The Tavistock and Portman NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 14th November 2024

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

Please refer to the agenda for timings.

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY 14th NOVEMBER 2024 AT 2.00PM – 5.20 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

24/00	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Service Presentation - Patient Safety	Discussion	Afia Nkrumah & Elizabeth Newington, Patient Safety Partners and Lucy Haggerty, Patient Safety & Clinical Governance Manager	V	2.05 (15)	
005	Minutes of the Previous Meeting held on 12 September 2024	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 AMBITIONS)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Medical Officer, Chief Nursing Officer	E	2.40 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	E	2.50 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
010	Review of Committee Terms of Reference	Approval	Director of Corporate Governance	E	3.00 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Comfort Break (10 minutes) 3.05pm – 3.15pm						
PROVIDING OUTSTANDING PATIENT CARE						
011	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.15 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
012	Mortality Report – Learning from deaths	Information	Chief Medical Officer	E	3.20 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
013	Final Report of the Cass Review of Gender Identity Service for Children and Young People	Discussion	Chief Medical Officer/Chief Nursing Officer	E	3.25 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
014	Learning from recent National Investigations	Discussion	Chief Medical Officer/Chief Nursing Officer	E	3.35 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
015	Gloucester House review on progress of Action Plan	Information	Chief Nursing Officer	E	3.45 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
DEVELOPING PARTNERSHIPS TO IMPROVE POPULATION HEALTH and building on our reputation for innovation and research in this area						
016	Medical Revalidation Report	Approval	Chief Medical Officer	E	3.55 (5)	Limited ☐ Partial ☐ Adequate☒ N/A ☐
DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion						
017	Feedback from Black History Month Events	Information	Pauline Williams, Chair Race Equality Network	E	4.00 (15)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
018	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	4.15 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education						
019	Education and Training Committee (ETC) Assurance Report	Assurance	E&T Committee Chair	E	4.20 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
020	Performance, Finance and Resources Committee (PFRC) Assurance Report	Assurance	PFR Committee Chair	E	4.25 (5)	Limited ☐ Partial ☐ Adequate ☐

						N/A ☒
021	Finance Report – Month 06	Information	Chief Finance Officer	E	4.30 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
022	Green Plan/Sustainability Strategy	Discussion	Chief Finance Officer	E	4.35 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
CLOSING ITEMS						
023	Board Schedule of Business 2024/2025	Information	Director of Corporate Governance	E	4.40 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
024	Questions from the Governors	Discussion	Chair	V	4.45 (5)	
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	4.50 (5)	
DATE AND TIME OF NEXT MEETING						
028	Thursday 16th January 2025 at 2.00pm – 5.00pm					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 01/11/2024)

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

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				FROM	TO	
			Providing advice and guidance to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative	12/02/2024	Present	No perceived conflict - Will withdraw from relevant business in relation to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service discussed by the Tavistock and Portman
SABRINA PHILLIPS	Associate Non-Executive Director	01 November 2022 (1st Term)	Employed by the Lambeth Living Well Network Alliance as Service Director (The alliance is a partnership of 5 organisations SLaM, SEL ICS (Lambeth),Lambeth ASC,Certitude, Thamesreach) - I am seconded out to the Alliance from SLaM (4)	01/01/2020	Present	Full time employment - No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by the Alliance.
			Interim Deputy Chief Operating Officer at SLaM	20/09/2023	30/11/2023	
			Employed as a Managing Director, adult mental health and learning disability services at Central and North West London NHS FT	01/11/2024	Present	Will withdraw from business decisions in competition with CNWL
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	23/02/2023	Will withdraw from business decisions in competition with University of Westminster
			Governor, Londale PNI School, Brittan Way, Stevenage	18/09/2018	Present	No perceived conflict - Will withdraw from business decisions in relation to the school as discussed by The Tavistock and Portman
SHALINI SEQUEIRA	Non-Executive Director	01 November 2021 (2nd Term)	Director, Sonnet Consulting Services Limited (1)	10/07/2018	Present	Personal company for consulting work - no conflict
KEN BATTY	Non-Executive Director	01 April 2024 (1st Term)	Council member QMUL, which included Barts and the London Medical School	01/01/2022	Present	No perceived conflict - Will withdraw from business decisions in competition with QMUL, Barts and London Medical School
			Chair, Mosaic LGBT+ Young Persons Trust based in Camden (3)	01/09/2019	Present	No perceived conflict - Will withdraw from business decisions in competition with MOSAIC LGBT+ Young Persons Trust
			Vice Chair, Inner Circle Educational Trust (provides support for Looked After Children in Canden)	01/10/2020	Present	No perceived conflict - Will withdraw from business decisions in competition with Inner Circle Educational Trust
			Independent Chair, Nominations Committee Royal College of Emergency Medicine which is a professional body. (3)	01/02/2021	Present	No perceived conflict - Will withdraw from business decisions in competition with Royal College of Emergency Medicine
EXECUTIVE DIRECTORS						
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12 November 2016	NIL RETURN			Sally left the Trust at the end of August 2024
MARK FREESTONE	Chief Education and Training Officer and Dean of Postgraduate Studies	10 June 2024	Honorary position as Professor of Mental Health at Queen Mary University of London	05/06/2024	04/06/2027	Will withdraw from any business decisions relating to QMUL.
			Director, North Thames NIHR ARC (Applied Research Collaboration)	01/04/2021	31/08/2025	No conflict to declare as T&P is a member of the ARC
			Director, Mark Freestone Consulting	08/11/2012	Present	Forensic Mental Health Research Consultancy (Sole trader). No direct conflict of interest.
			Honorary Senior Researcher, East London NHS Foundation Trust	01/07/2013	31/07/2026	Will withdraw from any business decisions relating to ELFT

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

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
THURSDAY 12th September 2024 AT 1:30 P.M.

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

PRESENT:

John Lawlor	Chair of the Board of Directors	JL
Shalini Sequeira	Non-Executive Director and Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Claire Johnston	Non-Executive Director and Chair Quality & Safety Committee	CJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality & Safety Committee	JJ
Ken Batty	Non-Executive Director	KB
Michael Holland	Chief Executive Officer	MH
Clare Scott	Chief Nursing Officer	CS
Mark Freestone	Chief Education and Training Officer and Dean of Postgraduate Studies	MF
David Levenson	Non-Executive Director & Chair of the Integrated Audit & Governance Committee	DL
Aruna Mehta	Non-Executive Director & Chair of the Performance, Finance and Resources Committee	AM
Rod Booth	Director of Strategy, Transformation & Business Development	RB
Sal Jarvis	Non-Executive Director and Chair Education and Training Committee	SJ

IN ATTENDANCE:

Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Gem Davis	Chief People Officer	GD
Sheena Bolland	Public Governor	SB
Pauline Williams	Operational Team Manager	PW
Peru Jeram	Staff Governor	PJ
Kathy Elliott	Lead Governor	KE
Frederick Peel	Head of Strategy & Transformation	FP
Arpan Walia	Business Manager to CEO and Chair	AW

APOLOGIES:

Chris Abbott	Chief Medical Officer	CA
Jane Meggitt	Interim Director of Communications and Marketing	JM
Peter O'Neill	Interim Chief Finance Officer	PON

AGENDA ITEM NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL welcomed all in attendance. Apologies were noted from Chris Abbott, Jane Meggitt and Peter O'Neill.	
002	**CONFIRMATION OF QUORACY**	
	JL confirmed that the meeting was quorate.	
003	**DECLARATIONS OF INTEREST**	
	No new declarations of interest were made.	
004	**SERVICE PRESENTATION**	
	Service Presentation on DET M58 Psychoanalytic Psychotherapy by Rodrigo Sanchez, Psychoanalyst & Course Lead for Adult Psychotherapies. Rodrigo Sanchez (RS) explained that the Consolidation Project aimed to improve Adult Psychotherapy training by increasing teaching hours, reducing reliance on inconsistent visiting lecturers, and integrating courses for a streamlined student experience. The new model (M58) offered more organized and extensive face-to-face and online teaching, addressing feedback for more support. Key challenges included securing more placements and competing with university departments for students. RS reported that the initiative had resulted in a significant increase in student intake. A number of Board members provided suggestions about potential areas to explore for placements. It was decided that Mark Freestone would provide a description of the M58 course to members so they could offer more suggestions. The Board thanked RS for the presentation and commended the team for their work.	
005	**MINUTES OF THE PREVIOUS MEETING HELD ON 11th July 2024**	
	The minutes of the previous meeting held on 11th July 2024 were agreed as an accurate record pending minor correction in the description of certain NED roles.	

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

It was noted that there were no matters arising.

All actions proposed for closure were approved.

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

JL provided a verbal update and highlighted the following:

- Lord Darzi had published a comprehensive 142-page review of the current state of the NHS. The former Health Minister had depicted the situation as problematic and suggesting that resolution would take longer than anticipated.

The CEO Report was taken as read.

- MH advised that the clinical structure review had been completed and the final structure and organogram for clinical services was published in August 2024, with implementation starting on 2 September 2024. The implementation plan included training for new roles and organizational development support for the new leadership team.

- NHSE had commenced a review of adult gender clinics in England in September, with completion expected by December. The main goal was to assess adherence to the service specifications and any reasons for deviations. MH advised that our GIC was scheduled for review on 5 November.

ACTION – New Organogram to be shared with the Boad Members.

The reports from the Chair and CEO were noted.

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

The report was taken as read.

Clare Scott highlighted the following in the report:

The Trust had reported 13 patient safety incidents, 9 incidents of violence and aggression, and 12 incidents of physical restraint in June, primarily at Gloucester House School. The new incident reporting system, Radar, went live in June 2024, bringing about improvements to incident reporting and review processes.

Waiting times are exceeding the 18-week target across several services, with significant delays in GIC, autism assessment, and trauma. A new clinic booking system and weekly waiting time huddles had been implemented to address these issues. Mandatory training compliance has improved to 80%, but appraisal completion remains low at 36.3%, in part due to data issues.

Gender Identity Clinic (GIC) Waiting List

The GIC faced significant demand and capacity constraints, with approximately 15,525 patients on the waiting list for a first appointment as of June 2024. Although the service receives around 450 referrals monthly, it is only able to fulfil around 70 new first appointments each month, resulting in a monthly backlog increase of 380 patients. A validation process has been initiated to confirm the waiting list, involving digital communications with patients to ascertain if they still needed appointments. Additionally, the GIC has developed a new screening pathway to streamline non-complex cases, aiming to reduce waiting times by redirecting such patients to more different staff for quicker assessments.

The M58 Course

The Trust's new model M58 course has been successful in increasing Year 1 student intake and addressing curriculum inconsistencies. However, ongoing challenges include recruitment, placement shortages, and resource competition with universities. Efforts to secure more placements and increase teaching consistency were ongoing.

The report was noted.

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

DL noted that the working relationship with the External Auditors, Grant Thornton, was progressing positively. He indicated that a "wash-up session" would be scheduled to review the 2023-24 audit cycle and identify areas for improvement.

However, DL expressed concerns regarding outstanding management actions with the Internal Auditors, RSM. These unresolved actions primarily related to the finance function, including issues highlighted in the HFMA follow-up report, key financial controls, accounts payable, and audits of company corporate credit card use.

MH assured the Board that these pending actions would be discussed regularly at Executive Leadership Team meetings to promote continuous improvement and better alignment,

The verbal report was noted.

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

The report was taken as read.

CJ highlighted the following:

1. **PSIRF Policy**: The Trust had approved the revised Patient Safety Incident Response Plan (PSIRP) in June 2024, leading to the development of the PSIRF policy, which clarified roles in responding to patient safety incidents. The Committee also approved the final policy after incorporating feedback from the PSIRF Transition Group.
2. **GIC Targeted Support**: The Gender Identity Clinic (GIC) has entered internal targeted support due to ongoing access concerns. Improvement metrics and exit criteria have been established, marking the GIC as the first service in this framework.
3. **Care Notes Incident Assurance**: The Committee reviewed actions taken following a February 2024 incident with the Carenotes system that led to an inability to access clinical information. Assurance was provided regarding the thoroughness of the investigation and compliance with Duty of Candour. An after-action review is planned.
4. **BAF Review**: The Committee focused on addressing risks related to high-quality care and patient access. Improvements were noted in staffing and quality assurance, with further reviews to be carried out in relation to Risk 1 to clarify key elements and assess mortality risk while awaiting first appointments.
5. **Safeguarding Reports**: The Committee reviewed the Annual 23/24 and Quarter 1 24/25 Safeguarding reports, highlighting ongoing efforts to address areas for improvement identified in the internal audit review.

The report was noted.

011 **Research and Development Annual Report**

The report was taken as read.

Dr Eilis Kennedy (EK) Director of Research and Development attended the meeting to present the annual report to the board. The annual report provided an update on Trust Research over the past year, highlighting key developments in interventional research. The Trust had received two significant grants for studies aimed at improving mental health and well-being in children and young people.

The first study, **"Watch Me Play!"**, focused on a remotely delivered intervention and recruited participants from various UK sites, with findings set to be published soon. The second study evaluated **Video Interaction Guidance (VIG)** for families of children with learning disabilities and successfully met its recruitment target, with follow-up data collection underway.

Additionally, EK reported on the ongoing **"Personalised Programmes for Children"** trial, which has faced recruitment challenges but continues to make progress. The Trust also contributed to the **Mentalisation for Offending Adult Males (MOAM)** study, the largest RCT for individuals with Antisocial Personality Disorder.

EK further highlighted the Trust's leadership of the **LOGIC study** on gender identity and its collaborative efforts on projects examining the impact of poverty on child development. The Trust has established strong research governance through its partnership with Noclor and provides ongoing training and development opportunities for staff.

The report was noted.

012 **Board Assurance Framework Update**

AK presented the latest iteration of the Board Assurance Framework (BAF), stating that all 13 strategic risks were actively managed by executive leads and lead committees. Most risks are showing progress towards lower target scores, indicating effective mitigation efforts. However, it was noted that specific areas such as IT security, workforce culture, operational performance, and financial sustainability continue to require significant attention.

Efforts were underway to ensure the effectiveness of controls and assurances in achieving target scores, with ongoing discussions at committee levels regarding the appropriateness of some target scores.

AK informed the Board that a new risk related to environmental sustainability (Risk 14) was being developed and was scheduled for discussion in the Performance, Finance, and Resourcing Committee meeting in September, to be included in the January 2025 BAF update.

Improvements are being made to the Corporate Risk Register (CRR) following the implementation of the Radar incident reporting and risk management tool, but further alignment between the BAF and CRR was needed. The Integrated Audit and Governance Committee continues to oversee this development.

In terms of areas for improvement, AK highlighted the need for actions to address gaps in control and assurance to be promptly updated. Key issues such as outdated reporting systems, fragmented contract management, and inadequate staff training needed addressing to prevent further escalation of high-rated risks.

AK also informed the Board that a new committee secretary would be starting in October.

The report was noted.

013 **Non-Executive Director Responsibilities**

The reports were taken as read.

AK advised that following Ken Batty’s appointment in April 2024, Committee memberships and NED champion roles had been reviewed.

The Board noted Non-Executive Directors commitments for 2024-25

016 **Guardian of Safer Working Hours Report**

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

The Guardian of Safe Working Hours (GOSWH) report was presented by CS, it addressed trainee concerns about fine payments and DRS login issues causing delays in reporting breaches. CS explained exception reporting by trainees, on-call breaches, fines for Q1 2024 were of ongoing interest. CS further added that junior doctors were encouraged to continue reporting breaches and to utilise the GOSWH fund for professional development.

The report was noted.

017 **People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report**

SS provided highlights from the POD EDI Committee meeting. The Committee had focused on BAF Risk 7 (inclusive culture) for this meeting, using it to guide and inform their discussions. They noted that bullying and harassment were likely underreported and discussed potential mitigations that could better address the issue.

The Race Equality Network was commended for its significant efforts, including organizing 14 events in three months, all led by Pauline Williams, who had no co-chair at the time of the meeting. Robust WRES/WDES action plans were developed, which the Committee believed would make a difference. These plans were prioritized by the EDI Programme Board to address areas needing immediate attention before the next staff survey in September.

SS also highlighted gaps in appraisal compliance, which needed to be addressed, along with statutory and mandatory training as covered in the IQPR dashboard. The Committee discussed room usage at the Tavistock Centre, acknowledging a lack of sufficient data and agreeing on principles for a new room usage system.

Reflecting on the meeting, SS and GD found it helpful to centre the discussion around specific themes, allowing for deeper exploration of the issues. Focusing on a few topics enabled thorough discussions, and they emphasized the importance of continually referencing the BAF and linking in with the EDI Programme Board.

The report was noted.

016 **Workforce Race Equality Scheme/Workforce Disability Equality Scheme Updates**

GD gave a verbal update on this agenda item.

She reminded the Board that at the last meeting a comprehensive discussion of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) had taken place. Following that discussion, the EDI Programme Board had collaborated to develop three key objectives. These objectives were then circulated among board members for review to ensure that they were accurately reflected in the intended statements. JL agreed that this collaborative approach would help to solidify the Board's commitment to advancing equality and inclusion within the workforce.

017 **Education and Training Committee (ETC) Assurance Report**

SJ presented this report.

She highlighted the Committee had discussed proposed changes to the Board Assurance Framework (BAF) risks 3 and 4, which focused on the validation of long courses and sustainable student recruitment, seeking Board approval for these adjustments.

Additionally, ETC had reviewed a detailed investigation into the Strategic Information Technology System (SITS), which supported student enrolment and progression. This independent review by STU3 highlighted that the initial implementation of SITS in 2015 had been incomplete, leading to operational challenges and the need for manual workarounds. Staff turnover further impeded the effective use of SITS, impacting communication with partners and accrediting bodies, and affecting income for the 2023/24 fiscal year. A recovery plan was put in place, with approval for up to £100,000 in additional capital investment.

Concerns regarding student debt had persisted over the past six months, particularly around the recoverability of debts and potential write-offs. To address this, a new Student Credit Controller position had been created to enhance debt identification and recovery efforts, with ETC feeling assured in managing the situation. DL added that this issue was being reviewed by the Integrated Audit Governance Committee as well.

SJ reported that since July, the Department of Education and Training (DET) had submitted over £641,000 in new tenders, with additional opportunities underway, including a £200,000 international contract. DET also planned to participate in a Trade Mission to China in October and would be developing a new prospectus for this purpose.

In terms of student recruitment for the 2024-25 cycle, results were promising, with 1,134 applications for long courses—an 18.5% increase—alongside a 50.6% rise in unconditional offers and an 11.9% increase in firm acceptances. Enrolment activities were set to continue into October, with expectations of

translating most of these applications into higher student numbers for the upcoming academic year.

The Board approved the proposed changes to the BAF risks. The report was noted.

018 **Performance, Finance and Resources Committee (PFRC) Assurance Report**

AM provided a verbal update to the Board, reporting that the Trust's reduced cash position was primarily due to the late payment of £1.9 million in former HEE income from NHSE. The contract and payment arrangements were still being pursued with NHSE, which had stipulated that the Trust must sign contracts before any payments are made—a change from previous arrangements. This issue appeared to be widespread, affecting multiple trusts across the country rather than being specific to this Trust.

AM also alerted Board members to several contracts that were at risk, including the decommissioning of PCPCS, and the potential risks associated with Surrey Mindworks and Haringey First Step.

AM expressed concern that waiting times remained the most significant performance risk and continued to increase. Although it is anticipated that the receipt of the ERF funding would lead to increased activity and reduced waiting times, this expectation had not yet been realised. AM and RB proposed that a board development session be held to explore strategies for addressing waiting times more thoroughly.

019 **Finance Report – Month 04**

Hanh Tran (HT) provided an update on the Finance Report.

The Month 04 Finance Report detailed the cumulative financial position up to July 31, 2024. During this period, the Trust reported a net deficit of £775,000, better than the planned deficit of £810,000, resulting in a positive variance of £35,000. While operating expenditure was behind plan by £775,000, this was offset by a positive income variance of £810,000. The Trust anticipated achieving its year-end deficit target of £2.2 million, with no significant risks identified.

Capital expenditure was limited to £160,000, falling short of the planned £348,000 by £188,000, primarily due to delays in backlog maintenance. The anticipated total capital expenditure for the year was expected to reach £2,468,000, including an additional allocation of £268,000.

At the end of Month 04, the cash balance was £658,000, significantly lower than the planned £1.85 million, mainly due to the late receipt of NHSE income. The Trust's deficit revenue plan for 2024/25 was set at £2.2 million, with a capital expenditure limit of £2.47 million and a planned year-end cash position of £1.9 million, contingent on receiving £7.5 million in cash support throughout the year.

	When asked about the cash flow situation, HT advised that the cash flow forecast anticipated a reduction in cash over the year, targeting an outturn of £1.95 million. The Trust was heavily reliant on the agreement of £7.5 million in cash support from NHSE, accessed through monthly applications for non-repayable public dividend capital (PDC). The report was noted.
020	**BOARD SCHEDULE OF BUSINESS**
	The Board schedule for 2024-25 was noted.
021	**QUESTIONS FROM THE GOVERNORS**
	There were no questions from the Governors.
022	**ANY OTHER BUSINESS**
	None
023	**QUESTIONS FROM THE PUBLIC**
	There were no questions from the public.
024	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	• It was noted that it was a long day, with the Board Development Session in the morning and the Closed and Public meetings in the afternoon. • The EDI aspects of the meeting were good and although there has been progression, there is still more work to do.
	Close
	The Chair closed the meeting at 4.05 p.m.

Date of Next Meeting in public: Thursday 14th NOVEMBER 2024 at 2pm, LECTURE THEATRE, TAVISTOCK CENTRE 120 BELSIZE LANE NW3 5BA.

Signature _____ Date _____

Action Log (Open Actions)

Actions are RAG rates as follows: ->				Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Meeting Date	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	Propose to close	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified. NHSE are providing Teams to assist with the second part of the training which is going to rolled out shortly. **UPDATE from Clare Scott: Part 2 of Tier 1 is available to Trusts on a limited basis and the prioritisation of spaces is being managed through L&D in each Trust**
09.05.24	8	Integrated Quality & Performance Report (IQPR)	To provide a list of what Mandatory & Statutory should be, and which are relevant	July Board meeting on 11.07.24	Gem Davies, Chief People Officer	Propose to close	The Statutory and Mandatory training list has been given to the Clinical Services Delivery Meeting to decide / approve. **UPDATE: At an ELT meeting in September 2024, a paper was provided and reviewed on the frequency of Statutory & Mandatory training. ELT agreed to the recommendations.**
12.09.24	7	Chair & Chief Executive Report	New Organogram to be shared with the Board Members	November board meeting on 14.11.24	Clare Scott, Chief Nursing Officer	Propose to close	**UPDATE: New Organogram circulated to Members by email and has been added to the reading room on BoardEffect on 7 November.**

MEETING OF THE BOARD OF DIRECTORS PART I (PUBLIC) – Thursday, 14 November 2024					
Report Title: Chief Executive's Report				**Agenda No.: 7**	
Report Author and Job Title:	Michael Holland, Chief Executive		**Lead Executive Director:**	Michael Holland, Chief Executive	
Appendices:	Appendix 1: NCL Health Alliance 6 monthly report – Autumn 2024				
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 12 September 2024				
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against the leadership responsibilities within the CEO's portfolio.				
Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☒ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	**Safe** ☒	**Effective** ☒	**Caring** ☒	**Responsive** ☒	**Well-led** ☒
Link to the Risk Register:	**BAF** ☒		**CRR** ☐	**ORR** ☐	
	All BAF risks				
Legal and Regulatory Implications:	Yes ☐		No ☒		
	There are no legal and/or regulatory implications associated with this report.				
Resource Implications:	Yes ☐		No ☒		
	There are no resource implications associated with this report				
Equality, Diversity and Inclusion (EDI) implications:	There are equality, diversity and inclusion implications associated with different aspects of this report.				

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

Chief Executive's Report

1. Introduction

It was nice to see a number of our Governors and Members present at our Annual Members' Meeting which was held at the WAC Arts Centre on Haverstock Hill on 29 October. The AMM gave us an opportunity to reflect on what we had achieved during 2023/24 and to look forward as the Trust continues to work with its proposed partners towards a potential merger. The meeting featured some polite but passionate debates about the organisation's future direction, and we are committed to continuing this conversation with all our stakeholders over the coming months. The slides that we relied on during the meeting will shortly be available for viewing on our website.

The Board of Directors is asked to note that Mark Freestone has been appointed as a Trustee of the Tavistock and Portman Charity. We are grateful to Mark for agreeing to take on this responsibility. The charity has one other unfilled vacancy which we will work with them to fill in due course.

2. Merger update

I would like to highlight that close working continues between the Trust, our proposed merger partners, NHS England (NHSE) and our commissioners to progress the merger to the formal transaction stage. We hope to be able to make an announcement very soon about next steps.

Following that, with our merger partners, we will need to undertake a period of detailed due diligence, looking at the risks and mitigations of a merger, including developing a Strategic Case and a Full Business Case setting out the proposal around the merger and why we feel it should progress. This would need to go to NHSE and then on to the relevant Minister at the Department of Health and Social Care, ahead of final Board approval and the formal consideration of the process followed, by the Council of Governors in 2025.

The Board of Directors remain committed to securing a strong future for the Trust and the unique and leading work we do.

Providing outstanding patient care

3. Clinical Structure review

The first two sessions to support implementation of the new clinical structure were held in September and October. Both sessions were held in person with clinical and operational leads, and they comprised of a combination of training and development components to support people in taking up their new roles. Additionally, the first introductory session of organisational development work was held in October. It is intended that this work will help equip the new leadership team to work better together to lead the newly formed clinical division.

4. Darzi Review

Lord Darzi's independent report into the state of the NHS was published on 12 September. It acknowledged that the NHS is "in serious trouble", noting that levels of public satisfaction with the service is at its lowest point ever. Most of the key access and waiting targets across

the service have not been met since 2015, with patients struggling to access GP appointments and more than 1 million people waiting for community and mental health services as at June 2024.

The review found that too much of the NHS budget is being spent in hospitals, and too little in the community and that productivity is low. Reasons put forward for the current state of the service included austerity in the 2010s, persistent shortages in capital funding and the lingering effects of the pandemic.

Lord Darzi identified a number of themes for prioritisation in the upcoming 10-year health plan, including re-engaging staff and empowering patients, providing financial incentives to permanently shift the focus of care closer to home, driving productivity in hospitals, especially with the use of technology, and clarification of roles and accountabilities across the service.

The Secretary of State for Health responded to the review by calling for three "big shifts – moving from hospital to community care, analogue to digital and from treating sickness to preventing it.

5. Change NHS: help build a health service fit for the future

As trailed in the Darzi review, the Government has launched a national conversation to inform development of the 10-year Health Plan. Here at the Trust, we will be running some staff engagement sessions to develop an organisation-wide response, and we are encouraging all colleagues to contribute their ideas, experience and expertise into the process.

6. NHSE Reviews of Gender Clinics

The NHS England national review of gender clinics continues and is due to be completed in December. Our GIC has responded positively to the data request in preparation for their review.

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

7. Black History Month

The Trust marked Black History Month during October with a range of events organised by the Race Equality Network. This year's theme was "Reclaiming Narratives," and marked a significant shift towards recognising and correcting the narratives around Black history and culture. The network hosted an event with guest speaker Leila Hassan Howe which emphasised this theme by shining a brighter light on stories, allegories, and history. It focused on correcting some historical inaccuracies and showcasing the untold stories and complexity of Black heritage. The emphasis was on taking back control of Black stories and honouring our heroes, while challenging narratives that have often overlooked the contributions and achievements of Black individuals both in the UK and globally.

On a more sobering note, it is important to remember that on 13 September, Stephen Lawrence would have celebrated his 50th birthday, just three years younger than me, had he not been killed in 1993. His racist murder, and the injustices that his families have faced since, must never be forgotten.

8. Staff Survey

The national staff survey launched on Monday, 30 September and we have an ambitious (but achievable) target response rate of 60%. The survey remains open until 29 November, and as at 1 November our response rate was 30%. We have chosen three local questions this year - the first is a repeat of last year's question relating to the impact of protected characteristics on experience working in the trust, and the other two are linked to living our new values.

Since the last survey we have been working closely with our colleagues to understand what matters most to them in order to improve staff experience in the organisation. We will review and update this work once we have the results of this current survey.

9. Inclusive leadership pledge

All members of the Executive Leadership Team have now signed NHS Confederation's inclusive leadership pledge, which demonstrates leaders' commitment to fostering an inclusive and safe working environment. In signing this pledge, the team and I will actively take steps to always challenge exclusion, show respect at all times and remain judgement free, ensuring that we are working in line with our values.

10. Staff engagement

Last year, we co-developed with staff, patients and students, a new vision, mission and values for the Trust. These are now displayed and evident throughout the organisation. The agreed next step was to seek to bring the values to life and to develop a set of behaviours that will underpin and shape everyday working practices and relationships, and to co-develop a values and behaviours framework so we are consistent in how we apply our values throughout the Trust.

Over the summer and autumn, we have been working with staff via engagement sessions and presentations at away days to draw out what the values mean to them. In the last month we have held six sessions and received over 400 responses; we are now turning these into 'I' statements which will form the basis of the behaviour's framework. These behaviours will also be integral to the career conversations and the just and learning culture approach to employee relations that we will shortly be rolling out.

11. Speak Up Month

October was also Speak Up Month, to raise awareness of Freedom to Speak Up. This year's theme was "Listen Up", emphasising the importance of listening when encouraging people to feel confident to speak up. A number of initiatives took place during the month, including in-person and virtual drop-in sessions. A big thank you to our Freedom to Speak Up Guardians, Sarah Stenlake and Sophia Shepherd for their help in putting this together.

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

12. British Psychoanalytic Council Accreditation

Between 21 and 25 October, the Trust was visited by an accreditation team from the British Psychoanalytic Council (BPC) to review the teaching and learning practices, course materials and governance framework for our psychoanalytic and psychodynamic therapy programmes. BPC accreditation allows our graduates from relevant courses to register with the BPC and practice as psychotherapists after graduating, which is a key appeal of our

courses. To do this we must demonstrate that our trainings cover both theoretical and practical aspects of psychoanalytic approaches, and that we and our graduates are held to the highest ethical standards.

I am very pleased to report that after a lot of hard work by our DET team, in particular Elisa Reyes-Simpson and Isabelle Bratt, the BPC panel have indicated they will be recommending that our accreditation be renewed for a further five years. This is a fantastic outcome, especially as our last visit in 2022 resulted in some concerns expressed, and a two-year re-accreditation window: it shows we have worked very hard on our internal processes to ensure the highest standards of training are upheld.

We will await the full formal decision from the BPC before the end of the year.

13. Welcome week and student enrolments

It was great to see so many students on site at the Tavistock Centre during the week of 27 September for welcome week. As well as offering them the opportunity to complete enrolment tasks and undertake inductions, it was also a chance to get to know other students and staff, with a range of social events, activities and tours.

1st November is the first of the 'census' dates for our enrolments and as at that date, we have 548 new students enrolled out of a total of 616 potential enrolments. 26 have deferred, withdrawn or intermitted meaning our maximum new student intake for September is 576 against a final total of 596 in the previous year (2023/24), currently a reduction of 3.4% ahead of our January intake which we hope will lead to a more favourable position.

