compulsory part of the Annual Report. Additionally, Internal Audit place significant reliance on the effectiveness of the BAF and its processes when providing their Annual Head of Internal Audit Opinion.

1.3 The purpose of this paper is to present the latest iteration of the Trust's Board Assurance Framework for scrutiny and further comment.

1.4 The Board Assurance Framework has since its development in February 2023 been reviewed on a significant basis by both the Board and Board committees. The process has become more embedded into the committee and business cycle and now forms a key function of the assessment of performance and risk across the Trust.

2. Background

2.1. The Board Assurance Framework is currently based on 15 strategic risks structured around the delivery of the following five strategic objectives agreed by the Board in December 2022:

- 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.

3. Summary of Key Messages

3.1. The full Board Assurance Framework is included at appendix A and this includes a revised risk dashboard. Included in the table is a rolling 12-month quarterly record of movement of each risk so as to see the trajectory of travel. Additionally, this is set next to the target risk score for each risk and also the risk appetite level for that risk. The risk appetite is transposed to a risk tolerance level which helps to map the extent that mitigation is required to bring the risk to an acceptable level. A further column provides a clear indicator of movement for that risk over the 12-month period.

3.2. The risks have continued to receive scrutiny and review by the Board Committees during the period with latest round of reporting as follows:

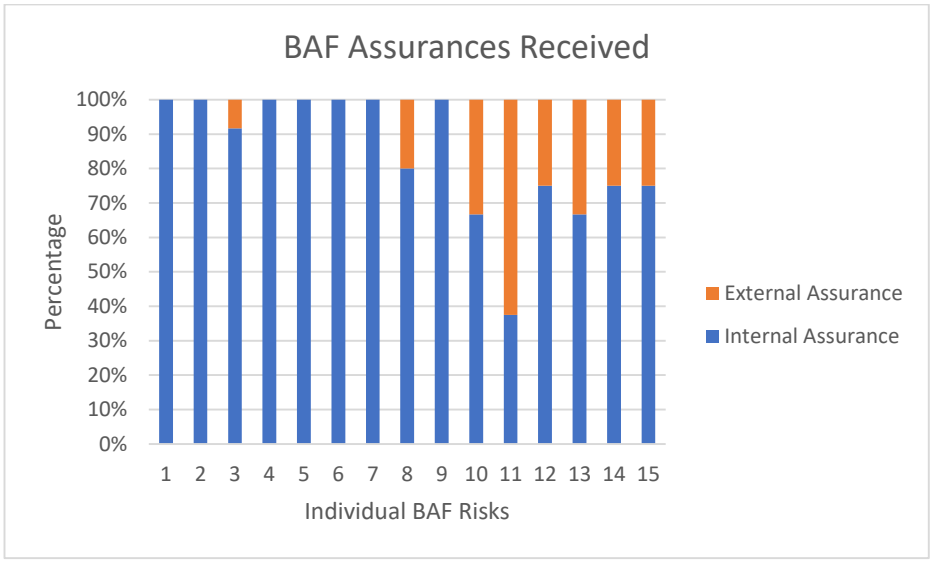
- Executive Leadership Team – received the full BAF on 18th September along with the 12+ corporate risk register.
- Quality Committee – received details of BAF risks 1,3 & 4 assigned to them for scrutiny on 7th September 2023
- POD EDI Committee – received BAF risks 5, 6 & 7 assigned to them for scrutiny on 7th September 2023
- Education & Training Committee – received a report on operational risk along with the full BAF for information at their meeting on 21st September 2023
- Performance, Finance and Resources Committee – received BAF risks 2, 8, 9, 10 & 11 assigned to them for scrutiny and comment on 26th September 2023
- Audit Committee – received the full BAF as part of a comprehensive risk report at its meeting on 28th September 2023

3.3 The underlying feedback from the committee was they welcomed the report and acknowledged the developments and progress being made. Specific comments received relating to the ease of navigating the document have led to some of the enhancements in reporting provided above. Additionally, narrative reports accompanying the extract reporting to committees will be enhanced to ensure committee members are drawn towards key issues and developments.

3.4 The Board Assurance Framework has enhanced over the past eight months in terms of content and detail, with most risks included now identifying all key controls along with populating assurances received. There remains though further work to translate the progress made to date into a clear reduction in the current risk exposure and this in part will come through being clear on what the net impact of implementing actions is on the risk score. To date only two risks have reduced in risk score over the period. Additionally, only one risk (BAF risk 14) current sits at the accepted tolerance level.

3.5 The most recent review has seen improvements in our identification of gaps in control and this should help drive work taking place over the coming period.

3.6 Work around identifying and documenting assurance has also continued and in the main is reflected in the enhanced detail provided for each risk. What we are yet to consistently see across all BAF risks is a level of balance between internal and external assurance recorded. As a reminder, Internal assurances are classified as those produced by us whereas external assurances relate to reports provided by parties that are external and independent of the Trust (e.g., regulators, Internal and External audit providers). A review of internal and external assurances within the Board Assurance Framework are documented below:



3.7 You can see from the above chart that there are currently seven risks within the Board Assurance Framework for which we receive no independent assurance over the effectiveness of controls. Overall, the split within the Board Assurance Framework is 83% Internal and 17% External assurance identified. Whilst the lack of external assurance is not on its own cause for concern, it does highlight where we may want to target our assurance resources going forward. There is scope to consider where our assurance is coming from and consider whether our auditors can provide more targeted assurance towards our strategic risks.

3.8 As the Trust work on strategy takes shape it will be timely to reconsider the current context of the Board Assurance Framework and whether it continues to reflect the key risks and concerns of the Board. This will be conducted in the first instance with the Executive Team and any proposed changes fed back through the committees and up to the Board.

4. Next Steps

4.1. The Governance Team will continue to work with Executive Leads to further identify actions to address gaps in control and assurance.

4.2. Targeted reporting to Board Committees will continue on a bi-monthly basis and this process and feedback will be reported through the Audit Committee and back to the Board.

4.3. The Governance Team will work with the Executvie Directors to re-evaluate the current format and context of the Board Assurance Framework in line with the agreed strategy developments.

4.4. A report on developments with the Board Assurance Framework will be brought back to the next Board meeting in December having considered the current format and context and also further considered and developed our assurance programme.

5. Recommendations

7.1. The Board is asked to receive this report for assurance, having considered the latest iteration of the Board Assurance Framework the proposed next steps and confirming the continued acceptance and appropriateness of the strategic risks for 2023/24.

BOARD ASSURANCE FRAMEWORK

Key Roles and Responsibilities for the BAF

Board	Has overall accountability for risk management and therefore utilises the Board Assurance Framework in order to be satisfied that internal control systems are effective.
Audit Committee	Provides the oversight and scrutiny of risk management arrangements on behalf of the Board and receives assurance that the Trust has robust operational and strategic risk management arrangements. The Committee specifically comments on the fitness for purpose of the Board Assurance Framework and the adequacy of assurance arrangements.
Board Committees	Scrutinise assurances in relation to the strategic risks for which they are the 'lead' committee and escalate levels of assurance to the Board (via highlight reports).
Executive Leadership	Ensure a robust control framework is in place to mitigate their respective strategic risks within the BAF to drive delivery of the Trust's strategic objectives and corporate strategy.
Governance Team	Develops Board and committee annual work programmes (which outline planned assurances in line with Board and committee duties) and co-ordinates the population of the Trust BAF, in conjunction with the Executive Team. The Team also provides risk management expertise to establish and support the Trust strategic risk management arrangements.

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

Consequence	
1	Negligible
2	Minor
3	Moderate
4	Severe
5	Extreme

Risk Appetite		
1	Averse	Avoidance of risk exposure
2	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of the risk occurring after the application of controls.
3	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of the risk occurring after the application of controls.
4	Open	We are willing to consider a range of options subject to continued application and / or establishment of controls: recognising that there could be a high-risk exposure.
5	Hungry	We are eager to be innovative and take on a very high level of risk but only in the right circumstances.

Dashboard summary of BAF risks and their movement over a rolling 12 month period.

Risk Ref	Risk Title	Executive Lead	Lead Committee	Inherent Risk LxC	Current Risk LxC (rolling 12 month period)				Target Risk	Appetite Level (Tolerance score)	Direction of movement over 12 months
					2022/23		2023/24				
					Q3	Q4	Q1	Q2			
1	Delays to treatment, long Wait times/demand	Chief Clinical Operating Officer	Quality	20 (4 x 5)		16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	9 (3 x 3)	Cautious (8)	↔
2	Maturity of Data quality to support transformation	Chief Finance Officer	Performance, Finance & Resources Committee	16 (4 x 4)		12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	8 (2 x 4)	Open (9)	↔
3	Quality of service provision	Chief Nursing Officer	Quality	20 (5 x 4)		16 (4 x 4)	12 (3 x 4)	12 (3 x 4)	8 (2 x 4)	Cautious (8)	↓
4	Quality Assurance	Chief Nursing Officer	Quality	20 (45x 4)		16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	8 (2 x 4)	Cautious (8)	↔
5	Workforce development, retention, recruitment	Chief People Officer	People, Organisational Development, Equality, Diversity & Inclusion	16 (4 x 4)		12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	6 3 x 2	Open (9)	↔
6	Lack of inclusive and open culture	Chief People Officer	People, Organisational Development, Equality, Diversity & Inclusion	20 (5 x 4)		12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	9 3 x 3	Open (9)	↔
7	Lack of management capability and capacity to manage People issues	Chief People Officer	People, Organisational Development, Equality, Diversity & Inclusion	20 (4 x 5)		12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	6 2 x 3	Open (9)	↔

Risk Ref	Risk Title	Executive Lead	Lead Committee	Inherent Risk LxC	Current Risk LxC (rolling 12 month period)				Target Risk	Appetite Level (Tolerance score)	Direction of movement over 12 months
					2022/23		2023/24				
					Q3	Q4	Q1	Q2			
8	Delivering financial sustainability targets	Chief Finance Officer	Performance, Finance & Resources	20 (5 x 4)		16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	8 (2 x 4)	Open (9)	↔
9	Maintaining an effective estate function	Chief Finance Officer	Performance, Finance & Resources	15 (5 x 3)		12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	8 (2 x 4)	Open (9)	↔
10	Sustainable income streams	Chief Finance Officer	Performance, Finance & Resources	20 (4 x 5)		16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	8 (4 x 2)	Hungry (15)	↑
11	IT infrastructure and cyber security	Chief Finance Officer	Performance, Finance & Resources	20 (5 x 4)		12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)	Open (9)	↔
12	Developing Partnerships	Chief Clinical Operating Officer	Executive Leadership Team	16 (4 x 4)		12 (3 x 4)	12 (3 x 4)	12 (3 x 4)	9 (3 x 3)	Hungry (15)	↔
13	Compliance with Information Governance requirements	Director of Corporate Governance	Executive Leadership Team	15 (5 x 3)		9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)	Cautious (8)	↔
14	Effective Performance and Risk management arrangements	Director of Corporate Governance	Executive Leadership Team	15 (5 x 3)		12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)	Open (9)	↓
15	Effectiveness of senior leadership	Chief Executive	Executive Leadership Team	20 (5 x 4)		12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	6 (2 x 3)	Open (9)	↔

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.

		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										**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**	1st August 2023
Risk Appetite	**Cautious**	5	4	**20**	4	4	**16**	3	3	**9**	**Date of Next Review**	1st October 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, waiting list and quality impact risk monitoring across key services (including GIDS, Adult Services, GIC and Autism Assessment).	Clear understanding of capacity to reduce waiting times and meet increasing demand for some services.	New three-year strategy has reduction of waiting times to 18 weeks across all services as an ambition. Teams are in the process of delivering a trajectory for all service areas. Delivery of this ambition will be tracked via weekly ELT Strategy Delivery Room and Monthly IQPR meetings which report through to Board.	Internal	Amber
Integrated Quality and Performance Review (IQPR) meetings for each operational service area.	Data flow is manual so possible errors.	IQPR report is considered by Board and Performance, Finance and Resources Sub-Committee.	Internal	Amber
Job planning to properly understand the capacity of each Team to meet demand for services.	Current reporting structures are out of date for key systems (Oracle, Carenotes, Quality Portal, ESR).	Existing systems still report previous monitoring group structures and therefore ownership of key information on finance and activity is not available at local level where required.	Internal	Red

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Key performance and information reporting systems are in the process of being automated and aligned to our new management structure which will enable data flow to correct operational monitoring groups.	Hector Bayayi	Draft Team budgets were issued at end of July 2023 and the Informatics Team are working to deliver initial Statistical Process Control data sets (for GIC and Trauma services) during August 2023.	
Ownership and accountability for finance and activity performance to be held at local level once system reporting aligned to new structure and working within local, Regional and National care systems to align / increase our income in-line with demand for services.	Sally Hodges	Noting progress above, final budgets to be validated with Teams during August and finalised in September 2023.	
Job planning implementation in place	Hector Bayayi	October 2023	

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Review existing clinical pathways and clinical models to ensure they remain fit for purpose.	Adult Trauma service review has commenced. Streamlined clinical model for appropriate GIC cases has been devised.	Ongoing service funding concerns impacting on delivery effectiveness and discharge blocks. Staff levels required to deliver waiting lists	IQPR meetings with contracting updates.