Improving Value, Productivity, Financial and Environmental Sustainability

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

The Trust incurred a net deficit of £1,114k in the period from 1 April to 30 September 2024, against a planned deficit of £1,182k, a positive variance of £38k. The Trust's expenditure month on month is stable and we are currently anticipating achieving our year-end deficit plan of £2.2m, subject to the emerging cost pressure relating to the recently announced pay award of £1.3m being mitigated by additional income sources.

Regional and National Context

15. NCL ICB system intentions 2025/26

I received a letter on 28 October from the CEO of the ICB highlighting some of its key priorities for the coming year. The letter confirmed the system's commitment to delivering the aspirations set out in its Population Health and Integrated Care Strategy, which aligns with aspects of the Darzi Review. Specifically, there was a reiteration of the system's intention to reduce the growth in demand for complex and expensive hospital care, in favour of investments into early intervention and preventative care.

To this end, the system has signalled the need to change the way services are organised and overseen in order to improve productivity and ensure financial stability, with greater reliance on provider collaboratives and lead provider models. We will continue to play a full part in working with partners to help the system to achieve these ambitions.

16. NCL Health Alliance – 6 monthly report: Autumn 2024

The 6 monthly report of the North Central London Health Alliance, the local provider collaborative for North Central London has produced its 6 monthly report which is included as an appendix to this report.

17. Urgent and emergency mental health care for children and young people: national implementation guidance

In October, NHSE published guidance incorporating statements from young people who have experienced a mental health crisis, as well as their families and carers, about the response that they want when in a crisis. Key themes within the guidance relate to receiving the right care at the right time, and being treated with dignity, respect and compassion. The Chief Medical and Nursing Officers will be considering how this will impact on the way the Trust provides care and works with its partners.

18. CQC report: The state of health care and adult social care in England 2023/24

During October, the Care Quality Commission (CQC) published its annual report on the state of health and adult social care in England. The report painted a stark picture of the difficulties that patients, particularly those living in more deprived areas, experience in seeking to access care, with the difficulties in primary and dental care particularly highlighted.

On mental health specifically, the report acknowledged the growth in demand for care, especially among children and young people, but it showed that the availability of services is not matching this increased need. As a result, women and people from some ethnic minority backgrounds in particular, are more likely to have to attend urgent and emergency care departments as a result of their mental health needs not being met. Long waiting lists for treatment in the community are now commonplace, and despite growth in the workforce, problems with staffing and skill mix remain. The report also found that the safety of mental health wards remains a cause for concern.

In addition to all these issues, the report raised a number of issues of specific concern, including that despite fewer new referrals in 2023/24, the average waiting time for autism diagnoses reached a peak of nearly a year (328 days) in April, and that Black people are still more than 3½ more likely to be detained under the Mental Health Act than White people.

19. CQC response to reviews about its future direction

During October, the CQC responded to 2 external reviews about its future direction that were conducted by Dr Penny Dash and Professor Sir Mike Richards. Both reviews reaffirmed support for a robust health and care regulator and acknowledged the dedication and experience of CQC staff. The CQC in response said that its leaders are committed to rebuilding trust in its work, and to ensuring that it provides a simple and seamless service to those it regulates.

NCL Health Alliance

6 monthly report - Autumn 2024

Report author

Kate Petts
Managing Director NCL HA
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Table of contents

1. Programme updates

1.1. Complex Long Term Conditions Service

Programme overview

In January 2024 NCL HA was tasked by partner CEOS, UCLP and supported by the ICB leadership to develop and test new models of or patients with long term conditions living in NCL. This has led to the development of the Complex Long Term Conditions Service (CLTCS) which builds on the primary care Long-Term Conditions locally commissioned service (LTC LCS)[1] and links to the NCL population health strategy. The new care model aims to improve health outcomes and the efficiency of healthcare utilisation for adult patients (registered with NCL GP) living with highly complex and multiple long-term conditions.

One of the most significant challenges facing the NHS over coming decades will be meeting the needs of the growing number of people with multiple health conditions. People with long term conditions (LTCs) account for around half of all GP appointments, two-thirds of outpatient appointments and 70% of hospital bed days. The groups at greatest risk include people from disadvantaged backgrounds, minority ethnic groups and those with serious mental illness. We know for the cohort of patients in the scope of our project compared to patients with no long-term conditions they are

- 3.5 times more likely to attend ED
- 4.7 times more likely to have outpatient appointments
- 12 times more likely to have an emergency admission

Since the start of the pandemic there has been a 21% increase in NCL of people with 3 or more long term conditions. The number of NCL residents living with a diagnosed long-term condition is projected to continue to rise in the coming years, growing a staggering 8% by 2030 compared to the slower overall population growth of 1%.

Work done by the Richmond Group of charities[2] reports that people with LTCs value careful coordination, shared decision making, prioritisation and a longer-term perspective. But, too often, what they find is that services are still characterised by siloed ways of working, a focus on acuity and a lack of forward planning**.**

The CLTCS programme aims to test improved models of care to bring changes across the system in the management of long-term conditions. Patients will be managed by secondary care consultants working directly at the interface with primary care to provide coordination of clinical decisions and intervention across specialties.

The programme brings together clinical and operational leadership across acute, community, mental health and primary care services. The leadership is supported by finance, workforce,

[1] **https://nclhealthandcare.org.uk/our-working-areas/supporting-people-with-long-term-conditions/**

[2] **https://www.richmondgroupofcharities.org.uk/publications/one-in-four-a-manifesto-for-people-with-multiple-health-conditions/**

analytics, digital and governance teams from providers and the NCL ICB. In addition, UCLP are commissioned to provide innovation and evaluation support to the programme.

The CLTCS is split into 3 phases

- ***Phase 1*** – development of the clinical model of care to deliver coordinated review and planning for patients between secondary care consultants and PCN leads. Commencing in November 24 with 5 PCN early adopter sites and increasing (subject to funding approval) in numbers in 25/26
- ***Phase 2*** – development of multi-speciality, multimorbidity in person clinics, Patients requiring in person assessment and treatment will be managed in a multi-speciality clinic approach that also access to innovation and research. Go live expected (subject to approval) in 25/26
- ***Phase 3*** – development of a connected approach with local authority and VCSE services (lined to integrated neighbourhood teams) (subject to approval for development in 25/26

Progress

Phase 1 progress -to date the CLTCS programme has

Clinical

- Developed a new clinical model to be tested in PCN sites.
- Appointed 5 PCNs (1 per borough)[3]
- 2 of the PCNs (South Islington and Welbourne) will go live in November with the other 3 sites commencing in early 2025
- Completed test runs of the clinical model in the PCN sites
- Confirmed staff portability arrangements
- Commenced scoping of increasing the number of PCNs included in the programme from 25/26

Workforce

- Appointed clinical leads from providers (acute, primary care, community and mental health) and as professional leads e.g. AHP and operational leadership
- Recruited to the clinical and operational posts

Digital

- Mapped the digital requirements and EPR capabilities for the programme
- Completed the DPIAs (32 to date) necessary to enable data access for clinical teams.
- Engaged the NCL Technical Data Authority group to support changes to digital system configuration and data sharing because of learning from our programme
- Undertaken a significant level of analytical analysis (supported by the NCL ICB analytics service) on the patient cohorts

Innovation

- Commenced conversations with innovation companies regarding opportunities to improve delivery focusing on risk stratification,
- Identified other innovation opportunities (if funded) that would support MDT working and patient engagement

[3] Each PCN has an average of 6.5% of their patients stratified into the high risk and complex cohort of the LTC LCS. There is a range of deprivation across the PCNs (Haringey PCN has 88% of its patients living in IMD 1-3 compared to 4.3% in Barnet)

Evaluation

- Created the programme evaluation approach led by UCLP
- Logic model workshop for programme leads held in early October

Finance

- Engaged finance leads across providers and the ICB to develop a baseline income and costing model for the patient cohort.

Enablers

- Commenced scoping of phase 2
- Communication and engagement plan developed and supported by UCLP

The 5 PCNs link to a named specialist LTC consultant in a neighbouring acute Trust, who in turn links to a panel of secondary care specialist to provide additional advice and support without the need for a new referral into their services.

Programme finance

The CLTCS is funded non-recurrently from the NCL HA budget the £300k covers

- Programme clinical leadership (backfill to release Consultants from providers)
- Staffing for 4 x PCN early adopter sites – LTC specialist consultant sessions, clinical coordinator, administrative coordinator, primary care input, support sessions from specialists in secondary care, mental health team and community health services.
- Patient and VCSE participation
- Research and evaluation

1 additional PCN funded through the ICB Long-Term Conditions and Proactive programme.

Next steps

2 PCNs will go live in November linked to UCLH and Whittington Health acute consultants, the 3rd PCN in Camden is planned for go live in January linked to the RFL. The final 2 sites will have start dates confirmed following initial go live. The comms and engagement for both staff and patients will increase from October including information on the service delivery, the team involved and the projected impact.

1.2. Clinical networks

Over the past 10 months the NCL HA team have been working with the NCL Director of Long-Term Conditions and Proactive care to develop a proposal for the reconvening of the 4-system wide long-term conditions. The structure and funding for the networks was approved by the NCL HA Executive in September with the view to standing the networks back up with clear priorities by the end of the financial year. Part of the network's proposal was the creation of an Innovation Collaborative hosted by UCLP. This agile and temporary enabling collaborative will be stood up to support the LTC Clinical networks on specific multi-morbidity LTC priorities or in cases where complex change has multiple dependencies / needs specialist support e.g. data/analytical. The networks will report into the NCL Population Health Committee.

The Health Alliance core team continues to directly support the NCL Red Cell network. Other networks including Orthopaedics, Ophthalmology, General Surgery, ENT, Dermatology, Gynaecology and Urology are supported either by lead providers, the Northern and Southern partnerships or the Cancer Alliance.

2. Organisational updates

2.1 Closure of the Company Limited by Guarantee (CLG)

As part of the move of the NCL HA into UCLP the decision was made to close the CLG associated with the former name of UCL HA. This process was formally concluded on 15 October 2024 **UCL HA filing history** following NHSE, NCL HA director and Companies House approval. As a result of the closure, some of the elements of the articles of association need to be restated in new governance documents that direct the actions of NCL HA both as a partnership and its function within UCLP. These elements will be drafted by UCLP, with input from provider governance leads and will be circulated by December 24 to all partner boards for approval.

2.2 Recruitment

Following the substantive appointment to the Transformation Director role in the summer, the NCL HA core team is now fully established. Three of the team remain substantively employed through UCLH, one is on a fixed term secondment from UCLH to UCLP and the remaining team members are directly recruited to UCLP. To limit future employment liabilities for UCLP future new or replacement appointments to the NCL HA core team will either be direct employment to UCLP or via fixed term (no more than 24 months) secondments.

2.3 Finance

The NCL HA ss funded by 13 equal provider contributions currently set at £50k per annum, the funding arrangement is in year 2 of a 3-year agreement which covers

- the core team (6 WTE) pay and non-pay
- contribution to the UCLP chair salary (as per the transfer to UCLP agreement)
- 10% corporate overhead contribution to UCLP

At month 6 the financial position of NCL HA is as follows:

	Budget 2024/25	Expenditure Apr-Aug	Forecast Sep-Mar	Forecast 2024/25	Forecast (more)/ less than budget
Item	£k	£k	£k	£k	£k
Pay	483	171	282	453	29
Pay - Long Term Health Hubs	109	26	69	95	14
Total pay	**592**	**197**	**351**	**548**	**44**
Non pay	21	10	13	24	(3)
Non-pay - Long Term Health Hubs	300	4	293	297	3
Total non-pay	**321**	**15**	**306**	**321**	**0**
Overheads	91	21	66	87	4
Total	**1,004**	**233**	**723**	**956**	**48**

Income	£k
2022/23 carry forward	106
2023/24 carry forward	344
2024/25 Membership contributions	650
Total income	**1,100**

Funds totalling £449k were transferred from UCLH to UCLP. This reflected an underspend in prior years due to vacancies and a pause in planning activity whilst NCL HA was embedded in UCLP. These funds are being used to invest in the Complex Long Term Health Service programme.

For 24/25 the membership contributions increased from £45k to £50k per member. This is to cover the recurrent costs of a full establishment in the Health Alliance team.

Staff costs are anticipated to be lower than budget owing to delays in recruitment. An estimate has been included for backdated NHS pay increases, but this is subject to confirmation

Included in the non-pay costs is £300k non recurrent funding for the CLTCS project. Expenditure for this will commence in the second half of the financial year. The allocation includes contingency allowing for the option to increase the number of funded clinical sessions, subject to project delivery. An overhead is allocated for UCLP in respect of the utilisation of corporate functions and costs such as finance, HR, communications, IT and office space.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Integrated Quality Performance Report (IQPR)			**Agenda No.: 08**
Report Author and Job Title:	Aaron Horner, Clinical Service Manager, Adult Unit	**Lead Executive Directors:**	Rod Booth, Chris Abbott, Gem Davies, Peter O'Neill & Clare Scott
Appendices:	Appendix 1 – IQPR report for Board September 2024		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☒		
Situation:	This is the IQPR for 24/25 Month 6 data.		
Background:	This data has been through local groups and Board Committees (including DET, IQPR's, QSC, PFRC) with the detail of areas of performance that need attention being brought to the attention of the Groups/ Committees. Focus is on A3's. A3's are now discussed weekly in ELT and in the Quality Improvement (QI) huddle, driving a clear focus on improvement in relation to the Strategic Ambitions.		
Assessment:	**Performance** • Waiting times over the 18-week target have continued to rise across the Trust, primarily in the Adult unit due to the long waits in GIC, PCPCS and Trauma. Camden Unit and Child & Family Units are now performing within / close to the 4-week target with the average first appointment being 3.65 and 5.12 weeks respectively (excluding Autism Assessment), which is stabilising due to the increased volume of triage appointment/new clinic mod). There are pockets of improvement in wait times for example in the Autism Assessment & Adult Psychotherapy Teams owing to new clinic booking systems, increasing the number of first appointment offered. • Mandatory and statutory training has been static for the past 4 months at ~ 80% against a target of 95%. Appraisal completion is well below target at 43%. However, there are some data quality issues with the inclusion of medical appraisals (which are recorded on a separate system) as well as challenges linked to the changes in line managers during the leadership review and the appraisal season changing to the link with pay progression, both which created a lag which is currently being addressed • The three strategic areas of focus for waiting times now all have trajectories that performance is being measured against. This has allowed the visibility of increased activity in areas where the elective recovery funding was focused. The weekly waiting time huddles have continued, where this work is monitored. GIC is receiving additional input through a targeted support programme which also meets weekly. **Quality & Safety** • The Trust has recorded 74% of ESQ Positive Responses in August, below the benchmark of 90%. A lower number of responses was received in this period which correlates with a lower number of		

	appointments during the summer holiday period. A smaller amount of feedback is likely to skew the scores either way if individuals are unhappy or happy with elements of their care. • Work is being progressed to set team level targets for amount of feedback to be collected each month and to ensure that teams can review the feedback comments monthly. A QR code has been developed to provide a number of ways in which service users and carers can give feedback. • The Trust continues to focus on investigating and responding to all overdue complaints and have reduced the number to 11 complaints overdue, with clear timeframes for responding to all 11. The Trust moved to a new complaints process and investigation template, all formal complaints are now responded to on the new template which is shared with the complainant along with a response letter, this provides transparency around the investigation. • The Trust reported 11 Patient safety incidents are recorded where there was actual or potential harm, one incident of violence and aggression and 0 incidents of restraint. Although this is within normal variation, this was down from July, the rationale being that the highest reporting area, Gloucester House School, was closed for summer holidays. • The Patient Safety Team continue to hold a daily huddle to review all incidents reported in the previous 24 hours and identify incidents where further review is needed. Work is underway to create forms within the incident and risk management system to support Gloucester House to move reporting of incidents and restraints from paper to electronic record. **People / Workforce** • The Trust declared 43.0% of Appraisal Completion in August 2024. Further to the recent change in the Trust appraisal cycle, the People Team continue to work with senior leaders to improve on the Trust appraisal position. Whilst there has been some improvement in comparison to the previous month, we remain quite some distance from the Trust target. The People Business partners will arrange targeted meetings with senior managers to agree an action plan to improve our current position. • The Trust declared 2.0% of Staff Sickness in August 2024.The number of reported health-related absence cases has risen slightly in comparison to the previous months. The people partnering team continue to provide support to manager regarding the management of staff absence in line with the policy. Training sessions are delivered to managers to upskill knowledge and improve capability. • The Trust declared 79.1 % of MAST Completion. Managers are encouraged to provide 'protected' time for their staff to complete their outstanding MAST modules. The people team continue to escalate non-compliance through the appropriate channels for urgent action. A further drive is required to attain the expected compliance level of 95% and actions will be put in place shortly to support this.
Key recommendation(s):	The Board is asked to review and **DISCUSS** the contents of this report.
Implications:	

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Principal Risks: 1, 2, 8, 9				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no specific legal and regulatory implications associated with this report.				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no specific EDI issues to note within 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:	Local IQPRs - September Quality & Safety Committee - October Performance, Finance and Resources Committee - 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	

Data for this report covers August 2024 (Preceding month)

The Tavistock and Portman
NHS Foundation Trust

Integrated Quality and Performance Report
Board September 2024

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

Executive Summary

Quality & Safety

- The Trust has recorded 74% of ESQ Positive Responses in August, below the benchmark of 90%. A lower number of responses was received in this period which correlates with a lower number of appointments during the summer holiday period. A smaller amount of feedback is likely to skew the scores either way if individuals are unhappy or happy with elements of their care.
- Work is being progressed to set team level targets for amount of feedback to be collected each month and to ensure that teams can review the feedback comments monthly. A QR code has been developed to provide a number of ways in which service users and carers can give feedback.
- The Trust continues to focus on investigating and responding to all overdue complaints and have reduced the number to 11 complaints overdue, with clear timeframes for responding to all 11. The Trust moved to a new complaints process and investigation template, all formal complaints are now responded to on the new template which is shared with the complainant along with a response letter, this provides transparency around the investigation.
- The Trust reported 11 Patient safety incidents are recorded where there was actual or potential harm, one incident of violence and aggression and 0 incidents of restraint. Although this is within normal variation, this was down from July, the rationale being that the highest reporting area, Gloucester House School, was closed for summer holidays.
- The Patient Safety Team continue to hold a daily huddle to review all incidents reported in the previous 24 hours and identify incidents where further review is needed. Work is underway to create forms within the incident and risk management system to support Gloucester House to move reporting of incidents and restraints from paper to electronic record.

Performance

- Waiting times over the 18-week target have continued to rise across the trust, primarily in the Adult unit due to the long waits in GIC, PCPCS and Trauma. Camden Unit and Child & Family Units are now performing within / close to the 4-week target with the average first appointment being 3.65 and 5.12 weeks respectively (excluding Autism Assessment), which is stabilising due to the increased volume of triage appointment/new clinic mod). There are pockets of improvement in wait times for example in the Autism Assessment & Adult Psychotherapy Teams owing to new clinic booking systems, increasing the number of first appointment offered..
- Mandatory and statutory training has been static for the past 4 months at ~ 80% against a target of 95%. Appraisal completion is well below target at 43%. However, there are some data quality issues with the inclusion of medical appraisals (which are recorded on a separate system) as well as challenges linked to the changes in line managers during the leadership review and the appraisal season changing to the link with pay progression, both which created a lag which is currently being addressed
- The three strategic areas of focus for waiting times now all have trajectories that performance is being measured against. This has allowed the visibility of increased activity in areas where the elective recovery funding was focused. The weekly waiting time huddles have continued, where this work is monitored. GIC is receiving additional input through a targeted support programme which also meets weekly.

People/workforce

- The Trust declared 43% appraisal rate completion in August 2024. Further to the recent changes in the Trust appraisal cycle, the people team continue to work with senior leaders to improve on the Trust appraisal position. Whilst there has been some improvement in comparison to the previous month, we remain some distance from the Trust target. The people business partners will arrange targeted meetings with senior managers to agree an action plan to improve our current position.
- The Trust reported 2% of staff sickness in August 2024. the number of reported health-related absence cases has risen slightly in comparison to the previous reporting periods. The people partnering team continue to provide support to managers regarding the management of staff absence in line with the policy. Training sessions are delivered to managers to upskill knowledge and improve capability.
- The Trust reported 79.1% of MAST completion. Managers are encouraged to provide ‘protected’ time for their staff to complete their outstanding MAST modules. The people team continue to escalate non-compliance through the appropriate channels for urgent action. A further drive is required to attain the expected compliance level of 95% and actions will be put in place shortly to support this.

Our Values and Strategy

Our 2024/25 Priorities:

The Tavistock and Portman NHS Foundation Trust

Partnerships, Innovation, Population Health, Research and Reputation underpinning all five areas

- People (including Equalities, Diversity and Inclusion)
- Waiting Times
- Experience & Outcomes
- DET, Commercial Growth and Financial Sustainability
- Merger

Integrated Quality and Performance Report

Month 6- 24/25

Metric	Waiting List Management	SRO	Chris Abbott	Target		Measure	

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

Problem Statement

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

Vision & Goals

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

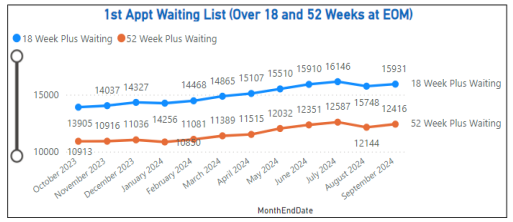
G1. Clearly defined pathways for patients within next 4 months

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

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

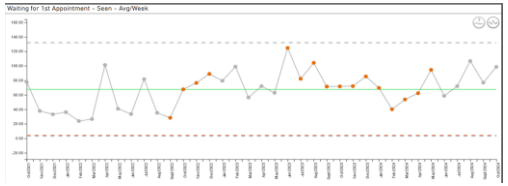
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

Historical Performance

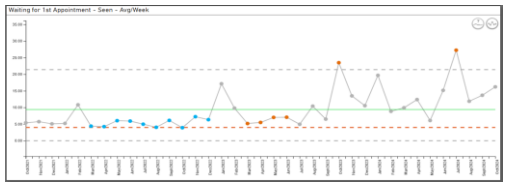


This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

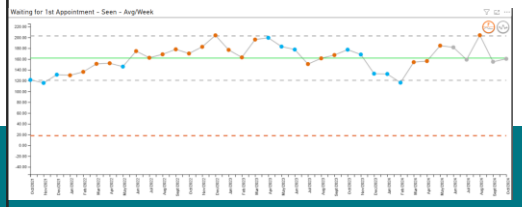
Trauma



Autism Assessment



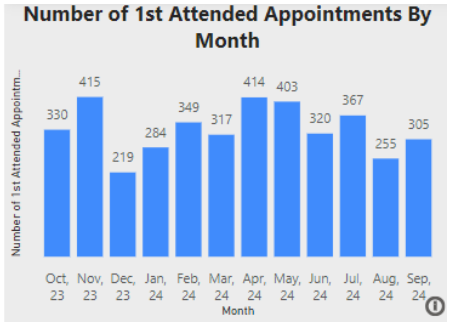
Adult Gender Identity Clinic (GIC)



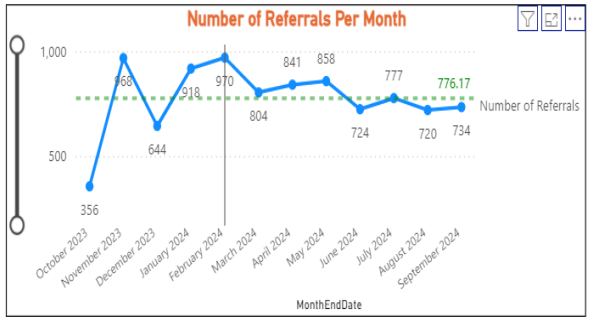
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

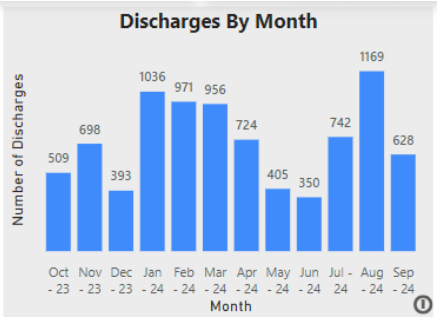
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
As at July 24, the Trust has approximately 4792 dormant cases open that have not been seen between in 3 -36+ months. The most sits in months 3 – 18 month	Clinical service Leads had limited access to accurate and contemporaneous data relating to dormant cases. The Trust did not have digitised data in reporting to support Patient Tracker List meetings. The PTL function has taken time to embed with clinicians	Digitise PTL reporting Improve integration of reporting and clinical review and counter measures Review clinical risk with view to deciding to discharge Close cases where patients no longer require a service or have been pre-contemplative for over 6 months Ensure review and discharge dormant cases from PTL per unit	Reduction of patients dormant for longer than 6-12 months and improvement of patient safety and review . Free up capacity to conduct first appointments to meet the referral to treatment target	
In some areas there is not enough resource for the numbers of patients being referred	Funding doesn't match demand and limited compliance with best practice and service specification.	Elective Recovery Funding to increase capacity for first assessments and treatment for a 12– 18 month Review current clinical pathways and indicative treatment episodes against best practice and service specifications Develop business case relating to unmet need to ensure these are appropriately funded or captured in the data	Reduction in wait times due to taking more people from the waiting list and better alignment to best practice and commissioned need.	Hector and GM/s
Units are yet to mature their pathway maps	Personalised or individualised care has driven	The mapping of 'as is' and 'to be' pathways is taking	Having greater standardisation will prevent treatment	Sally Hector

Integrated Quality and Performance Report

Month 6 - 24/25

Metric	Waiting List Management – Autism Assessment	SRO	Chris Abbott	Target	18 weeks	Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Problem Statement

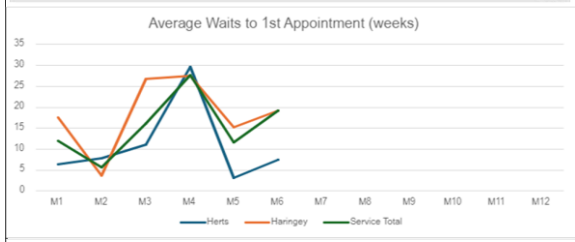
The Autism Assessment (ASC) waits have been growing exponentially with a 285% increase in referrals for assessment since 2019. Due to the nature of the way we triaged patients, the waiting time for the actual assessment could be non-transparent. There are approximately 240 patients waiting with an average of 30 assessments completed each year.

Vision & Goals

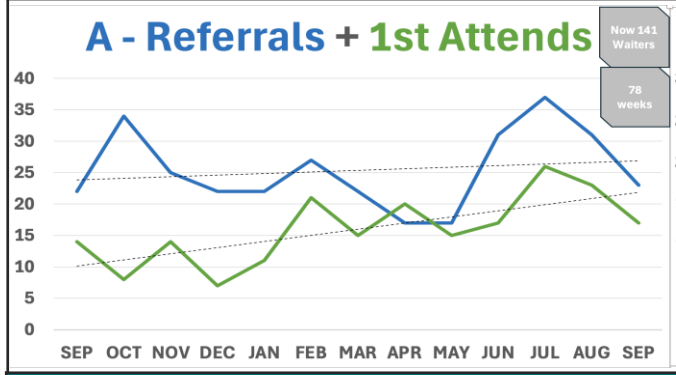
Vision: No patients waiting longer than 18 weeks for Assessment

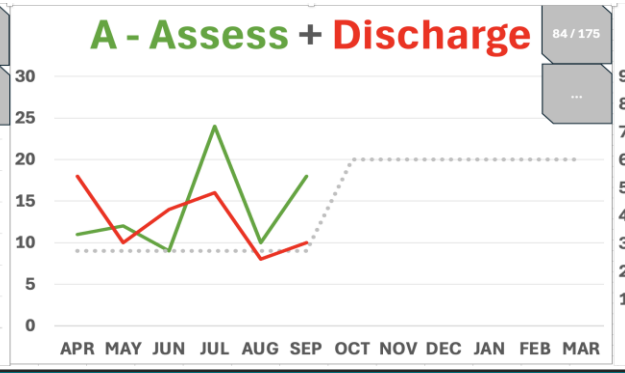
Goal 1: Additional 175 Assessments over baseline + **Goal 2:** 50% reduction of average Wait Times

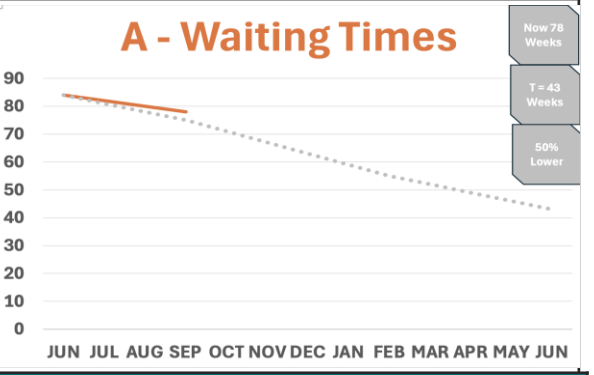
Historical Performance



Monthly Stratified Data







Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Wasted (DNA and CbP) Assessment slots are diminishing our capacity by 15-20%	DNA and cancellation rates caused by multiple factors including: 1) Patient comms / reminders 2) Clinic scheduling / lack of a reserve list 3) As yet unknown reasons why patients cancel last minute	1) Developing a reserve list process for short notice invitations 2) Establishing a text message reminder system 3) Auditing reasons why patients cancel	• DNA and cancellation rates to reduce to 5% DNA overall and 10% cancellation overall from a July '24 baseline for DNA/ CbP and CbHCP • Increased assessment throughput in BAU and ERF in line with trajectories	RB/MC/ TR/AH
The assessment pathway is taking too long for patients to get through	1) 'Assessment Lead' bottleneck not being effectively exploited 2) Costly scheduling of assessments 3) Lack of standardisation; template letters and modular approach to report writing, incl. review of report components (quality)	1) Reduce triages for 'Assessment Leads' to exploit the bottleneck 2) Establish a 'Clinic Booking Model' to streamline assessment scheduling 3) Adopt use of 'Template Letters' on Carenotes across the service	• Reduction of time spent on diagnostic pathway from baseline set At 15 weeks to 8 weeks by March 2025. • Reduction in overall time spent doing an assessment from 28 hours currently to 25 hours by November 2024 and to 18 hours in March 2025to align with NCL target	RB/MC/ TR/AH
Patients are waiting too long for initial triage	1) Poor patient comms 2) Inadequate scheduling process 3) Cumbersome / non-value adding forms	1) Improve comms; template letters and admin-lead 'Green' letters 2) Pilot admin-lead scheduling 3) Review / streamline triage form	• Performance against 4 week wait time with baseline set from April 2024.	RB/MC/ TR/AH
Team is not yet at full capacity	Recruitment, onboarding and job planning of staff still ongoing / outstanding for final few new staff	Onboarding and job planning for remaining new staff	Full capacity by October 2024	RB/MC/ TR/AH

Progress against activity target month 6

Number of assessments to date ERF	80 assessments at month 6 against a total project plan of 87.5. Some variation in target allowed for delayed start dates for team
Reduction on Waiting times	With the number of young people waiting 52+ weeks for assessment showing a 12 percent reduction from 89 to 79. 42+ weeks has remained constant but 19+ weeks has shown a 25% reduction.
Reduction in waiting list numbers	Reduction from 320 to 292.

Integrated Quality and Performance Report

Month 5 24/25

Metric	Waiting List Management – Trauma	SRO	Chris Abbott	Target		Measure	

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

Problem Statement

The Adult Trauma pathway currently has significant demand/capacity constraints, with the waiting list currently holding ~937 patients (for wait for first appointment) as of Nov 23. Patients in this service are often seen weekly for a year and may also have group therapy for a further year. The trauma service average annual referrals has increased by 350% between 2019 and 2023.

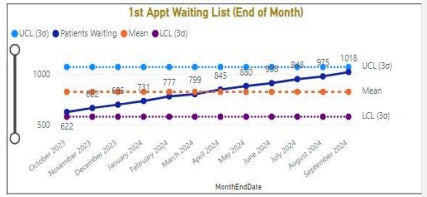
Vision & Goals

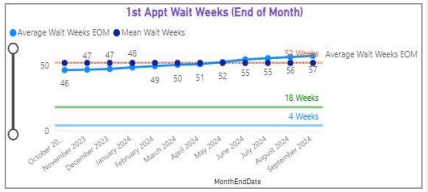
Vision: No user services waiting longer than 18 weeks for treatment

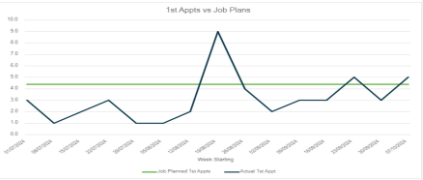
Goal 1: Reduction of Average Waiting Time by 15% to target of 135 weeks by Jun 2025

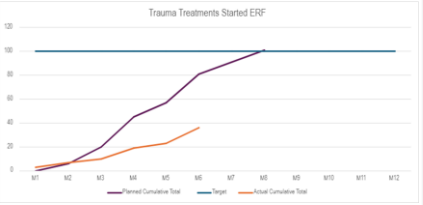
Goal 2: 100 additional patients entering treatment by Jun 2025 (above baseline TBC)

Historical Performance









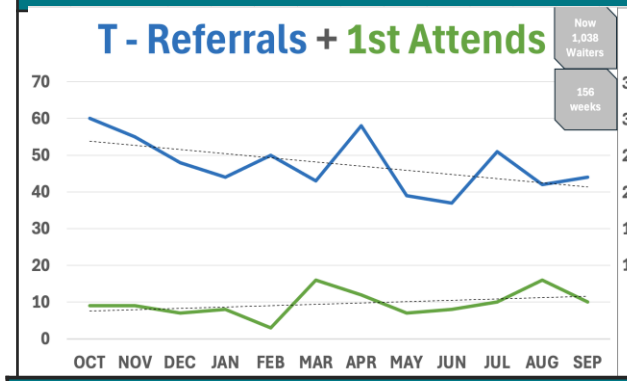
The number of patients waiting for 1st appointment continues to grow and is now >1k

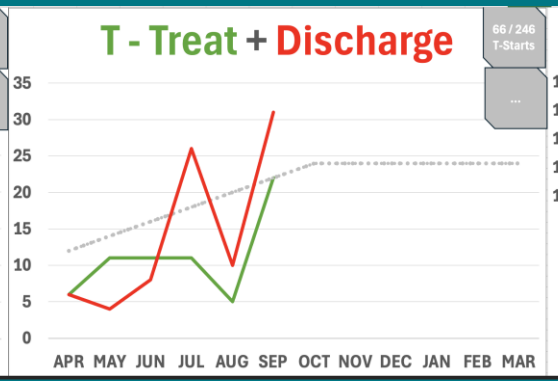
The average wait of those on the waiting list is 57 weeks, the wait for 1st appointment is ~3 years

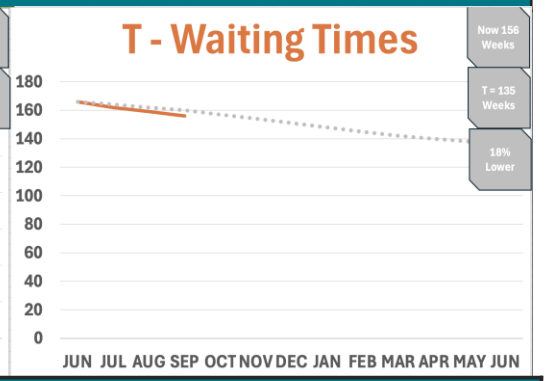
Performance against job planned 1st appts is improving, with the ERF team now being ready to undertake these complex appointments

In M1-6 the ERF funded staff started 36/81 planned treatments – data for this metric is unreliable and is being validated

Monthly Stratified Data







Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Capacity for 1st appointments / performance against job planned 1st appointments	ERF staff being trained to undertake 1st appts. Substantive staff not having fixed slots/competing priorities	ERF staff now trained and starting to undertake 1st appts. To be reviewed in kaizen	Reduction of Waiting List by 15%	RB/PP/AH
Volume of patients starting treatment / performance against ERF treatment target (100 in 18 months)	To be identified	To review in Kaizen event Data being validated to ensure accuracy	An additional 100 Treatment starts above last year's baseline	RB/PP/AH
Overall demand (referrals) being significantly higher than teams capacity to treat them	100% year on year increase in referrals & lack of associated funding increase	Kaizen event will review how to reduce demand Request to board to stop accepting out of area referrals and pause all referrals temporarily Request to keep ERF funded staff once proven impact / requirement	Improved alignment between demand and capacity	RB/PP/AH

Integrated Quality and Performance Report

Month 6 – 24 / 25

Metric	Waiting List Management - GIC	SRO	Chris Abbott	Target		Measure	

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

Problem Statement

The Adult GIC pathway currently has significant demand/capacity constraints, with the waiting list currently holding around 15,525 patients waiting for 1st appointment as of June 2024.

Although 112 referrals have been registered; on average the service is receiving up to 450 referrals each month which are not being registered within the 24-hour KPI due to admin challenges.

There is a high Clinical staffing vacancy, approximately 15 WTE including the ERF posts.

The service is completing approximately 70 new first appointments monthly therefore each month there is a backlog of approximately 380 patients.

Vision & Goals

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

G1. To create 'To Be' pathways for the CX clinic on the digital platform by Sept 2024

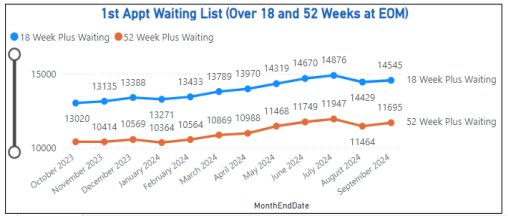
G2. Clear demand and capacity modelling for 1st appointments

G3. Increase the number of 1st appointments by fully recruiting into the establishment

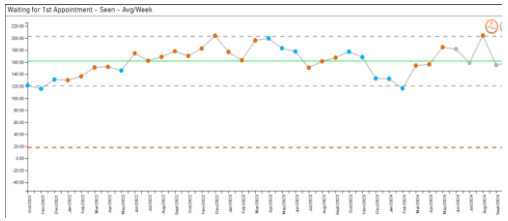
G4. For all patients over 36 months to be clinically reviewed with next steps actioned via the PTL.

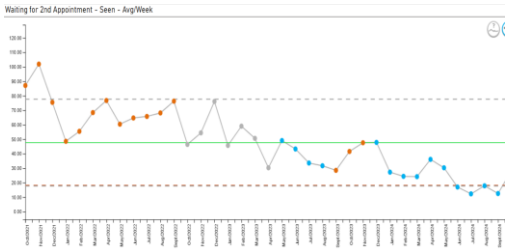
G5. To create activity v planned waiting times for 1st appt trajectories for ERF staff as well as BAU

Historical and Current Performance



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

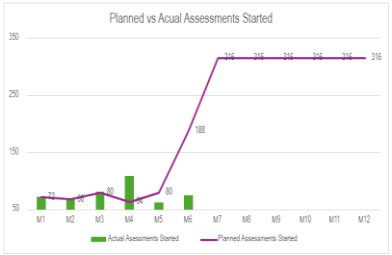




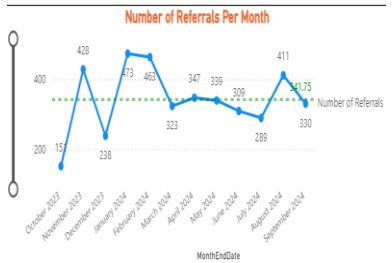
These 2 charts indicate the average time pts have waited each month for 1st and 2nd appts.

Monthly Stratified Data

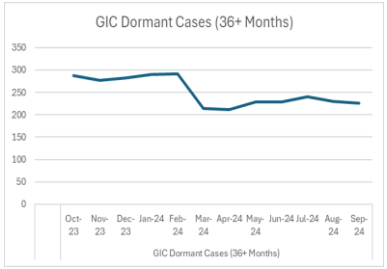
A. Planned V Actual first assessment activity



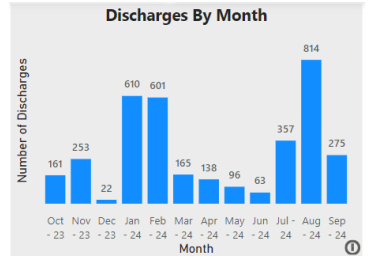
B. Number of referrals by month registered



C. PTL review of dormant cases



D. No. Of Discharges



Concern	Cause	Countermeasure	Owner and Deadline
Unclear how much clinical capacity the service has for 1st appointments for Core and CP	Job planning is not completed therefore demand and capacity modeling has not taken plan.Poor visibility on activity using Trajectories for expected planned activity vs actual service delivery	Job plans almost complete and Aaron/Nene will complete the D&C modelling including vacant posts due to be filledMap out planned 1st assessments for relevant staff and report planned vs actual activity weekly, Clear trajectories of service activity of BAU and ERF posts	AH/NU
Recruitment Challenges	Difficulties obtaining candidates with relevant skills	Review posts being readvertised and update/enact workforce plan	JB/DA/GL
Increasing waiting list with high number of long waiters	Poor engagement with long waiters	The service will complete a waiting list validation using the digital platform, texting 16,000 (with SMS consent recorded)if GIC appointment is still needed	GL/AC/JB
Low number of discharges	Lack of clarity on reduction of patients in PTL, SOP around team actioning discharge outcomes	Report PTL reviews monthly in IQPR showing discharges and patient who need appointments	GL/AC
To-Be pathway mapping	Clarity on patient pathway and impact on waiting times	Improved patient experience by redirecting non-complex patients to junior staff resulting in patients being seen quicker	JB/RJ/AC
Incremental transfers to pilot clinics	Unable to transfer to multiple pilot sites at a time as it may lead to duplication of data being shared resulting in poor patient experience	Bulk transfers completed in August. Further transfers being negotiated.	NU/Referral Team
High number of referrals on ERS system	Skeleton staff and performance issues in team and referral form mandatory fields to be reviewed.	Liaise with people team to ensure policy and procedures are being followed. Bank staff approved to support until December. Develop recovery plan to improve numbers of referrals added to CN	NU/AC

Integrated Quality and Performance Report

Month 5 - 24/25

Metric	User Experience	SRO	Clare Scott	Target	90%

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

Problem Statement

Across the Trust, since April 2023, the average monthly positive feedback percentage is 86% in service user satisfaction (ESQ/FFT) which is less than our target of 90%. This is relative to the amount of feedback that we receive which is low. The average number of monthly forms completed Trust wide was 99 and this may impact the positive feedback score significantly when the number of responses is increased. The limited feedback received is impacting on services ability to respond to people's experiences and make improvements where needed.

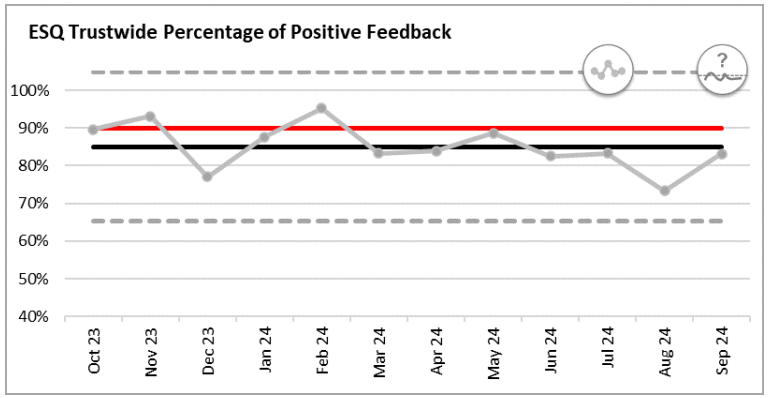
Vision & Goals

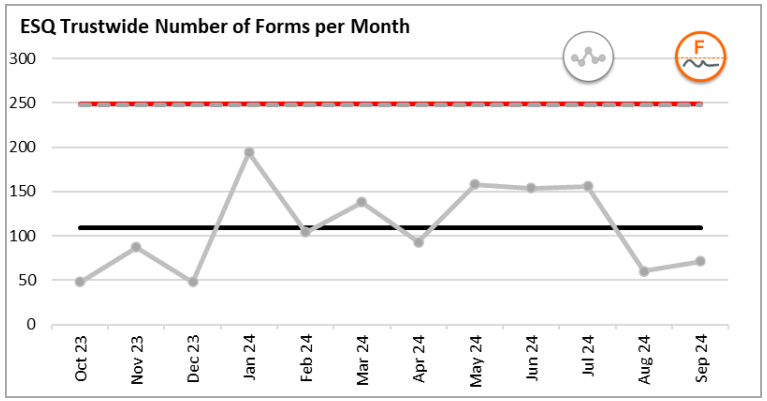
Vision: For all users to have a positive experience across the trust.

G1: Number of ESQ form rates to be monitored against benchmarks set in March 2024

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

Historical & Current Performance





- Normal data variation in data, is marked in grey.
- Significant improvement would be marked in blue.
- Deterioration or failing to meet the target is marked in amber.
- The number of forms completed includes Trust Internal ESQ and GIC PEQ forms.

Progress on Improvements

Concern	Countermeasure in progress	Owner
There isn't a standardised **ESQ form** being used Trust wide and the demographic questions need revising	• To discuss and agree if variations can remain or if a standardized ESQ is needed • Demographic questions have been agreed	Nimisha, Sonia, Marcy, Ravneet
The **collection process** for ESQs needs to be reviewed including deciding which system to use, where the feedback will be stored, whether the logic will continue to be used and what the role and responsibilities are for collection.	• Following a functionality options appraisal, Radar will be used to collect service user feedback as opposed to the current system which is Qualtrics • To work with informatics to understand how feedback will be stored on Radar • To decide whether the logic as to when an ESQ is due will continue to be followed or if we will move towards impromptu feedback only or if both methods will exist • To understand roles and responsibilities of collecting and disseminating feedback for the PPI, Quality Assurance team and Managers once the new Radar system for feedback collection is in place	Nimisha, Sonia, Marcy, Ravneet
There will be various new ways for service users to provide feedback at any time; currently, there is no **training** developed to train staff of these upcoming changes such as patient correspondence being updated to have a URL/QR code to direct them to provide feedback.	• A process map to be created to show the new processes to collect feedback • A comms strategy to be developed to help get the message out re new processes and the importance of collecting feedback	Nimisha, Sonia, Marcy, Ravneet
There is a discrepancy between when **quantitative and qualitative data** is distributed to Managers There is lack of clarity of where feedback is being discussed at team level	• We need a process where quantitative and qualitative data is efficiently sent to Managers each month in one email. • Develop a process for feedback to then be disseminated to the wider team and engage Managers to understand what this feedback loop will look like. • To have a process in place for services to show what they have done with the feedback	Nimisha, Sonia, Marcy, Ravneet
We need to develop how **impromptu feedback** can be provided.	• This includes creating ways to provide feedback on patient correspondence, paper ESQ forms, QR codes being added in patient spaces including in physical spaces via posters and digital spaces such as NCLwaitingroom	Nimisha, Sonia, Marcy, Ravneet, Comms
There are no team level **targets** for how much feedback should be received per team each month,	• We need to set team level targets to be able to monitor approximately % of feedback that should be received in each team.	Nimisha, Sonia, Marcy, Ravneet

Integrated Quality and Performance Report — Month 5 – 24/25

Metric	Outcome Measures	SRO	Chris Abbott	Target		Measure	

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

Problem Statement

The accuracy of meaningful clinical outcome data collected across all services needs improvement as inaccurate, incomplete, or missing data prevents us from demonstrating and understanding the outcomes for our patients and the impact of our clinical work.

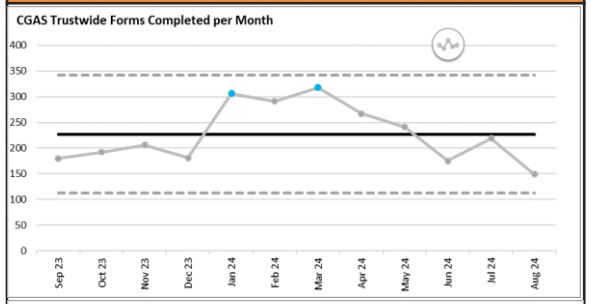
Vision & Goals

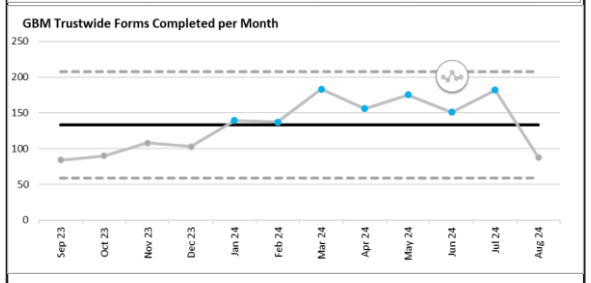
Vision: The overall vision is to ensure compliance with the new NHSE waiting time standards and have increased matched pairs of outcome measures to help us improve our services, evidence their effectiveness, and reduce health inequalities.

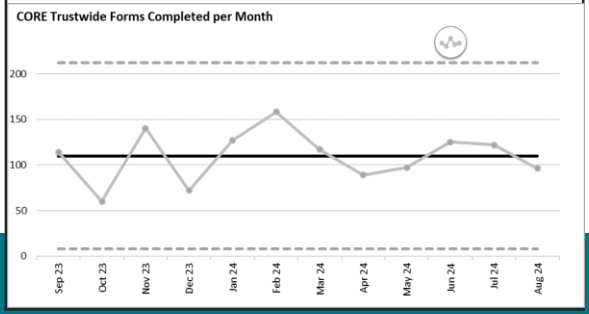
G1: Our first goal is to ensure that we begin collecting OM from a patients first appointment

G2: Our second goal is to ensure that we improve the rates of matched pairs of outcome measures to evidence improvement and clinical effectiveness

Historical Performance







Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Clinicians and teams are not aware of the need to collect Outcome Measures from the first appointment, aligned with the new NHSE waiting time metrics. **(G1)** Clinicians and teams are not collecting matched pairs of outcome measures **(G2)**	**Carenotes Changes:** Submitted a proposal to Informatics to make 10 changes to Carenotes, to make the collection of T1 and T2 easier. Some changes include: • Cleaning up the assist panel so it only shows missing OMs and removes OMs that have not been completed once an episode (intervention) has ended • Letter templates to pull through CGAS and GBM data, making it meaningful for CYP service users (sharing learning for Adults) • A text box reminder to pop up once someone opens an assessment summary, asking them to complete OMs • Enabling clinicians to save GBMs even if there is only one goal	• All changes requested to Carenotes were signed off by Change Board on the 8th of October. Informatics to agree a timeline for when changes will be made. • Comms to be designed and circulated to ensure all staff are aware of all Carenotes changes before they happen. • Set up a service user co-production group to incorporate feedback into changes	
	3 improvement pilots: to test improvements and new ideas: • Adult Psychotherapy (Introducing DIALOG) (Date TBC) • Autism and LD (Increase collection through process design / digitization) (23rd October) • First Step (Introduction GBMs in professional consultations) (21st November)	• Rachel and Luke to meet with First Step team to initial their GBM pilot. • Meet with Autism Team / Ops and Admin Manager to set up new process for collecting RCADS pre-appointment using Qualtrics. • Meet with Adult Psychotherapy team to find some power users of DIALOG to test the roll out of the new measure.	
	Training: Creation of a 3 phased training plan that will deliver improvement training at a Trust-level, Unit Level, Ops/Admin and Team Manager Level. The initial Trust-wide training discusses: • The clinical importance of collecting OMs both at first appointment and in pairs • How OMs can improve the clinical outcome for patients • How OMs can be useful at a team and organizational level • What service user voice and why they feel OMs are important • Setting out the new standardized logic for when T1 and T2 is required • Adaptations for culture, diversity and complexity • Some do's and don't of best practice	• Work in partnership with Training working group to finalise the Trust-wide training slides. • Conduct two training sessions beginning in late November early December. • During November and December engage with Service and Clinical leads to develop specific Unit level training. • Deliver Unit training in December/New Year.	

Integrated Quality and Performance Report

Month 5 - 24/ 25

Metric	EDI score	SRO	Gem Davies	Target		Measure		People Culture	Waiting Times	User Experience & Outcomes	DET, Commercial Growth and Sustainability	Merger

Problem Statement

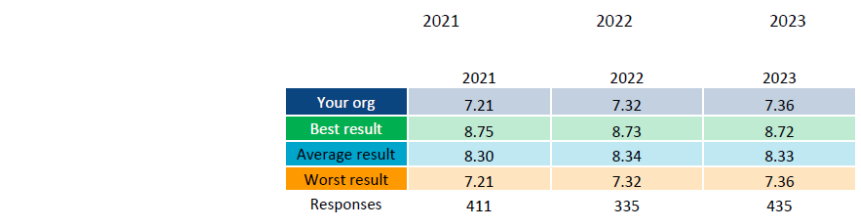
The EDI score for the Trust is amongst the lowest scores compared to our benchmark peers nationally. The score is currently (2023) 7.36, with the median score being 8.33 nationally and the best performing trusts being 8.72. If we were to meet the median score, this would improve the experiences of staff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

Vision & Goals

Vision: To consistently match or exceed the national average score

G1: Improve EDI from 7.36 to national average 8.3 by March 2025

Historical Performance



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

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

The findings from this year's WRES data are encouraging. Progress has been made in 7 of the 9 indicators, but there has been regression in two of them. Despite significant improvements made in the seven indicators this reporting year, the Trust remains positioned among weakest performing trusts nationally regarding differentials in experience and inequalities between employees from a Global Majority background and White staff.

This WDES report paints a very mixed picture:

- Enormous progress was made in 8 of the 10 WDES metrics this year: two of them were over 14 percentage points.
- However, despite these impressive improvements the Trust remains in the weakest performing category nationally.

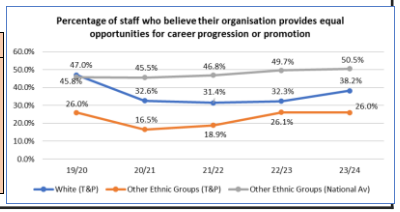
WDES Metrics	Workforce Disability Equality Standard Metrics based on 2023 Electronic Staff Record and HR recruitment database	Trend	Summary of Key Findings
Metric 1	Workforce representation (Declaration rates)	Improving	The number of staff who have shared their Disability or Long-Term Health Condition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

Root Cause/ Gap Analysis

There are a number of root causes which are the potential source of discontent at present.

- Current organisational culture
- Historical experiences of our people and resulting reluctance to apply / develop / speak up
- Behaviours, lack of appropriate response, and systemic culture
- Inherent NHS culture embedded in job advert, job design, job descriptions, pathways to success, glass ceilings and sticky floors
- Good people getting missed or overlooked for stretch assignments and opportunities as they can't be free up or are 'too good' at what they currently do

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



Progress on Improvements (subject to WRES / WDES refresh)

Desired Future State

NHS
The Tavistock and Portman
NHS Foundation Trust

- Staff committed to our values and the NHS People Promise
- People with protected characteristics being treated fairly
- Eradication of discrimination, bullying, harassment and abuse
- A culture where there are clear consequences for discrimination, bullying, harassment and abuse
- Saff with protected characteristics being prioritised in support for career progression
- A happier workforce
- A motivated workforce
- Staff feeling valued
- Understanding and appreciation of difference
- A culture in which all staff have a positive experience
- Extended goodwill
- Better communication and feedback channels

Excellence Inclusivity Compassion Respect

Integrated Quality and Performance Report

Month 5 – 24/25

Metric	Staff Experience	SRO	Gem Davies	Target		Measure	

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

Problem Statement

Staff experience across the organisation is inconsistent. We are repeatedly hearing via the staff survey that there is a disparity of treatment, career progression, and development. We need to improve the culture of the organisation and create transparent mechanisms for recruiting, retaining, developing and engaging our people.

Vision & Goals

Vision: To tangibly improve staff experience and engagement within the organisation, ultimately leading to better staff survey scores and an improved culture.

Goal 1: To achieve a 60% response rate to the next staff survey

Goal 2: To achieve at least two nominations per value for the staff appreciation scheme

Historical Performance

Key Performance Indicators	Trust Target	Apr-24	May-24	Jun-24	Trend (Against Previous Month)
Sickness Absence	3.07%	1.84%	1.79%	1.82%	↑
Turnover	2.20%	1.32%	1.85%	0.70%	↓
Vacancy	15.00%	11.98%	13.16%	13.74%	↑
Statutory and Mandatory Training	95.00%	77.08%	78.95%	80.11%	↑
Appraisal (Rolling 12 months)	95.00%	28.67%	23.21%	36.27%	↑

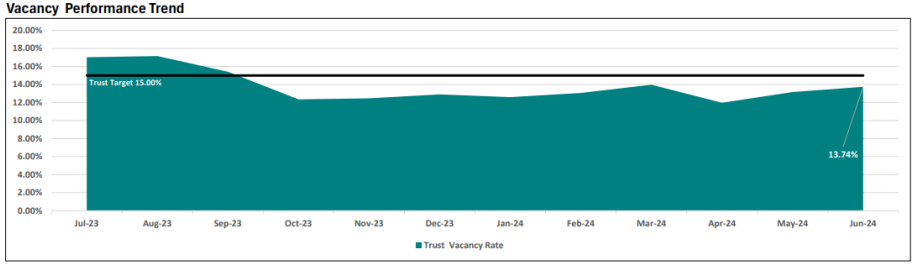
Years Service & Voluntary Turnover Rates by Years Service

Months	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Trust Overall Turnover Rate	1.51%	2.57%	1.88%	0.57%	1.07%	1.61%	2.46%	0.75%	8.32%	1.32%	1.85%	0.70%
of which are Voluntary	0.96%	0.75%	1.14%	0.50%	0.93%	1.05%	1.15%	0.61%	1.00%	1.28%	1.16%	0.48%
<1 Year	0.15%	0.30%	0.39%	0.15%	0.15%	0.29%	0.25%	0.55%	0.29%	0.16%	0.16%	0.16%
1 to 2 Years	0.30%	0.18%	0.30%	0.00	0.56%	0.09%	0.54%	0.00	0.12%	0.32%	0.32%	0.16%
2 to 5 Years	0.17%	0.15%	0.15%	0.26%	0.15%	0.55%	0.29%	0.00	0.37%	0.47%	0.24%	0.16%
5 to 10 Years	0.35%	0.12%	0.15%	0.00	0.07%	0.07%	0.00	0.06%	0.22%	0.22%	0.16%	0.00
10 to 15 Years	0.00	0.00	0.15%	0.09%	0.00	0.05%	0.07%	0.00	0.00	0.00	0.29%	0.00
15 to 20 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.11%	0.00	0.00
20 to 25 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
25 to 30 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
>=30 Years	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

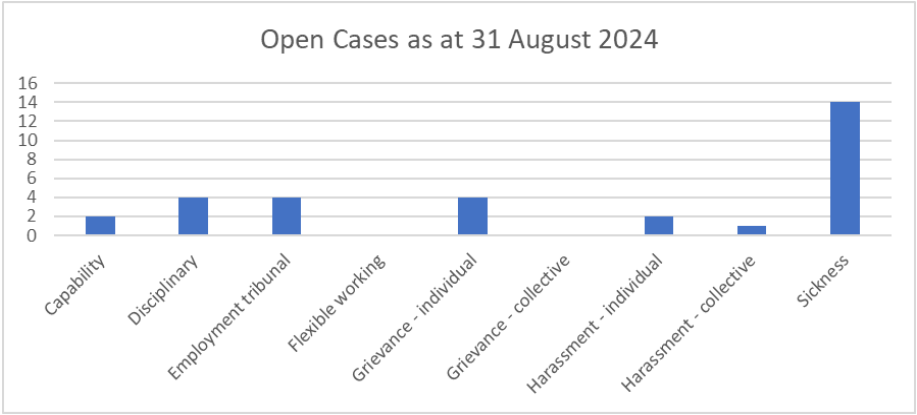
Top Sickness Absence Reasons Year on Year Comparison

	FTE Days Lost Jun-24				FTE Days Lost Jun-23			
Absence Reason	Long Term	Short Term	Grand Total	Absence Rate	Long Term	Short Term	Absence Rate	Year On Year Difference
Trust Overall Sickness	169.53	173.57	343.10	1.82%	169.20	21.60	0.95%	↑
S10 Anxiety/stress/depression/other psychiatric illnesses	48.00	0.00	48.00	0.25%	50.00	0.00	0.25%	↓
S11 Back Problems	0.00	23.00	23.00	0.12%	27.00	0.00	0.13%	↓
S12 Other musculoskeletal problems	21.40	17.80	39.20	0.21%	0.00	0.00	0.00	↑
S13 Cold, Cough, Flu - Influenza	0.00	56.10	56.10	0.30%	0.00	0.00	0.00	↑
S15 Chest & respiratory problems	0.00	11.80	11.80	0.06%	0.00	3.60	0.02%	↑

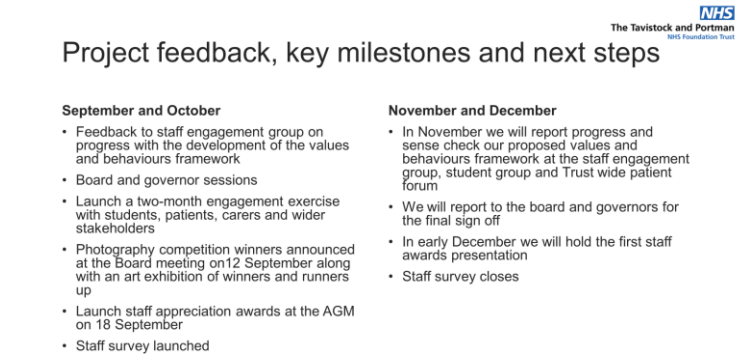
Vacancy Performance Trend



Root Cause/ Gap Analysis



Progress on Improvements



Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

Business Rules

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

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

Watch Metrics Score Card

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

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Trend from previous month	Mean	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Are we safe?	Patient safety incidents (actual or potential harm)	N/A	↓	11.25	12	18	12	10	9	8	10	4	11	13	17	11
	Open SI / PSI investigations	TBC	→	2.92	3	3	3	3	3	3	2	3	3	3	3	3
	Violence & aggression incidents	<5	↓	6.50	8	9	11	6	6	4	8	2	7	9	7	1
	Restraint incidents	0	↓	3.22	1	1	0	0	0	1	4	5	6	12	9	0
Are we effective?	52-week+ dormant cases	0	↑	2028	2473	2380	2350	2366	2266	2185	2126	2080	1922	2034	2000	2008
	No of referrals (including rejections)	919	↓	828	828	914	977	646	919	981	804	836	861	721	766	688
	No. of attendances	7046	↓	6508	6221	6485	7851	5067	6922	6927	6525	6251	7351	7437	7237	3821.5
	No. of discharges	919	↑	696.75	553	493	680	376	1024	966	943	697	397	343	723	1166
	% of Trust led cancellations	<5%	↑	4.24%	3.75%	5.04%	3.20%	5.71%	4.44%	4.06%	3.36%	4.48%	4.22%	4.04%	3.71%	4.83%
	% of DNA	<10%	↑	9.79%	9.47%	9.44%	9.00%	9.50%	9.47%	9.08%	9.15%	10.55%	9.74%	10.10%	10.54%	11.43%
Are we caring?	Number of formal Complaints received	<10	↑	5.00	7	5	7	3	5	5	2	2	6	7	4	6
	Number of compliments received		↓	98.50							81	61	203	124	67	55

Watch Metrics Score Card

The Tavistock and Portman NHS Trust

CQC Measure	Metric	Target	Trend from previous month	Mean	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Are we caring?	Number of informal (local resolution) complaints	TBC	→	1.73	0	4	1	1	0	0	4	7	2	0	0	0
	ESQ positive responses (%)	90%	↓	85.2%	90%	90%	93%	77%	87%	91%	82%	84%	89%	82%	83%	74%
Are we responsive?	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS/FirstStep	0	↓	34.08	56	58	51	54	53	38	20	26	20	17	12	4
	18-week RTT breaches Autism Assessment (1st appointment)	0	↓	82.42	30	40	50	67	77	90	98	107	111	113	104	102
	18-week RTT breaches GIC (1st appointment)	0	↑	13850.58	12792	13061	13174	13429	13298	13458	13814	14053	14365	14772	14923	15068
	18-week RTT breaches Trauma (1st appointment)	0	↑	620.00	426	449	480	517	558	607	640	689	720	752	781	821
	18-week RTT breaches PCPCS (1st appointment)	0	↑	110.67	61	48	46	70	71	80	114	150	161	181	170	176
Are we well-led?	Mand and stat training (old structure)	95%	↓	73.7%	56.3%	55.7%	75.8%	76.9%	78.0%	75.7%	76.2%	77.1%	79.0%	80.1%	80.4%	79.9%
	Appraisal completion (old structure)	95%	↑	58.3%	79.7%	78.9%	79.6%	81.5%	80.7%	80.4%	30.8%	28.7%	23.2%	36.3%	41.8%	43.0%
	Staff sickness (old structure)	3.07%	↑	2.11%	2.39%	2.23%	3.98%	3.17%	1.45%	1.61%	1.34%	1.84%	1.79%	1.82%	1.63%	2.00%
	Staff turnover (old structure)	2.20%	↑	2.0%	1.9%	0.6%	1.1%	1.5%	2.5%	0.8%	8.3%	1.3%	1.9%	0.7%	1.9%	2.3%
	Vacancy rate (On Hold) (old structure)	15%	↓	10.58%	15.41%	12.35%	12.46%	-12.90%	12.60%	13.06%	13.98%	11.98%	13.16%	13.74%	12.49%	8.29%

Delivering our vision – How are we doing?