			As above noting external NHSE meetings to support identification of delivery capacity

Principal Risk 2	**Maturity of Data quality to support transformation**	**Strategic Objective**	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.
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.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Peter O'Neill Interim Chief Finance Officer										**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**	12th September 2023
Risk Appetite	**Open**	4	4	**16**	3	4	**12**	2	4	**8**	**Date of Next Review**	1st December 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	Amber
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	Green
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	Combination of system and human led checks at multiple levels. Automated processes have been created which monitor both source and destination systems and to a pre-determined schedule update the data warehouse. Further monitoring software is utilised which messages key staff groups in IT on the success / failure of the schedule for remedial action. Periodic "sense" checks are completed via automated reporting to key staff groups. External functions utilise the data warehouse and also run further reports on the data accuracy and raise issues to the Informatics team where required.	Internal	Red
Implement sophisticated tools to analyse the stored data flexibly	Expertise in the analytical tools is increasing but still at early stages of maturity	Assurance will be primarily through the acceptance processes for project phase deliveries ensuring the systems and services delivered have achieved the relevant quality criteria for live operation.	Internal	Red
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. Work has commenced on re-structuring core systems in line with Strategic Review and new dashboards and SPC charts are being developed in line with the PID	Multiple reporting options are available both via the data warehouse and the core systems Project board established and meets monthly.. Demonstrations of existing dashboards created by Informatics to key managers and execs within the trust.	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Improve maturity of infrastructure to support data provision	Director of Infrastructure	FY 23/24	Work on the IQPR programme has now been signed off and will have a number of data related improvements.
Improve data collection processes where gaps identified	*Should be operationally led with IT support*	Ongoing	Initial planning meetings held with Clinical and DET senior management.
Analyse and support next phase of data management and 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**
Phase 1a – Implementation of the data warehouse infrastructure	Primarily completed and operational in FY22/23. Last planned phase element in 23/24 (Phase 1b)	None	Internal project team, Change Board and Trust Capital program
Phase 1b - Introduction of the integration service which will enhance data collection and distribution capabilities.	Specification completed and selection of vendors is underway. Will complete in FY23/24	Lack of resources in both funding and personnel. Higher priority work.	Internal project team, Change Board and Trust Capital program
Phase 2 – Commission data reporting system and complete initial data insights for key clinical, educational and corporate areas.	Primarily completed and operational in DET and Corporate FY22/23. Completion delayed in Clinical due to CareNotes outage.	Access to key individuals time in clinical, corporate and DET. Steep learning curve for Informatics team on the new data environment. Resource constraints within Informatics. No further significant issues/outages with core systems.	Internal project team, Change Board and Trust Capital program
Phase 3 – Expand the data provision to all teams based on trust strategic, operational and tactical imperatives. Will potentially require sub phases providing incremental and agile delivery in pre agreed time boxes.	Initial engagement sessions have been held detailing the capabilities of the data infrastructure from a user perspective. New requirements are being gathered for phased delivery.	CareNotes recovery completion Access to key senior resource to set appropriate direction Overall Trust strategic plan to guide the framework for knowledge and insight delivery Resource constraints within Informatics. No Corporate equivalent of Clinical and Educational Boards.	Internal project team, Change Board and Trust Capital program. Clinical and Educational leadership boards

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	Clare Scott 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**	22nd August 2023
Risk Appetite	**Cautious**	4	5	**20**	3	4	**12**	2	4	**8**	**Date of Next Review**	22nd October 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)
Appropriately skilled staffing. Structure in place following strategic review with clinical and professional leadership clearly defined.	Pockets of agency staff use remain and there is a need to fully embed the new structure following strategic review.	POD EDI staffing report to each meeting (latest Jan 2023) includes current staff vacancies. Committee and Board oversight through IQPR Workplans progressed and new clinical services delivery Board commencing September		Internal	Amber
Job planning		Job planning policy approved by Policy Approval Group 15th May 2023.		Internal	Amber
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 discussed by Quality committee July 2022 and approved at July 2022 Board meeting. Sub structure to be developed in Q3		Internal	Amber
Mandatory training	Resus training/BLS	CQC inspection feedback letters for both Portman clinic (1/2/23) and CAMHS Service (8/2/23) gave overall positive feedback on level of service provision and safety of practices covering all the key controls listed Ofsted inspection report (Gloucester House) outcome positive	Mandatory training compliance reported through the POD EDI Committee bi-monthly	Internal	Amber
Supervision/clinical safeguarding Process	CareNotes access issues has prevented reporting around this		CQC improvement plan BLS Clinical supervision – presented in Quality report to Quality Committee bi-monthly Reported in IPQR monthly. Supervision structures are held at team level, underpinned by new supervision policy. Teams report supervision in a monthly log. Safeguarding supervision taking place, this will be strengthened by developing an improved structure through the Safeguarding forum. Included in the Quality report bi-monthly.	(External CQC)	Amber

Quality assurance tools and methodology Quality report, summarises all aspects of quality related metrics and programmes of work. IPQR Clinical Governance meetings	Sub-committee structure for quality Metrics – the data and information for Quality report and IPQR doesn't always correlate; will be reviewed				Amber
Quality Framework Improvement Plan in place			Quality Framework monitoring report to Quality Committee	Internal	Green
Strategic review on structures			All professional leads now in place		Green
Learning from deaths process CMO			Highlight report from the Risk and Safety Group presented to Quality Committee	Internal	Green
Senior Clinical Management structure has been agreed			Chief Nurse Officer and Chief Medical Officer In post		Green
Clinical Audit Schedule agreed - CMO			Does this report into Quality Committee	Internal	Green
Complaints Process	Lessons learnt process from complaints Timeliness of response Funding for dedicated role Policy needs review Structure of team		Report to Quality Committee Jan 2023 stated response rates at 33% against a target of 80% for Q2. Process under review, trajectory and timeframe for overdue complaints to be closed.	Internal	Amber
Incident reporting process through Quality Portal	Lessons learnt process for SIs, Incidents and never events Quality Portal not fit for purpose, will not concord with LFPSE – new system with procurement		New system procurement at decision making stage.	Internal	Amber
Staff sickness and absence reporting		Quality committee receive reports at each meeting (latest Jan 2023) on sickness and absence levels.		Internal	Amber
CAS Alerts process in place		CAS Alerts reported through Quality Committee at each meeting (Jan 2023 latest)		Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Review Quality Governance processes including patient safety.	Clare Scott	31st December 2023	Implementation dates pushed back - Progress made but new ELT appointments made; review of ELT portfolios to take place first week of September. Work continuing but will progress at pace following priority setting approved.
Review sub structure of Quality Committee to align and co-ordinate reporting	Clare Scott	31st October 2023	
Complaints turnaround improvement and lessons learnt process	Clare Scott	Trajectory developed 28th September. Overdue complaints closed by 30th November 2023. Framework for lessons learned included in review QG processes	
Develop effective lessons learned process for Sis, Incidents and Never Events	Clare Scott	31st December 2023	

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Implementation of the Quality Improvement Plan based on the 11 defined areas of improvement required	Progress currently in line with anticipated delivery dates with short extension on timescales for the following: • Development of Quality Strategy • Duty of Candour audit		Internal working document on progress with the plan presented and discussed at the SOF3 meetings and through Quality Committee.

	• Establishment of Morbidity & mortality meetings • Safeguarding capacity business case • Program of learning events sharing findings from R&D • Review how patient voice heard by the organisation		

Principal Risk 4	**Quality Assurance**	**Strategic Objective**	Improve delivery of high quality clinical services which make a significant difference to the lives of the people & communities we serve.
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.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Clare Scott Chief Nurse										**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**	22nd August 2023
Risk Appetite	**Cautious**	4	5	**20**	4	4	**16**	2	4	**8**	**Date of Next Review**	22nd September 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 New incident reporting and risk management system being procured.	Internal	Amber
Key quality Policies, Procedures & Guidelines in place for all key aspects of quality governance	Policies not up to date	Policy and Procedures review group now sitting every 3 weeks. Dates agreed for meetings over the next 12 months.	Internal	Amber
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 IQPR	Internal	Amber
Quality governance structure	Sub structure that feeds the committee lacks structure and co-ordination.	Terms of reference approved by Board July 2022 Formal agenda for each meeting minutes from the Quality Committee recorded and signed off.	Internal	Amber
Quality improvement Plan		Report on implementation progress presented to SoF3 meetings and through Quality Committee bi monthly	Internal	Amber
SoF3 oversight meetings		SoF3 oversight Meeting minutes and papers	Internal	Amber
CAS Alert process in place		Reported through the Quality Committee (latest July 2023)	Internal	Amber
Receiving and responding to feedback and complaints	Lessons learnt process from complaints Timeliness of response Funding for dedicated role Policy needs review Structure of team			
Quality assurance tools and methodology Quality report, summarises all aspects of quality related metrics and programmes of work. IPQR Clinical Governance meetings	Sub-committee structure for quality Metrics – the data and information for Quality report and IPQR doesn't always correlate; will be reviewed	Minutes of Quality Committee, IPQR and Clinical Governance meetings. Quality Report IPQR report	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Implementation of Quality Improvement Plan actions	Clare Scott, Chief Nurse Officer	30th September 2023	target data moved to end of September 2023 in line with other national quality deadlines which will inform the plan (e.g. PSIRF)

			Significant progress has been made in the actions of the improvement plan, but some remain open until final completion.
Review of key policies	All Executives	Programme for all Trust policies set over next 12 months	Policy review group relaunched now sitting e very three weeks to clear backlog of policies requiring refresh.
Upload core records to CareNotes system	Clare Scott, Chief Nurse Officer	31st January 2023	Is this complete?
Review Quality Portal effectiveness with view to consideration of alternative arrangements	Caroline McKenna, Chief Medical Officer	31st January 2023	Group formed to scope and commence procurement of replacement system. Final stages of procurement process, decision to be made on system by 31st August 2023
SOF3 action plan implementation	Clare Scott, Chief Nurse Officer		

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
As recorded under Risk 3 Quality of service provision			

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 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.	**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.**

Executive Lead	Chief People 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	POD EDI Committee	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	25th August 2023
Risk Appetite	**Open**	4	4	**16**	4	3	**12**	3	2	**6**	**Date of Next Review**	25th October 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. Positive POD EDI Committee discussions held on elements of progress Talent management and succession planning programmes in future. There has been an uptake of career and wellbeing conversations	Internal	Amber
Recruitment and approval group approval of roles for recruitment to be replaced by a more robust establishment control process (ECP)		ECP in place and log actively updated. ECP log indicates improved workforce planning / skill mix reviews Skill mix and structure reviews occurring	Internal	Amber
NLPSS Operations meetings weekly		Verbal feedback only not record of meetings held. Performance report from NLPSS Reduction in vacancy rates Exit interview analysis and, in time, onboarding interview analysis	Internal	Amber
Chief People Officer meeting with NLPSS fortnightly		Chief People Officer meeting pack with update from previous meeting includes plans for recruitment.	Internal	Amber
Trust Recruitment and selection Policy and Procedures	ESR limitations in reporting recruitment data No current performance pack for directorate on compliance	Formal assurance on adherence to procedures from NLPSS performance report and internal workforce dashboard. Recruitment and selection policy revised in line with NCL standards and includes NLPSS Improved NLPSS KPIs	Internal	Red
Some KPIs in place for time to hire	Not all recruitment processes have KPIs currently	Vacancy rates and recruitment KPIs included in IQPR packs	Internal	Red

		Improvements in demographic-reflective hiring and declarations of protected characteristics		

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	Work by NLPSS is ongoing to ascertain best practice
NLPSS agreeing KPIs across NCL	Chief People Officer	31st March 2023	KPIs are identified and will be reported on
Camburg updating RAG terms of reference formalising routes for approval/standardised process	Chief People Officer	31st March 2023	Draft produced which requires significant review. ECP process will supersede this in the coming months.
CPO and Associate Director of HR to design and implement full ECP with support and input from finance colleages	Chief People Officer	30th June 2023	ECP brainstorming session diarised for mid-March
Align ESR and Oracle information to improve reporting capability	Associate Director of HR	31st March 2023	Data cuts have been sent to department heads to review and confirm accuracy. Working with finance colleagues on understanding vacancy position.
Performance pack to be developed	Associate Director of HR	31st March 2023	February performance report has been received from NLPSS. Initial internal workforce dashboard has been created and will be presented at 23rd March POD EDI Committee

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	Inclusive recruitment training delivered and practices in place	Need to roll out further training and guidance to managers on best practice recruitment	February performance report has been received from NLPSS. Initial internal workforce dashboard has been created and will be presented at 23rd March POD EDI Committee
Review of productivity, establishment, finance	Process has started with the Clinical division and will then move to Corporate followed by DET.		

Principal Risk 6	**Lack of inclusive and open culture**	**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	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.		

		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**	15th March 2023
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	**Date of Next Review**	15th May 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	Green
Health & Wellbeing group (includes review of cost of living issues)		Key issues fed back to POD EDI Committee through the Associate Director of EDI Improvements in health and wellbeing indicators reported	Internal	Amber
Occupational Health and employee assistance programme		OH and EAP provision aligned with ICS	Internal	Green
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	Amber
	No central planning process for interview panel involving BAME candidates			Red
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. Informal resolutions form majority of outcomes	Internal	Red
	Process to ensure equity for BAME candidates for senior roles (band 8 and above)	Inclusive recruitment training delivered and practices in place Internal reporting of issues (incl FTSU) more reflective of staff survey reporting	Internal	Red
	Improved process around recruitment and treatment of disabled candidates.	Just and learning culture approaches included in all revised policies Armed forces covenant, disability confident status, and other inclusive statements, implemented competently	Internal	Red

Chief Clinical Operating Officer sponsoring EDI programme and providing link with the Board		Feedback through EMT Board development sessions implemented on EDI considerations	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Race Action plan (63 points)	CEO/Execs		Revised race action plan communicated and enacted

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Revised, refreshed RAP to be created and presented to POD EDI Committee			New RAP communicated (once complete)
Reasonable adjustments process implemented	This has commenced, with funding secured from finance and reasonable adjustments are being signed off	Reasonable adjustments policy has not yet been created	Continued use of reasonable adjustments process and staff reporting RA in place in staff survey
Employee relations policies being refreshed with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	CPO has feedback on first round of policy drafts viewed, and these are going back for amendment		New policies and training (once complete)

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**	25th August 2023
Risk Appetite	**Open**	4	5	**20**	3	4	**12**	2	3	**6**	**Date of Next Review**	25th October 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 Planned - Just and learning culture approaches included in all revised policies	Internal	Amber
Management structure in place with revised job descriptions clarifying line management responsibilities	Manager leadership training required	Strategic review paper to EMT approving structure.	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Management & Leadership development programme to be rolled out across the Trust. Three separate programmes, one for Bands 5-*b, one for Bands 8c and above and back to basics training on core process and policy.	Head of HR	Ongoing	Learning and development training (x2) and back to basics training in place Coaching of managers by HRBP (and senior team where required). Managers report feeling more competent to resolve issues as a result of the training packages / coaching from HRBPs Informal resolutions form majority of outcomes Appropriate attendance levels at training sessions recorded
All HR Policies to be reviewed over next 12 months (priority to be given to Recruitment & Selection, disciplinary, capability, grievance and flexible working policies) with a just and learning culture approach to ensure transparency of policy, fairness and consistency of application, and a starting point of seeking to learn and develop rather than punitive measures	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	30th June 2023	Steady improvement in people relations KPIs

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
New suite of policies	As above		
Three training programmes	Learning and development training (x2) and back to basics training in place		
KPIs and associated dashboard	People relations KPIs consulted on with managers and SEG and implemented		SEG report feeling confident in new approaches

Principal Risk 8	**Delivering financial sustainability targets**		
Description	A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**

Executive Lead	Peter O'Neill Interim Chief Financial Officer	**Inherent Risk** (Before consideration of controls)			**Current Risk** (After considering existing controls)			**Target Risk** (Risk after implementing all agreed action)			**Original Assessment Date**	19 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**	10 July 2023
Risk Appetite	**Open**	5	4	**20**	4	4	**16**	2	4	**8**	**Date of Next Review**	30th September 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 (LTFP)	Requires updating		Internal	RED
2022/23 Annual Plan / Budget		Approved by Board on 6 July 2023	Internal	GREEN
Monthly Finance Reports		Reviewed by ELT, PFRC and Board. Report for 12 months ended March 2023 shows Trust on Plan	Internal	GREEN
In Year Reforecasts		At PFRC in January and Board in February, unchanged full year forecast noted	Internal	GREEN
2023/24 Annual Plan / Budget	Required for 23/24	Updated version submitted to NCL ICS (28 April) but Board approval outstanding	External	AMBER
	Detailed CIP programme			RED
	Commercial Strategy			RED

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Updated LTFP	CFO	June 2023	Currently awaiting revised Trust strategy
2023/24 Budget	CFO	June 2023	Draft submitted to April Board. Updated version to go to May PFRC and June Board
Detailed CIP programme	CFO	June 2023	Process approved. Detailed workings required
Commercial Strategy	Director of Strategy and Transformation	October 2023	Under development

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.	Revision to current LTFP not yet started	Requires finalisation of 23/24 Plan and development of new Trust strategy	n/a
Deliver the 2022/23 Out-Turn within Plan	Report for 12 months ended March 2023 shows Trust on Plan	Subject to external audit	March Finance Report (PFRC May 2023)
Develop and deliver the Action Plan following the HFMA review	Action plan developed. Delivery against plan on-going	Development of CIP key outstanding issue	Self Assessment (October / March / May Audit Committee) Internal Audit review – follow up in May
Commercial Strategy			

Principal Risk 9	**Maintaining an effective estate function**	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**
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.		