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 11 Patient Safety Incidents in August Patient safety incidents are recorded where there was actual or potential harm. The number of patient safety incidents recorded during August remained within common cause variation; although it was noted that the reporting was down from July, the rationale being that the highest reporting area, Gloucester House School, was closed for summer holidays. The Patient Safety Team hold a daily huddle to review all incidents reported in the previous 24 hours and identify incidents where further review is needed.	**Patient safety Incidents** 11
The Trust reported 1 incidents of Violence & Aggression incidents in August The incidents of violence and aggression reported fell below the target, although this is due to Gloucester House being closed for the holidays during the reporting period and is consistent with previous school holidays. The Patient Safety team continues to work with the school to streamline how and where incidents are reported to capture this on Radar. The school also records a number of 'lower level' incidents of violence and aggression in paper format and this will move to Radar which may result in a higher number of incidents in the future. The patient Safety team are in the process of carrying out a thematic review of violence and aggression in the school.	**V&A Incidents** 1
The Trust reported 0 physical restraint Incidents in August All restraints reported for the Trust occur in Gloucester House School; during the month of August the school was closed, accounting for no incidents of restraint. Work continues with the school to move reporting of restraints from paper to the incident reporting system, making the reporting accessible and transparent; the forms are currently being created to enable this.	**Restraint Incidents** 0

Delivering our vision – How are we doing?

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

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 6 Formal Complaints in August The Trust continues to focus on investigating and responding to all overdue complaints and have reduced the number to 11 complaints overdue, with clear timeframes for responding to all 11. In total there are 23 complaints open. The Trust moved to a new complaints process and investigation template, both the old and new processes were running adjacent while the new policy was embedded. All formal complaints are now responded to on the new template which is shared with the complainant along with a response letter, this provides transparency around the investigation.	**Formal complaints 6**
The Trust has recorded 55 Compliments in August The number of compliments received continues to exceed the number of concerns or complaints received. Recording and reporting of compliments is currently under review for improvement and to ensure the logic used is accurate. This sits as part of the A3 quality improvement project focused on User Experience. The event module for Compliments in the new Radar system is now live, this will enable a strengthened reporting framework as all compliments received will be categorised. The next step is to ensure that compliments are consistently shared with teams and used for learning in the same way as complaints are.	**Compliments 55**
The Trust has recorded 74% of ESQ Positive Responses in August The positive response score was below the benchmark of 90% for August. This was reviewed with clinical services in the service user experience and feedback A3 quality improvement group and in the Integrated Quality Performance review meeting. There was a lower number of responses in August which correlates with a lower number of appointments during the summer holiday period. A smaller amount of feedback is likely to skew the scores either way if individuals are unhappy or happy with elements of their care. Further work is being done to set targets for the amount of feedback to be collected by each team. Additionally work is being progressed to ensure that teams can review the feedback comments monthly. Work is currently underway to create a QR code to provide a number of ways in which service users and carers can provide feedback with the aim of making it easier for them to provide feedback.	**Positive responses 74%**

Delivering our vision – How are we doing?

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

The Tavistock and Portman NHS Foundation Trust

The Trust declared 43.0% of Appraisal Completion in August 2024

Further to the recent change in the Trust appraisal cycle, the people team continue to work with senior leaders to improve on the Trust appraisal position. Whilst there have been some improvement in comparison to the previous month, we remain further away from the Trust target. The People Business partners will arrange targeted meetings with senior managers to agree an action plan to improve our current position.

% Appraisal completion 43.0

The Trust declared 2.0% of Staff Sickness in August 2024

The number of reported health-related absence cases has risen slightly in comparison to the previous months. The people partnering team continue to provide support to manager regarding the management of staff absence in line with the policy. Training sessions are delivered to managers to upskill knowledge and improve capability.

% Staff sickness 2.00

The Trust declared 79.1 % of MAST Completion

Managers are encouraged to provide 'protected' time for their staff to complete their outstanding MAST modules. The people team continue to escalate non-compliance through the appropriate channels for urgent action. A further drive is required to attain the expected compliance level of 95% and actions will be put in place shortly to support this.

MAST training (%) 79.1

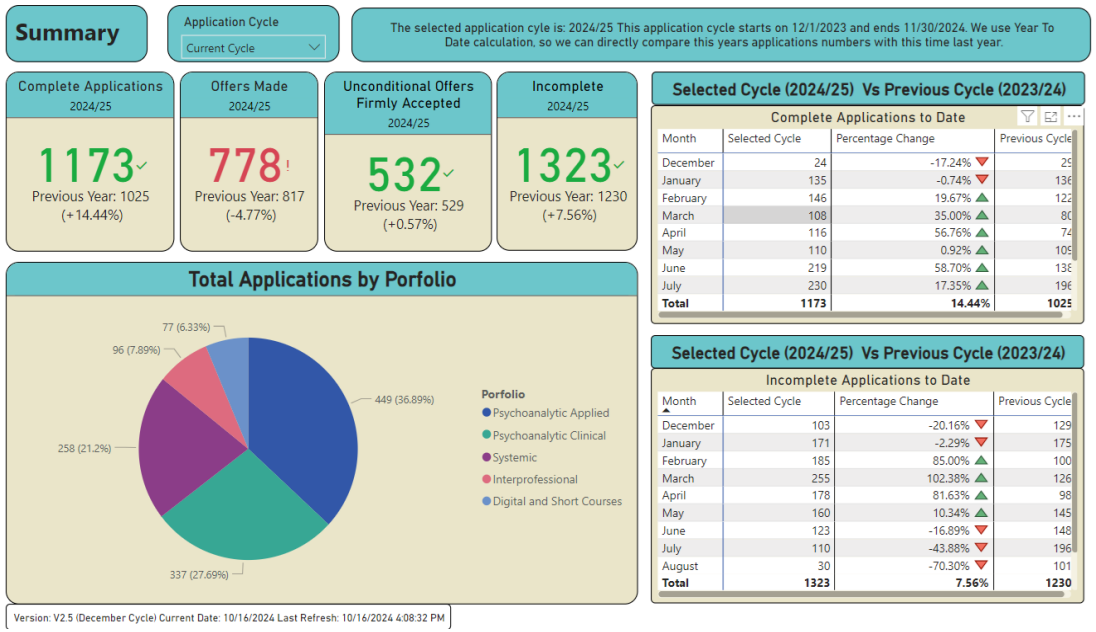
Service Line Overviews

Education & Training

The Tavistock and Portman NHS Foundation Trust

Successes	Challenges
• A standardised approach to the student recruitment and admissions cycle, including firm application deadlines for the 2024/25 cycle and an earlier recruitment opening for 25/26 (October) in line with the sector and to increase the number of expected applications.	• Whilst we have seen an increase in the number of applications from international students, we are at a disadvantaged when compared with our competitors in converting applications to acceptances owing to our small size (e.g., unable to offer student accommodation).
• 14.4% increase applications compared to the same point last year in an increasingly challenging environment for HE student recruitment	• Student support: Lack of flexibility in SITS (student monitoring system) to support a more flexible/modular form of delivery as well as ensuring data integrity; lack of staff knowledge and training in SITS operation.
• Introduction of a dedicated Project Management Officer within DET through the redeployment of experienced project management staff from NWSDU.	• To meet the increasing demands placed on the Trust – regulatory; statutory data returns; institutional conditions imposed by University partners; and the need to deliver a high student experience with increasing numbers – we require all posts in Professional Services approved at ELT and FIRM (January 2024) to be recruited well in advance of the start of the 2024/25 academic year.
• The Institutional Review Panel recommended that the Trust be re-approved as a partner institution of the University of Essex for a further five years, following the recent Institutional Review (2023).	• Our clinical psychoanalytic psychotherapy training (M1) has recruited very poorly this year and needs to be repositioned; it is currently suspended.

Student Recruitment Activity Overview



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

Complete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle
December	24	-17.24%	29
January	135	-0.74%	136
February	146	19.67%	122
March	108	35.00%	80
April	116	56.76%	74
May	110	0.92%	109
June	219	58.70%	138
July	230	17.35%	196
Total	**1173**	**14.44%**	**1025**

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

Incomplete Applications to Date

Month	Selected Cycle	Percentage Change	Previous Cycle
December	103	-20.16%	129
January	171	-2.29%	175
February	185	85.00%	100
March	255	102.38%	126
April	178	81.63%	98
May	160	10.34%	145
June	123	-16.89%	148
July	110	-43.88%	196
August	30	-70.30%	101
Total	**1323**	**7.56%**	**1230**

Analysis

Student recruitment: Postgraduate recruitment cycle is now complete: 1173 applications were received via MyTAP, an increase of 14.4% on the previous year, with 532 offers accepted (an increase of 0.6%). This figure does not include the 367 applications received via a separate portal for our M4 training in educational psychology, or the 14 applications submitted to our Executive Coaching Programme via our website.

Courses in high demand include the Introduction to counselling and psychotherapy (D12/ED12); the MA in Consulting and leading in organisations: psychodynamic and systemic approaches (D10); the consolidated Psychodynamic Psychotherapy (M58) training; and the professional doctorate in Advanced practice and research: social work and social care (D55). We are preparing to launch of several new short courses and have announced the imminent publication of a new online training in Child sexual abuse disclosure: how to support adult survivors - with over 100 people registering their interest so far.

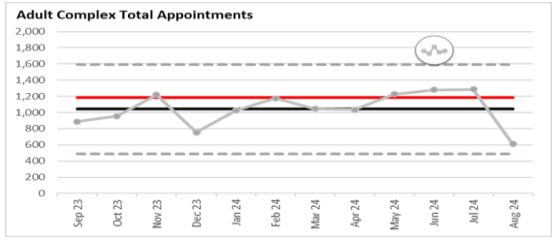
Staffing: Current Professional Services staffing, and structures fail to meet operational needs or support growth ambitions. Teams face single points of failure, posing risks to operations, finances, and Trust reputation. Academic Registry has approved 7.0 WTE new positions to meet statutory and university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

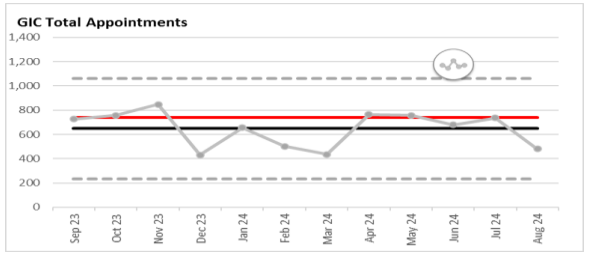
Concern	Cause	Countermeasure	Owner	Due Date
Visiting Lecturer contracts	Reliance on VLs with contractual difficulties	Move to a Senior Lecturer/Lecturer/ Associate Lecturer model; consultation with affected staff.	CETO / Directors of Education	December 2024
Regulatory changes (OfS)	Office for Students' regulatory focus on franchise/partnership model	Identify stronger institutional partnership with university partner(s) including exploration of (T)DAPs	CETO / Directors of Education	Ongoing
SITS	Our SITS (student academic monitoring) system was implemented in 2017 and in many respects has not been fit for purpose.	An external review of SITS was undertaken and reported in July 2024. Significant issues with staff knowledge and training were identified. Recruitment & training underway to address these.	Director of Education (Operations)	End October 2024

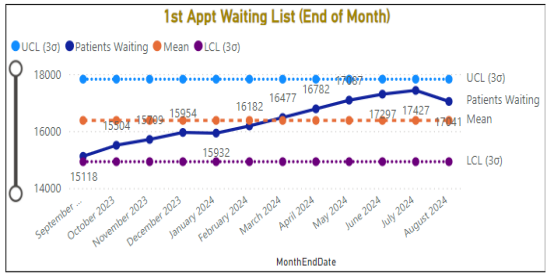
Adult Unit Overview

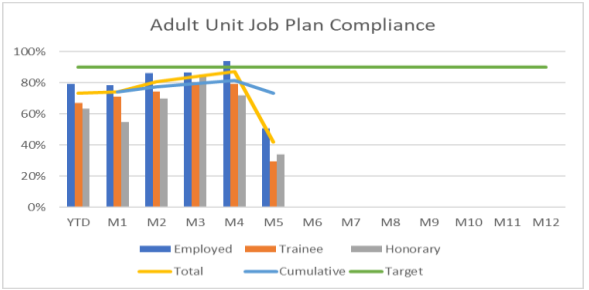
	Successes	Challenges
Safe	•Traum Keizen notably will bring co-production views on our priorities in terms of what constitutes good clinical quality and what our patients think we need to develop.	•MAST compliance is at 83% and will be a focus of the new operational team managers over the next few months
Effective	•Activity above plan in Adult Complex from May to July, with job plan compliance being above 90% in the same periods. •CORE form completion remained in line with 12 month average despite low attendances in August	• August activity very low across most services. This is to be expected given it being the peak month for leave and patient unavailability as well as students leaving or taking breaks. However, work is needed culturally to leave processes to reduce impact on capacity in future years
Caring	•User experience of the services remains high with the monthly average at just over 80% in GIC and Adult MH. •Continued progress on reducing number of outstanding complaints with 6 being closed over July & August, weekly meeting with service leads and complaints team in place since May helping keep up momentum.	•Need to switch focus on ESQ to identifying learning and establishing actions plans, that are visible to patients whilst continuing to increase methods and rates of collection as part of the A3 project
Responsive	• 0 patients waiting 18 weeks for 1st appt in Adult Psychotherapy for the first time following successful QI project • Waiting list for GIC 1st appt down by 426 in August following ~600 patients being transferred to other providers	•18w breaches continue to grow in Adult Trauma. Further investment is required & pause in accepting referrals
Well Led	• New leadership group are building relationships with staff who form a re-constituted Unit, quite different to previous structures and bringing MH and non MH services together.	•Appraisal rates at 69% in August. Operational Team Managers will prioritse following up with all new clinical line managers in Sept to ensure dates are booked and forms are submitted.

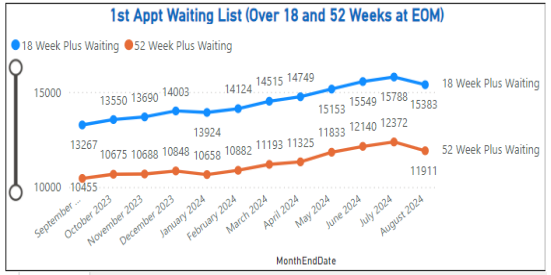
Activity Overview

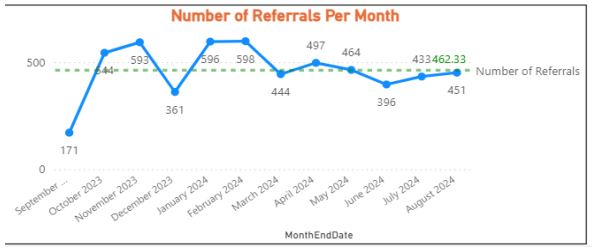












Analysis

Activity for July was above or very close to plan in all Adult Services. However, activity in August was significantly below plan across the board, which was expected due to the high volume of leave and students leaving/taking breaks**.**

Job plan compliance for the Adult Unit was at 87% in July, 42% in August and is at 74% year to date. All underperformances are being reviewed to identify the route cause(s) and action plans are created where required. These figures don't include GIC or PCPCS as the job plans are still being finalized/implemented. They will be included from M6 onwards.

Referrals for Q2 continue to be high. Rejection rates in Portman have been audited with plan being finalized to address some processes an areas of concern

Waiting times – 1st appt waiting list reduced in GIC due to ~600 patients being transferred to other providers. Waiting list continues to increase in trauma but should improve one ERF staff fully operational and when we stop out of area referrals, and pause the waiting list overall. We are pleased to report 0 18 week breaches in Adult Psychotherapy for the first time.

Attendance rates were 68% in July and 63% in August. The DNA rate was 9% for both months, patient cancellation was 16% and trust cancellation was 7% then 9%.

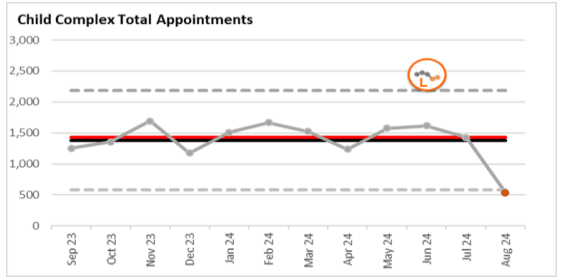
Next Steps

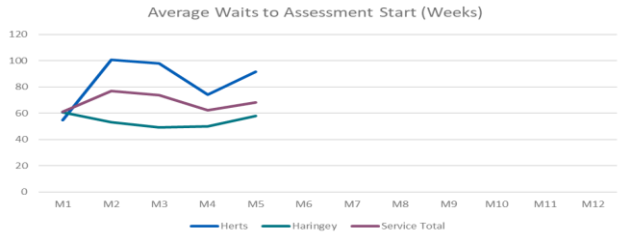
Concern	Cause	Countermeasure
Waiting list growth in Trauma	Significant increases to demand	Kaizen and A3 review of services. Commissioner engagement
Job plan performance (trainee and honorary)	TBC	

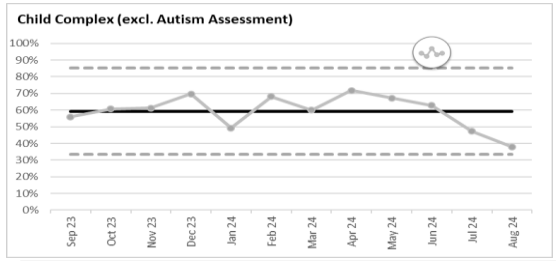
Child and Family Unit overview

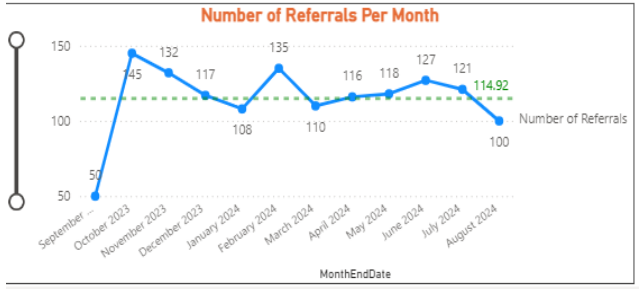
	Successes	Challenges
Safe	•No serious incidents in the reporting period. •RADAR implementation across teams with Service Line Risk Register in place, 3 Incidents open to CMH – Complex and 1 to FDAC • 4 risks currently open across Child Complex – highest at 16 for Autism Waiting List.	• Appraisal rates in the new unit are at 44.82% against a Trust target of 95%. Line managers are reporting many have been undertaken but documents still being finalized before being submitted. Q3 priority to finalise outstanding appraisals. Working with managers with backlogs to book meetings and submit forms.
Effective	• Autism A3 project has progressed against plan and has delivered 61 assessments by Month 5 with some evidence of stabilisation of numbers waiting in month 5. 1st appointment in M5 reduced to 11 weeks from 26. • Contract discussions with Hertfordshire re Autism Assessment • CGAS performance across teams at 82% • AYAS acceptance rate returned to 75% in August.	• Accurate data sets not yet available across new service line. • Improvement priority for Q3 and Q4 will be GBM • Lack of operational manager in previous Child Complex teams may lead to delays in recruitment and increased pressure on Clinical Teams Leads to carry out tasks outside of job description.
Caring	• User experience of the services remains high with an average 84% positive ESQ score over the past 12 months. • Continued progress on reducing number of outstanding complaints.	• Need to switch focus on ESQ to identifying learning and establishing actions plans, that are visible to patients
Responsive	• 45% of all cases in Child Complex seen within 4 week waiting time target • Close monitoring of Dormant cases with all cases waiting 26+ weeks in Autism Assessment	• All pathways are showing a significant reduction in activity over Month 5 including the Autism Service, this is partly due to seasonal adjustment but also to do with hight levels of sickness absence in one team.
Well Led	• Task and Finish Group implemented PTL across all teams. • PTL operating well in two teams across Complex	• CMH supervision reported compliance remains low with clinical supervision at 44% .We anticipate increased compliance when operational managers take this on post leadership review. • On going challenge with accurate budgeting across the Unit, Clinical and Service Lead work closely with Finance to complete review Q3 • Review of contract for Surrey Mindworks

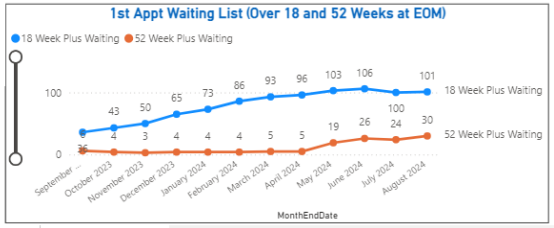
Activity Overview











Analysis

Activity - Child Complex activity in June maintained target performance in July with a seasonal reduction for August. Due to staffing issues in the EDAS service, activity is below target as well as performance on 1st appointments. recruitment underway anticipating recovery Q4.

Job plan compliance We have not been able to provide unit level data for M5 due to the changes in unit structure and staff leave. However, individual team performance is detailed in each team slide. Overall picture is one of underperformance in August.

Referrals evidence seasonal adjustment for August.

Waiting times – 45% of all cases were seen within the 4 WWT. The reduction in performance is attributable in part to EDAS and Autism waits. Monitoring through the PTL meeting in Q3. 18 week RTT data Excluding FDAC and First Step for Month 5 due to lack of validation. 1st appointment waits in Autism have reduced to 11 weeks.

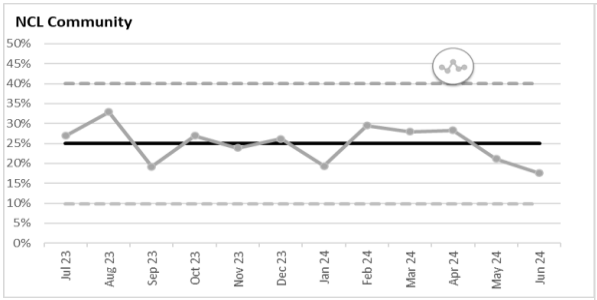
Attendance rates show seasonal decreases for August with a 10.3% DNA rate. 2.3% cancellation by Trust and 12.01% cancellation by patient.

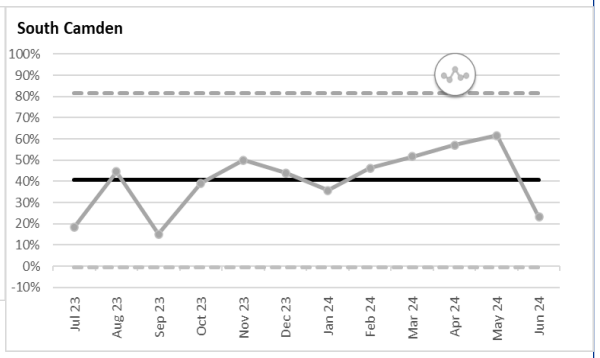
Concern	Cause	Countermeasure
Waiting list growth in Autism	Significant increases to demand	Kaizen and A3 review of services. Commissioner engagement
Job plan performance (trainee and honorary)	To be identified in June/July	To be identified in June/July
Increase in waiting times for 1st appt across Child Complex teams in July and August	Seasonal adjustment and staff vacancies	Robust management through PTL Meetings.

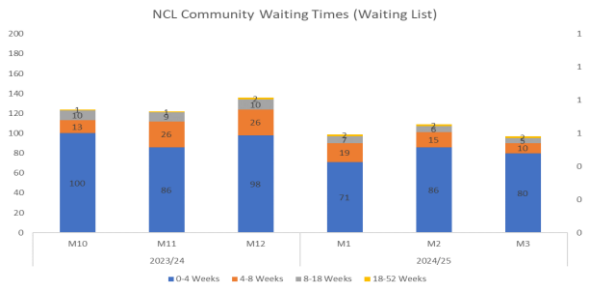
Camden Unit Update

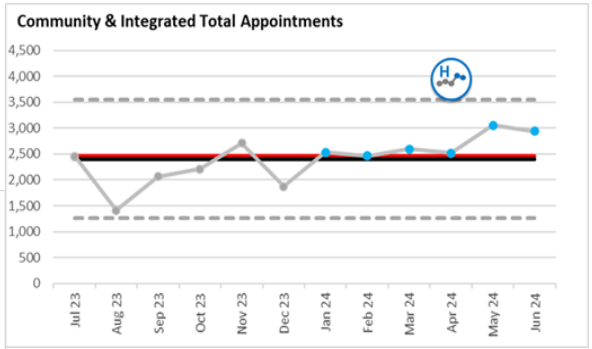
	Successes	Challenges
Safe	• The number of patients waiting for their first appointment in NCL Community has reduced and is within target for first appointments at 3.82 weeks. (4.39 the previous month).	• Vacancy rate in the service line has increased and is at 13.67%. • Recruitment challenges are causing particular issues in some teams such as WFS and CAISS and 1st Step.
Effective	• Total appointments in service line is above target. • Case Note audits by clinical leads/managers planned quarterly.	• Dormant cases require further stratification to understand more fully. In CAMHS teams risk needs to be re-visited before d/c can go ahead.
Caring	• 20 compliments received in June	• ESQ number of forms returned are low - Service User Experience A3 Working Group are working on improving numbers.
Responsive	• The NCL Community Service wait times to first appointment have reduced.	• The job planning process data has been queried by some team managers, PCPCS data affected by excel corruption • Large increase in SAR in NCL Community Service
Well Led	• Job Plan compliance in the service line stands at an overall average of 79.3%. (This is at 82.3% if we exclude CAISS where there are known significant staffing problems.)	• Considerable challenges within Gloucester House Day Unit due to a number of issues. • Concerns within WFS about impact of leadership review on relationship with the LA.

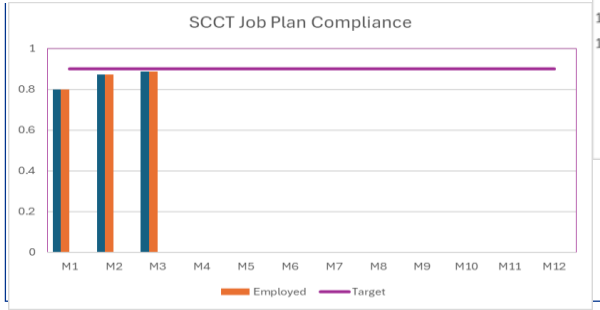
Activity Overview











Analysis

Consultation with CAISS team may be necessary to change the working hours if NCEL finalise the proposed draft specification to enhance each borough's AOT across NCL following the closure of Simmons House.

ESQ data shows high levels of positive feedback. A deep dive of the service line data capture and pathways planned.

The **job planning** process remains a challenge but average compliance against target is at 79.3% (82.3% if one excludes CAISS which has specific recruitment issues and 87% compliant if we exclude CAISS and PCPCS.) This compares to 55% overall in January. New JP template will assist hopefully as would new training.

The interim service review report for Gloucester House has been sent to ELT with 38 recommendations. Financial and service recovery plans being drafted. Estates issues being addressed this week & August.

CSMs assure that clinical **supervision** and line management is taking place but lack of returns means data on this is poor. Line management supervision returns stand at 45% (35% last month) and clinical supervision at 41% (28% last month).

Gloucester House Outreach requires urgent approval of vacant posts or we will be unable to deliver in September.

Next Steps

Concern	Cause	Countermeasure	Owner	Due Date
Job Planning data. collection unclear – job plans not being adhered to comprehensively leading to low performance figures for some staff.	Unclear process on collecting JP data. Team Managers not holding clinicians to agreed JPs.	New job planning template distributed to team managers Focus in July to Oct on JPs.	GM, AD CSM	Monthly updates to IQPR
Vacancy rate and recruitment difficulties	Unsuccessful recruitment or recruitment delays	Workforce plan completed, for some teams, in process of completion for others. Short term mitigations in place.	CSM/AD/GM	31 Aug 24
Gloucester House Day Unit service provision risks	A number of factors including staff safety issues and oversight	Daily risk updates from SLT. Review of service	AD/SSM/SLT	September

Contracts and Finance

Delivering our vision – How are we doing?