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Peter O'Neill Interim Chief Finance Officer										**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**	12th September 2023
Risk Appetite	**Open**	5	3	**15**	4	3	**12**	4	2	**8**	**Date of Next Review**	1st December 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)
Leases in place for Leif house, Birmingham and Leeds- Hard FM providers for London, Leeds and Birmingham, focused on statutory compliance.	PAM – aligns to 5 CQC domains, an assessment was completed in Feb, and work carried out over a number of months with a submission made in Sept.	The PAM assessment included governance, hard and soft FM, patient experience, effectiveness and efficiency	Internal	Green
10-year Capital plan –6 facet survey has provided an asset replacement plan and is reviewed annually	Capital plan is risk based with defined backlog asset replacement, it is manual process, and	This replacement plan was aligned to the Trust strategies, as the Trust strategies are being refreshed, the Estates strategy will follow suit, with an aim to replace assets based on failure rates	Internal	Amber
Current cleaning standards are higher than the NHS national standards, informal arrangement around assurance	NHS National cleanliness standards 2021, assurance model has not been introduced into the Trust, adherence is due by July 23	Training has commenced with staff, and will involve several interventions as a root and branch assessment of what frequency areas are cleaned and an assurance model developed, staff engagement has been slow and will go live from 1st November	Internal	Amber

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
Detailed Estate revenue model to support finance model, this will follow the Estates Budget	Estates lead	December 2023	Planning in progress

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
Premises Assurance Model assessment- a gap analysis, and timeline	Assessment and timeline will be shared with PFR	The review has highlighted gaps, and an action plan developed in line with operational activities. PAM submission made and will work with Quality team to align on IPC	Report will be shared with PFR and peer review with Royal Free Ltd
Introduction of a CAFM (computer aided facilities management system) in 2023, this will automate the asset failure rates and provide a better understanding of the systems across our estate	Contracts signed and asset hierarchies will commence in March, this has slowed down as contractor has not had resources, the asset uploads are now complete	Asset will be coded, and staff trained over the coming year	Progress will be shared through FIRM
Develop a soft FM and Hard FM strategy	Consolidate fragmented contracts, and staffing model, in line with service operating hours	Ability to deliver as the team are in transition alignment to NHS national standards	PAM review

10-year capital plan based on the 6 facet survey	Surveys have been carried out on some assets- electrical supply, lighting and fire doors and will look at fire alarms, heating systems over the coming months to support 24-25 planning cycle.	Aging estate, will require upgrades over coming years	Specialist surveys undertaken with authorising engineers

Principal Risk 10	**Sustainable income streams**		
Description	The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.	**Strategic Objective**	**Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.**

		Inherent Risk (Before consideration of controls)			Current Risk (After considering existing controls)			Target Risk (Risk after implementing all agreed action)				
Executive Lead	Peter O'Neill Interim Chief Finance Officer										**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**	10th July 2023
Risk Appetite	**Hungry**	4	5	**20**	4	5	**20**	4	2	**8**	**Date of Next Review**	30th September 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 Review, PFRC Oversight	Internal	Amber
Internal Monitoring Reporting on current DET services	Not in place	DET Exec Review, Education & Training Committee Oversight, PFRC Oversight	Internal	Red
External (Commissioner) 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 Review, DET Exec Review, PFRC Oversight, Commissioner Review Meetings	Internal / External	Green
Alignment of internal services reporting with financial controls	None	External Financial Audit (annual)	External	Green
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 Review	Internal	Amber

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 – *completed in early May*.	ESR and finance information updating was fully completed in early May – except minor errors to some staff groups (from TRAC advertising errors). New ECP process to be defined (to dovetail with a monthly finance reconciliation process) – to ensure ESR is routinely updated. This process will be brought to PODEDI Committee for approval.
Address service specifications with commissioners during contracting round	Commercial Director	June 2023	Due to the lack of detailed budgets and staffing, the commissioner has requested that we work through a fully developed proposal on the service specifications throughout 23/24, aligning our services with NCL core services. This is currently on track and the initial scope of work is being developed for end of May for agreement with the commissioners by mid-June.
Development of Internal Reporting for DET Services	Director of Education (Operations)	July 2023 (to be confirmed)	Enhanced DET performance reporting is starting from the PFRC meeting in May. This will provide a level of assurance/control but will not be finalised. DET performance will be reported regularly and will improve during the remainder of the year in line with the DET Operations Improvement Programme which is aligned with the IQPR programme.

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 (May 2023)	Initial plan has been developed to review the missed opportunities and the current open opportunities	Need to ensure Commercial Strategy aligns with Trust-wide Strategy	Board approval of Commercial Strategy

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	Peter O'Neill Interim 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**	12th September 2023
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	3	3	**9**	**Date of Next Review**	1st December 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	Green
Implementation of security software on all servers	None	Usage of leading industry standard products maintained in accordance with best practice	External	Green
Successful completion of IG Toolkit annually	Full compliance with mandatory IG training	NHS DSPT toolkit annual submission. External validation of submission IT has also created a new cyber information video which will assist staff in recognising threats and communication to all staff has been sent.	External	Amber
Compliance with industry standard Cyber Security Accreditations	None presently. However, each year adds additional controls.	External validation with independent Cyber Essentials agency officially accredited from 11/5/23. Including extended control of mobile devices which meant implementing a completely new MDM system and roll it out within a few months. It also includes security testing suppliers as well which is a hot area after CareNotes. We will continue this process going forward. An NCL CIO led Cyber group has been created to combine skills and resource to better tackle potential cyber threats and share rare skills in this area.	External	Green
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	Green
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.	Internal/External	Green
Business continuity plans for all relevant trust areas	Continuous assessment of suitability and regular BCP scenario testing.	Regular BCP scenario testing with feedback loops for continuous improvement approach. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested Lessons learned for the Cyber outage of CareNotes have now been created and relevant functions are implementing the findings	Internal	Amber

Third party system supply cyber assurance	No formal process to ensure suppliers are operating critical systems on the trust's behalf to acknowledged and agree cyber standards.	Regular (suggested annual) update from system suppliers to a structured questionnaire requiring assurances on compliance with evidence. Would be appropriate to engage a 3rd party assessment service	External	Amber

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
Annual review and implementation of new standards for cyber safety	Director of Infrastructure	Annual submission to Cyber Essentials to achieve ongoing accreditation.	In progress
Review of BCP plans across the trust with recommendations for improvement. Note due to the responses to the pandemic and latterly to the CareNotes outage BCP plans have been stress tested twice since 2020 and have successfully managed associated risks and maintained trust effectiveness.		By end of FY 23/24	To be agreed
Review supplier base and engage 3rd party assessment service	Director of Infrastructure	Q2 FY23/24	To be agreed

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	Cyber Essentials accreditation at the plus level was officially granted on 11/5/23 having implemented a number of extended controls including additional software for mobile device management.	None	External Cyber Essentials accreditation organisation. Trust Audit program
Engage 3rd party cyber assessment of trust suppliers across all of the infrastructure to ensure compliance to trust / NHS standards	Planning is underway via the recovery of the CareNotes system and will deliver outcome in Q1 FY23/24. Intention is to pilot with Advanced (CareNotes supplier) and then roll out to all other system suppliers	Will require funding of the service to be acquired. Higher priority work impacting internal technical resource	NHS (digital team) 3rd party assessor Trust audit programme

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.**

Executive Lead	Sally Hodges , Chief Clinical Operations 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**	1st August 2023
Risk Appetite	**Hungry**	4	5	**20**	3	4	**12**	3	3	**9**	**Date of Next Review**	1st October 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)
Attendance at the following key meetings: 1) ICS partnership meetings 2) Provider Collaborative meetings 3) Place based meetings including Local Authority attendees	Identify key relationships and allocate relationship managers	Record of attendance at ICS, Provider Collaborative meetings and Placed Based meetings including agreed actions and minutes. Linking in with North Mid Programme Board (NCL ICS partner) for shared learning on rolling out the same Quality Improvement framework from August onwards.	Internal	Green
	Understand the gaps in clinical service provision across the ICS where we can add value	Engagement in mapping workshops	Internal	Green
	Engage with leading partners over population health needs.			Red
	Lack of presence currently across the other 4 NCL boroughs (Islington, Haringey, Barnet, Enfield)			Red
System Oversight Framework Level 3 Meetings (Regional and ICS): 1) ICS led Performance Improvement Meeting Regionally Led SOF3 Oversight Meeting	Fully validated budgets at Team level and waiting time reduction trajectories.	Integrated Quality and Performance Review meetings.	External	Amber
Building local, regional, national and international strategic partnerships by engaging with systems tendering for new services that we are a specialist provider of (to support the submission of the best bid possible to grow our income).	Capacity to cover both clinical services and commercially specialist education and training portfolios.	ELT consideration via new scoring matrix for the consideration of bids (based on alignment of Trust strategic ambitions, capacity to deliver and financial impact)	Internal	Amber

Action to address gap in assurance/control	**Lead Officer**	**Date of implementation**	**Status**
Establish a matrix of key relationships across the ICS and allocate individuals to be relationship managers	Sally Hodges, CCOO		
Undertake a clinical led piece of work, actively engaging with leading partners to determine the population health needs for services where T&P can add value.	Michael Holland, CEO		
Developing strategic partnerships to support growth and delivery of care, education and training to individuals where our services can make a positive difference.	Sally Hodges CCOO / Elisa Reyes-Simpson Interim Director of DET / Rod Booth, Director of Strategy	Live and ongoing	Progressing with a number of service bids submitted and work in train to develop international partnerships.

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

Develop greater presence across the other 4 NCL boroughs (Islington, Haringey, Barnet, Enfield) specifically where not the current primary provider. This to include: • Mapping across the borough meetings for engagement (specifically including Adult and Physical Health services) • Identify contacts for each meeting, allocate who will attend • Establish internal communication systems to ensure feedback is received and reported back through the Trust • Developing an understanding of where the Trust can be helpful and add value.	We are attendees at the NCL ICS Population Heath Board and Performance Meetings which is supporting an analysis of local demand and our activity in meeting this demand (and more importantly identifying where there are gaps in provision and equity of access to services). We also attend a. number of Regional and Camden Borough meetings with partners to support the shared ambition of delivering prevention-based services for children, young people and families.	Deploying our engagement strategy at each level of partnership to maximise our contribution and be recognised as an equal partner leading on service delivery and pathway improvement across the areas we work in.	Internal and External

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	Sheila Murphy 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**	12th May 2023
Risk Appetite	**Cautious**	5	3	**15**	3	3	**9**	3	2	**6**	**Date of Next Review**	12th July 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	Amber
Key policies on Information Security, Information Management, GDPR		IG Progress Report to PFRC provides update on current compliance	Internal	Green
Formal procedures for recording, reporting and responding to GDPR requests (FOI, SARs)	Current compliance meets the required standards @ May 2023 but there are significant gaps with staff resource.	IG Progress Report to PFRC provides update on current compliance	Internal	Amber
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	Amber
Plan for achieving compliance with DSPT approved by NHS Digital July 2022		IG Progress Report to PFRC provides update on current compliance	Internal	Amber

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	Currently being achieved but concerns remain over resourcing
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**

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	Adewale Kadiri 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 Leadership Team	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Likelihood**	**Consequence**	**Risk Score**	**Date of Last Review**	7th August 2023
Risk Appetite	**Open**	5	3	**15**	3	3	**9**	3	2	**6**	**Date of Next Review**	1st October 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)
Operational risks all being managed through restricted access shared folders using spreadsheets.	Limitation in functionality through spreadsheets needs to be addressed through procurement of a new risk system.	Report to ELT on 10th July provided status with all operational risks. Report to ETC on operational risk in July. Procurement process for new system has been completed with clear specification requirements defined and assessed for risk management.	Internal	Amber
Approved risk management strategy and policy	Need to update for the BAF process and incorporate recommendations from RSM following appetite development sessions.	Compliance with policy will be reported through sub-committees, audit committee and EMT as part of regular reporting once risk policy has been revised. (Sept 2023) Internal audit annual review of risk has awarded "Partial Assurance" recognising there are areas for improvement around training, the system in use and review of risk by the Board. (May 2023)	Internal External	Amber
Committee terms of reference include reporting and scrutiny of key risks	Processes for ensuring risks are included on agendas are not robust Awaiting outcome of risk appetite work to determine the escalation level of operational risk to Board sub committees.	POD EDI, Quality, PFRC and ETC are now all receiving risk update reports as standing items on their agenda. This includes changes and updates to strategic BAF risks but also key operational risks. BAF report is presented to each Audit Committee for oversight and scrutiny of process.	Internal	Amber
Risk reviewed by Board sub-committee	Consistent reporting needs to be reinstated. Only BAF risks at present	POD EDI, Quality, PFRC and ETC are now all receiving risk update reports as standing items on their agenda. This includes changes and updates to strategic BAF risks but also key operational risks. Internal audit annual review of risk acknowledged this process is now embedded. (May 2023)	Internal External	Amber
12+risks escalated through ELT		EMT monthly report on the BAF now includes update on operational risk status incorporating the 12+ risk register.	Internal	Amber
Refreshed BAF document embedded in to Board and Board sub-committee cycle of business.		Board Papers Feb 2023, April 2023, May 2023 include BAF review. POD EDI, Quality, PFRC committees in January, March May have reviewed BAF risk position.	Internal	Green

Action to address gap in assurance/control	Lead Officer	Date of implementation	Status
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	End of May 2023	These are now in place and being used by directorate management on a regular basis.

Strategic Delivery Metrics			
Key Strategic deliverables	**Progress to date**	**What are the current challenges/risks to progress?**	**Sources of Assurance**
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. Interim arrangements for operational risk whilst a new system is procured to be embedded within directorates	Risk register reporting through sub-committee meetings from May onwards
Instil a Trust wide risk appetite framework	RSM delivered a workshop with the Board on 10th May to agree the outline appetite for key themes.	The revised risk appetite needs to be fully incorporated in to operational and strategic risk thinking to be clear on the expectations around mitigation and acceptance levels.	Risk Appetite has now been agreed. Confirmation paper to go to September Board.
Deliver risk management awareness training across all levels of the Trust	RSM Board level training has been delivered during March, April and May. Work continues to agree an approach for rolling out training to all managers but will be in place by end of December 2023. Additionally, training on the new risk system will be required once installed (Oct 23)	Scheduling of training may be difficult in some areas. Requires buy in to ensure well attended.	Record of attendance to be retained and training pack.

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 April 2023
Risk Appetite	**Open**	5	4	**20**	4	3	**12**	2	3	**6**	**Date of Next Review**	19th June 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	Green
New CEO in post		N/A		Green
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	Amber
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	Amber
	Lack of performance reporting and accountability across all levels			Red
	Loss of corporate and organisational knowledge and history when staff leave			Red

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**

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Trust's Constitutional changes on Board Members' Voting Status			**Agenda No.:021**
Report Author and Job Title:	Dorothy Otite, Governance Consultant	**Lead Director:**	John Lawlor, Chair of the Trust Board
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This report outlines proposed changes to the Trust's Constitution being recommended to the Board of Directors for ratification by the Council of Governors (Council); to alter the Board of Directors' composition by increasing the number of voting Executive Directors by two (i.e., from five to seven), to address the Board's balance between Non-Executive Directors and voting Executive Directors, in order to comply with the NHS England (NHSE) Code of Governance for NHS Provider Trusts (2023).		
Background:	**NHSE Code of governance for NHS Provider Trusts (2022):** The Trust seeks to work to the Code of Governance on a comply or explain basis. The Code of Governance outlines best practice advice in Corporate Governance for Foundation Trusts. Provision 2.7 of the Code of Governance states that: 2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent. **The Tavistock and Portman NHS Foundation Trust's Constitution:** Section 20 of the Trust's Constitution outlines the Board of Directors' composition currently as: the Chairman, seven Non-Executive Directors and five Executive Directors, as follows: 20.2 The Board of Directors is to comprise: 20.2.1 a Non-Executive Trust Chair; 20.2.2 not less than five nor more than seven other Non-Executive Directors; and 20.2.3 up to five Executive Directors. Paragraph 42 of the Trust's Constitution sets out how the Trust may amend its Constitution: 42.1 The Trust may make amendments to this Constitution with the approval of the Board of Directors, Council of Governors and Members. Amendments take effect as soon as the following conditions are satisfied, as long as the amendment is in accordance with Schedule 7 of the 2006 Act. 42.2 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors: 42.2.1 at least one member of the Council of Governors must attend the next Annual General Meeting and present the amendment, and the Trust must give the Members an opportunity to vote on whether they approve the amendment.		

	42.2.2 If more than half of the Members present and voting at the Annual General Meeting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result. 42.3 Amendments by the Trust of its Constitution are to be notified to the Regulator.
Assessment:	**Proposed changes:** The Trust currently has a Non-Executive Chair; seven Non-Executive Directors; and five voting Executive Directors. As provision 2.7 of the Code of Governance states that, 'At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.', then, in order to be balanced and comply with the Code of Governance, the Board would either need to decrease its composition of the Non-Executive Directors to five or increase its voting composition of Executive Directors to seven. It has been considered and is being proposed to amend the provisions of the Trust's constitution as follows: 20.2.3 not less than five nor more than ~~five~~ seven Executive Directors as follows: 20.2.3.1 a Chief Executive (who is the Accounting Officer); 20.2.3.2 a Chief Finance Officer; 20.2.3.3 a Chief Clinical Operating Officer; 20.2.3.4 a Chief Medical Officer who is a registered medical practitioner; 20.2.3.5 a Chief Nursing Officer who is a registered nurse; and 20.2.3.6 Two other Executive Directors. **Process:** Once an amendment to the Constitution has been approved by the Board of Directors, the Council of Governors, and Members it takes effect immediately.

Key recommendation(s):	The Board is asked to:
	• **APPROVE** a change to section 20.2.3 of the Trust's Constitution; and addition of sub-sections 20.2.3.1 to 20.2.3.6 to the Trust's Constitution:
	  ○ 20.2.3 to increase by two (from five to seven) the number of voting Executive Directors on the Board of Directors to enable a more effective unitary Board;
	  ○ 20.2.3.1 to 20.2.3.5 to specify five voting Executive Directors; and
	  ○ 20.2.3.6 to refer to the two other voting Executive Directors.
	• **APPROVE** that a resolution is laid to the Annual Members' Meeting on 11 October 2023, to approve the change to section 20.2.3 of the Trust's Constitution; and addition of sub-sections 20.2.3.1 to 20.2.3.6 to the Trust's Constitution.

Implications:					
Strategic Objectives:					
☐ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 15: Effectiveness of senior leadership				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust must comply with the provisions of the Trust Constitution.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no EDI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:	Executive Appointments and Remuneration Committee – 13 September 2023; and Council of Governors – 14 September 2023 (post meeting approval)				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 11 October 2023			
Report Title: Review of Committee Terms of Reference 2023/24			**Agenda No.:022**
Report Author and Job Title:	Dorothy Otite, Governance Consultant	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Education and Training Committee Revised Terms of Reference Appendix 2: Executive Appointment and Remuneration Committee Revised Terms of Reference Appendix 3: People, Organisational Development, Equality, Diversity, and Inclusion Committee Revised Terms of Reference Appendix 4: Performance, Finance and Resources Committee Revised Terms of Reference Appendix 5: Integrated Audit and Governance Committee Revised Terms of Reference Appendix 6: Quality and Safety Committee Revised Terms of Reference		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☐ Assurance ☐		
Situation:	This report provides the Board with the revised Terms of Reference (ToR) of the six Board sub-committees for ratification following approval by the sub-committees during the September cycle of meetings.		
Background:	The ToR of Board sub-committees should be reviewed annually to ensure they are operating at maximum effectiveness; and any proposed changes should be presented to the Board of Directors for approval. **Terms of Reference (ToR):** During 2022/23, the Board of Directors approved the ToR of three of six Board sub-committees (i.e., Quality Committee; Performance, Finance and Resources Committee; and People, Organisational Development, Equality, Diversity and Inclusion Committee). The remaining three Board sub-Committees have not recently had their ToR approved by the Board (i.e., Audit Committee; Executive Appointment and Remuneration Committee; and Education and Training Committee). **Committee Effectiveness and Annual Review:** At the end of 2022/23, in line with the Committee Terms of Reference, each Committee undertook an annual effectiveness evaluation and reported the outcomes to the Board of Directors. As part of the review, recommendations were proffered for the amendment of all the Board sub-committee ToR. These changes have been included in the revised ToR documents. **Process:** The process for review of the ToR was led by the Governance Consultant in consultation with the Committee Chairs and Lead Executives who agreed to the proposed revisions to the ToR prior to being presented to the Committees for approval.		
Assessment:	All Board sub-committees received and approved the proposed revisions to their ToR during the September cycle of meetings; and recommended them to the Board of Directors for ratification.		

	Cross Committee summary of key changes: • Re-naming of two sub-committees: Quality renamed Quality and Safety; and Audit renamed Integrated Audit and Governance, reflecting the Board's commitment to 'Safety' and 'Governance'. • Purpose and Objectives: strengthened and/ or provided clarity to existing clauses. • Membership: streamlined membership of Committees to reflect current Board membership and job titles. • Required attendees: introduced a required attendees list including the Director of Corporate Governance or representative. • Voting: added a new clause around voting. • Quorum: added that the Trust Chair or Vice Chair are to count towards quoracy if in attendance; and introduced e-Governance approvals. • Relationships with other Committees/Groups): introduced a new clause on relationships with other Committees/Groups. • Servicing arrangements: included reference to maintaining an annual forward planner. • Committee Governance structure: included a Committee Governance structure for each sub-committee to reflect current arrangements. The Board is asked to note the future governance structure is being considered at the time of writing and will be approved by the sub-committees during the year without a requirement to present any changes to the structure to the Board for ratification.
Key recommendation(s):	The Board is asked to **APPROVE** the revised Terms of Reference of the six Board sub-committees attached as appendices 1 – 6 of this report.

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

Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	All BAF risks – as these are assigned to the Committees.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Board of Directors established the sub-committees in accordance with the Trust's Constitution. The Terms of Reference of the Committees should therefore be read in conjunction with the Trust's constitution. Proposed changes to the Terms of Reference of Committees are required to be presented to the Board of Directors for approval.				
Resource Implications:	Yes ☐	No ☒			
	There are no additional resource implications associated with this report.				

Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒		No ☐	
	POD EDI Committee: The Terms of Reference of the Committee includes the Committee's oversight and assurance responsibility for the Trust's Equality, Diversity, and Inclusion strategy, plans and delivery. Quality and Safety Committee: One of the amendments to the Terms of Reference of the Committee includes the Committee supporting a particular focus on quality impact assessments. This will ensure due regard is had to the elimination of unlawful discrimination and promotion of equality of opportunity. Executive Appointment and Remuneration Committee: One of the revisions to the ToR is in relation to strengthening the EARC's appointment role by seeking assurance that the Trust is compliant with all relevant standards of good practice including those relating to equality, diversity, and inclusion. Education and Training Committee: One of the amendments to the Terms of Reference of the Committee includes the Committee's oversight responsibility for EDI matters for the Department of Education and Training.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	• Quality Committee – 7 September 2023. • People, Organisational Development, Equality, Diversity, and Inclusion Committee – 7 September 2023. • Executive Appointment and Remuneration Committee – 13 September 2023. • Education and Training Committee – 21 September 2023. • Performance Finance and Resources Committee – 26 September 2023. • Audit Committee – 28 September 2023.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman NHS Foundation Trust

Education and Training Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Chief Education and Training Officer
Date issued:	October 2023 v 0.2
Review date:	October 2024

Education and Training Committee
Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal sub-committee of the Board to be known as the Education and Training Committee ("the Committee"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to oversee the implementation of strategies relating to the provision of Training and Education services and to ensure resources are sufficiently aligned/ allocated to enable delivery and future development to ensure achievement of strategic aims and objectives.

2.2. The Committee will also provide assurance to the Board that appropriate and effective governance mechanisms are in place to ensure the provision of high-quality education and training services and that requisite standards are met.

3. OBJECTIVES

The principal duties of the Committee are set out below:

3.1. To consider and resolve strategic issues relating to training and education and its interface with other areas of the work of the Trust.

3.2. To oversee plans for the development of our training and education activities including student recruitment, portfolio development and new business development.

3.3. To oversee plans for the development of digital education and transnational education by the Trust.

3.4. To have oversight of strategic relationship with our University Partners.

3.5. To review key metrics relating to the financial and operational performance of training and education.

3.6. To hold and progress an organisational risk register for Training and Education work.

3.7. To have oversight of issues on the interface between training and education and other activities of the Trust.

3.8. To have oversight and review the Annual Student Survey.

3.9. To have oversight of fundraising and utilisation of the bursary fund within the Department of Education and Training.

3.10. To have oversight and review of all matters relating to equality, diversity and inclusion in the Department of Education and Training.

Other:

3.11. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

4.1.1. Non-Executive Directors x 3 (one designated Chair)

4.1.2. Chief Education and Training Officer and Dean of Postgraduate studies

4.1.3. Chief Medical Officer

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Associate Non-Executive Director
- Director of Corporate Governance or representative
- Director of Education, Learning & Teaching
- Director of Education, Operations
- Director of Workforce Innovation Unit
- Director of Education (Governance and Quality)
- Senior Finance Business Manager
- Head of DET Operations
- Associate Director of Nursing

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair, Vice Trust Chair and Chief Executive Officer to attend.

4.4. At the discretion of the Committee Chair, other persons (Trust managers and staff, and other interested persons) may be invited to attend and participate in Committee meetings. However, only members of the Committee have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.5. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

4.6. If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends, they must be able to fully participate in the meeting but will have no voting rights).

4.7. Attendees who are deputising for members and/or required attendees must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

Voting:

4.8. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. This shall be a minimum of one Executive Director and one Non-Executive Director.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet on a bi-monthly basis. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee will report to the Board of Directors with an update on its activities.

7.2. The minutes of Committee meetings shall be formally recorded, and an assurance report will be drafted by the Lead Executive on behalf of the Chair to be submitted to the next available Board meeting. This assurance report will draw attention to the Board any issues requiring disclosure or action.

8. SOURCES OF INFORMATION

8.1. The Committee will receive and consider sources of information from any individual or department relevant to the case under consideration.

9. AUTHORITY

9.1. The Committee has the authority to establish sub-groups and task and finish groups.

9.2. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

9.3. The Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.4. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. SERVICING ARRANGEMENTS

10.1. The administration of the meeting shall be supported by member of the Corporate Governance team (Committee Administrator) who will draft agendas, arrange to take minutes of the meeting, create and chase actions in the action log and provide other appropriate administrative support to the Chair and Members.

10.2. Meetings of the Committee will be called by the Committee Chair. The agenda will be approved by the Committee Chair prior to circulation.

10.3. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time if possible. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

10.4. The Committee Administrator will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

10.5. The Committee Chair's assurance report will be submitted to the Board following each meeting.

10.6. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. RELATIONSHIPS WITH OTHER COMMITTEES/ GROUPS

11.1. The Committee will receive assurance reports from the following meetings:

- Academic Governance and Quality Sub-Committee
- Learning and Teaching Sub-Committee
- DET Development Sub-Committee
- Student Experience Sub-Committee

11.2. The Committee will receive escalations from other Board sub-committees in relation to matters identified at these meetings within its terms of reference.

11.3. The Committee will escalate matters to other Board sub-committees in relation to matters identified in its meeting within other Board sub-committee terms of reference.

12. MONITORING EFFECTIVENESS AND REVIEW

12.1. At least once a year the Committee will review its own performance against its terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

The Tavistock and Portman NHS Foundation Trust

Appendix 1 – Education and Training Committee Governance structure

The Tavistock and Portman NHS Foundation Trust

Executive Appointment and Remuneration Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Director of Corporate Governance
Date issued:	October 2023 v 0.2
Review date:	October 2024

Executive Appointment and Remuneration Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors **("Board")** hereby resolves to establish a standing committee to be known as the Executive Appointment and Remuneration Committee ("**the Committee**"). This Committee has no executive powers other than those delegated in these terms of reference.

2. PURPOSE

2.1. To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the board and for determining their remuneration and other conditions of service.

2.2. The Executive Appointment and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for Executive Directors described in the Trust's constitution and the Code of Governance of NHS Provider Trusts.

2.3. The Committee's Executive Appointments role aims are to:

- Ensure effective recruitment processes for Executive Director positions.
- Make effective appointment decisions that are based on robust assessment evaluations and a fair, equitable and transparent process.
- Seek assurance the Trust is compliant with all relevant standards of good practice including those relating to equality, diversity and inclusion.

2.4. The Committee's Remuneration role aims to ensure that the Trust has a remuneration policy that is sufficient to attract, retain and award individuals with the right skills and experience and this policy is sufficiently competitive in the wider employment market.