Effective use of resources

The Tavistock and Portman NHS Foundation Trust

The Trust declared £996k deficit YTD planned position for month 5, with a year end planned deficit of £2,200k.	 **24/25 YTD planned position £996k deficit**
The Trust declared £989k deficit YTD actual position for month 5, a positive variance of 7k against plan. This is a stabilisation of of the position from previous months, with planned expenditure back on target. The Trust still anticipates delivering its planned year end deficit of £2,200k. .	 **24/25 YTD actual position £989k deficit**

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (PUBLIC) – 14 November 2024

Committee:	Meeting Date	Chair	Report Author	Quorate	
Integrated Audit & Governance Committee	03 September 2024	David Levenson, Non-Executive Director	Dorothy Otite, Governance Consultant	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 9**		

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 highlighted to the Board of Directors are issues relating to the outstanding Internal audit management actions.	**Assurance rating**
1. External Audit Progress Report • Relationship with External Auditors is progressing positively. • A "Wash-up" session is planned to review the 2023/24 audit cycle and identify areas for improvement. • Importance of accountability was highlighted by the Committee and an annual private discussion with the Committee is to be planned to follow the wash-up session.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit Update • Data Security and Protection Toolkit report – further work is required to ensure alignment of the Trust's responses with evidence provided. • With regards the outstanding management actions, the Committee were re-assured that the outstanding actions would be discussed regularly at the Executive Leadership Team meetings to promote continuous improvement and better alignment.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
3. Local Counter Fraud • No significant issues were raised by RSM. • The Director of Corporate Governance highlighted the need for more focus on gifts and hospitality declarations through raising staff awareness of the policy.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Oversight of Board Assurance Framework (BAF) and Trust Risk Registers (TRR)/ Operational Risk Register • The Committee noted progress made on the BAF and the need for better alignment between the Corporate Risk Register and the BAF to ensure efficiency and streamlined processes.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Breaches of Gifts, Hospitality and Interests Policy • No breaches of the policy were reported. • The Committee requested for the Gifts, Hospitality and Interests Policy to be brought back to the next meeting following a review of the policy, to ensure it is fit for purpose.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
6. Information Governance Report	Limited ☐

• While there were no reportable IG incidents during 2023/24, the Committee noted a Training Needs Analysis was planned for 2024/25 to ensure senior managers received the appropriate training.	Partial ☒ Adequate ☐ N/A ☐
7. Cyber Security Report • No significant issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
8. Terms of Reference • Revised Terms of Reference for the Committee was agreed and recommended to Board for ratification.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Single Tender Waiver Report • No significant issues were raised. • The Committee sought assurance around the tender process to ensure proper governance and compliance arrangements are in place. The item will be brought back to the next meeting of the Committee.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
10. Overpayments/ Underpayments to Staff (Referred from PFRC) • The Committee noted measures in place to mitigate overpayment incidents including a payroll audit; and required a detailed overpayment report (redacted to protect individual's privacy) to be brought back to the Committee to ensure effective oversight.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
11. Losses and Special Payments Report • No significant issues were raised.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- Approval of the revised IAGC Committee Terms of Reference

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:

None

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

Item	Purpose	Date
Revised IAGC Terms of Reference	Approval	To Board on 14 November 2024

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Thursday, 14 November 2024			
Report Title: Review of Committee Terms of Reference 2024/25			**Agenda No.: 10**
Report Author and Job Title:	Dorothy Otite, Governance Consultant	**Lead Executive Director:**	Adewale Kadiri, Director of Corporate Governance
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 Committees for ratification following approval by the Committees.		
Background:	**Terms of Reference (ToR):** The ToR of Board Committees should be reviewed annually to ensure they are operating at maximum effectiveness; and any proposed changes presented to the Board of Directors for approval. For 2023/24, the Board of Directors approved the revised ToR of the six Committees in October 2023.		
Assessment:	All Board Committees received and approved the proposed revisions to their ToR; and made recommendations to the Board of Directors for ratification. **Cross Committee summary of key changes:** • Committees/ Groups – consistency in the use of the terms "Committees" and "Groups". For clarity, Committees of the Board are now called "Committees" and Operational Groups reporting into Board Committees are now called "Groups". • Attendance by Governors – inclusion of new clause covering attendance by nominated members of the Council of Governors as observers at Committee meetings, • Replacement of Committee 'Administrator' with Committee 'Secretary'. • Replacement of 'Forward Planner' with 'Schedule of Business'.		
Key recommendation(s):	The Board is asked to **APPROVE** the revised Terms of Reference of the six Board Committees attached as appendices 1 – 6 of this report.		
Implications:			

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	All BAF risks – as these are assigned to the Committees.		

Legal and Regulatory Implications:	Yes ☒	No ☐
	The Board of Directors established the 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: The Terms of Reference of the Committee supports the 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: The Terms of Reference of the Committee includes the Committee's appointment role by ensuring that the Trust is compliant with all relevant standards of good practice including those relating to equality, diversity, and inclusion. Education and Training Committee: 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 and Safety Committee – 24 October 2024. • People, Organisational Development, Equality, Diversity, and Inclusion Committee – 5 September and 7 November 2024. • Performance Finance and Resources Committee – 5 September and 7 November 2024. • Education and Training Committee – 3 September 2024. • Integrated Audit & Governance Committee – 3 September 2024. • Executive Appointment and Remuneration Committee – 11 July 2024.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

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:	November 2024 v 0.3
Review date:	November 2025

Education and Training Committee
Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal 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 regularly review education and training related risks within the Board Assurance Framework and the Corporate Risk Register for which the Committee is deemed to have oversight; and seek assurance that effective controls are in place to mitigate such risks.

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 of the Annual Student Survey process and enhancement of student experience.

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. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

4.5. 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:

4.6. 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 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:

4.9. 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. 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 groups (including 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 Secretary) 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 Secretary 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 Schedule of Business 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 Group
- Learning and Teaching Group
- DET Development Group
- Student Experience Group

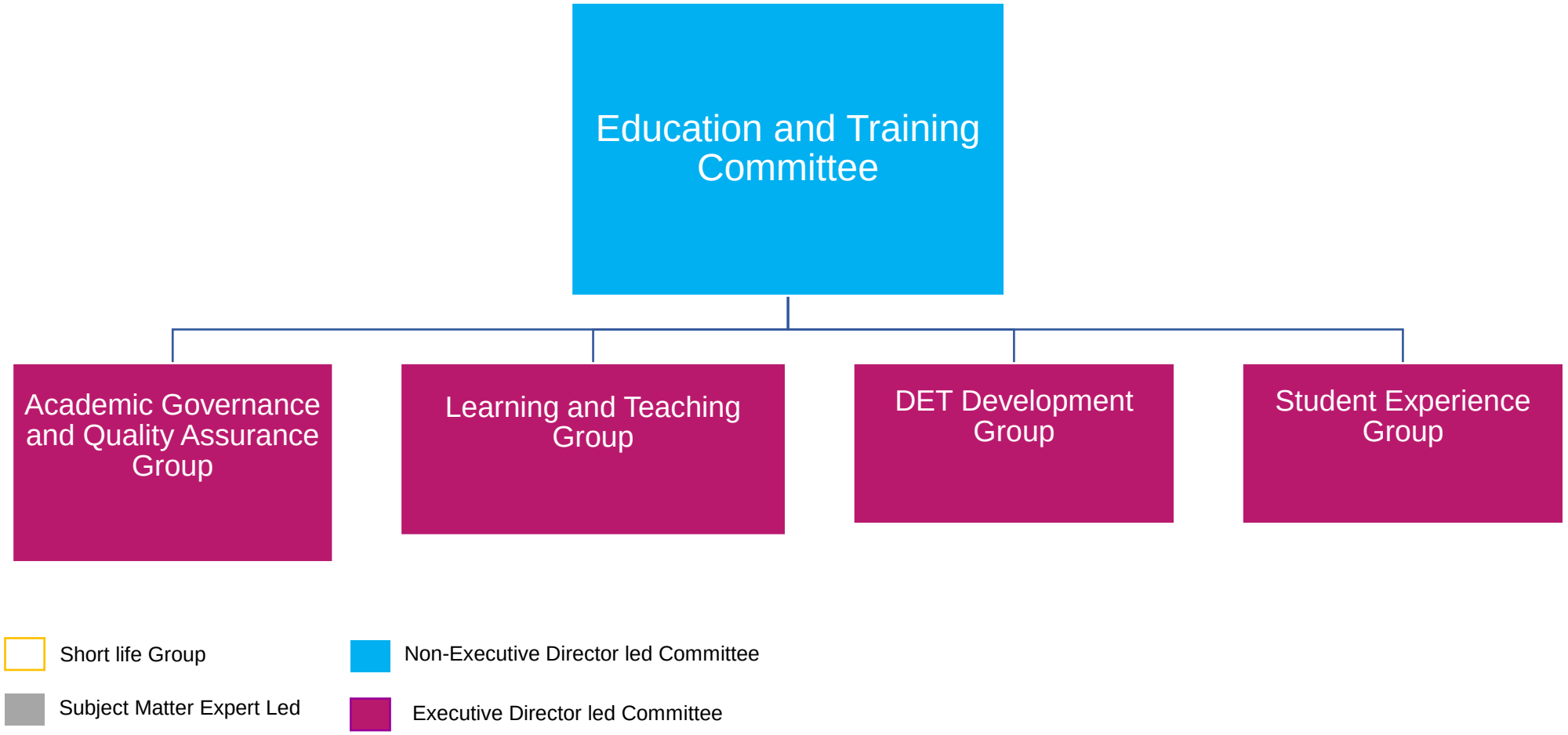
11.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

11.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board 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.

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:	November 2024 v 0.3
Review date:	November 2025

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.

3.8. Approve redundancy payments of £100,000 or more.

Appointments Role

The Committee will:

3.9. 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.

3.10. 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.

3.11. 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.

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

3.13. 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.

3.14. 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.

3.15. 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.

3.16. 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.

3.17. 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.

3.18. 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.

3.19. 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:

3.20. 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:	November 2024 v 7.0
Review date:	November 2025

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 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 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 Nursing 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
- Deputy Chief People Officer
- 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. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

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

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

Attendance:

4.7. 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.

4.8. 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.

4.9. 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

4.10. 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. GROUPS

5.1. The POD EDI Committee has the authority to establish groups (including 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 groups 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 Secretary) 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 Secretary 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 Schedule of Business 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 group meetings (see Appendices 1 and 2 for the POD EDI Governance Structure charts):

- EDI Programme Board
- People Delivery Group

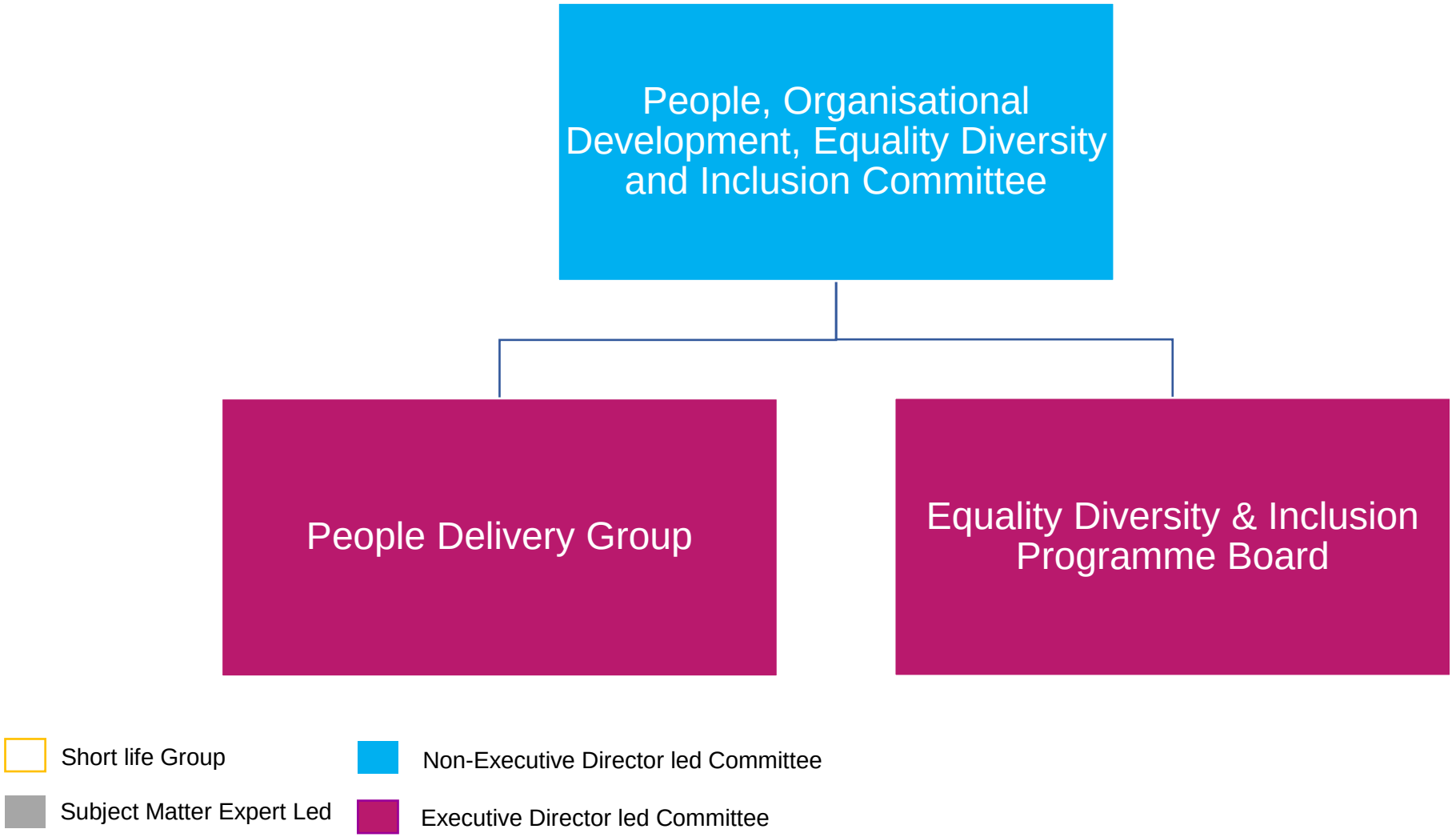
13.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

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

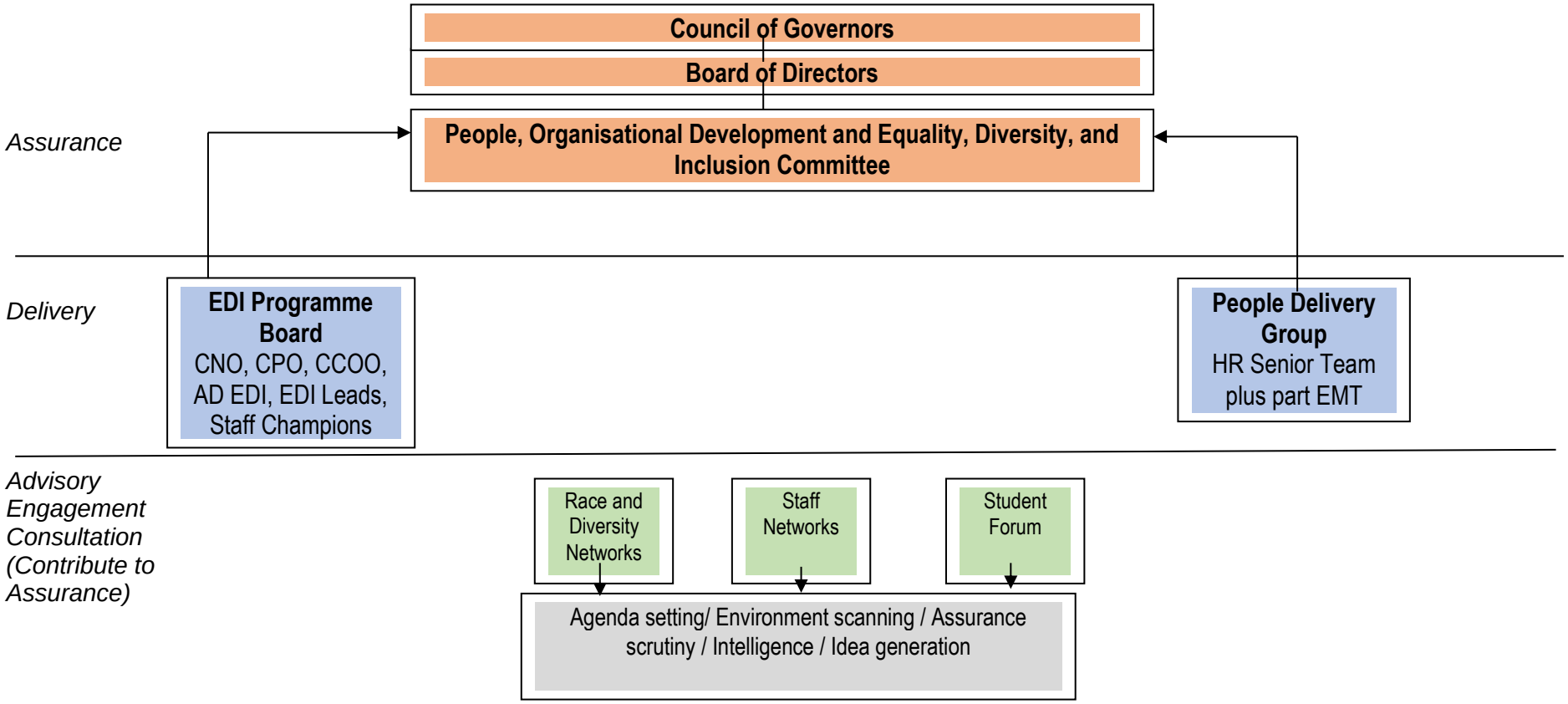
14. MONITORING EFFECTIVENESS AND REVIEW

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.

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 / Director of Strategy and Business Development
Date issued:	November 2024 v 3.0
Review date:	November 2025

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 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)
- 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
- Director of Education (Operations)
- Deputy Chief Finance Officer

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 will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

5.6. 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.

5.7. Attendees hold no voting rights.

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

Attendance:

5.9. 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:

5.10. 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 three members, to include at least two Non-Executive and at least one Executive Director 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 groups (including 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 Secretary) 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 Schedule of Business 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 group meetings (see Appendix 1 for the Committee's Governance Structure chart).

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

11.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board 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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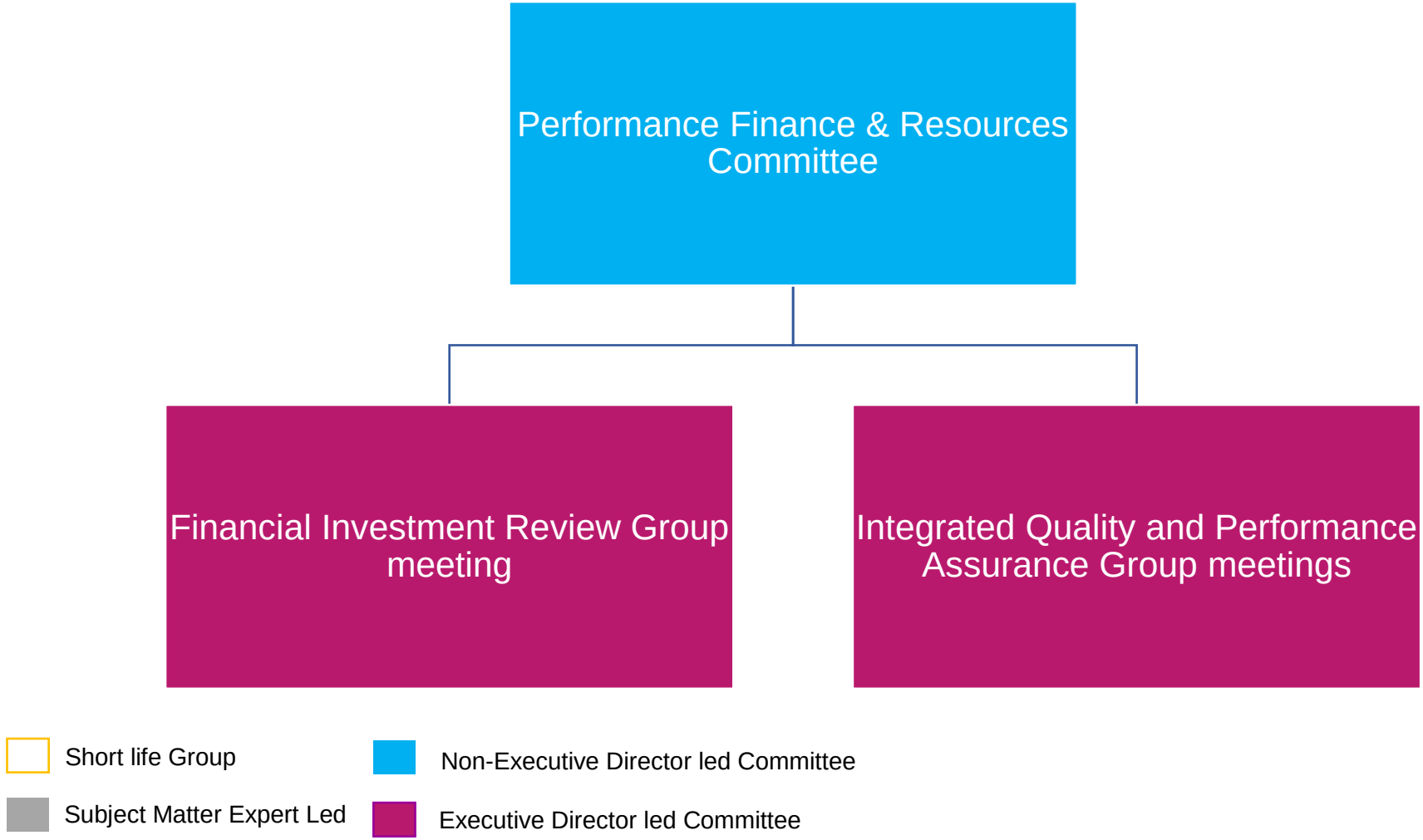
Appendix 1 – Performance, Finance and Resources Committee Governance Structure



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:	November 2024 v 8.1
Review date:	November 2025

Integrated Audit and Governance Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("**Board**") hereby resolves to establish a formal 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. Partnerships / Joint ventures

3.6.1. 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.

4.8. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

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 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 groups (including 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 Secretary) 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 Schedule of Business 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 groups. The Committee does not currently have any groups in its Governance structure.

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

10.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board 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

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:	November 2024 v 0.3
Review date:	November 2025

Quality and Safety Committee

Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors ("Board") hereby resolves to establish a formal 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 Integrated Audit and Governance 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 (Executive Lead)
c) 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
- Medical Director
- Associate Director of Quality
- Associate Director of Nursing
- Director of Therapies

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. The Committee will be open to nominated members of the Council of Governors attending meetings as observers. While not members of the Committee, they will be given an opportunity to provide feedback at the end of meetings.

4.5. 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.

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

Attendance:

4.7. 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.

4.8. 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).

4.9. 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:

4.10. 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 three members, to include two Non-Executive and one Executive Director 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 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 Secretary) 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 Schedule of Business 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 groups (see Appendix 1 for the Committee Governance structure chart).

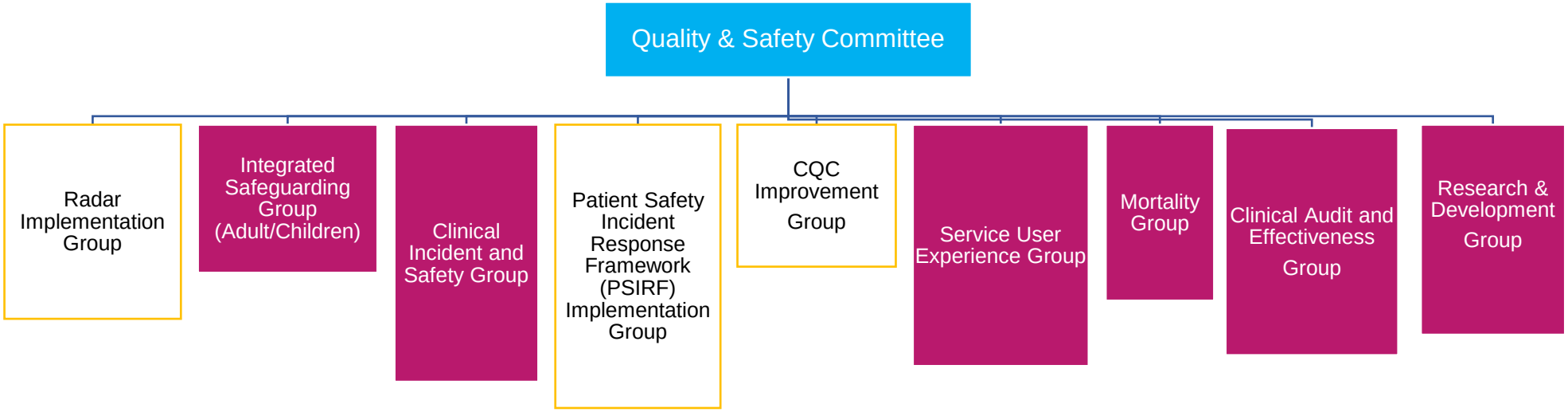
10.2. The Committee will receive escalations from other Board committees in relation to matters identified at these meetings within its terms of reference.

10.3. The Committee will escalate matters to other Board committees in relation to matters identified in its meeting within other Board 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 - Quality & Safety Committee Governance structure



Short life Group

Subject Matter Expert Led

Non-Executive Director led Committee

Executive Director led Committee

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	24th October 2024	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 11**		

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. Quality & Safety Report The Committee noted the further reduction of complaints that are open and overdue (23 and 11 respectively as of the end of September 2024), and the positive work with teams which has led to a significant difference in the quality and compassion of complaint responses. The Trust's first Patient Safety Incident Investigation (PSII) was commissioned in April 2024 and signed off by Trust Board in September 2024. Since then, the coronial inquest has been held, with the coroner commenting positively on the quality of our investigation and PSII report. The action and learning from the recommendations will be monitored by the Clinical Incident & Safety Group. The Committee considered the NHSE national review of adult gender clinics and learned about the outcome of the Trust's internal 'mock inspection' of our Gender Identity Clinic (GIC) service in preparation for this. It was noted that the mock inspection was a positive, well-received and open process, with service users whose perceptive contributions were particularly helpful and appropriately challenging. The Committee stressed the importance of robust public feedback and consultation as part of the review of the national service and thanked all involved for the hard work. An update on the mock inspection report and recommendations will be presented to the Committee at its December 2024 meeting.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Clinical Audit Plan 2024/25 The Committee noted that compliance against the audit plan is currently behind schedule. However, with the recent launch of the Radar module, (Local Risk Management System) the Audit team are optimistic of	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

catching up on outstanding audits by the end of the year. The implementation of this new module is anticipated to streamline processes, although there are challenges that need to be addressed including training and engagement with the new system and approach. A concerted effort is being made to ensure all staff are familiar with the procedures for conducting audits, especially in using the new system, but behind this the Trust is embarking on a plan which encompasses a communication with front line teams to raise awareness and encourage engagement in taking part in clinical audits.	
3. Patient and Public Involvement (PPI) Team Annual Plan The progress against the annual plan was presented. The Committee noted that there was a lack of progress overall. The development of a service user engagement and involvement reimbursement policy, along with relevant standard operating procedures is being prioritized. Verbal assurance was provided to the Committee about the welcome shift underway, to involve current service users in the PPI register rather than only former patients, with a broadening of the types of roles they are taking up. A recovery plan is now in place to mitigate against further delays in delivering the objectives. A positive area of improvement was noted that the number of service users involved in PPI since the start of year has doubled to 30. There is a plan in place to further increase engagement and ensure that the service users recruited are representative of the populations the Trust serves.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Infection Prevention and Control (IPC) Six Month update The Committee received the six-monthly IPC report which included a summary of the gaps identified through the National Infection Prevention Control Board Assurance Framework. The Trust now have a senior Infection Prevention and Control lead Nurse from Moorfields Eye Hospital working with us to incorporate preventative IPC actions which brings an improvement in the effectiveness of the Trust's IPC arrangements. The BAF document consist of 54 KLOEs • 29 deemed not to be applicable to the Trust • 10 assessed as green (fully compliant) • 14 assessed as yellow (partial compliant) • 1 assessed as red (non-compliant). This area relates to food hygiene training for Gloucester House staff and is being addressed as a matter of urgency. There is a deadline set for the end of the October 2024 for a resolution or plans put in place to reach compliance. Teams are coordinating with Estates and Facilities to achieve full compliance, particularly for improvements related to hygiene and infection control across various sites.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Update Report on DrDoctor Implementation (Patient Portal) The Committee received an update on the new patient portal procured for the GIC which is designed as a centralised information source for patients, including appointment reminders, clinical letters, digital assessments, explainer videos, and signposting to additional resources. The portal will integrate with the NHS app, which currently includes primarily acute trusts,	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

positioning the Trust as a leader in mental health digital access. It was noted that the Trust is the first mental health trust to have seized the opportunities DrDoctor presents and are taking part in an NHS England bidding round for further funding to extend the system Trustwide. The implementation is proceeding as planned although about 4 weeks behind the scheduled plan due to the impact of summer holidays absences.	
6. Trust Response to National Reviews The paper was received and approved for onward reporting to the Trust Board in November 2024. The paper notes a number of common themes reported by staff following engagement sessions about the outcomes of the national reviews. An improvement plan will be devised for oversight of the internal recommendations to address the themes. Updates to the improvement plan will be presented to the Committee on a quarterly basis.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the reduction of BAF risk 2 from a current score of 16 to 12 (Likelihood: 3, Consequence: 4).

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:

To review Terms of Reference virtually due to issue with circulation of full paper pack ahead of the Committee.

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

Item	Purpose	Date
Terms of Reference (following virtual review by Committee)	Approval	14/11/2024

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Learning from Deaths Report			**Agenda No.: 12**
Report Author and Job Title:	Dr C McKenna, Deputy Chief Medical Officer (DCMO)	**Lead Executive Director:**	Dr Chris Abbott, CMO
Appendices:	Appendix 1: Mortality data for the past 3 years		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	This paper provides information on deaths during the year 2023/24 of patients known to the Trust or where death occurred within six months of discharge. Deaths that occurred on waiting lists where patients had not yet been seen by Trust services are also reported. Overarching themes from mortality reviews are highlighted.		
Background:	The Tavistock and Portman NHS Foundation Trust (The Trust) is committed to accurately monitoring, reporting, reviewing and where appropriate investigating deaths of patients known or recently known to the service and on waiting lists for Trust services. The main purpose is to ensure that any issues identified are addressed in order to improve patient safety and quality of care outcomes and to highlight good practice.		
Assessment:	Appendix 1 gives details of deaths in the Trust for the years 2021/22, 2022/2023 and 2023/24. During the year 2023/24 there were 20 deaths where the deceased had had at least one attended appointment or death had occurred within 6 months of the last appointment. During the year 2023/24 there were 23 deaths where the deceased was on the waiting list for Trust services. The cause of death is as yet unknown in a significant number of cases and this gap in information is discussed further. It is clear from mortality audits that where the cause of death is known a significant number of people died from expected or unexpected natural causes. It also seems more likely that the cause of death in people aged 18-25 years is from unnatural causes.		
Key recommendation(s):	The Board is asked to review and **DISCUSS** this report; and note: • The Trust should continue the work to ascertain cause of death for all people who were connected with Trust services and a report on identified causes of death should be presented to the Board each year. • The harm review process for people on waiting lists for Trust specialist services should be continually prioritised.		
Implications:			
Strategic Ambitions:			

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☐	Caring ☒	Responsive ☐	Well-led ☐
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF Risk 2: Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust must respond promptly to requests from Coroners Officers for witness statements and to attend Coroner's inquests. There may be legal and regulatory implications related to Prevention of Future Death Reports (Regulation 28).				
Resource Implications:	Yes ☒	No ☐			
	It is likely that there are resource implications in relation to measures to reduce the length of waiting lists in several of the Trust specialist services – Adut Gender Service, Adult Trauma Service, ASD Service.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Timely access to some of the Trust services is not available to a significant number of people due to long waiting lists and as evidenced in this report deaths from a range of causes have occurred on Trust waiting lists. The Trust is actively seeking solutions to this issue but recognises the distress this causes to people seeking services and to their families.				
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 the first version of this report.				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Report Title: Learning from Deaths Report

1. Purpose of the report

1.1. The aim of the report is to update the Trust Board on mortality data for 2023/24 and on learning from deaths.

2. Background

2.1 The Trust supports a learning culture in relation to deaths of patients known to services or on waiting lists for Trust services. The Trust is committed to accurately monitoring, reviewing, and understanding mortality to improve patient safety and quality of care and to highlight good practice. This approach is underpinned by guidance, reports and strategy published over the last several years and includes National Guidance on Learning from Deaths (National Quality Board 2017 ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk), NHS England's Serious Incident Framework (2015), CQC Review – Learning, candour and accountability (20161213-learning-candour-accountability-full-report.pdf (cqc.org.uk)) and the NHS Patient Safety Strategy 2019 (NHS England » The NHS Patient Safety Strategy). In 2023, the Patient Safety Incident Response Framework (PSIRF) replaced the Serous Incident Framework of 2015(NHS England » Patient Safety Incident Response Framework).