3. OBJECTIVES

The principal duties of the Committee are set out below:

Remuneration Role:

The Committee will:

3.1. Establish and keep under review a remuneration policy in respect of Executive Board Directors.

3.2. Approve the design of, and determine targets for, any performance-related pay schemes operated by the Trust.

3.3. Consult the Chief Executive Officer about proposals relating to the remuneration of the other Executive Directors.

3.4. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors and Senior Managers on locally-determined pay, including:

3.4.1 Salary, including any performance related pay or bonus;

3.4.2 Provisions for other benefits, including pensions and cars;

3.4.3 Allowances;

3.4.4 Payable expenses;

3.4.5 Compensation payments.

3.5. In adhering to all relevant laws, regulations and Trust policies:

3.5.1 establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

3.5.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors (and senior managers on locally-determined pay), while ensuring that increases are not made where trust or individual performance do not justify them;

3.5.3 be sensitive to pay and employment conditions elsewhere in the Trust.

3.6. Monitor, and assess the output of the evaluation of the performance of individual Executive Directors, and consider this output when reviewing changes to remuneration levels.

3.7. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments to avoid rewarding poor performance.

Appointments Role

The Committee will:

3.8. Regularly review the structure, size and composition (including the balance of skills, knowledge and experience on the board, and its diversity), making use of the output of board evaluation processes as appropriate, and make recommendations to the Board, and Nominations Committee of the Council of Governors, as applicable, with regard to any changes.

3.9. Give full consideration to and make plans for succession planning for the Chief Executive Officer and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

3.10. Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

3.11. Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise.

3.12. When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

3.13. Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

3.14. Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.15. In order to ensure that poor performance is not seen to be rewarded, carefully consider what compensation commitments (including pension contributions) the Directors' terms of appointment would give rise to in the event of early termination. Contracts should allow for appropriate claw back provisions to be considered in case of a Director returning to the NHS within the period of any putative notice.

3.16. Ensure that a proposed Executive Director is a "Fit and Proper Person" as defined under the regulation under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and meets the Fit and Proper Person Requirements as described in the NHS England Fit and Proper Person Test Framework for Board Members.

3.17. Consider the re-appointment of any Executive Director at the conclusion of their term of office (if applicable) having given due regard to their performance and ability to continue to contribute to the Board of Directors in the light of the knowledge, skills and experience required.

3.18. Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Other:

3.19. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

4.1.1. The Committee comprises the Trust Chair and all Non-Executive Directors of the Trust.

4.1.2. When appointing or removing the Chief Executive Officer, the Committee shall be the Committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act).

4.1.3. When appointing or removing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act (that is the Trust Chair, the Chief Executive Officer and the Non-Executive Directors).

4.1.4. The Trust Chair shall Chair the Committee.

Attendance by Other Officers or Individuals:

4.2. Only members of the Committee have the right to attend Committee meetings, and the authority to vote and determine decisions on behalf of the Committee.

4.3. At the invitation of the Committee, meetings shall normally be attended by the:

4.3.1. Associate Non-Executive Director

4.3.2. Chief Executive Officer

4.3.3. Chief People Officer

4.3.4. Director of Corporate Governance

4.4. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

4.5. Any non-member, including the Committee Administrator, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Voting:

4.6. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. Business will only be conducted if the meeting is quorate. The Committee will be quorate with four members present.

5.2. If the meeting is not quorate the meeting can progress if those present, determine. However, no business shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet as required, but at least twice in each financial year. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee is accountable to the Board of Directors.

7.2. The minutes of Committee shall be formally recorded, and an assurance report will be drafted by the Lead Executive on behalf of the Chair to be submitted to the next available Board meeting. This assurance report will draw attention to the Board any issues requiring disclosure or action.

7.3. The Committee will prepare and submit an annual report of the Trust's remuneration practices that will form part of the Trust's Annual Report and ensure each year that it is put to Members at the Annual General Meeting.

7.4. The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

8. SOURCES OF INFORMATION

8.1. The Committee will receive and consider sources of information relating to NHS remuneration, provided by the Chief People Officer or from other sources as required.

9. AUTHORITY

9.1. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference.

9.2. The Committee is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.3. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

10. SERVICING ARRANGEMENTS

10.1. The Committee will be supported by a member of the Corporate Governance team (Committee Administrator).

10.2. Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Administrator and approved by the Committee Chair prior to circulation.

10.3. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time.

10.4. The Committee Administrator will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

10.5. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

The Tavistock and Portman NHS Foundation Trust

People, Organisational Development, Equality, Diversity and Inclusion Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Chief People Officer
Date issued:	October 2023 v 6.0
Review date:	October 2024

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

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("**Board**") hereby resolves to establish a formal sub-committee of the Board to be known as the People, Organisational Development, Equality, Diversity and Inclusion Committee ("**POD EDI Committee**"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

2. PURPOSE

2.1. The POD EDI Committee is the primary Board sub-committee for providing assurance and raising any concerns to the Board about delivery of the people related duties listed below.

2.2. The POD EDI Committee will give attention and scrutiny to the Health and Wellbeing of the Trust's People.

2.3. The POD EDI Committee will ensure that due attention and scrutiny is given to the oversight and assurance on the Trust's Race Equality and broader Equality, Diversity, and Inclusion strategy, plans and delivery.

2.4. The Chair of the POD EDI Committee will provide an assurance report to the Board after each meeting.

2.5. The POD EDI Committee will take responsibility for the risks pertinent to the people agenda as described in the Board Assurance Framework (BAF).

2.6. The Committee will be serviced by two primary operational delivery groups: The EDI Programme Board and the People Delivery Group.

2.7. The Committee will have close links to the staff diversity network groups which will be advisory to the Committee and will be routes for engagement and consultation as well as providing contributions to Committee assurance. The Staff network groups will be invited to assist in organisational agenda setting, undertake environment scanning, intelligence and idea generation.

3. OBJECTIVES

The principal duties of the Committee will be to provide the Board with independent and objective assurance in relation to:

3.1. National People Plan Promises (PPP):
- (a) Team working
- (b) Flexible working
- (c) Learning & Development
- (d) Health and Wellbeing
- (e) Speaking up and listening
- (f) Recognition and Reward
- (g) Compassion and inclusivity

3.2. Trust People Plan

3.3. Race Equality Strategy (RES) and Race Action Plan (RAP)

3.4. Equality, Diversity and Inclusion Strategy and Action Plan

3.5. Staff Health and Wellbeing

3.6. Trust Workforce plans (including succession planning and talent management)

3.7. Metrics and reporting:
(a) The Trust's workforce performance and sustainability indicators (including but not limited to, sickness absence, training, appraisal, employee relations, people practices and bank, EDI, interim and agency usage and expenditure, recruitment activity and checks and establishment control processes) and any necessary corrective plans and actions.
(b) The effective identification and mitigation of workforce and organisational development risks
(c) The HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.
(d) CQC / Ofsted/ OFS people related regulatory requirements and reporting

3.8. Oversight of regulatory framework:
(a) Meeting legal and regulatory requirements in relation to the workforce (such as WRES, WDES and Gender Pay Gap).

3.9. External drivers and opportunities:
(a) National reports and best practice relating to workforce and organisational development.

3.10. Other:
(a) To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members:

4.1. Membership of the Committee shall be as follows:

- Non-Executive Director (Chair)
- Non-Executive Directors (x 2)
- Chief People Officer (Lead Executive)
- Chief Clinical Operating Officer
- Chief Education and Training Officer

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Staff side Representative
- Associate Director of Human Resources Operations
- Associate Director of Equality Diversity and Inclusion
- Staff Diversity Network Chairs (on rotation)
- Director of Corporate Governance or representative

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair and Chief Executive Officer to attend.

4.4. Other staff may be invited to attend meetings as considered appropriate on an ad-hoc basis.

4.5. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.6. Members are expected to attend at least 75% of meetings annually and be allowed to send a Deputy to one meeting per annum. An annual register of attendance of members will be published by the Committee.

4.7. The Committee is focussed on the staff of the Trust and notes the NHS Patient Experience Improvement Framework and the positive impacts on patient care that is made by engaged staff. The Committee does not include Patient or student representatives as the interests of these groups are represented elsewhere in the Trust governance.

4.8. Associate members: The Committee will accept associate members of its main membership in order to enable development of Trust leaders and where this can be used to increase committee diversity.

Voting

4.9. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. SUB-COMMITTEES

5.1. The POD EDI Committee has the authority to establish sub-committees and task and finish groups.

6. QUORUM

6.1. This shall be a minimum of two Non-Executive Directors and one Executive Director.

6.2. Business will only be conducted if the meeting is quorate. If the Trust Chair is in attendance, this will count towards the quorum.

6.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee

7. CHAIR

7.1. The Committee will be chaired by a Non-Executive Director. In the absence of the Chair, another Non-Executive Director will take on the chairing of the Committee.

8. FREQUENCY

8.1. The Committee shall meet up to 6 times per annum, normally two weeks before the Board meeting. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

9. ACCOUNTABILITY AND REPORTING

9.1. The POD EDI Committee shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities.

9.2. The minutes of the Committee will be available to the Board on request.

9.3. The POD EDI Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit or where action or improvement is needed.

9.4. The Committee will report on its activities at least once a year to the Board to fulfil the requirements set out in the Equality Act 2010 (Specific Duties) Regulations 2011.

9.5. The Chair shall attend the Annual General Meeting (AGM) and be prepared to respond to any questions on the Committee's activities.

10. AUTHORITY

10.1. The POD EDI Committee is authorised by the Board to instigate any activity within its terms of reference.

10.2. It is authorised to seek information it requires from any staff, and to call any staff to attend a meeting as and when required.

10.3. All staff are directed to co-operate with any request made by the POD EDI Committee.

10.4. The POD EDI Committee is authorised to obtain outside legal advice or other professional advice at the Trust's expense, and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10.5. The POD EDI Committee is authorised to establish standing sub-committees in order to deliver its purpose.

10.6. The POD EDI Committee is authorised to establish limited life task and finish groups in order to deliver its purpose.

11. SOURCES OF INFORMATION

11.1. The POD EDI Committee will receive and consider sources of information from any relevant individual or department.

12. SERVICING ARRANGEMENTS

12.1. The administration of the meeting shall be supported by member of the Corporate Governance team (Committee Administrator) who will draft agendas, arrange to take minutes of the meeting, create and chase actions in the action log and provide other appropriate administrative support to the Chair and Members.

12.2. Meetings of the Committee will be called by the Chair. The agenda will be drafted by the Committee Administrator and approved by the Chair prior to circulation.

12.3. Notification of the meeting, location, time, and agenda will be forwarded to members, and others called to attend, at least seven days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance, then they will be forwarded to Members at the same time as the agenda.

12.4. The agenda will be clearly split at each meeting to ensure that appropriate Committee time is given to both general people matters and EDI and race matters.

12.5. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the POD EDI Committee, including recording names of those present and in attendance.

12.6. The POD EDI Committee Chair's assurance report will be submitted to the Board following each meeting.

12.7. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

13. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

13.1. The Committee will receive assurance reports from the following POD EDI sub-committee meetings (see Appendices 1 and 2 for the POD EDI Governance Structure charts):

- EDI Programme Board
- People Delivery Group

13.2. The Committee will receive escalations from other Board sub-committees in relation to matters identified at these meetings within its terms of reference.

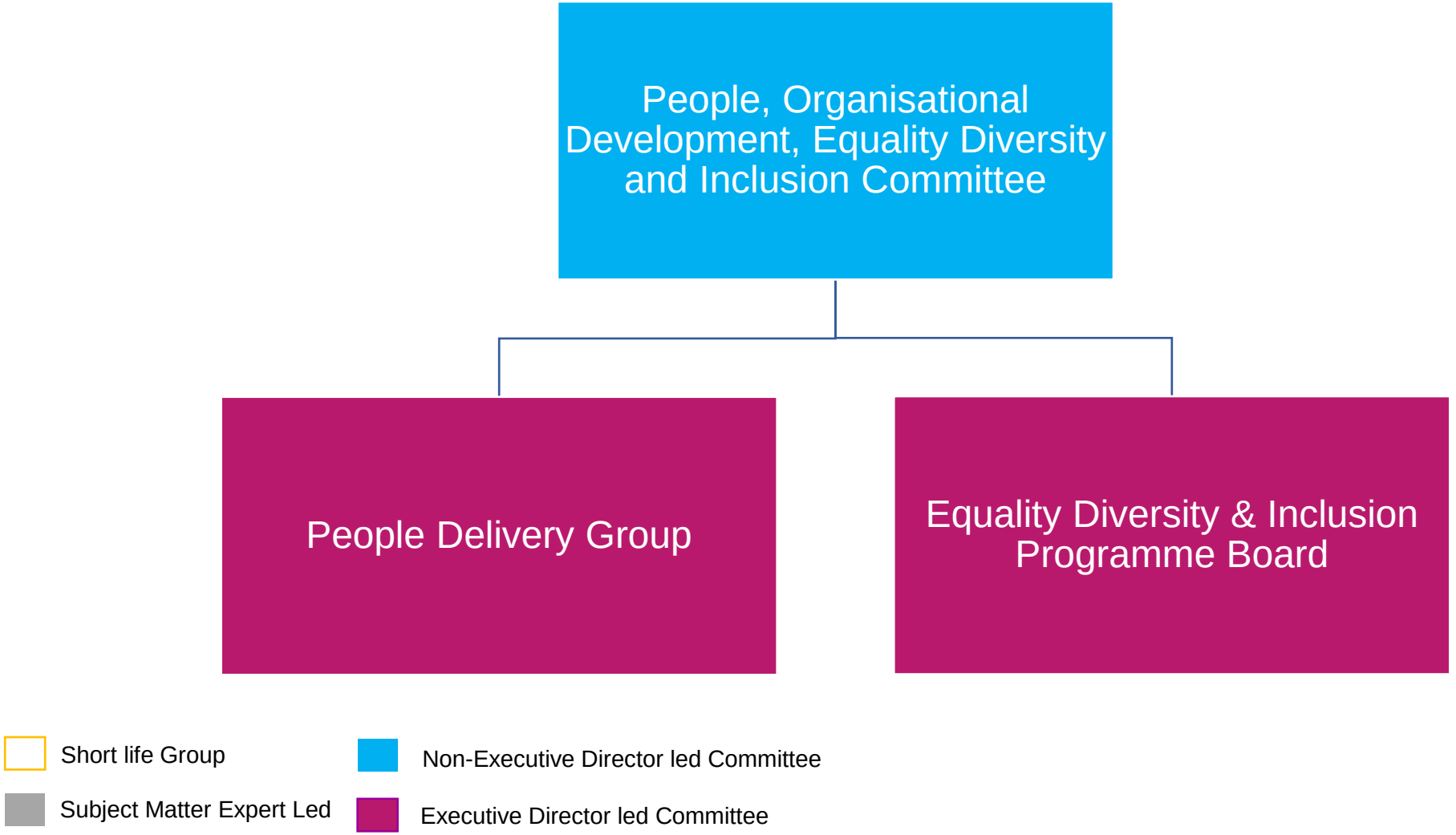
13.3. The Committee will escalate matters to other Board sub-committees in relation to matters identified in its meeting within other Board sub-committee terms of reference.