2.2 The Trust also seeks to monitor current national data on the relationship between health inequalities, provision of health care and population morbidity and mortality (www.ons.gov.uk).

2.3 The Trust seeks to work with families/carers of patients who have died and recognises the importance of their insights to improve services and learn lessons.

2.4 The Trust has a system to identify, and record known deaths of service users and of those on waiting list for services on the Trust electronic patient record system.

2.5 All deaths (open, waiting list, deceased within 6 months of case closure) are reported as incidents and reviewed including those deaths where the Trust is not the main care provider. Deaths are reported irrespective of cause of death, if known.

2.6 Deaths of patients discharged i.e. if care provided in the last six months prior to death, are reported as incidents and investigated where appropriate.

3. Assessment

3.1 Demographic Batch Service Trace is a national system which allows the Trust to check patients who have an electronic patient record with the Trust against the NHS Spine to see if any are marked deceased on the Spine. The trace report shows any changes to patient details such as date of death. The Trust runs a report three times per week.

3.2 All deaths are logged on the Trust management and reporting system (recent system change in June 2024 following procurement process). A safety huddle takes place each day (Monday-Friday) and in the event of a death, relevant clinical staff are

alerted, and a request is made to a senior clinician to complete a mortality review and to consider duty of candour. Subsequently, if indicated, a Patient Safety Incident Investigation (PSII) or After-Action Review (AAR) is commissioned.

3.3 Mortality reviews are completed in all cases and subsequently reviewed and discussed at the monthly Clinical Incident and Safety Group meeting.

3.4 The Trust Patient Safety Partners attend the Clinical Incident and Safety Group monthly meeting.

3.5 The clinician completing the mortality review attempts to ascertain the cause of death usually by contacting the GP and/or if indicated a Coroner's Officer.

3.6 However, as some of the Trust specialist services have a national remit and without knowing where a death occurred, it may not be possible for the Trust to liaise with a Coroner's officer, or it may not be known if it is relevant to liaise with a Coroner's Officer.

3.7 Attempts are consistently made by clinicians over an extended period to ascertain information on cause of death. Despite these efforts the cause of death is as yet unknown in a significant number of deaths reported during 2023/24 (open cases and waiting lists).

3.8 The cause of death may subsequently be confirmed at Coroner's inquest.

3.9 The data reported here is crude mortality which gives a contemporaneous view of mortality data across the Trust but cannot give a risk adjusted view.

3.10 Until more information is available about cause of death it is not possible to relate the findings to population data.

3.11 A significant number of deaths which occurred during 2023/24 where cause is now known were due to expected or unexpected natural causes, for example, cancer and cardiovascular disease.

3.12 It also seems more likely that the cause of death in people aged 18-25 years is from unnatural causes.

3.13 Unnatural unexpected deaths include those that potentially meet priorities within the Patient Safety Incident Framework including likely suicide, trauma, drug overdose.

3.14 Apparent suicides will be reported on separately once further information is available.

3.15 No deaths reported in the year 2023/24 were of people with a known learning disability.

3.16 During the year 2023/24, there were 20 deaths where the deceased had had at least one attended appointment or death had occurred within 6 months of the last appointment. (Appendix 1).

3.17 During the year 2023/24 there were 23 deaths where the deceased was on the waiting list for Trust services (Appendix 1).

3.18 During 2023/24 no deaths were declared as Serious Incidents and reported on StEIS. However, the Trust liaised with other organisations reporting a death as a serious incident and where the patient was also known to Trust services.

4. Coroner's Inquests

4.1 During the year 2023/24. the Trust received notifications of inquests related to deaths of patients open to Trust services and/or on the waiting list for Trust services. Where requested Trust clinicians provided witness statements and attended the Coroner's Court.

5. Prevention of Future Deaths

5.1 The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths.

5.2 The Trust received one Regulation 28 Report during the year 2023/2024 (and one Regulation 28 report in the preceding year 2022/2023). Both Regulation 28 Reports related to deaths of patients on the waiting list for the Adult Gender Clinic and highlighted the lack of provision of mental health care for those on the waiting list for gender services, the length of the waiting list and possible relationship to unnatural death and delays in accessing gender affirming care.

5.3 The Trust has an active Quality Improvement programme within the Adult Gender Clinic and the Trust is working closely with NHS England (NHSE) in relation to the planned review of Adult Gender Dysphoria Clinics (Autumn 2024).

5.4 The Trust is working with NHSE and other providers to develop and progress innovative way of reducing waiting lists including development of new triage and peer support roles.

5.5 The Trust has employed a new nursing team within GIC and they will be triaging all new referrals into the service, assessing for evidence of mental health concerns or neurodiversity and they will be taking appropriate action to ensure the right support is in place.

6. Medical Examiner System

6.1 Since 9 September 2024, all deaths in England and Wales are independently reviewed without exception, either by a medical examiner (a senior doctor who provides independent scrutiny of deaths not taken at the outset for coroner investigation) or a coroner. Medical examiners carry out a proportionate review of medical records and speak with doctors completing the Medical Certificate of Cause of Death.

6.2 The Trust (Tavistock and Portman NHS Foundation Trust) medical practitioners do not sign the Medical Certificate of Cause of Death (MCCD).

6.3 The Trust will work with Medical Examiners in the way that is deemed most appropriate in consultation with the Medical Examiner's Office.

7. Key learning from Mortality Reports

7.1 There is a lack of complete information on cause of death and difficulty accessing this information.

7.2 Mortality reviews suggest that people who died had complex mental and physical health co-morbidities and social stressors.

7.3 There has been learning for the Trust about the way assessments and risk assessments are recorded, about the lack of clinician time to manage complex situations, and about the integration of information from various sources and the need for liaison with other services.

7.4 In relation to patients attending or on the waiting list for the Trust national or specialist services, the information available cannot provide answers to queries about the rate of natural or unnatural deaths – i.e. if the rates are the same/higher/lower/ than in the general population and/or if the rates of natural/unnatural deaths are the same/higher/lower in particular age groups compared to those age groups in the general population.

7.5 There may be an assumption that deaths from unnatural causes are more likely on a waiting list. This may not be correct. However, in order to understand more fully what is happening to those on waiting lists particularly where the waiting time to be seen is lengthy the Trust must continue to work with GPs, Coroners Officers and if appropriate with families to establish cause of death even if this takes additional resources and time.

8. Recommendations

8.1 The Trust should continue the work to ascertain cause of death for all people who were connected with Trust services during 2023/24 and subsequent years. This may take additional time and resource, but the Trust is committed to this work in order to continue to build a comprehensive narrative about cause of death.

8.2 A detailed reported on identified causes of death should be presented to Trust Board each year.

8.3 The harm review process for people on waiting lists for Trust specialist services should be continually prioritised. Further development of the triage model should be tested and rolled out to other services with significant waiting times.

8.4 Services should continue to review the learning from incidents that has been highlighted in this report and ensure learning is disseminated across the Trust so that action plans can be put in place where relevant and a review process of the impact of these actions can be carried out.

8.5 The Trust must continue to actively seek to reduce waiting list times.

9. Conclusion

9.1 The Trust is developing innovative ways of reducing waiting lists and providing support to those on waiting lists.

9.2 The Trust will continue to work with Coroners, Medical Examiners, GPs, other Trusts and with families in order to seek relevant information.

9.3 The Board is asked to consider the data presented in this report and to note the work that is continuing to improve processes particularly in relation to ascertaining causes of death.

Appendix 1: Mortality Data

Deceased and open (at least one attended appointment and deceased date is on or before referral discharge date)

Table 1: All Ages

Year	2021/2022	2022/2023	2023/2024
Number of deaths	17	22	19

Table 2: Under 25 years old on deceased date

Year	2021/2022	2022/2023	2023/2024
Number of deaths	4	2	1

Deceased and on waiting list (had not attended appointment and deceased date is on or before referral discharge/rejected date

Table 3: All Ages

Year	2021/2022	2022/2023	2023/2024
Number of deaths	20	30	23

Table 4: Under 25 years old on deceased date

Year	2021/2022	2022/2023	2023/2024
Number of deaths	6	7	4

Closed and death within 6 months of last appointment (Deceased date is after referral discharge date, at least one attended appointment and last attended appointment date is within 6 months of deceased date)

Table 5: All Ages

Year	2021/2022	2022/2023	2023/2024
Number of deaths	1	1	1

Table 6: Under 25 years old on deceased date

None

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Learning from the Cass Review of Gender Identity Service for Children and Young People			**Agenda No.: 13**
Report Author and Job Title:	Dr Chris Abbott, Chief Medical Officer	**Lead Executive Director:**	Dr Chris Abbott, Chief Medical Officer
Appendices:	Appendix 1 – Cass Review Recommendations		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	The Cass Review makes 32 recommendations and many of these are relevant to services the Trust currently provide and so the learning points must be considered.		
Background:	The Cass Review report was published in April 2024 and the Gender Identity Development Service (GIDS) was brought to a managed close by NHS England (NHSE) at the end of March 2024, just prior to publication of the report. Up to that time GIDS was the only specialist service for children and young people in England, Wales and Northern Ireland.		
Assessment:	The Trust is committed to providing high quality, safe and evidence-based interventions. A number of the recommendations made by Dr Cass can be generalised to the services we currently provide.		
Key recommendation(s):	The Board is asked to consider the recommendations from the review and **DISCUSS** the actions being taken/ planned by the Trust to address these.		

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☐
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF Risk 2: Failure to provide consistent high-quality care				
Legal and Regulatory Implications:	Yes ☐	No ☐			
Resource Implications:	Yes ☒	No ☐			
	Consideration regarding staffing skill mix, research staff and new models of care delivery.				
	Yes ☒	No ☐			

Equality, Diversity and Inclusion (EDI) implications:	Equality in access to care			
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

Report Title: Learning from the Cass Review of Gender Identity Service for Children and Young People

1. Background

1.1 The Cass Review report was published in April 2024 and the Gender Identity Development Service (GIDS) was brought to a managed close by NHS England (NHSE) at the end of March 2024, just prior to publication of the report. Up to that time GIDS was the only specialist service for children and young people in England, Wales and Northern Ireland.

1.2 The Review makes 32 recommendations, (see Appendix 1) and the Trust would agree with much of what is recommended. An NHSE document outlining the steps taken to implement the recommendations of the Review was recently published in August 2024.[2] Prior to this the NHSE interim service specification for specialist gender incongruence services for children and young people was published in June 2023 (updated in March 2024)[3]

2. Integrated holistic multi-disciplinary approach

2.1 The Trust fully supports the integrated holistic multi-disciplinary approach recommended in both the Review and the NHSE interim service specification and would agree that there is no 'one size fits all approach' to care rather that each individual requires a 'holistic assessment' and 'personalised care plan'.

2.2 All Trust services should provide a holistic approach to care and the context of people's lives, and their lived experience must be included within a personalised narrative.

2.3 In the Trust services, particularly, the Adult Gender Service, the importance of the knowledge, skills and expertise held within a multidisciplinary framework must remain central to the clinical work and there should not be a focus on one particular discipline over another. The impact of co-occurring mental and physical health needs and neurodevelopmental needs should be considered at every point in the pathway of care:

- 2.3.1 *A holistic assessment of needs to inform an individualized care plan*
- 2.3.2 *Recommend screening for neurodevelopmental conditions, including autism spectrum disorder and a mental health assessment*
- 2.3.3 *Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress from gender incongruence and cooccurring conditions* (Review Recommendations)

2.4 While recognising the pressure on services with long waiting lists there is a need to ensure that there is sufficient time for assessment in order to robustly integrate the patient voice and multidisciplinary perspectives prior to consideration of the treatment pathway.

2.5 For all Trust services there should be ongoing training and development to ensure that staff/teams have the necessary range of skills to manage complex presentations.

3. Working across the system

3.1 The Review highlights the importance of working across networks. Networked relationships can help to avoid working in silos leading to unhelpful decision making

and lack of reflective thinking. The Trust must continue to take opportunities to work across Trust boundaries and to fully understand gaps, needs and opportunities.

4. Transition to Adult Services

4.1 Transition to Adult Services is highlighted as a key challenge in the Review particularly the risk that young people fall through gaps in services at the point of hand over. This is highly relevant to Trust services – both CAMHS transferring young people to adult community services and Trust adult services receiving referrals of young adults.
4.2 The Trust has a particular concern in regards to those transitioning to adult gender care as many of these young people have experienced very long waits and may have developed mental health co-morbidities as a result of this at a time where developmentally, the individual is at a vulnerable stage of life.
4.3 The developmental trajectory of 18–25-year-olds was specifically highlighted by the Review and the Trust should consider the training needs of the workforce involved in services for this age group.

5. Evidence based interventions

5.1 The Review speaks to the polarisation of views regarding what good care looks like and the lack of a robust evidence base within several domains of care for the children and young people patient group.
5.2 All services within the Trust should be providing evidence-based interventions, and where the evidence base is lacking, the service should be seeking involvement in research to further the evidence for future delivery.
5.3 Psychodynamic and psychoanalytical psychotherapy is not included in many guidelines published by NICE yet it is core to what we do, both clinically and educationally. The Trust should be actively involved in the conversation in regards to the benefits of such interventions and actively engage in research and review of clinical outcome measures to establish the reasons such interventions should remain within the NHS.
5.4 Where possible the Trust should actively engage in guideline development, and this is especially important in areas where consensus needs to be built and where evidence is limited. The Trust should also consider that international guidelines may not be sufficient to guide clinical practice in an NHS context.

6. Managing case variation

6.1 Pathway based care ensures that all patients access the same care and/or intervention regardless of the clinician they meet of the area they are seen in. Variation must be avoided. Clinical pathways need to be in place across all clinical areas in the Trust.
6.2 This should be reviewed promptly. MDT meetings should be used to discuss all cases not just those deemed to be high risk, and deviation from a pathway should only happen in a small number of cases and after MDT agreement, alongside regular reviews as to the appropriateness of such a variation. Clinical outcome measures can be used to guide decision making.

7. Research

7.1 The Trust has a strong research portfolio above what would be expected in a Trust of our size, and this has included multiple publications in the field of gender healthcare. Trust must continue to focus on its research strategy including further integration within clinical teams.

7.2 Research should underpin all we do, including the earlier recommendations in this paper but this cannot be held just within the research team. Clinicians should be encouraged to engage in research and time should be given to them in their job plans.

8. Contentious Topics

8.1 Polarisation of views regarding what good care looks like in gender care has been, and continues to be, more heightened and 'aggressively voiced' than other areas of health care for children. This remains an ongoing challenge to the coherent safe delivery of services.
8.2 It is vital that we, as a Trust, are able to discuss contentious topics in an open and transparent manner that promotes curiosity and the desire to engage in work that will answer the questions as to what good care looks like.
8.3 Conversations as to evidence base, service development and the use of NHS funding should be done in an objective manner and not a subjective one. In order to promote this, the Trust must think about psychological safety and ensure that clinical leaders in the Trust have the skills needed to promote debate and discussion in a safe environment.

9. Actions

9.1 The Trust is working alongside NHSE to review the skill mix and disciplines within adult gender services with an aim of enriching the MDT with underutilised professionals. The learning from this review can be disseminated across services.
9.2 A review of skill mix and disciplines across services can follow the above work to identify gaps based on NICE guidance around clinical interventions and we will work with teams on structured workforce plans to manage these gaps.
9.3 Consideration around safe transition to adult services – a medical consultant post within adult gender to hold expertise in younger age group.
9.4 Review and update of the Trust Transition Policy to ensure it is fit for purpose and followed appropriately. As adult services in Camden are not part of our Trust, engagement with the larger network is vital to make this a success.
9.5 Engagement with services to review/map pathway driven care across the Trust (already underway in Camden CAMHS, GIC and Adult Trauma) and as a result of this, gaps can be identified between the clinical offer and NICE guidelines.
9.6 Once pathway gaps identified, action as to whether research team can support clinicians in specific work focused on increasing the evidence base and where the focus should be. This was discussed with the medical consultants on the medical away day 4th November 2024 and positively received.
9.7 Policy regarding MDT clinical discussions to be reviewed Trust wide including the change to all cases being discussed at MDT, not just those that are challenging or high risk. Shift to the use of pathways will allow monitoring of variation and clear narrative must be given for any move away from an agreed careplan. Significant outliers should be highlighted in local IQPR.
9.8 Discussion with clinical leadership team regarding the use of audit to manage case variation and to ensure NICE guidelines are being followed. This should become part of the annual audit plan.

References:

1. Cass H. Independent Review of Gender Identity Services for Children and Young People: Final Report. Cass Review, 2024 (https://cass.independent-review.uk/home/publications/final-report/)

2. NHS England » Children and young people's gender services: implementing the Cass Review recommendations

3. NHS England » Interim service specification for specialist gender incongruence services for children and young people

Appendix 1 Review Recommendations

Recommendation 1: Given the complexity of this population, these services must operate to the same standards as other services seeing children and young people with complex presentations and/or additional risk factors. There should be a nominated medical practitioner (paediatrician/child psychiatrist) who takes overall clinical responsibility for patient safety within the service.

Recommendation 2: Clinicians should apply the assessment framework developed by the Review's Clinical Expert Group, to ensure children/ young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan. This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment. The framework should be kept under review and evolve to reflect emerging evidence.

Recommendation 3: Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress and cooccurring conditions. This should include support for parents/carers and siblings as appropriate.

Recommendation 4: When families/carers are making decisions about social transition of pre-pubertal children, services should ensure that they can be seen as early as possible by a clinical professional with relevant experience.

Recommendation 5: NHS England, working with DHSC should direct the gender clinics to participate in the data linkage study within the lifetime of the current statutory instrument. NHS England's Research Oversight Board should take responsibility for interpreting the findings of the research.

Recommendation 6: The evidence base underpinning medical and non-medical interventions in this clinical area must be improved. Following our earlier recommendation to establish a puberty blocker trial, which has been taken forward by NHS England, we further recommend a full programme of research be established. This should look at the characteristics, interventions and outcomes of every young person presenting to the NHS gender services. • The puberty blocker trial should be part of a programme of research which also evaluates outcomes of psychosocial interventions and masculinising/ feminising hormones. • Consent should routinely be sought for all children and young people for enrolment in a research study with follow-up into adulthood.

Recommendation 7: Long-standing gender incongruence should be an essential pre-requisite for medical treatment but is only one aspect of deciding whether a medical pathway is the right option for an individual.

Recommendation 8: NHS England should review the policy on masculinising/feminising hormones. The option to provide masculinising/feminising hormones from age 16 is available, but the Review would recommend extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18.

Recommendation 9: Every case considered for medical treatment should be discussed at a national Multi-Disciplinary Team (MDT) hosted by the National Provider Collaborative replacing the Multi Professional Review Group (MPRG).

Recommendation 10: All children should be offered fertility counselling and preservation prior to going onto a medical pathway.

Recommendation 11: NHS England and service providers should work to develop the regional multi-site service networks as soon as possible. This could be based on a lead provider model, where NHS England delegates commissioning responsibility to the regional services to subcontract locally to providers in their region.

Recommendation 12: The National Provider Collaborative should be established without delay.

Recommendation 13: To increase the available workforce and maintain a broader clinical lens, joint contracts should be utilised to support staff to work across the network and across different services.

Recommendation 14: NHS England, through its Workforce Training and Education function, must ensure requirements for this service area are built into overall workforce planning for adolescent services.

Recommendation 15: NHS England should commission a lead organisation to establish a consortium of relevant professional bodies to: • develop a competency framework • identify gaps in professional training programmes • develop a suite of training materials to supplement professional competencies, appropriate to their clinical field and level. This should include a module on the holistic assessment framework and approach to formulation and care planning.

Recommendation 16: The National Provider Collaborative should coordinate development of evidence-based information and resources for young people, parents and carers. Consideration should be given as to whether this should be a centrally hosted NHS online resource.

Recommendation 17: A core national data set should be defined for both specialist and designated local specialist services.

Recommendation 18: The national infrastructure should be put in place to manage data collection and audit, and this should be used use this to drive continuous quality improvement and research in an active learning environment.

Recommendation 19: NHS England and the National Institute for Health and Care Research (NIHR) should ensure that the academic and administrative infrastructure to support a programme of clinically based research is embedded into the regional centres.

Recommendation 20: A unified research strategy should be established across the Regional Centres, co-ordinated through the National Provider Collaborative and the Research Oversight Group, so that all data collected are utilised to best effect and for sufficient numbers of individuals to be meaningful.

Recommendation 21: To ensure that services are operating to the highest standards of evidence the National Institute for Health and Care Research (NIHR) should commission a living systematic review to inform the evolving clinical approach.

Recommendation 22: Within each regional network, a separate pathway should be established for pre-pubertal children and their families. Providers should ensure that pre-pubertal children and their parents/carers are prioritised for early discussion with a professional with relevant experience.

Recommendation 23: NHS England should establish follow through services for 17-25-year-olds at each of the Regional Centres, either by extending the range of the regional children and young people's service or through linked services, to ensure continuity of care and support at a potentially vulnerable stage in their journey. This will also allow clinical, and research follow up data to be collected.

Recommendation 24: Given that the changing demographic presenting to children and young people's services is reflected in a change of presentations to adult services, NHS England should consider bringing forward any planned update of the adult service specification and review the model of care and operating procedures.

Recommendation 25: NHS England should ensure there is provision for people considering detransition, recognising that they may not wish to reengage with the services whose care they were previously under.

Recommendation 26: The Department of Health and Social Care and NHS England should consider the implications of private healthcare on any future requests to the NHS for treatment, monitoring and/or involvement in research. This needs to be clearly communicated to patients and private providers.

Recommendation 27: The Department of Health and Social Care should work with the General Pharmaceutical Council to define the dispensing responsibilities of pharmacists of private prescriptions and consider other statutory solutions that would prevent inappropriate overseas prescribing.

Recommendation 28 The NHS and the Department of Health and Social Care needs to review the process and circumstances of changing NHS numbers and find solutions to address the clinical and research implications.

Recommendation 29: NHS England should develop an implementation plan with clear milestones towards the future clinical and service model. This should have board level oversight and be developed collaboratively with those responsible for the health of children and young people more generally to support greater integration to meet the wide-ranging needs of complex adolescents.

Recommendation 30: NHS England should establish robust and comprehensive contract management and audit processes and requirements around the collection of data for the provision of these services. These should be adhered to by the providers responsible for delivering these services for children and young people.

Recommendation 31: Professional bodies must come together to provide leadership and guidance on the clinical management of this population taking account of the findings of this report.

Recommendation 32: Wider guidance applicable to all NHS services should be developed to support providers and commissioners to ensure that innovation is encouraged but that there is appropriate scrutiny and clinical governance to avoid incremental creep of practice in the absence of evidence.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Trust Response to Recent National Reviews			**Agenda No.: 14**
Report Author and Job Title:	Nimisha Deakin, Associate Director of Nursing and Patient Experience. Clare Scott, Chief Nursing Officer (CNO)	**Lead Executive Director:**	Clare Scott – Chief Nursing Officer
Appendices:	Appendix 1: Letter from NHSE 18th August 2023 Appendix 2: Paper to Trust Board, response to NHSE letter re: Lucy Letby, 11th October 2023		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☒		
Situation:	This paper aims to provide the Trust Board with information and assurance on the Tavistock and Portman Foundation Trust (TPFT) response to three national reviews of relevance to the Trust and the services provided: • Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024 • Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024 • Thirlwall Inquiry - to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of formal neonatal nurse Lucy Letby – ongoing.		
Background:	1. On 30th September 2022, Claire Murdoch, National Director, Mental Health NHSE, wrote to provider CEOs for mental Health, Learning Disability and Autism services in response to the BBC Panorama programme, exposing abusive practice in an NHS Trust inpatient service. The letter asked Trust Boards to proceed on the basis that this could be happening elsewhere and to review the safeguarding of care in your organisation and identify any immediate issues requiring action now. A subsequent Independent Review was commissioned by NHSE. 2. Following the conviction of Valdo Calocane (VC) in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008. VC is diagnosed with Serious Mental Illness and received care and treatment under NHFT. In March 2024, the CQC published the first part of the review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since the last inspection in July 2023.		

	In August 2024 the second part of the review was published. The issues identified in NHFT were noted as not unique to the trust and found systemic issues with community mental health care. The report made recommendations relevant to all providers. 3. 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, who was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust. A paper was presented to Board in October 2023 to provide the Tavistock and Portman Foundation Trust's (TPFT) response to the points outlined in the letter from NHSE. The Thirlwall Inquiry was commissioned to examine events at the Countess of Chester Hospital with Terms of reference.
Assessment:	From the internal review there was a strong narrative that we should be open to there being a risk that harm could happen here. There were concerns at all levels in the organisation that patient and staff voices were not being heard consistently. There was a consistent theme of the need to strengthen visibility of leadership, with a strong sense that there are gaps in communication from board to floor, with discussions not taking place at team level. The review identified that the clinical voice is not being heard as strongly as it should be, with concerns that operational elements and productivity are priorities. Where the clinical voice is heard, it is from a few senior clinicians with some 'more junior' clinicians feeling silenced or not valued. Areas of good practice were identified; these included the Executive Team being more accessible and visible; the CEOs weekly communications and the all-staff meetings. It was noted that the Trust has responded to areas where there were known gaps and have introduced priority areas of focus including improving patient voice and involvement, FTSU accessibility, clear reporting structures (IQPR), embedding PSIRF, incident reporting and patient safety partners. Furthermore, the clinical structure review has been implemented to strengthen responsibility and accountability, allowing us to look at ways of improving on leadership oversight and better board to floor communication.
Key recommendation(s):	• The Quality and Safety Committee recommended the paper for onward reporting to Trust Board; and • The paper makes recommendations that the Trust should consider implementing to address the gaps identified.

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

	international provider of training & education	for innovation and research in this area	equality, diversity and inclusion		
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 2: Failure to provide consistent, high-quality care				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Trust has a duty to ensure that reviews and recommendations from national reviews and inquiries are considered and implemented where relevant to the Trust business.				
Resource Implications:	Yes ☐	No ☒			
	None currently identified				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	No issues highlighted from the initial gap analysis; further work aims to identify any potential implications relating to equality, diversity and human rights, with a particular focus on hearing the voice of patients, carers and families. This will also consider where staff, with a range of protected characteristics, may not feel empowered to speak up and where concerns are raised, how this is heard and responded to.				
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:	**1.** Clinical Services Delivery Group – July 2024, October 2024 **2.** Trust Board (Lucy Letby section) – October 2023 **3.** Trust Board Seminar – October 2024 **4.** Paper to Executive Leadership Team – October 2024 **5.** Paper to Quality and Safety Committee – October 2024				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

Report Title: Trust Response to National Reviews

1. Purpose of the report

This paper aims to provide the Quality and Safety Committee with information and assurance on the Trust response to three national reviews of relevance to the Trust and the services provided:

- Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024
- Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024
- Thirlwall Inquiry - to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of formal neonatal nurse Lucy Letby – ongoing.

The paper summarises findings, along with recommendations to strengthen the systems and processes in place.

2. Background

There have been a number of recent national reviews that are relevant to the services that the Tavistock and Portman provides. The three most relevant ones being:

- Independent Review of Greater Manchester Mental Health NHS Foundation Trust - January 2024
- Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust – March 2024 and August 2024
- Thirlwall Inquiry - to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of formal neonatal nurse Lucy Letby – ongoing.

All three reviews made recommendations relating to patient safety and quality of care. As part of a healthcare system which has a complex and dynamic with many moving parts it is important that we take the learning and recommendations as an opportunity to reflect on our own settings and be proactive in considering areas that need attention.

The context of the NHS Trusts where the reviews took place are different to the TPFT in that we are a small specialist provider with no inpatient setting. However, due to the size, specialism and location to some of our services there is a potential for isolation and the development of a ‘closed culture’, at risk from not being open and curious about our own practice. We considered the concept of closed culture in a health or care service and the increased risk of harm if we do not maintain a culture of curiosity.

Therefore, it is important that we considered the findings from the reviews and assess ourselves against them. The approach taken was to identify key themes of learning and recommendations and to apply them to our services.

In response to findings and recommendations, a high-level gap analysis was carried by the nursing directorate. Subsequently sessions were held with group of staff from across Tavistock and Portman NHS Foundation Trust, asking if ‘this could happen here’ with discussions focussing on key areas.

National Reviews and Findings

Independent Review of Greater Manchester

Mental Health NHS Foundation Trust - January 2024

On 30th September 2022, Claire Murdoch, NHS England's National Mental Health Director, wrote to provider CEOs for mental Health, Learning Disability and Autism services in response to the BBC Panorama programme, exposing abusive practice in an inpatient service at Edenfield Centre, Greater Manchester Mental Health NHS Trust. The letter asked Trust Boards to proceed on the basis that the abuses could be happening elsewhere and to review the safeguarding of care. Subsequently NHSE commissioned an independent review. The review was published in January 2024, findings highlighted that:

- The Trust was not focused on understanding experiences of patients, families and carers.
- There was a focus on operational targets over quality of care.
- Staff were not listened to and felt disconnected from Trust leadership.
- Staff were fearful to speak up.
- There was a failure to respond to concerns.
- There was poor leadership visibility.
- Weak governance processes (floor to board)
- Healthy debate and challenge discouraged.
- Executive leadership team did not work well together.
- Some Trust leads lacked compassion & empathy.
- Culture of fear and intimidation
- Diversity was lacking There was a weak and fragmented clinical voice.

The review made a number of recommendations around patient, carers and voice, clinical leadership, culture, workforce, governance, improvement planning and wider system oversight. Key areas of focus were:

- to ensure that the voice of patients, families and carers is heard at all levels; where concerns are raised, these are responded to quickly and that the lived experience voice must be central to service design delivery and governance.
- Develop a strong clinical voice from floor to Board and Board to floor. To develop a culture of care that places focus on quality of care as its utmost priority.
- That the Trust has an appropriately skilled, culturally competent workforce.
- There is the right governance structure in place (and the right culture) that supports timely escalation and that, where escalations happen, they are responded to.

Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2.- August 2024

Following the conviction of Valdo Calocane (VC) in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008. VC is diagnosed with Serious Mental Illness and received care and treatment under NHFT. In March 2024, the CQC published the first part of the review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since the last inspection in July 2023.

In August 2024, the second part of the review was published. The issues identified in NHFT were noted as not unique to the Trust and found systemic issues with community mental health care. The report made recommendations relevant to all providers.

The review of the evidence related to VC's care (along with 10 benchmarking cases) supports many of the findings of the wider review of patient safety and quality of care provided by NHFT. The review identified concerns with:

- assessing and managing risk in the community
- quality of care planning, and the engagement and involvement of families
- poor quality discharge planning.
- medicines management and reviews
- managing people who find it difficult to engage with services.
- clinical decision making around detaining patients under the Mental Health Act.

The report concluded that there was no single point of failure but a series of errors, omissions and misjudgements. Recommendations were made in the following areas:

- Review treatment plans on a regular basis.
- Ensure clinical supervision of decisions.
- Ensure that regular auditing.
- Involving and engaging patients' families and carers in all aspects of treatment
- Have a robust policy and processes for discharge.
- Ensure regular medicines monitoring.

The Thirlwall Inquiry – to examine events at the Countess of Chester Hospital.

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, who was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

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NHSE set out steps that they have taken and continue to take towards strengthening patient safety monitoring, including the national roll-out of medical examiners, the implementation of the Patient Safety Incident Response Framework and the strengthened Freedom to Speak Up policy.

A paper was presented to Board in October 2023 to provide the Tavistock and Portman Foundation Trust's (TPFT) response to the points outlined in the letter from NHSE asking Boards to ensure:

- All staff have easy access to information on how to speak up.
- 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.
- 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 Thirlwall Inquiry is continuing.

TPFT outlined where gaps were identified in areas such as systems around Freedom to Speak up, the plans that were implemented to ensure increased access and raising awareness and ensuring staff feel supported to speak up.

Themes across the three national reviews
Although all three are separate incidents with separate reviews there are themes in common:

- Hearing patient, carer, family voice
- Hearing staff voice
- Responding to feedback
- Greater focus on productivity and finance than quality and safety

3. Trust Methodology

In response to the NHSE letter following the conviction of Lucy Letby, a review of reporting including a triangulation of data was carried out by the Chief People Officer, Chief Nursing Officer, Director of Corporate Governance and the Chief Medical Officer.

A paper was received by Trust Board in October 2023, which summarised the main findings and recommendations of our self-assessment; recommendations were made around Freedom to Speak up, to recruit a second guardian, to develop a tool kit for staff to be supported and kept informed throughout the process and to remind all staff of the national freedom to speak up role. Additionally, a high-level 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 and it was noted that work was under way to refine and complete this by December 2023. This is now complete.

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, support staff.

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

Focused discussions
Following this the Nursing Directorate has led focused discussions with clinical teams to share learning in response to all three events and the national reviews. to carry out a self-assessment/gap analysis, seek assurance and highlight any areas where we may need to

make improvements. These discussions were taken to the, then, Clinical Services Delivery Board, followed by a request for discussions to be undertaken at team level.

The review asked key questions in the following focused sessions:

- Clinical Services Delivery Group
- Nurses Away Day
- Trust Board Seminar
- Clinical Division leadership session

Key questions asked:

- Did you see the Panaroma programme in September 2022; have you read the review and recommendations.
- How would we know if this is happening here?
- Is this happening here? E.g. themes from the recommendations
- How can/do patients share feedback & concerns How do we respond?
- How is the voice of the patient (and their families where appropriate) captured?
- Do we have evidence of a closed culture in the Trust? *CQC defines a closed culture as a poor culture in a health or care service that increases the risk of harm.*
- What is the mechanism for Floor to Board and Board to Floor feedback within teams?

4. Summary of sessions, strengths and gaps identified.

Feedback from Nurses Session

- Nurses in the trust work over a range of clinical services.
- It was reported that when new to the organisation there is curiosity and questioning of systems around gathering feedback from patients or incident reporting. However, within teams, incident reporting is discouraged unless they met a certain threshold or criteria, when further explored, there was uncertainty about what this was.
- There was variation in collecting service user feedback, this often relies on clinicians, there is a risk of not hearing all voices.
- There was also confusion over how service user feedback is received or collated.
- There was a feeling that the voice of patients was not always believed, with concerns about power imbalance, as we do not have a culture of patient involvement at all levels.
- There was a lack of awareness of staff experience survey feedback findings and no experience of this being discussed at team level or of a local action plan. Therefore, how do we learn to improve experience?
- There is an experience of “feeling silenced”, this was described as not feeling heard or suggestions not being considered by senior staff and clinicians who have worked in the Trusts for a long time. Not all voices were valued or heard.
- There was concern that clinical practice is often one to one therefore an increased risk if we do not have robust systems to hear patient voice or concerns.
- There was limited evidence of communication from Board to floor, staff reported that they felt there was a barrier somewhere in the reporting structure and that messages were not reaching them; an example given was the response to the civil unrest and the development of action plans for the staff survey.

5. Feedback from Clinical Leadership

- There was agreement that the Trust should be open to the possibility that service users could be abused by staff.
- There is knowledge of a number of incidents over the years where staff have been inappropriate with boundaries.
- Community service, patients are often seen individually, which can be riskier than working on an inpatient ward where people can identify concerns about practice.
- It was identified that service users are sometimes afraid to complain in case it affects their care, and they only raise concerns after they have been discharged.
- Returns of Experience of Service Questionnaires are exceptionally low, making it difficult to understand people's experience of care and areas for improvement.
- Concerns raised are picked up through complaints and are responde to through a formal investigation process.
- Two teams have sevice user forums
- There is some service user involevement work at team level led by trainees but this is not always well collated and shared more widely.
- Trust Wide Forum is made up solely of ex-service usesr and there is limited engagement and feedback from current service users.
- Some felt that the clinical voice had become less heard, and that the Trust had moved to a much more operational leadership.
- There was a feeling of a lack of curiosity and silo working in response to fatigue and numerous changes in the Trust.
- It was noted how there was a lot of thoughtful reflection (at times more around self rather than patients and teams), which didn't always result in action.
- The group wondered if staff did not advocate for their patients because they did not feel safe or able to do so.
- All agreed it was important to revive the clinical voice.
- It was felt that the Board to floor feedback mechanisms in the Trust do not work well.

6. Feedback from Teams level discussion

- Response from managers regarding request to facilitate team level discussion on the reviews highlighted that discussions were not held across all teams; this was not progressed. This highlights a risk that we do not listen to a range of views.
- One service clinical lead and two team clinical leads did respond with feedback, views focused on their experience of numerous changes. There was an experience of less clarity about roles, responsibilities and processes.
- There was an experience of feeling there being more centralised control and less devolved authority; with more pressure and feeling that decisions are made to be about financial stability and not clinical quality, care and capacity.
- A concern that there is a culture that contradicts our value of compassionate leadership.
- We have systems for patients talk to their clinicians, some write in by email, some make informal complaints with a wish to be heard without making a formal complaint.
- Some teams have active patient co-production and participation (e.g. trauma panel) which takes forward the service development alongside feedback from those with lived experience.
- It was reported that the process of patients having direct contact with board is felt by some teams to have potential for re-traumatising, although teams understand it can also feel valuable

Trust Board Seminar Feedback

- The Board felt that we needed to be open to abuses happening here, there would be a risk if we weren't open and curious to this.
- Discussion around whether managers and senior leadership at team, unit, triumvirate and executive level are visible enough and how easy it is to visit services. The was a view that leaders are visible enough now and that there are enough systems and structures to see things through a range of different lenses; this would support concerns to be raised, although there was still a question of whether concerns may be raised and held at a local level. However, it was noted that there are a lot of closed doors that act as a barrier.
- There is sometimes difficulty meeting patients due to the type of services we deliver.
- There are some concerns about how information is getting to teams and what can be done to improve communication through the different clinical leads.
- It was highlighted that the majority of engagement and involvement work is with a small number of ex-service-users, we need to do more to work with current service users and work in partnership.
- There are robust reporting processes in place with good data and the integrated quality performance review and report (IQPR) in place. The assessment was that this helps us to recognise and identify issues or concerns but what do we do with it, how do we enact change? There needs to be more work externally to understand what the norm is.
- The patient's voice is captured in feedback, although this is low levels and through complaints. We need to do more to survey children on their experiences so that we don't only hear from their parents.
- The clinical voice is heard strongly but tends to be a few 'loud' clinical voices. We need to think about hearing every new concern.
- The Trust has done a lot to hear the administrative voice in the organisation.
- We need to consider how we make Freedom to Speak up Literature more accessible, in different languages and raising the awareness of both Guardians.
- Not everyone wears identity badges, there was a recommendation for the 'hello my name is 'badges to encourage openness and relationship building across teams.
- It was raised that local induction is variable, there was a suggestion of a new starter 'buddy' system, someone that checks in for the first 6 months.

7. Data and other feedback

- Incident data indicates that we have underreporting of incidents across the Trust.
- We receive low numbers of Service User feedback and do not have 'live' access to the qualitative narrative for experience of care questionnaires.
- Executive visits to sites have highlighted that there has been a lack of connection with leadership in some teams.
- Trust wide Forum raised request to have service users at board and ELT level in the organisation.

8. Summary of discussion and key highlights

Areas of concern

- There is a gap in gathering the views of all staff, there was feedback that team level discussions on work this did not take place, therefore there is a risk of dominant voice and poor staff feedback at all levels.
- There is a gap in the feedback loop on things like staff survey, patient feedback and general communication from board to floor. Numerous changes have had an impact on communication and connection.

- A risk was identified that our patients are more vulnerable as much of our work is on a 1:1 basis.
- Without a culture of strong user experience feedback we are not ensuring we are open to hearing about patient experience. There is a need for more service user feedback with systems to respond and learn from responses.
- The clinical voice is not robustly heard, a diverse range of clinical voices are not routinely heard.
- With many of our services being specialist it can be difficult to have good system oversight
- There is evidence of confusion about incident reporting and as a result underreporting.

10. **Areas of positive work identified**

- The leadership team developed Trust Strategic Pillars to address the areas where the greatest concern was identified. The pillars have a number of workstreams that are assigned to executive leads and are progressed through quality improvement methodology. Specific areas relevant to this review are 'Outstanding patient care' with a focus on waiting times and making service more accessible, and patient experience, with a focus on increasing the amount of feedback we receive and using this to improve services.
- There is a 'Staff experience' pillar with two workstreams, one of these focusing on equalities, diversity and inclusion (EDI). Additionally, progress has been made in the EDI programme Board to develop a 'future state' and reduce the number of priorities for all staff to own; with the intention that this will ensure the Trust hears from all staff.
- The Trust has successfully implemented PSIRF (Patient Safety Incident Response Framework), with a focus on learning. This has included the introduction of three Patient Safety Partners (PSP).
- A new risk management and incident reporting system has been procured and implemented.
- Development of values, vision and mission framework, these were co-produced with staff.
- Formal Board sign up to Sexual Safety Charter and Anti-Racism Statement with associated action plans developed.
- Recruitment of a second FTSUG (freedom to speak up guardian)
- Clinical Structure Review undertaken with the aim of providing a clear responsibility and accountability structure across the clinical division and strengthening clinical leadership. A training programme and organisational development for new clinical structure has commenced to support fulling embedding.
- Development of Integrated Quality Performance report & floor to Board reporting structures and accountability framework for this through the implementation of a targeted support framework.
- The Trust has started it's drive for continuous improvement through QI methodology.

9. Recommendations

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, we receive 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.

The recommendations set out below encompass all themes identified as gaps through the stakeholder sessions, a high-level improvement plan will be developed for existing Quality Improvement collaboratives and workstreams to report into with some new workstreams identified and developed over the current financial year. Progress against the improvement plan will be monitored in the Services Delivery Group and will report up to ELT and Quality and Safety Committee.

Summary of recommendations and actions to progress:

Leadership

- ✓ Formalise continued leadership visits, including exec and non-exec visits to all teams across the Trust, to review visibility of clinical senior leadership, to consider structure and purpose of visits.
- ✓ Review hybrid working, are all teams on site enough.
- ✓ Develop a new starter 'buddy' system, someone that checks in for the first 6 months.

Clinical

- ✓ Develop a consistent approach to gaining feedback from service users
- ✓ Review of Portman through the lens of the Nottingham recommendations
- ✓ Review Risk assessments and crisis plans through monthly audit plan.
- ✓ Review discharge and DNA policies.

Cultural

- ✓ Develop a standardised approach to local induction for all staff – work is being progressed by People Directorate.
- ✓ Restorative Just Culture - further implement RJC, including training for leaders at all levels in the Trust to ensure performance concerns are identified proactively and addressed promptly, fairly and effectively.
- ✓ Speaking up - we need to think about hearing every new concern from staff.
- ✓ Consider how we make Freedom to Speak up Literature more accessible, in different languages and raising the awareness of both Guardians.
- ✓ Create an 'open door' culture.
- ✓ Wear 'Hello my name is' badges.

Experience and Governance

- ✓ Formalise the triangulation of key data for a consistent approach across the Trust – work has progressed through the IQPR report; further work to standardise the reporting structures from floor to Board and Board to floor is needed.
- ✓ Survey children on their experiences so that we don't only hear from their parents.
- ✓ Triangulate service user and carer feedback from surveys, FTT, complaints and compliments and develop a system of using this feedback to improve services and experiences with service users and carers.
- ✓ Provide further local training to teams on the patient safety incident reporting framework (PSIRF) and reporting of incidents.
- ✓ Engage external partners more in reviews, e.g., MIND, Healthwatch, FTSUG, Advocacy
- ✓ Work to further understand how we enact change where issues are identified.

- ✓ Review of all the reporting meetings to ensure that the right people are at the appropriate meetings allowing team managers to be more involved and visible Kaleidoscope leadership development work.

NHS England

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

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

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

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

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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 regards 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.

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Gloucester House Review (UPDATE)			**Agenda No.: 15**
Report Author and Job Title:	Nell Nicholson - Strategic Lead for Education and Partnerships	**Lead Executive Director:**	Clare Scott – Chief Nursing Officer
Appendices:	Appendix 1 – Improvement Plan – update October 24		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	This paper provides a summary of the progress on the improvement plan following the review of Gloucester House in April 2024. The scope of the Gloucester House review centered mainly around: • Safety • Staff wellbeing • Quality of Education The report suggests there has been progress across all of these domains though evidence of this will be reviewed through the Gloucester House Review Oversight Group and monitored by the Gloucester House Steering Committee. The suitability of the estate and the financial situation going forward were not in the original scope of the review but do need to be considered in terms of longer-term viability. There are interdependencies between the business plan for the service, the recovery plan to achieve financial sustainability, balanced with the ability to safely increase pupil numbers and provide good quality and education in the current environment. Further work is planned to clearly establish the business plan with finance and the business development unit, with clinical and teacher pay rises and a review of the staffing model taken into account. Discussions have progressed with Camden Local Authority to identify an alternative estate for the school. The interdependence of the Review Action Plan and these overarching concerns around shorter and longer term options/viability need careful consideration. There is a wider Project Plan being developed by the Clinical Service Manager to consolidate all the interdependent facets including the original improvement plan, finance, estates and governance, so that all factors that impact on the school are considered and addressed to ensure that improvements are sustainable. Both the Steering Committee and the Oversight Group have had a change in chair to reflect the changes to leadership since the retirement of the Chief Clinical Operating Officer. The Steering Group has met this term and received improved reporting on the school, although the development of a data set aligned to Integrated Quality Report is still in development.		

	The Oversight Group has not met yet this term, this is vital to reviewing progress against the plan and dates have been set. The Improvement Plan has been updated by Gloucester House SLT and is attached as Appendix 1.
Background:	Gloucester House is an independent special school with a fully integrated specialist clinical team located in a large Victorian house in Hampstead and is part of the Tavistock and Portman NHS Foundation Trust. For over 50 years Gloucester House has pioneered therapeutic educational work with children. The school is accredited for up to 21 children aged between 5-14 (Ks 1,2 & 3). Following the most recent Ofsted inspection in 2022, the school was rated Good; the next inspection is expected by end 2025. In recent years the service had some structural changes; a Clinical Lead was introduced as Head of Service under the strategic review and a new Head Teacher joined in January 2023. The Clinical Lead line managed the headteacher and was responsible for the service. Following the Tavistock clinical review (July 2024) the structure has been revised. In the new structure the headteacher and the clinical lead share responsibility for education, therapy, quality, safety and finance in the school. The Strategic Lead for Education and Partnerships (a new role following the recent clinical restructure) line manages the headteacher. The clinical lead is supervised by the Service Clinical Lead for the Children and Families Unit. The Strategic Lead for Education and Partnerships is responsible for the progress of the improvement plan and reports to the Manager Director who chairs the Oversight Group. **Gloucester House Review** Concerns were raised by progress support workers relating to incident reporting, team structure, the PSW role, sexual safety and racism in July 2023. These were brought to the freedom to speak up guardian (FTSU), a formal grievance and the equality diversity and inclusion (EDI) team. In November 2023, further concerns were raised through freedom to speak up, due to the nature of some of the concerns raised, a review of incident reporting and safeguarding was commissioned by the Chief Nursing Officer. The recommendations were incorporated into the overall improvement plan in partnership with senior leadership for Gloucester House. Additionally, there were challenges in a number of areas including key operational functions and providing a financially sustainable service. A full-service review was commissioned by the Chief Nursing Officer, conducted by the Associate Clinical Director and the Service Manager. The review was completed in July 2024 and presented to Trust Board in September 2024. **Findings** There were a number of gaps and areas of concern across finance, the service model and senior leadership structure along with governance systems and structures underpinning this; educational outcomes and curriculum implementation; clinical outcomes, safeguarding, regulatory

	assurance; and staff wellbeing. There was an absence of data including feedback and engagement from external stakeholders. A total of 61 recommendations were made across all domains, some of these overlaps and span more than one area. An improvement plan was developed to address some urgent recommendations requiring immediate action. A risk register is also in the process of being developed.
Assessment:	The review Terms of Reference included a review of systems and processes for the following areas: • Current staffing skill mix and organisational/management/leadership structures. • Current strengths, what is working well in the service. • Identify gaps/issues in the service. • Review safeguarding, clinical and educational outcome information to identify themes. • Finances, budget and business model; to include resources (staffing) and minimum pupil numbers. • consider culture and equalities. • Review patient/pupil wellbeing and safety, incident themes, restraint data and practice. • Staff wellbeing, review staff survey, local responses and local discussions. • Review evidence base for Gloucester House model and models for other similar or comparable services for comparison. • Take account of previous and current Action Plans and consider previous and current barriers to implementation. **Estate** Separate to the review there are ongoing risk assessments underway to consider whether the environment is fit for purpose and the cost and practical feasibility of remedial works that may be essential. An initial review with the Director of Estates and Facilities identified a number of priorities for essential maintenance work and repairs. A consultant has been engaged to carry out a full review, an early conservative estimate indicates costs of approximately £2-3m to address urgent areas such as damp, leaking rooves and safety around windows. The future of the estate should be taken into consideration when considering the future of the school.
Key recommendation(s):	The Board is asked to **NOTE** the progress made against the original improvement plan and the potential impact of the environment on the ability to safely progress with the recovery plan.

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

	provider of training & education	research in this area			
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 2: Failure to provide consistent, high-quality care. **If** the Trust is unable to meet nationally recognised quality standards across its clinical services, **Then**, the Trust will not be able to deliver the high quality, safe, evidence-based and reflective care to patients. **Resulting in** poor patient experience and risk of harm, potential regulatory enforcement or penalties and reputational damage.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The school is regulated by Ofsted and must meet regulatory requirements to provide high quality, safe education in a therapeutic environment.				
Resource Implications:	Yes ☒	No ☐			
	A full review of the business model may identify resource implications in the future.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Recommendations have been made that relate to staff wellbeing and speaking up. There has been progress on this in the Review Improvement Plan. Concerns raised re equitable access to the service and outcomes not being consistent for all young people is being reviewed by the headteacher – particularly in relation to outcomes for young black males. Some concerns have been raised about the findings and the process of the recent review by some staff in the service.				
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 12th February 2024 – report for review and approval. Quality and Safety Committee – May 2024 Gloucester House Review Oversight Group – June 2024 and July 2024. Board Seminar – September 2024				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

		Reccomendation	Key actions	Timescale	Lead	Updates	RAG Status
Finances							
	1.1	Draft a recovery plan to reach break-even. This will be based on staff recruitment timelines including induction and mandatory training, co-ordinated with a phased introduction of new pupils. The plan will need to consider costs against income (number of pupils enrolled) and ensure that the increase in pupil numbers is aligned with pupil safety and welfare, staff wellbeing, safeguarding and the strategy referred to in the Steering Committee (21.6.24). This process will be supported by the Tavistock & Portman leadership team .	Referral meetings at GH to ensure target met. Consideration to be applied re clinical capacity.	Rough plan by end of July / Sept plan	NN / SLT	5.11.24 -Recovery Plan completed by NN/SB with input from GH SLT July 2024. No further amendments September 2024; some anomalies/discrepancies with the financials to be agreed between business development & finance eg. the business plan worked up by BDU indicated 18 pupils were needed to break even & updated today by BDU with the AFC & teacher payrises potentially 19 whilst director of finance mentioned 14 at Board in October. Pupils: Two pupils to join in autumn term, two for spring term - on track for autumn term though as one of these is Barnet need to check with school re target for 12 paid places by December takes this into account. Clinical staffing: RH returning following a half term absence; psychotherapy post appointed to (24.10.24) following ad extension; two teachers apointed and starting mid November	Add RAG Colour
	1.2	The recovery plan will need to be signed off by Finance Dept and Contracts with agreed contribution over the year. Recovery financially may have to be supported financially by the Trust while the school is stabilised and a safer working environment created for staff (ie graded contribution over time until full pupil numbers attained).	Financials and issues with the building need further work due to interdependencies	Sept	NN / SLT	5.11.24 - Board have seen and agreed plan October 2024 - however the financials are not yet in this document. BDU and finance linking. Work force planning meeting to take place to ensure can meet budget but concerns re building need attention before able to implement.	
Systems and Structures							
	2.1	Staffing structure for service to be reviewed urgently in line with budget. Consider support staff numbers and staff deployment.	SLT makeup to be reviewed. Suggestion - to include a second clinician. This proposal could be considered by the oversight group on behalf of the team.	End of July	NN/ SB / CS / SH	NN to arrange meeting with CS/ SH for end of July. Pre meet to be diarised prior to end of July with Dayo/ SB/ NN/ HB/ TM/ LK/ Selina / MG. Dayo to lead Workforce planning meeting. 5.11.24 - meeting to be convened; NN to organise; delay due to ongoing financial discrepancies & other parts of the quality of education, safety & staff wellbeing being prioritised. 23/09/2024 Workforce Plan: Business case discussed with Matt from Business Development. The current cycle has the least qualified staff working with the most complex cases Action: Nell to schedule a Workforce Plan meeting. SLT (Senior Leadership Team) suggested meeting beforehand for internal discussion (SW, CG, TM). (see above)	
	2.2	Meeting structures to be reviewed including curriculum meetings, debrief and reflective practice. This work to be done in consultation with the team.		Sept- completed October	TM / SW	Staff Questionnaire to feed into this decision 23/09/2024 External reflective practice was discussed previously in July. Completed. Proposal to move meetings 10 minutes earlier, so staff can be informed about discussions. Action: RF to share a wellbeing practice questionnaire with SW, who will follow up for responses. 07/10/24 SW shared the incident and debrief process flowchart with the team. Questionnaire completed- outcomes fedback to SLT and the team. Wellbeing Committee set up. CG- Curriculum meetings take place weekly on a Tuesday at 11am focusing on upcoming curriculum events;monitoring, data etc. Meetings are minuted and actioned.	
Educational outcomes							
	3.1	Review of assessment system including target setting and data across all subjects by senior leaders and develop a plan to address		01/09/2024 - new date Dec 2024	TM/ CG	Assessment System (Solar): CG requested an analysis of the data. Assessment policy not reviewed yet. Action: CG, TM, SW to review the assessment system. Diarised for a meeting on October 21st. New date to be set on the 11th November. Currently reviewing the assessment policy and will make admentments where needed. This will also be updated alongisde the new curriculm (Maestros) own assessment system.	
	3.2	Student Case studies to include: Outcome data for pupils who have left. look at a number of case studies including plans, impact for persistent attenders particularly in combination with the lack of progress recorded on Solar for those pupils. Clarification of destinations including ethnicity, age and gender of each pupil.	Case examples - academic / outcome / educational data Triangulate with incidents data. Focus on pupils who did not progress academically with education SLT to consider how to effectively work together for overall progress. To work with education SLT to consider pupils whose attendance was poor and/or did not progress clinically to plan for more complex pupils going forward.	End of Sept 24	CS	23/09/2024 Curriculum: Review outcomes for pupils who have left; important to ensure no racial bias. Action: GH to provide evidence, TM to ensure data is presented clearly. Small sample size may skew data, but transparency is key. 07/10/24 Initial overview now complete, cgoing back 3 years. Analysis complete. Findings to be discussed at SLT. Now breaking down into pupil's. 14/10/2024 Nearing completion.Impact report received. TM to send. Thinking how to present case study. TM gave an example. The area we need improvement are academic progress and attendance which is however improving.	
	3.3	Moderation across the curriculum.	Diarise into curriculum meetings	Plan to be in place by Oct 24 - Dec	TM/ CG	23/09/2024 Done cycle of monitoring now and then moderation? 07/10/24 During review significant work done to review data. 14/10/24 dates on calendar and teachers informed it will be happening- Green Diariased – review to come. New moderation date to be set for writing inline with the new OFSTED expectations. Setting a	
	3.4	Use the GHOR model for teaching offsite	Meeting between Sarah P and Educational Team	Sept / Oct 24	TM / CG	23/09/2024 Action CG to meet with Sarah to discuss and feedback 07/10/24 - CG has re-written the GHOR model for GH home learning; inlcluding reviewing and re-writing the parent/school agreement and the home learning risk assessment which needs to be reviewed by SLT. Nov CG met Sarah P discussed structure. CG to collate information given to support with delivery of home school learning. 14/10/24 CG met with Sarah and disccused feednback, structure to be put into place	

3.5	Use an assessment calendar to ensure assessment points are adhered to and monitored	Assessment calendar created and shared with all staff	Sep-24	TM/ CG	23/09/2024 Assessment calendar, to be sent 07/10/24. Complete. CG regularly reviews and amends calendar where needed for monitoring and assessment to ensure nothing gets missed.	
3.6	Thorough investigation of attendance data. Clear descriptors for attendance	Access gained to SIMS data analysis Summary of attendance	Sept - System to be agreed	NN + SLT	23/09/2024 Attendance data Action: RF and TM to work on attendance data- 07/10/2024 Complete	
3.7	Exploration of context e.g. possible change in cohort etc.		Dec-24	NN/TM	To explore in line with Outcome data gathered by TM	
3.8	For the education SLT to produce a coherent curriculum overview as a matter of priority		Nov-24	TM / CG	23/09/2024 G sent doc sent document no reply yet Action: Curriculum maestro – to be looked into. Curricululum Maestro purchased and TM/CG are in the process of creating it. CG has a meeting with Maestro to be shown how to use it on the 13th of Nov. Teachers also have access to it. 07/10/24 Complete ordered. Overview produced for core subjetcs.	?
Curriculum - design and implementation						
4.1	To reintroduce use of website and shared drive for subject planning, overview, subject action plans and subject specific assessment that is not Solar. The website needs urgent attention to ensure curriculum information, policies, outcomes and contact information are updated.		Sep-24	TM	23/09/2024 Discussion around PHSE and other curriculum schemes. Action: TM and CG to meet with Sam to discuss curriculum needs. Maestro system reviewed but deemed inadequate for the current cohort. Exploring other systems. 07/10/24 To discuss in Curriculum meetings. 14/10/24 Maestro purchased we will have a shared place where staff can access. Every page of website delegated to individual SLT/Staff Members with clarity on who takes resposibility for each page.	
4.2	Learning walks of subject co-ordinators alongside senior leaders		Sep-24	CG	23/09/2024 Review of learning Walks. To be planned. 07/10/24. Learning walk of writing and Fresh Start to take place week beginning 11th, maths to follow following week. DHT and subject coordinators. Revise and plan in Curriculum Meetings. 14/10/2024 CG spoken with subject coordinator. On planning stage. TM-CG to discuss further; learning walks talking place including those with external roles(such as governors, board members, LA representatives or SIP)	
4.3	Education SLT work with teachers to consider the evidence base for pupil progress and achievement.		Oct-24	NN / SLT	23/09/2024: Action: Baseline assessments scheduled for October 21st Meeting. 5.11.24 - meeting not yet happened due to other priorirtes in the school on 21.10.24; date to be rescheduled	
Clinical Outcomes						
5.1	Current clinical lead to evaluate outcome data.		End of Sept- completed	SW	This is to be reviewed by SW 07/10/24 Meeting with NN and LK and JW planned. We met on the 23/10/24 and established outcome measures and timeframes. Action to complete outcome tools	
Safeguarding						
6.1	The progress against the safeguarding review and the Camden Safeguarding audit need to be completed urgently.		Nov-24	SLT	September 2024 - All Safeguarding review actions were completed; however one action (reflective practice) cannot be sustained due to clinical capacity in the Autumn Term (sickness / appointment gap). This will be resolved with the appointment of a substantive C&A Psychotherapist. 23/09/2024 Independent School Regulations: SLT and Steering Committee to focus on compliance with Independent School Regulations. Action: NN to share the regulations with the Steering Committee Complete Ocotber 24. Action: Undertake Camden Safeguarding Audit (currently underway November 2024)	
6.2	Chair of Steering committee to complete spot check of SCR	Review of register	Oct-24	CS	Spot check review of register completed with actions for the opeartional lead to follow up on two actions. Further spot checks have been planned a minimum of quarterly, one per term.	
6.3	DSLs and First Aiders to be trained as a matter of priority. Sept 2024- First Aiders have completed training. A clear system has been put in place for when a pupil is hurt eg injury form completed and carers notified.	Traning to be arranged and attended	Sep-24	TM	23/09/2024 Training sessions booked Complete	

	6.4	Focussed review of restraint recording procedure	Meet to discuss restraint log being electronicon the RADAR system. To establish clear criteria for when incidents require restraint and where this reported and recorded.	Nov-24	SW/TM/LH/RH	23/09/2024 Policy outdated. Action: SW to check with Team Teach definition of restraint. Been delayed as RH not in work. Met and ongoing work with regards to incident reporting and restraint log being on radar. 07/10/24 For SW and TM and RH to meet (PSIRF team)	
	6.5	Focussed review of training and updated training schedule for restraint. CG to be trained as a TT instructor. Looking for availability with TT.	All staff to be trained.	Oct-24	SLT	23/09/24 Everyone trained. - Ensure new teachers are trained as soon as possible. Nov 2024	
23/09/24 Regulatory Assurance							
	7.1	Gloucester SLT to focus on addressing the Independent School Regulations. Steering Committee members to focus on these for assurance purposes on their visits to the school.	NN to send	Sep-24	TM	Action for Steering Committee	
	7.2	Leaders and teachers evaluate progress and next steps against Ofsted and Challenge Partners targets.		Sep-24	TM / CG	23/09/24 Actioned by Tom; embedded within the School Development Plan for 2024/25; clear focus on a shared and sequenced curriuclum (See actions 4.1-4.3)	
	7.3	DHT to have challenge partners training	To book training.	Nov-24	CG	23/0924 Action for CG. 14/10/2024 CG booked Training.	
Staff Wellbeing							
	8.1	Develop working parties to include team members in the review and implementation of the recommendations identified.	To idenitfy staff members	Oct-24	SW	SW has expressions of interest- Sam/Joel/Xanthe Reviewed reflectic practice and each staff member is assigned a RP partmer. Excell spreadhsheet filled in after each RP attended session. Staff involved in what they would like time/break or a more formal debrief. NN suggested to share with Steering committee. Wellbeing questionnaire completed, SW to anaylise results and to deliver training workshop with whole team. Staff fed back preference for Wellbeing room, flowchart completed. Next step order resources and deliver wellbeing and debrief process to team. Wellbeing commitee to be set intyernally with staff who expressed interest.	
	8.2	Review of Reflective Practice Structures	To review excell spreadsheet	Sep-24	SW	Staff assigned to RP partners. Excell spreadhsheet completed for recording of RP.	
	8.3	Review of post incident procedures/processes	See 2,2	Sept-Oct 24	SW	23/09/2024 Asked staff for input. Action RF to share questionnaire with SW 14/10/24 SW shared outcome of staff survey. Plan of action made from the results if the survey that was shared with SLT 04/11	
	8.4	Review of wellbeing structures	See 2,2	Sept-Oct 24	SW	23/09/2024 Action RF to chase questionnaire and send results to SW 07/10/24 Explored with team and questionnaire shared.See point 8.1/2.2	
	8.5	Consideration to be given as to why some areas need revisiting from the previous investigation and whether longer term strategies, systems and structures can be embedded more effectively.		Ongoing	NN / AH	23/09/2024 Consideration to be given as to why some areas need revisiting from the previous investigation and whether longer term strategies, systems and structures can be embedded more effectively. Still work to be done. Project plan under development to consider interdependencies such as estates and business plan.	