14. MONITORING EFFECTIVENESS AND REVIEW

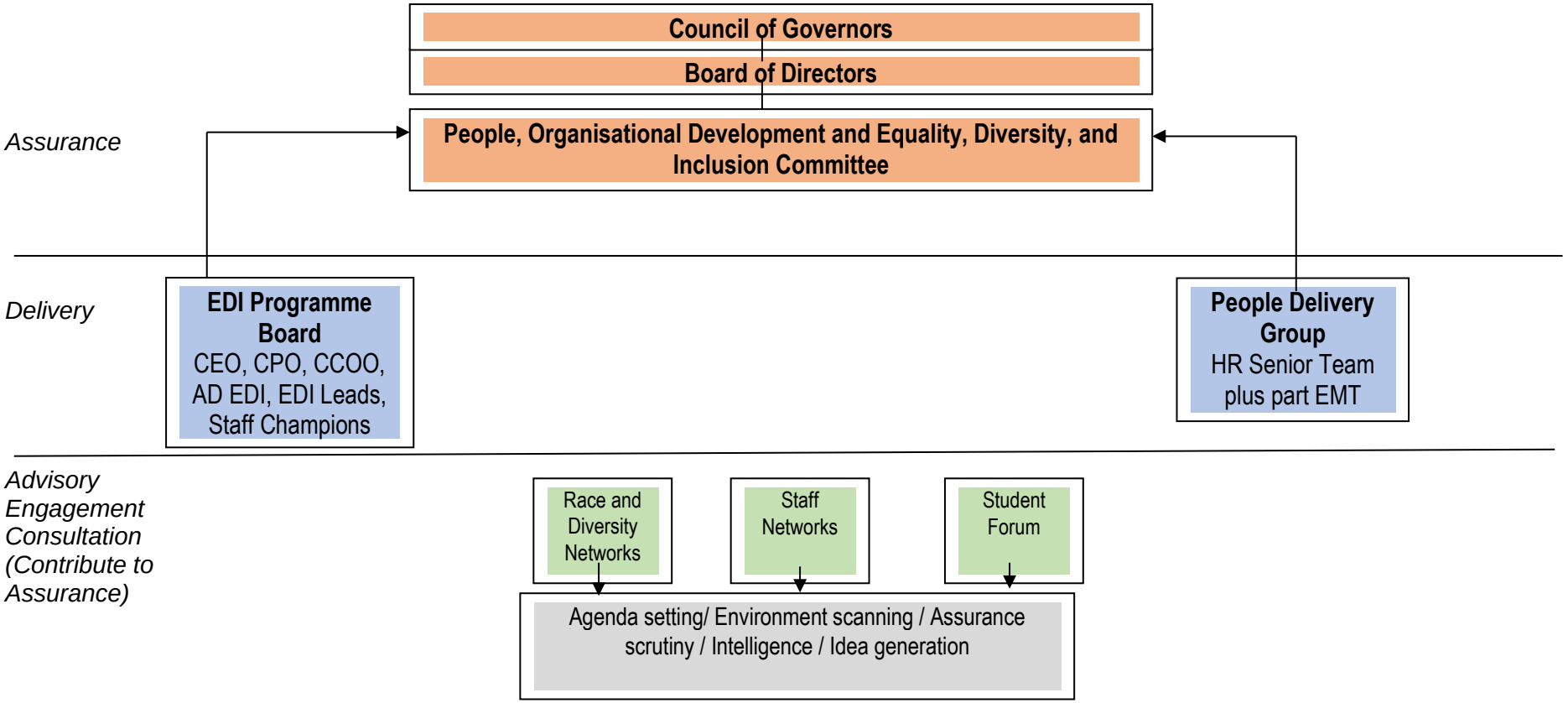
14.1. At least once a year the POD EDI Committee shall review its own performance against its terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Tavistock and Portman NHS Foundation Trust

Appendix 1 – POD EDI Governance structure



Appendix 2 - **Relationship to other Assurance, Advisory and Operational Groups and Committees**



The Tavistock and Portman
NHS Foundation Trust

Performance, Finance and Resources Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Chief Finance Officer / Chief Clinical Operating Officer / Director of Strategy and Business Development
Date issued:	October 2023 v 2.0
Review date:	October 2024

Performance, Finance and Resources Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") of The Tavistock and Portman NHS Foundation Trust ("Trust") hereby resolves to establish a formal sub-committee of the Board to be known as the Performance, Finance and Resources Committee ("Committee"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to maintain an overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. In addition to overseeing the financial and operational performance of the Trust, and receiving appropriate assurances from Executive Directors.

2.2. In particular, the Committee will seek assurance that finances, workforce and other resources are being used in an effective and efficient manner and that this is reflected in operational activity.

2.3. As part of its oversight and assurance of these matters, the Committee will:

a. Consider relevant financial and operational strategies, prior to submission to the Board for approval;

b. Review risks associated with the strategies defined in and their mitigation;

c. Consider finance and other relevant reports;

d. Approve business cases with delegated authority from the Board, in accordance with the Trust's Standing Financial Instructions ("SFIs") and Scheme of Delegation ("SoD");

e. Review progress against the delivery of business plans previously approved by the Committee;

f. Oversee the development of specific financial plans as may from time to time be required by NHS England (NHSE) including financial recovery plans, and other financial undertakings;

g. To consider the impact of the Integrated Care System plans on the Trust;

h. Review and monitor financial plans and their link to operational performance;

i. Ensure that there is good triangulation between financial, performance, quality and safety and workforce plans;

j. Oversee financial risk evaluation, measurement and management;

k. Oversee the capital programme;

l. Maintain oversight of the finance function, key financial policies and other financial issues that may arise;

m. Maintain oversight of the Trust's performance against the contract activity plan;

n. Maintain oversight of the Trust's performance across its clinical, education and training and corporate activities;

o. Escalate appropriate matters to the Board.

3. SCOPE

3.1. The Committee's work will be focused on testing the robustness of assurances received that finances and resources (notably, but not exclusively, workforce resources) of the Trust are utilised to achieve effective and efficient operational performance across clinical, education and training and corporate activities.

4. OBJECTIVES

The principal duties of the Committee are set out below:

Financial Strategy and Performance

4.1. To consider the Financial Strategy, ensuring that the financial objectives are consistent with the Trust's strategic direction and quality priorities.

4.2. To review and consider the annual revenue and capital budgets, in-year reforecasts, and longer-term financial plans of the Trust before their submission to the Board for approval.

4.3. To review annual operational plans including efficiency targets and savings projects.

4.4. To review key medium term planning assumptions.

4.5. To monitor the achievement of the financial strategy, and financial targets; associated activity targets and how these relate to the performance of the Trust in non-financial domains such as patient safety and effectiveness.

4.6. To monitor productivity, cost improvement and savings targets.

Operational Performance

4.7. To scrutinise the Trust's operational performance across its clinical, education and training and corporate activities (noting that the primary responsibility for the scrutiny of education and training operational performance is held by the Education and Training Committee).

4.8. In scrutinising the operational performance of the Trust's clinical services attention will be paid, in particular, to levels of activity (including clinician productivity), waiting lists, patient outcomes and compliance with contractual requirements, together with other key relevant measures / performance indicators.

4.9. In scrutinising the operational performance of the Trust's corporate services, the Committee shall focus its attention on the following functional areas:

a. Finance, Contracts and Procurement

b. Estates and Facilities (including Health & Safety)

c. Information Management and Technology

d. General Data Protection Regulation (GDPR); and Cyber Security

e. Human Resources.

4.10. To support and oversee the development of a revised Integrated Quality Performance Report (IQPR).

Operational Strategies and Business Case consideration

4.11. The Committee shall scrutinise, consider and, if appropriate, recommend relevant operational strategies prior to submission to the Board for approval.

4.12. The Committee shall scrutinise, consider and, if appropriate, approve business cases, in accordance with the Trust's SFIs and SoD.

4.13. The Committee shall receive regular updates on the progress of business cases which it has approved.

4.14. The Committee shall review the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

Risk Management

4.15. At each meeting the Committee shall consider the risks associated with the strategies and business plans which it has approved together with reviewing the risks within the Board Assurance Framework and the Corporate Risk Register for which the Committee is deemed to have oversight.

Other

4.16. To review proposals for land and property development and / or other transactions prior to submission to the Board of Directors, in line with the Trust's SFIs and SoD.

4.17. To develop the Trust's cash management policies in line with NHSE guidance on Managing Operating Cash.

4.18. To oversee arrangements for outsourced financial functions.

4.19. To undertake any other tasks delegated to the Committee by the Board.

5. MEMBERSHIP AND ATTENDANCE

Members:

5.1. Membership of the Committee shall be as follows:

- Non-Executive Directors x 3 (one designated Chair)
- Chief Finance Officer (Joint Executive Lead)
- Chief Clinical Operating Officer (Joint Executive Lead)
- Director of Strategy and Business Development (Joint Executive Lead)

5.2. If members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Required Attendees:

5.3. The following staff will be required to attend meetings of the Committee:

- Director of Corporate Governance or representative
- Chief Education and Training Officer
- Deputy Chief Finance Officer
- Clinical Divisional Directors.

Attendance by Other Officers or Individuals:

5.4. The Committee will be open to the Trust Chair; Vice Chair; and Chief Executive Officer to attend.

5.5. The Committee may also invite other senior officers of the Trust and specialist advisors (internal or external) to present papers on an ad-hoc basis.

5.6. Attendees hold no voting rights.

5.7. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

5.8. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

Voting:

5.9. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

6. QUORUM

6.1. A quorum for the Committee shall be four members, to include at least two Non-Executive and at least two Executive Directors of the Board.

6.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

6.3. If the meeting is not quorate the meeting can progress if those present, determine. However, no business shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

7. FREQUENCY

7.1. The Committee shall meet six times per financial year. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

8. ACCOUNTABILITY AND REPORTING

8.1. The minutes of Committee meetings shall be formally recorded.

8.2. A Chair's assurance report will be submitted to the next available Trust Board meeting. This summary will also draw attention to the Board any issues requiring disclosure or action.

9. AUTHORITY

9.1. The Committee has the authority to establish sub-committees and task and finish groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

9.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

9.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

10. SERVICING ARRANGEMENTS

10.1. The Committee shall be supported administratively by a member of the Corporate Governance Team (Committee Administrator) whose duties in respect of this include:

a. Calling of meetings
b. Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
c. Ensuring that those invited to each meeting, attend
d. Taking the minutes and helping the Chair to prepare reports to the Board
e. Keeping a record of matters arising and action points to be carried forward between meetings
f. Arranging meetings for the Chair
g. Advising the Committee on pertinent issues/areas of interest/policy developments

10.2. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

11. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

11.1. The Committee will receive assurance reports from the following sub-committee meetings (see Appendix 1 for the Committee's Governance Structure chart).

11.2. The Committee will receive escalations from other Board sub-committees in relation to matters identified at these meetings within its terms of reference.

11.3. The Committee will escalate matters to other Board sub-committees in relation to matters identified in its meeting within other Board sub-committee terms of reference.

12. MONITORING EFFECTIVENESS AND REVIEW

12.1. The Committee will undertake an annual effectiveness evaluation against its Terms of Reference and Membership, the outcome of which will be reported to the Board in accordance with the Annual Business Cycle.

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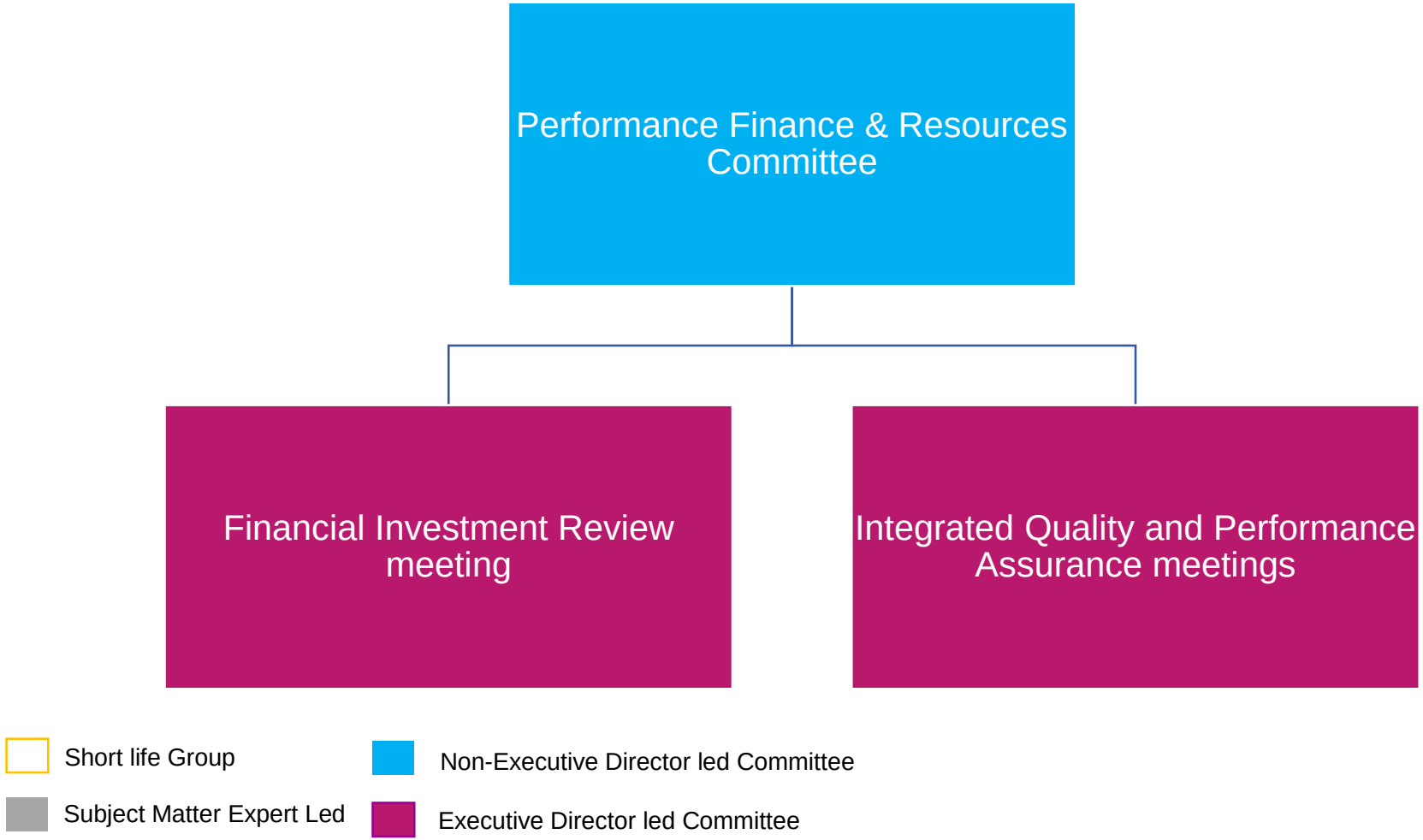
The Tavistock and Portman NHS Foundation Trust

Appendix 1 – Performance, Finance and Resources Committee Governance Structure



The Tavistock and Portman
NHS Foundation Trust

Integrated Audit and Governance Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Director of Corporate Governance
Date issued:	October 2023 v7.1
Review date:	October 2024

Integrated Audit and Governance Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("**Board**") hereby resolves to establish a formal sub-committee of the Board to be known as the Integrated Audit and Governance Committee ("**Committee**"). This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of the Board, the prime purpose of the Committee is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board on its work in support of the Annual Report, Quality Account, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, and the completeness of risk management arrangements. Its key responsibilities are to:

2.1.1 monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;

2.1.2 review the Trust's internal controls (clinical and financial) and risk management systems;

2.1.3 review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;

2.1.4 make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;

2.1.5 develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;

2.1.6 monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;

2.1.7 approve the appointment and/or removal of the internal auditors;

2.1.8 report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;

2.1.9 review arrangements by which staff within the Trust may speak-up /raise confidential concerns over financial control and reporting, clinical quality and patient safety and other matters.

3. OBJECTIVES

The principal duties of the Committee are set out below:

Integrated Governance, Risk Management and Internal Control

3.1. The Committee will review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's strategic objectives. In particular, the Committee will review the adequacy of:

3.1.1 All risk and control-related disclosure statements (including the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

3.1.2 The structures, processes and responsibilities for identifying and managing key strategic risks facing the organisation;

3.1.3 The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements as set out in the Annual Governance Statement and other relevant guidance;

3.1.4 Any significant audit adjustments and changes in accounting policies and practices;

3.1.5 The policies and procedures for all work related to fraud and corruption as required by current legislative bodies;

3.1.6 The Board Assurance Framework in identifying the Trust's strategic objectives and the assurances required to evidence control of the financial risks to their achievement.

3.1.7 Arrangements for the oversight of procurement and non-pay spend.

3.1.8 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Local Counter Fraud Specialists and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

3.2. The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors, by the:

3.2.1. Determination of the specification for an internal audit service through the procurement process to identify a provider and make a recommendation to the Board of Directors for their appointment; including any questions of resignation and dismissal;

3.2.2. Review and approval of the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Board Assurance Framework and co-ordination with the work of external audit;

3.2.3. Consideration of the major findings of internal audit work and management responses. In the case of limited assurance audit reviews, the Committee may

request attendance of the appropriate director in whose portfolio the actions sit in order to provide assurance;

3.2.4. Where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the Committee for approval;

3.2.5. Monitor and review of the effectiveness of the internal audit function on an annual basis;

3.2.6. The Head of Internal Audit will have unhindered and confidential access to the Chair of the Committee

3.3. External Audit

3.3.1. Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance;

3.3.2. Report to the Board of Directors identifying any matters where action or improvement is needed and making recommendations for action;

3.3.3. Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements;

3.3.4. Discuss with external audit, the main issues and parameters for audit planning in preparation for the Annual Audit Plan;

It is the role and responsibility of the Council of Governors to appoint, or remove, the external auditor.

The Committee will:

3.3.5. Develop and agree with the Council of Governors, the criteria for the appointment, re-appointment and removal of the external auditors;

3.3.6. Make recommendations to the Council of Governors in relation to the above;

3.3.7. Approve the remuneration and terms of engagement of the external auditor;

3.3.8. The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

3.3.8.1. consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.

3.3.8.2. review and agree, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan.

3.3.8.3. discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

3.3.8.4. review of all audit reports that are specifically drawn to the attention of the Committee by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the

annual audit plan, together with the appropriateness of management responses.

3.3.8.5. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

3.3.8.6. The External Audit (Partner) will have unhindered and confidential access to the Chair of the Committee.

3.4. Counter Fraud Services

3.4.1. The Committee will ensure that there is an effective counter fraud function that meets the NHS Counter Fraud Authority (NHSCFA) requirements, and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors, by the:

3.4.1.1. Determination of the specification for a counter fraud service through the procurement process to identify a provider and make a recommendation to the Board of Directors for their appointment;

3.4.1.2. Review and approval of the annual counter fraud plan, ensuring that there is consistency with the potential risks and needs of the organisation;

3.4.1.3. Receipt of quarterly reports on the work of the counter fraud service in the delivery of the annual plan;

3.4.1.4. Receipt of reports on referrals to and the outcome of investigation carried out by the counter fraud service, including assurance on the actions taken against perpetrators and additional controls recommended to avoid recurrence;

3.4.2. The Committee will also receive and review the Trust's Counter Fraud Functional Standard Return (CFFSR) and monitor the implementation of any actions arising from requirements where the Trust is rated as non-compliant or partially compliant either through this return or following NHSCFA quality assessment activity.

3.4.3. Monitor and review of the effectiveness of the counter fraud service.

3.5. Financial Reporting

3.5.1. Monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing any significant financial reporting judgements. In doing so, the Committee shall additionally utilise the findings of the Performance, Finance and Resources Committee;

3.5.2. The Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

3.5.2.1. changes in, and compliance with, accounting policies and practices and estimation techniques;

3.5.2.2. major judgmental areas;

3.5.2.3. significant judgements in the preparation of the financial statements;

3.5.2.4. significant adjustments resulting from the audit;

3.5.2.5. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

3.5.2.6. letters of representation;

3.5.2.7. explanations for significant variances;

3.5.2.8. unadjusted misstatements in the financial statements.

3.5.3. The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.6. Freedom to Speak Up

3.6.1. Receive assurance procedures to enable staff to speak-up in confidence, about possible inappropriateness in matters of: clinical quality, patient safety, financial reporting and control or other matters;

3.6.2. Monitor the implementation and use of the procedures, including proportionate and independent investigation and follow-up action;

3.6.3. Receive quarterly and annual reports on speaking up and the outcomes of matters raised through the procedures;

3.6.4. Provide the Board of Directors with assurance that the procedures are robust and effective.

3.7. Partnerships / Joint ventures

3.7.1. The Committee will ensure that suitable and sufficient governance arrangements are in place between the Trust and any partner(s) to ensure that the Trust's legislative, financial, operational and reputational interests are protected. This will include reviewing legal or formal documentation or falls within the remit of the NHSE Transaction guidance.

4. MEMBERSHIP AND ATTENDANCE

Membership:

4.1. The membership of the Committee will be confined to Non-Executive Directors only, not including the Trust Chair and shall comprise a minimum three named Non-Executive Directors appointed by the Board of Directors, one of whom shall be the Chair of the Committee.

4.2. The Board of Directors will appoint the Chair of the Committee.

4.3. Members are required to attend at least 3 out of 4 meetings per year. An annual register of attendance of members will be published by the Committee.

Attendees:

4.4. The External Auditor, Internal Auditor, Local Counter Fraud Specialist, Chief Finance Officer and Director of Corporate Governance will normally be in attendance at the Committee

meetings. However, at least once a year the Committee will meet with the External and Internal Auditors without any Executive Directors being present.

4.5. The Chief Executive; and other Directors may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director, in order to provide additional assurance.

4.6. The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

4.7. The Committee will be open to the Trust Chair and the Trust Vice Chair to attend.

Voting

4.8. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. A quorum for the Committee shall be two members.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Trust Vice Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee will meet as a minimum on a quarterly basis with additional meetings being called by the Chair of the Committee where necessary.

6.2. One meeting should include a discussion of the Governance Report (ISA260) between the External Auditors and the Non-Executive Directors.

6.3. The External Auditor or Head of Internal Audit may request a meeting, at any time, if they consider that one is necessary.

7. ACCOUNTABILITY AND REPORTING

7.1. The minutes of Committee meetings shall be formally recorded.

7.2. The Committee shall report to the Trust Board on how it discharges its responsibilities.

7.3. The Chair's assurance report will be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

8. AUTHORITY

8.1. The Committee has the authority to establish sub-groups and task and finish groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

8.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

9. SERVICING ARRANGEMENTS

9.1. The Committee shall be supported administratively by a member of the Corporate Governance Team (Committee Administrator) whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair of the Committee and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend.
- Taking the minutes.
- Keeping a record of matters arising and action points to be carried forward between meetings.
- Arranging meetings for the Chair of the Committee
- Advising the Committee on pertinent issues/areas of interest/policy developments

9.2. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

10. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

10.1. The Committee will receive assurance reports from meetings of its sub-committees (see Appendix 1 for the Committee Governance structure chart).

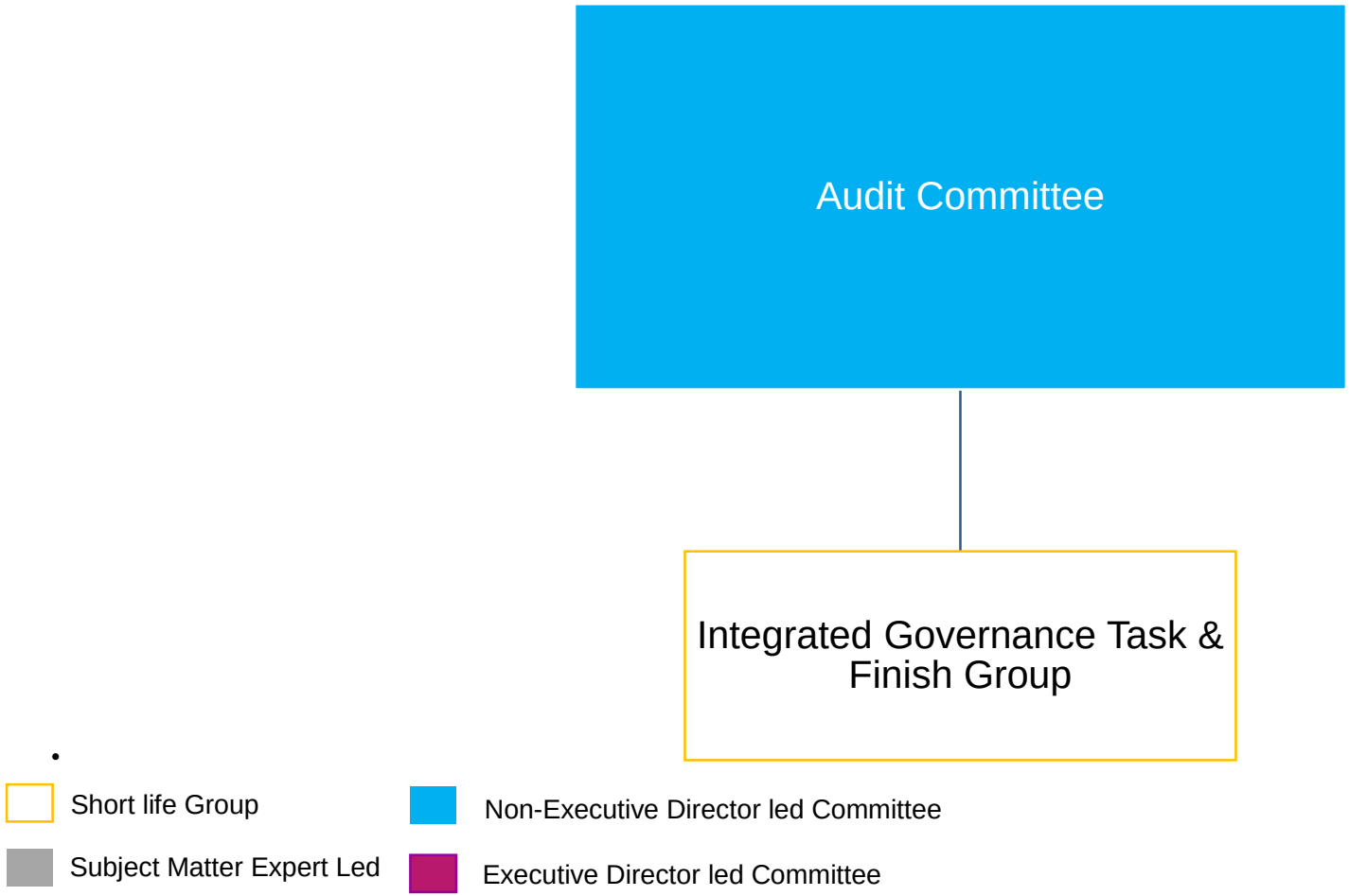
10.2. The Committee will receive escalations from other Board sub-committees in relation to matters identified at these meetings within its terms of reference.

10.3. The Committee will escalate matters to other Board sub-committees in relation to matters identified in its meeting within other Board sub-committee terms of reference.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Appendix 1 – Integrated Audit and Governance Committee Governance Structure



The Tavistock and Portman NHS Foundation Trust

Quality and Safety Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	TBC
Responsible Executive Director:	Chief Medical Officer/ Chief Nursing Officer
Date issued:	October 2023 v 0.2
Review date:	October 2024

Quality and Safety Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal sub-committee of the Board to be known as the Quality and Safety Committee. This Committee has no executive powers other than those delegated in these terms of reference. The Committee will be chaired by a Non-Executive Director.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2. PURPOSE

2.1. On behalf of Trust Board, the prime purpose of the Committee is to seek and obtain assurance that the safety, rights and quality of service delivery is maintained to all of our service users, carers, staff and the public.

2.2. The Committee will also provide assurance to the Board that appropriate and effective governance mechanisms are in place for all aspects of quality including patient experience, health outcomes and compliance with national, regional and local requirements.

2.3. The Committee will promote an open and transparent reporting and learning culture across the Trust to support quality, safety and clinical effectiveness.

3. OBJECTIVES

The principal duties of the Committee will be to provide the Board with independent assurance in relation to:

3.1. Quality and Safety Strategy and Performance, Annual Plan & Report

3.1.1. To scrutinise and recommend to the Board of Directors the Trust's Quality and Safety Strategy.

3.1.2. To ensure that the Trust's Quality and Safety Strategy and performance are consistent with mandatory requirements and national guidance.

3.1.3. To scrutinise the Quality Performance metrics on the Integrated Quality Performance Report (IQPR) and to ensure the Committee supports appropriate triangulation and benchmarking.

3.1.4. To oversee the delivery of the Trust's Quality Improvement Programmes seeking assurance that key milestones, targets and outcomes are achieved.

3.1.5. To scrutinise the Strategic content and direction of the Quality Account for approval by the Board of Directors and Council of Governors.

3.1.6. To gain assurance that the quality priorities set out in the Quality Account are being implemented.

3.2. Safeguarding

3.2.1. To gain assurance that safeguarding is compliant with national and local requirements such that patients are safe in the Trust's care.

3.2.2. To review and recommend to the Board the Adult and Child Safeguarding Annual report.

3.3. Mental Capacity Act and Mental Health Act

3.3.1. To gain assurance that the Trust is compliant with the relevant requirements of the Mental Capacity Act; Mental Health Act; and other related acts or legislation.

3.4. Patient safety

3.4.1. To support the development of the Trusts approach to Patient Safety.

3.4.2. To scrutinise a quarterly report on the themes from serious incidents and gain assurance that they are understood and actions to reduce recurrence are implemented.

3.4.3. Oversee an effective system for safety within the Trust, aligning with the National Patient Safety strategy reporting principles of:

- Openness and transparency
- Just culture
- Learning and continuous improvement

Supporting a particular focus on; patient safety, and including the quality impact assessments for financial improvement, staff safety and wider health and safety requirements.

3.5. Patient Experience

3.5.1. Oversee the review and development of a revised patient engagement strategy.

3.5.2. The Committee will consider reports from the Patient Experience team, which will consider Complaints, feedback from PALS and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

3.5.3. The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

3.6. Clinical Effectiveness and Outcomes

3.6.1. To review and recommend for approval by the Audit Committee the annual clinical audit programme.

3.6.2. To gain assurance, via clinical audit reports that practice is clinically effective.

3.6.3. To gain assurance that Clinical outcomes are effectively monitored to ensure high quality care is delivered.

3.6.4. To gain assurance that the Trust is complaint with NICE guidelines and other related bodies.

3.6.5. To oversee the development of the learning from deaths process, seeking assurance that key milestones, targets and outcomes are achieved.

3.7. Infection Prevention & Control

3.7.1. To gain assurance that the Trust has in place such systems of work and controls that ensure infection prevention and control is effectively managed and compliant with legislative requirements.

3.7.2. To approve the annual infection prevention and control plan.

3.7.3. To scrutinise and recommend to the Board the Annual Infection Control Statement.

3.8. Regulatory Assurance

3.8.1. To scrutinise Care Quality Commission (CQC); the Office for Standards in Education, Children's Services and Skills (Ofsted); and other quality related compliance reports and ensure that actions are taken to address all issues identified in the compliance reports.

3.9. Assurance Framework

3.9.1. The Committee shall maintain the Quality section of the Board Assurance Framework and the Corporate Risk Register.

3.10. Other

3.10.1. To undertake any other tasks delegated to the Committee by the Board.

4. MEMBERSHIP AND ATTENDANCE

Members

4.1. Membership of the Committee shall be as follows:

a) Non-Executive Directors x 2 (one designated Chair)
b) Chief Nursing Officer (Joint Executive Lead)
c) Chief Medical Officer (Joint Executive Lead)
d) Chief Clinical Operating Officer

Required Attendees:

4.2. The following staff will be required to attend meetings of the Committee:

- Associate Non-Executive Director
- Director of Corporate Governance or representative
- Associate Medical Director
- Associate Director of Quality
- Associate Director of Nursing

Attendance by Other Officers or Individuals:

4.3. The Committee will be open to the Trust Chair, Vice Trust Chair and Chief Executive Officer to attend.

4.4. Other staff or individuals may be invited to attend meetings as considered appropriate on an ad-hoc basis. Such attendees will hold no voting rights.

4.5. Only members have the authority to vote and determine decisions on behalf of the Committee.

Attendance:

4.6. Members are required to attend at least 5 out of 6 meetings per year. Required attendees are expected to maintain a good standard of attendance. An annual register of attendance of members will be published by the Committee.

4.7. If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

4.8. Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

Voting:

4.9. When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the Chair of the meeting shall have a second or casting vote.

5. QUORUM

5.1. A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

5.2. Business will only be conducted if the meeting is quorate. If the Trust Chair or Vice Trust Chair are in attendance, this will count towards the quorum.

5.3. If the meeting is not quorate, the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be approved by e-Governance (virtually by members) and ratified at the subsequent meeting of the Committee.

6. FREQUENCY

6.1. The Committee shall meet on a bi-monthly basis. The Chair may call additional meetings to ensure Committee business is undertaken in a timely way.

7. ACCOUNTABILITY AND REPORTING

7.1. The Committee shall report to the Trust Board on how it discharges its responsibilities.

7.2. The minutes of Committee meetings shall be formally recorded.

7.3. A Chair's assurance report will be submitted to the next available Trust Board meeting. This report will also draw attention to the Trust board of any issues requiring disclosure or action.

8. AUTHORITY

8.1. The Quality Committee has the authority to establish sub-groups and task and finish groups.

8.2. The Committee will have close links to the staff diversity network groups which will be advisory to the committee and will be routes for engagement and consultation as well as proving contribution to committee assurance. The Staff network groups will be invited to assist in organisational agenda setting, undertake environment scanning, intelligence and idea generation.

9. SERVICING ARRANGEMENTS

9.1. The Committee shall be supported administratively by the Corporate Governance Team (Committee Administrator) whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

9.2. The Committee will maintain an Annual Forward Planner that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

10. RELATIONSHIPS WITH OTHER COMMITTEES / GROUPS

10.1. The Committee will receive assurance reports from meetings of its sub-committees (see Appendix 1 for the Committee Governance structure chart).

10.2. The Committee will receive escalations from other Board sub-committees in relation to matters identified at these meetings within its terms of reference.

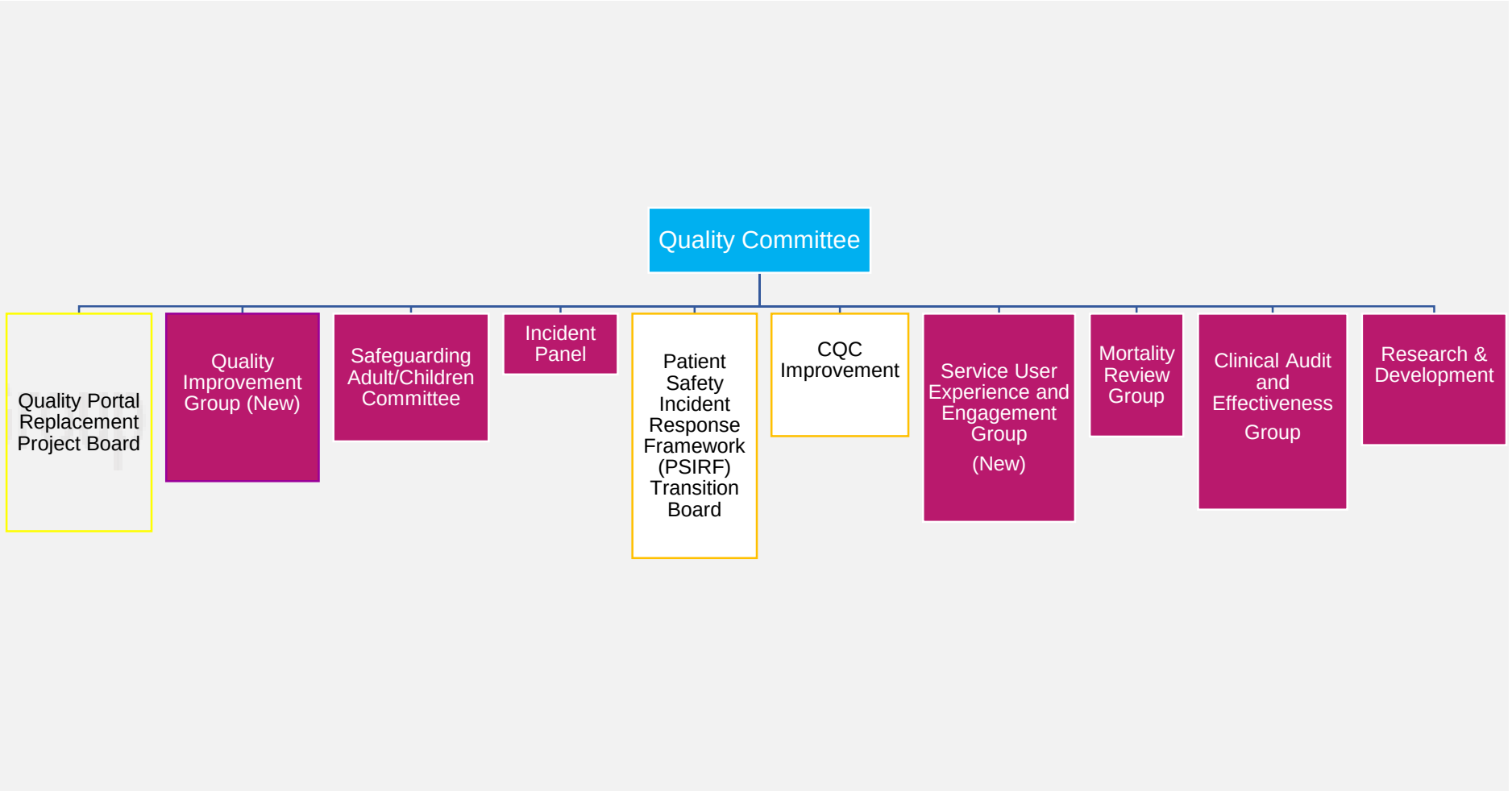
10.3. The Committee will escalate matters to other Board sub-committees in relation to matters identified in its meeting within other Board sub-committee terms of reference.

11. MONITORING EFFECTIVENESS AND REVIEW

11.1. The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

The Tavistock and Portman NHS Foundation Trust

Appendix 1 - Quality Committee Governance structure



NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Wednesday, 11 October 2023			
Report Title: Public Board of Directors Forward Planner 2023/24			**Agenda No.:** 24
Report Author and Job Title:	Amanda Hawke, Corporate Governance Manager	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Board of Directors (Public) Forward Planner 2023/24		

Executive Summary:	
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐
Situation:	This report provides the Board with the Public Board of Directors Forward Planner for 2023/24 (attached as Appendix 1) for information.
Background:	It is good corporate governance practice for the Board to agree a forward plan of its activities and be apprised of any changes to the planner during the year. The Public Board Forward Planner for 2023/24 was approved at the June 2023 meeting and is being presented to each meeting of the Public Board for information (highlighting any changes).
Assessment:	The Governance Manager administers the Board Forward Planner and there have been no updates to the planner since the last Public meeting of the Board.
Key recommendation(s):	The Board is asked to **NOTE** the Public Board of Directors Forward Planner for 2023/24.

Implications:

Strategic Objectives:

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

Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, the BAF is a standing item on the Board Forward Planner.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Board Forward Planner includes Statutory items for oversight by the Board.				

Resource Implications:	Yes ☐		No ☒	
	There are no additional resource implications associated with this report.			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from Publication under the FOI Act which allows for the application of various exemptions to information where the Public authority has applied a valid Public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received			2023					2024			Board / Committee / Meeting			
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**Apr ▼**	**Jun▼**	**Jul▼**	**Oct ▼**	**Dec ▼**	**Feb▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**	**Purpose** Matches the purpose on the request sent to the report owner and author following agenda setting.	**Author(s)**
Date of Meeting			**19 Apr**	**14 Jun**	**27 Jul**	**11 Oct**	**13 Dec**	**21 Feb**						
Paper Deadline			**29 Mar**	**xxx**	**xxx**	**xxx**	**xxx**	**xxx**						
Standard monthly meeting requirements														
Opening / Standing Items (every meeting)														
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/ C	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Closing Matters (every meeting)														
Annual Board Forward Planner (For approval in Apr 23 and Feb 24)	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Bi-monthly (6)														
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly		
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	D	P	P	P			Corporate Reporting	Bi-monthly		
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			High Quality Clinical Services	Bi-monthly		
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Develop & Deliver a Strategy & Financial Plan	Bi-monthly		
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Bi-monthly		
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly		
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly		
Integrated Governance Action Plan Report	Assurance	CEO		P	D	P	P	P	Audit Committee		Well-led & Effectively Governed	Bi-monthly	Review progress of governance recommendations and seek assurance of embedding required improvements. Board to receive updates bi-monthly from the Audit Committee	Dorothy Otite, Governance Consultant
Quarterly (3 - 4)														
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDOCG	P			P	P	P			Well-led & Effectively Governed	Quarterly		Frazer Tams, Interim Risk & Assurance
Audit Committee Chair's Assurance Report	Assurance	NED		P			P	P			Well-led & Effectively Governed	Quarterly		
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Great & Safe Place to Work, Train & learn	Quarterly		
Guardian of Safer Working Report	Information	ICMO			P		P	P			High Quality Clinical Services	Quarterly		
Six-monthly (2)														
Mortality / Learning from Deaths	Assurance	ICMO			P			P			High Quality Clinical Services	6 monthly		
Annual (1)														
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (Audit; POD EDI; ETC; PFR; Quality; EA&R)	Discussion	Chair		P							Well-led & Effectively Governed	Annual		
Review of Committee Terms of Reference	Approval	Chair				P					Well-led & Effectively Governed	Annual		
Medical Revalidation	Discussion	ICMO				P					Great & Safe Place to Work, Train & learn	Annual		
Freedom to Speak Up Guardian Annual report	Discussion	CPO			P	R			POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Prepardness, Resilence and Response (EPRR)	Discussion	ICNO					P		Audit Committee		Well-led & Effectively Governed	Annual		
Quality Priorities 2023-2024	Discussion	ICNO	P						Quality Committee		High Quality Clinical Services	Annual		
Staff Survey Results and Action Plan	Discussion	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Workforce Disability Equality Standard (WDES)	Approval	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		

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Workforce Race Equality Standard (WRES)	Approval	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Gender and Race Pay Gap	Approval	CPO		D	P				POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Equality, Diversity and Inclusion Annual Report 2022/23 (including Department of Education & Training)	Approval	CPO		D	P				POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Research and Development Annual Report	Discussion	ICMO	D	P							High Quality Clinical Services	Annual		Director of Research and Development
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		D	D	P			Quality Committee		High Quality Clinical Services	Annual		
Annual Objectives and Strategic Priorities (Final)	Approval	CEO				P					Corporate Reporting	Annual		
Compliance Against Provider Licence	Approval	IDOCG		P					Audit Committee		Well-led & Effectively Governed	Annual		
Budget 2023/24	Approval	CFO		P							Develop & Deliver a Strategy & Financial Plan	Annual		
UCL Alliance Business plan	Approval	CFO		P							Effective, Integrated Partner within the ICS & Nationally	Annual		
Non-Executive Director Commitments 2024/25 (including Champions and Committee Membership)	Approval	Chair						P			Well-led & Effectively Governed	Annual		
Board and Board Committee Meeting Dates 2024/25	Approval	IDOCG					P				Well-led & Effectively Governed	Annual		
Honorary Doctorate Nominations	Approval	ICETO					P		Education & Training Committee		Great & Safe Place to Work, Train & learn	Annual		
National Annual Patient Survey report (when available)	Discussion	ICNO							Quality Committee		High Quality Clinical Services	Annual		
Board Skills Review	Discussion	Chair							RemCo		Well-led & Effectively Governed	Annual		
Fit & Proper Persons Test	Discussion	Chair		D	P				RemCo		Well-led & Effectively Governed	Annual		
Board Development Programme	Discussion	Chair			P				RemCo		Well-led & Effectively Governed	Annual		
Financial Recovery Plan	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Annual		
Strategy / Policy Approval/Ratification (usually every 3 years)														
Year 1 (2023/24)														
Modern Slavery Statement	Approval	ICNO									Well-led & Effectively Governed	Annual		
Scheme of Delegation	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual		
Standing Financial Instructions	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual		
People Strategy and Plan	Approval	CPO							POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Staff Engagement Strategy (Internal Communications Strategy)	Approval	CPO	P						POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Year 2 (2024/25)														
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly		
Green Plan/ Sustainability Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly		
External Board Review (once every three years) Report	Discussion	Chair							RemCo		Well-led & Effectively Governed	3 yearly		
Year 3 (2025/26)														
Ad hoc/ As Appropriate														