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Annual Medical Revalidation Report			**Agenda No.: 16**
Report Author and Job Title:	Chris Abbott – Chief Medical Officer (CMO)	**Lead Executive Director:**	Chris Abbott – Chief Medical Officer (CMO)
Appendices:	Appendix 1: A framework of quality assurance for responsible officers and revalidation		
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 license to practice once every five years and as a part of this must engage fully in the cycle of appraisal and Continuing Professional Development (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 Ambitions:			
☒ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☐ Developing a culture where everyone thrives with a focus on equality, diversity, and inclusion	☒ Improving value, productivity, financial and environmental sustainability
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	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:	Responsible Officer's Advisory Group (ROAG) – 15/10/24			
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

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance.

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS, and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: n/a Comments: The Chief Medical Officer Dr Chris Abbott is the Trust Responsible Officer since September 2023. Action for next year: n/a

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes, an appropriate level of finding is available to the RO. Action from last year: No specific actions Comments: Continue to monitor Action for next year: Continue to monitor.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To continue to maintain accurate records and review our processes. Comments: The Trust maintains accurate records of all doctors who have a prescribed connection, and these are reviewed/updated regularly through the Responsible Officer's Advisory Group which meets monthly. A designated HR Business Partner attends the ROAG meeting. Action for next year: Continue to monitor our processes and if indicated make any adjustments to enhance our efficiency.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Update Appraisal and Revalidation Procedure. Comments: In progress

Action for next year: Review Appraisal and Revalidation Procedure on yearly basis.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: The Trust to explore undertaking a peer review of the Trust appraisal and revalidation processes. Comments: The Trust has not had a recent peer review Action for next year: In light of the possible merger in 2025 between the Trust and another Trust consider peer review once plans known.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To continue to support this group of doctors when these doctors are in post in the organisation. Comments: The Trust has locum and short term placed doctors working in the organisation currently and for last several months. The appraisal lead arranged to meet each doctor to support their CPD and their appraisal. They are each signed up to our appraisal system (SARD). Action for next year: Continue as we are doing now.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: Appraisal lead will audit cohort of appraisal summaries to ensure compliance with expected standard.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: The statement above is correct for this organisation. The expectation of an annual appraisal is embedded in the policy, medical employment contracts and in job planning. ROAG continues to meet monthly and monitor and includes the CMO/RO, Appraisal Lead, Revalidation Manager, HR Business Partner for Medical Workforce, Deputy Chief People Officer, and a Non- Executive Director who is a senior medical practitioner. All doctors are expected to provide their appraiser with a Manager's Report from each of their employments. The RO has regular meetings with the GMC ELA.

Action for next year: Continue to monitor our processes.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

Comments:

Action for next year:

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Update Appraisal and Revalidation Procedure to include cross reference to new Job Planning Policy for Medical Consultants, Specialist and Specialty Doctors

Comments: The statement above (No 8) is correct for this Trust,

Action for next year: Continue to review.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue to monitor.

Comments: The need for training new appraisers and running refresher training for current appraisers is considered at the termly appraisers meeting. We have the necessary number of trained appraisers to carry out timely appraisals.

Action for next year: Continue to review training need and number of appraisers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Continue to monitor. During the coming year appraisal lead will audit a cohort of appraisal summaries to ensure compliance with standard expected

Comments: There are regular peer appraisers' meetings in which any issues can be discussed including standards expected. The appraisal lead and revalidation manager attend relevant external training/update events.

Action for next year: Continue internal peer reviews meetings. Canvas appraisers for their thoughts on development events and arrange same.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: No changes envisaged i.e. in relation to providing report to Trust Board. Comments: This report has been presented to Revalidation Officer Advisory Group (October 2024) and Board Meeting (November 2024) Action for next year: Continue.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	**38**
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	**27**
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	**1**
Total number of agreed exceptions	**10**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: No changes envisaged. Comments: The RO continues to make timely recommendations to the GMC about all doctors with prescribed connection to the designated body. Action for next year: Continue to monitor.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No changes envisaged. Comments: the above statement is correct in relation to this Trust as designated body. Action for next year: Continue to monitor and discuss our processes at ROAG.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue to review effectiveness of clinical governance structures in the Trust. Comments: Effective clinical governance structures are in place to support doctors. Action for next year: New leadership structures in place since 1 September 2024 including clinical governance structures. Review effectiveness of these new structures in relation to doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continue to monitor. Comments: The above statement is correct in relation to this Trust and designated body. Action for next year: Continue to review and monitor.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

Action from last year: Continue to monitor and improve processes. Comments: the above statement is correct in relation to this Trust and designated body. The Trust has appropriate structures and processes in place. Action for next year: Continue to review and monitor.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type, and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Continue to monitor and improve processes. Comments: The above statement is correct in relation to this Trust and designated body. Appropriate structures and processes are in place. The Responsible Officer's Advisory Group considers any individual issues. If necessary, concerns will be discussed with the Practitioner Performance Advice Service at NHS Resolution and with GMC ELA. Action for next year: Continue to review and monitor processes.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: The statement above is correct in relation to this Trust and designated body. The RO will continue to respond to all requests for transfer of information using the Medical Practitioner Transfer Form (MPIT)

Action for next year: Continue to review and monitor.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Review process for gathering high level data.

Comments: The above statement is correct in relation to the Trust and designated body.

Action for next year: Continue to monitor and discuss at ROAG.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to monitor via ROAG.

Comments: the above statement is correct. There is a dedicated HR Business Partner for medical discipline who attends ROAG along with the Deputy Chief People Officer.

Action for next year: Continue to receive input from HR BP.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

The Trust values its medical workforce for the significant contribution they make to ensuring delivery of high-quality services for our patient population.

The Responsible Officer Advisory Group is effective and is well supported by the HR function.

Changes have been made to the way the Trust manages Honorary Contracts.

Appraisers meet three times/year.

Some more work is needed to ensure the task undertaken by appraisers is fully recognised within job plans.

No doctors for whom this Trust (TPNSHFT) is the designated body is currently subject to GMC fitness to practice procedures or any imposed conditions or undertakings

Overall conclusion:

The systems and processes within the Trust support medical appraisal and revalidation. Any issues or concerns are discussed at the monthly Responsible Officer's Advisory Group

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body.

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _Tavistock and Portman NHS FT

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed:

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
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MEETING OF THE BOARD OF DIRECTORS PUBLIC – Thursday, 14 November 2024			
Report Title: Race Equality Network Presents Black History Month Event Thursday 3rd October 2024			**Agenda No.: 17**
Report Author and Job Title:	Pauline Willliams Race Equality Network Chair	**Lead Executive Director:**	Rod Booth, Director of Strategy & Business Development (Executive Sponsor)
Appendices:	Appendix 1: PowerPoint Presentation to be delivered at the Meeting that aligns with this report		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides an update on the Black History Month Event.		
Background:	1st October to 31st October the Trust observed Black History Month (BHM) 2024 the theme for this years' BHM was "Reclaiming Narratives".		
Assessment:	Reclaiming these specific stories at this event involved highlighting the voices, achievements, and resilience of Black individuals and communities that mainstream histories have overlooked or minimised. The learning from the event will now allow individuals to take ownership of the full, nuanced history, focusing on Black perspectives, and correcting misrepresentations.		
Key recommendation(s):	The Board is asked to **NOTE** the contents of the report and to empower the REN to provide opportunities to continue to share inspiring stories, highlight significant contributions, support our patients and staff and continue to engage with the rich tapestry of Black heritage and culture for years to come.		

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☒	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 7: Lack of a fair and inclusive culture				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes ☒	No ☐			

	The Trust will continue to support the EDI themes			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	Educating all Staff using the Black History Event to support and share stories			
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

Report Title: Race Equality Network Presents the Black History Month Event

Thursday 3rd October 2024

1. Purpose of the report

The purpose of this report is to provide an overview of the Black History Month event held at the Tavistock and Portman NHS Trust on Thursday October 3rd – 5th Floor Lecture Theatre. This report will cover the key speakers, and discussions held during the event, highlighting the themes celebrated and the significance of this year's Black History Month theme of 'Reclaiming Narratives. The event honoured the contributions of Natasha Trent and Lelia Hassan-Howe. This event was planned and organised by Pauline Williams – Chair of the Race Equality Network (REN), Luster Alfred – EDI Manager and Bryan Knight - Communications and Engagement Officer. The event endorsed the lived experiences of black people in the UK during the 1960's through to 1990's, and highlighted stories of racism, togetherness, and encourage meaningful dialogue on historical and current issues affecting the Black people. This report aims to capture the essence of the Black History event and its impact on attendees and how we will continue to support the "Reclaiming Narratives" theme,

2. Background: Black History Month Event Report: October 3rd - Theme: "Reclaiming Narratives"

Stories are a powerful tool that shapes how we understand our past, present, and future. For too long the history of black communities has been told through lenses that are often misrepresented, often oversimplified or entirely overlook the lived experiences for Black and Asian People. Black History Month 2024 is set to be a transformative year, illustrating what "Reclaiming Narratives" really means. It's not just telling our stories but taking control of the narrative itself. This October 2024 - our Black History Month event concentrated on the empowering theme of "Reclaiming Narratives" Where all staff were invited to join in with the conversations, to educate themselves and finally to encourage and shine a spotlight on the untold stories of the unsung heroes, and the everyday individuals who have made an indelible positive impact on our Black communities.

3. Natasha Trent's Poetry Performance

The event began with a moving poetry reading by Natasha Trent from our People's Team. Natasha, known for her powerful written words, presented her original poem titled *'Who Are You'.* Natasha's poem eloquently captured the essence of reclaiming narratives to challenge established perspectives and encouraging the audience to redefine their understanding of Black History using the theme of "Reclaiming Narratives" through poetry. Natasha's words inspired a sense of empowerment, resilience, and unity, setting a powerful tone for the rest of the programme.

4. Conversation with Activist Leila Howe

The main highlight of the event was an engaging and insightful conversation with Leila Hassan-Howe, a trailblazing activist who began her journey in the 1970s as a member of the Black Power movement. Leila has been a trailblazer in the fight for racial justice and collective politics in the UK for decades. Her activism began in the 1970s as part of the Black Power movement, she became a member of the Black Unity and Freedom Party here in the UK. Leila played a pivotal role in the

transformation of the Institute of Race Relations, helping to radicalise it during a key period in its history.
Along with her husband, the late Darcus Howe, Leila co-organised the Black People's Day of Action in March 1981. This historic event became the largest demonstration of Black people in the UK at the time, following the devastating New Cross Fire that claimed the lives of 13 young Black people which remains unsolved today.
Leila was also a founding member of the Race Today Collective, based in Brixton, and served as both assistant editor and later editor of the highly influential *Race Today* journal from 1973 until its closure in 1988.
Today, Leila continues her vital work as Chairperson of the Darcus Howe Legacy Collective, which is dedicated to preserving her late husband's impactful contributions to social justice movements in Britain and around the world.
In addition to her work as an activist, Leila is also an accomplished editor. In 2019, Leila co-edited *Here to Stay, Here to Fight*, and in 2023.

Leila also co-edited a special issue of *Race Today*—the first since 1988—designed to introduce Britain's radical Black History to new generations.
In 2023, Leila was conferred with an honorary fellow of Goldsmiths in recognition of her written work and activism.
In her conversation, Leila Howe spoke about the challenges Black individuals face in navigating systemic prejudice and the ongoing need to reclaim and amplify their histories. Her insights into the struggles and victories of the Black community resonated deeply with the audience, inspiring reflection and dialogue on the importance of sustained activism and allyship.

5. A Powerful and Educational Experience

The event was not only educational but also emotionally impactful. The stories, shared experiences, and candid discussions shed light on the prejudice faced by Black individuals, both historically and today. It served as a reminder of the importance of reclaiming, rewriting, and preserving the narratives that shape the Black experience.
Let us reflect on what the theme for Black History Month this year represented, and remembering there's a call to action and reclaim narratives that have often been left untold or distorted.

6. Conclusion

Reclaiming these specific stories at this event involved highlighting the voices, achievements, and resilience of Black individuals and communities that mainstream histories have overlooked or minimised. The learning from the event I hope will now allow individuals to take ownership of the full, nuanced history, focusing on Black perspectives, and correcting misrepresentations.
I urge us to continue our thinking and continue to remember that "Reclaiming Narratives" is also about celebrating everyday acts of taking control of how we tell our stories and taking control of the narrative itself in ways that are respected. "Reclaiming Narratives" empowers the present by honouring the past, ensuring that the richness and diversity of Black and Asian experiences are seen, heard, and understood—not just for the month of October but every day of the year. This stands as a tribute and a commitment to truth, justice, and a more inclusive future. Although Black History Month officially concluded on 31st October 2024, our commitment to celebrating Black history, Black culture, and Black achievements does not stop there. Let's all continue to share inspiring stories, highlight significant contributions, support our patients and staff and continue to engage with the rich

tapestry of Black heritage and culture for years to come. This will allow us all to dive deeper, into untold stories and amplify voices that deserve recognition all year round.

Let's keep the conversation alive together.

The Tavistock and Portman
NHS Foundation Trust

Race Equality Network Chair Presents Black History Month Event Thursday 3rd October 2024

Pauline Williams – REN Chair

Luster Alfred – EDI Manager

Thursday 14th November 2024

Natasha Trent Poem

- Who Are You?
- Leila talk - OneDrive

Race Equality Presents Black History Month

- Black History Month Presentation
- Videos and Slides

Video Clip:
BBC News: British Black Power Movement

Leila Hassan Howe and Bryan Knight

- Leila talk – OneDrive

- Leila's shared her lived experience and the lived experiences of others on how the British Society treated immigrants

Leila Hassan Howe interviewed by Bryan Knight our staff member from our comms team

- This clip speaks to the UK in the 1960's – 1980's where black people wanted change
- Immigrants who came to the UK were not welcomed by all white communities
- Black people who wanted jobs or housing faced discrimination and hostility
- Children in schools faced racism in their education system
- Activists in the Black Power Movement wanted change not through violence but just wanted their voices to be heard

- Uprising: The events of 1981 are a key part of our national history – BBC

- Leila talk - OneDrive

The Anti-Racist Groups and Collective During 1970's to 1980's

- In the 1970s and 1980s, anti-racist groups and collectives in the UK, such as the British Black Panther Movement, the Race Today Collective, and the Asian Youth Movements, worked tirelessly to combat racism and promote equality

- These groups, primarily led by Black and Asian individuals, aimed to challenge institutional racism, police harassment, and discriminatory policies affecting minority communities. Rather than promoting violence, they focused on peaceful social action, community campaigns to support and raise awareness

- These Anti-Racist Groups and collectives sought to bring about social change, to empower marginalised voices, and foster a fairer society in which all racial groups could thrive

Black Lives Matter Global Campaign

- Black Lives Matter Protests Around the World
- Leila talk - OneDrive

Black History Month and Beyond

Although Black History Month officially concluded on 31st October 2024, The Race Equality Network, EDI Team, Peoples Team and Communications Team will continue to commit to celebrating Black history, culture, and achievements will not stop there.

We will continue to share inspiring stories, highlight significant contributions, and engage with the rich tapestry of Black heritage through to 30th September 2025. This extended period allows us all to dive deeper into untold histories and amplify voices that deserve recognition all year round. Let's keep the conversation alive together and continue the theme of "Reclaiming Narratives"

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (PUBLIC) – 14 November 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	5 September 2024	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 18**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline: The Committee looked at the BAF risk around capacity and capability of managers	**Assurance rating**
1. EDI considerations • Gender pay gap - this points to the need for more career development of women to see more women move into the most senior posts where we have a gap. In addition, it is potentially unrealistic to think a lot more men will apply for administrative roles. • Just culture - this is not properly understood in the Trust as yet, and more discussion is needed on this. • EDI Programme Board has undertaken significant work on rationalising our EDI action plans and thinking about out desired future state. Now we need to publicise what we have done and what we are focussing on.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. L&D and OD updates • Capacity and capability of managers: – this is an issue of culture – the MDP has been useful but how is it impacting cultural change in managers – service line managers: there is resistance to change at this level which we need to look into – admin programme: this will be beneficial for development of this group of staff some of whom are managers – we are at risk on this BAF risk • Appraisals. Data on completion is not positive (but may not be reliable) and there are challenges with making them meaningful for staff. We are working towards career conversations.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Other	Limited ☐ Partial ☐

• Data: There are still some issues around the data in ESR and other systems being complete, consistent and reliable, which is affecting the ability of POD EDI to get assurance around BAF risks	Adequate ☐ N/A ☒
4. Reflections • Psychological safety for individuals who speak out and want to make a difference is paramount – a culture that needs to change. • Well chaired, allowing all to come in and say what they needed; this is important particularly for topics such as the BAF risk. • Meeting has gone deeper than usual. There are a lot of challenges, as a group they need to look at these areas. From these foundations they will start to build together. • It remains a good idea to have a deep dive on one BAF risk; it anchors all the discussions on one topic. • Value and appreciate the honesty, and openness of discussion. • Very interesting topics were discussed. Promoting our progress in these areas is key to engagement and future improvement.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

There was no specific item requiring decision making.

Risks Identified by the Committee during the meeting:

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

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

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

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

Item	Purpose	Date
None		

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (PUBLIC) – 14 November 2024

Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	1 November 2024	Sal Jarvis, Non-Executive Director	Mark Freestone, Chief Education and Training Officer (CETO)	☒ **Yes**	☐ **No**
Appendices:	none		**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	Assurance rating
1. BAF risk • The OfS have released a briefing paper about their plans for what are now referred to as sub-contracting agreements (formerly 'franchising'). They are likely to be investigating this issue over the coming months and then will issue further guidance about how these are to be managed, if differently. We anticipate this will mean the status quo will prevail until September 2026, and it is possible BAF risk 3 could be downgraded to reflect this decreased urgency.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

2. Success Stories
• It was very exciting to see several successes by DET staff over the past two months:
  ○ Course lead for the M23 Social Work MSc Programme on the nomination of the Anti-Racist Movement (ARM), which she founded and led, for the Social worker of the Year 's Social Justice Advocate award.
  ○ An Associate Lecturer In Social Work, has been nominated for the Lionel Hersov Memorial Award for a practice team who have demonstrated the use of an evidence base in clinical practice.
  ○ Professional Lead for Family Therapy, has been nominated for the Eric Taylor 'Translational Research into Practice' Award, awarded to an individual who has made a sustained contribution to the translating research into practice.
• The CETO and other senior DET staff had the great pleasure of attending and speaking at the first Tavistock Alumni event on 9th October. Around 40 attended out of 50 invitees and it was a very warm, sociable event with a real sense of bringing together old friends who had not seen each other in a while. I spoke briefly about the Trust's recent past and future and met with a range of alumni, some flourishing post-Tavistock and others just beginning their journey as qualified professionals. All were very positive about their time at the Trust.
	Limited ☐
	Partial ☐
	Adequate ☒
	N/A ☐

3. Development	Limited ☐

• DET makes use of over 400 Visiting Lecturers on non-substantive contracts which may be masking underlying staff deficits. A consultation is planned on the use of Visiting Lecturers as well as consolidation of academic roles in the Trust around the 'Lecturer/Senior Lecturer' titles, that will also align us better with University providers. This consultation should take place in early November and report before the end of the calendar year 2024. • ETC heard a paper from the Associate Head of Contracts in relation to DET KPIs which outlined that agreements with placement providers are not being consistently sought or processed for our students. Actions are underway to close gaps in assurance including a review of all DET KPIs which has stalled after the loss of a staff member. • Recruitment for academic support staff is experiencing significant challenges at the Shared Services stage, with requests for appropriate advertisement via, e.g. jobs.ac.uk being challenged or delayed. This is causing delays to optimising DET processes as required for ongoing validation and reporting.	Partial ☒ Adequate ☐ N/A ☐
4. Student Recruitment • 1st November is the first of the 'census' dates for our enrolments and we have 548 new students enrolled out of a total of 616 potential enrolments. 26 have deferred, withdrawn or intermitted meaning our maximum new student intake for September is 576 against a final total of 596 in the previous year (23/24), currently a reduction of 3.4%, awaiting January start which we hope will lead to a more favourable position.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

None.

Risks Identified by the Committee during the meeting:

- Risk in relation to BAF Risk 3.

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
None		

CHAIR'S ASSURANCE REPORT TO BOARD OF DIRECTORS – 14 November 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	5 September 2024	Aruna Mehta, Non-Executive Director	Rod Booth, DoS and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 20**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Integrated Quality and Performance report: • It was noted that waiting times remained the most significant performance risk and continued to increase. • Although the receipt of Elective Recovery Fund monies was anticipated to result in increased activity and reduced waiting times, this expectation had not yet been realised, noting new staff in post were expected to make an impact on waiting times next month. • It was proposed to hold a Board development session to explore strategies for addressing waiting times more thoroughly and the Trust response.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
2. Finance report: • The Trust's reduced cash position was primarily due to the late payment of £1.9 million in HEE income from NHSE. The contract and payment arrangements were still being pursued with NHSE, which had stipulated that the Trust must sign contracts before any payments are made—a change from previous practices. This issue appeared to be widespread, affecting multiple trusts across the country rather than being specific to this Trust. • It was noted that three contracts were at various stages of risk, including decommissioning of the psychotherapy service in Hackney and a renegotiation of contracts with commissioning partners in Surrey and Haringey.	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
3. Escalation • Board development session on waiting times.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

- The Committee was not required to make any decisions.

Risks Identified by the Committee during the meeting:		
• Delays on NHSE cashflow payments being mitigated with escalation		
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**
Board development session on waiting times.		

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Finance Report – As at 30th September 2024 (Reporting Month 06)			**Agenda No.: 21**
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Finance Officer
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 06 (cumulative position to the 30th of September 2024) Finance report. **Income & Expenditure** The Trust incurred a net deficit of £1,144k in the period, against the plan of £1,182k, a positive variance of £38k. The Trust is anticipating achieving its year-end deficit plan of £2,200k, subject to a new risk, a funding gap relating to the 2024/25 pay award being mitigated in full. At the time of writing the extent of the pay award risk was being finalised, but early estimates are c.£1.3m. The additional cost of the recently announced pay award has not been matched by additional income from NHSE via NCL as in previous years. **Capital Expenditure** To date capital spend is limited, totaling £679k, £18k behind the planned spend to date of £714k. This is significantly closer to the plan than previous months with the anticipated catch up in spend starting to impact on the reported position. Anticipated expenditure at the year-end is expected to be on plan (including the additional capital allocation of £268k) at £2,468k. **Cash** The cash balance at the end of M06 was £1,231k against the planned balance of £1,849k. This is an improvement on the previous month but a reduction in the cash support of £200k due to increased aged debtor balances (NHSE debtor of £600k) contributed to the lower than targeted cash position. The Trust are working with NHSE to rectify this anomaly for future periods.		
Background:	The Trust has an agreed deficit revenue plan for 2024/25 of £2.2m, with a Capital Expenditure limit of £2.47m (including the additional allocation from NHSE) and a planned year-end cash position of £1.9m, based on accessing £7.5m cash support in year.		
Assessment:	**Income and Expenditure** The Trusts agreed deficit plan of £2,200k was contingent on the delivery of recurrent efficiency targets of £2,500k and the release of non-recurrent balance sheet opportunities of £2,656k, a total of £5,156k. The Trust will in addition continue to identify and pursue additional income opportunities, not currently part of the 24/25 plan, as part of its development of the medium-term financial plans designed to achieve a balanced financial position in future periods. This being a key part of the merger development and delivery work. **Capital Expenditure** The agreed capital spend limit for the year is £2,468k, an increase on the previously advised figure of £2,200k, which was broadly similar to that in		

	23/24. The increase is due to the Trust sharing in the additional capital awarded to the ICS for delivering a balanced plan in 24/25. Initial planning was based on an expected allocation of c.£1,950k, thus a limited degree of replanning of the capital program will be required in the early part of 24/25 to reflect the additional available capital. **Cash** The agreed plan included a reduction in cash over the year to an outturn of £1,950k, which is driven by the deficit, non-cash income sources in the financial plan for 24/25 and the planned capital spend. This cash flow forecast in the 24/25 plan is reliant on cash support of £7,500k being agreed throughout the year by NHSE. The cash support comes into the Trust via a monthly application for additional non repayable PDC.
Key recommendation(s):	The Board of Directors is asked to **NOTE** the position outlined in the report.

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 9: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 11: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust securing new income streams from the current service configuration.		
Legal and Regulatory Implications:	Yes ☒	No ☐	
	It is a requirement that the Trust submits an Annual Plan to the ICS and monitors and manages progress against it.		
Resource Implications:	Yes ☐	No ☒	
	There are no additional resource implications associated with this report.		
	Yes ☐	No ☒	

Equality, Diversity, and Inclusion (EDI) implications:	There are no specific EDI issues to note within 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 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

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC – Thursday, 14 November 2024			
Report Title: Green Plan Update - October 2024			**Agenda No.: 22**
Report Author and Job Title:	Benita Mehra, Estates Consultant	**Lead Executive Director:**	Peter O'Neill, Interim Chief Finance Officer
Appendices:	Appendix 1 – Green Plan Update October 2024		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	The attached is the draft Green Plan update (previously considered by the Board in December 2023) for discussion and update. An updated version will be brought back to the Board in the new year.		
Background:	The Trust is committed to the NHSE wide target reduction in our carbon footprint by 80% by 2032 and reducing to zero by 2040. An all-staff meeting took place in September 2024, staff were asked for feedback on sustainability (the number of responses ranged from 92 – 115), primary feedback included the suggestions below: • What can you do as a team: working from home, shared offices, printing less, discuss sustainability in team meetings, more vegan food • What can you do as an individual: turn off lights, use public transport, cancel unused bookings, reduce car and bus use, turn off plugs • What can we do as an organisation: Merge, work from home, digital first, no posters, invest in buildings, no leaflets		
Assessment:	The plan attached as Appendix 1 is an update from previously circulated document, with additions for the carbon footprint assessment and travel plan survey outcome. Identified next steps being: • Section to be added for the outcome of the all-staff interactive session • Addition of pictures • Service Delivery Group – clinical input • Potential for 'fume absorbing plants' to be added to all sites • Net zero group to be set up in conjunction with merger partner to be investigated • Updated draft to Board in November for feedback, with finalised document back to January Board. With respect to Sustainable Care Models: pathways for the delivery of excellent quality and safety of care for patients, whilst ensuring efficient use of resources - further engagement is required with colleagues to strengthen this section by ensuring it sufficiently considers and provides the relevant mitigations e.g. preventative healthcare and metrics around self-sufficiency.		
Key recommendation(s):	The Board is asked to **DISCUSS** the suggested updates and provide comments for consideration and inclusion in the finalised document.		

Implications:					
Strategic Ambitions:					
☐ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☒ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☐ Developing a culture where everyone thrives with a focus on equality, diversity, and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 14: Failure to deliver sustainable reductions in the Trust's environmental impact, and to align with the NHS net zero target.				
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 additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no specific EDI issues to note within 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:	Initial draft updated by ELT, 28th October 2024, and considered by PFRC 7th November 2024.				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

The Tavistock and Portman NHS Foundation Trust

Green Plan 2024 - 2027

Contents

Our Manifesto

We live in a time of environmental crisis. The natural world and the finely balanced ecosystem on which all humans depend for our well-being and survival is threatened. As people everywhere engage with this frightening external reality, complex emotional defences may result, leading to an increase in environment related anxiety. People who are directly experiencing environmental disaster may also suffer mental health difficulties because of displacement, loss, and threats to their survival.

The Trust acknowledges that the prevailing scientific evidence demands urgent action and significant change to avoid environmental disaster. The Trust is committed to making these changes and has established an Environmental Group to support us to achieve them.

As a mental health Trust, with national and international reach, we aspire to be leaders in the field of sustainable healthcare and education. As a Trust which is fundamentally concerned with the emotional wellbeing of our community, we want to create ways of thinking about these frightening realities, whilst offering support and containment to those who are suffering as a result of climate change, and hope that with positive action, we can play our part in correcting the environmental course we are on.

We will use our experience and platform to lead change by striving to influence clinical and educational landscapes and policy decisions, by making explicit links between the environment, mental health and wellbeing. These issues have never been more pressing, and it is time they are put centre stage.

We recognise that the Trust and the services we deliver can have a detrimental impact on the natural environment. The Trust is committed to playing its part in addressing the great rebalancing that needs to happen by minimising its impact, reducing its consumption and giving back to the natural world. To achieve this our activities across energy use, procurement and service delivery will need to be refocused to ensure that we are sustainable, and we can keep providing our support into the future.

We are challenging ourselves to make serious positive change and are committed to becoming a carbon neutral, and ultimately, carbon negative organisation which actively removes carbon dioxide from the atmosphere, rather than adding it. To achieve this the Trust will implement a three-step process:

1) Measure our carbon footprint, understand our impact and identify which changes make the biggest difference
2) Reduce our emissions
3) Offset any emissions which cannot be reduced, through carbon removal projects

To achieve this, change is required at all levels of the organisation. Whilst the Trust must be responsible for driving change at an organisational level, all staff, patients and students have the power to make a difference through the actions and choices they make every day. Through information, support and challenge the Trust aims to inspire and enable all its stakeholders to take positive action and make evidence-based, environmentally conscious decisions at an individual level too.

We know that engagement with, and support from, stakeholders across the Trust will be essential if we are to meet our goals. The Trust will be actively seeking suggestions, views and feedback to support us on this journey.

1. The Trust's Green Plan

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS.

Understanding that climate change and human health are inextricably linked, the NHS stated its aim to be the world's first net zero national health service.

NHS Carbon Reduction

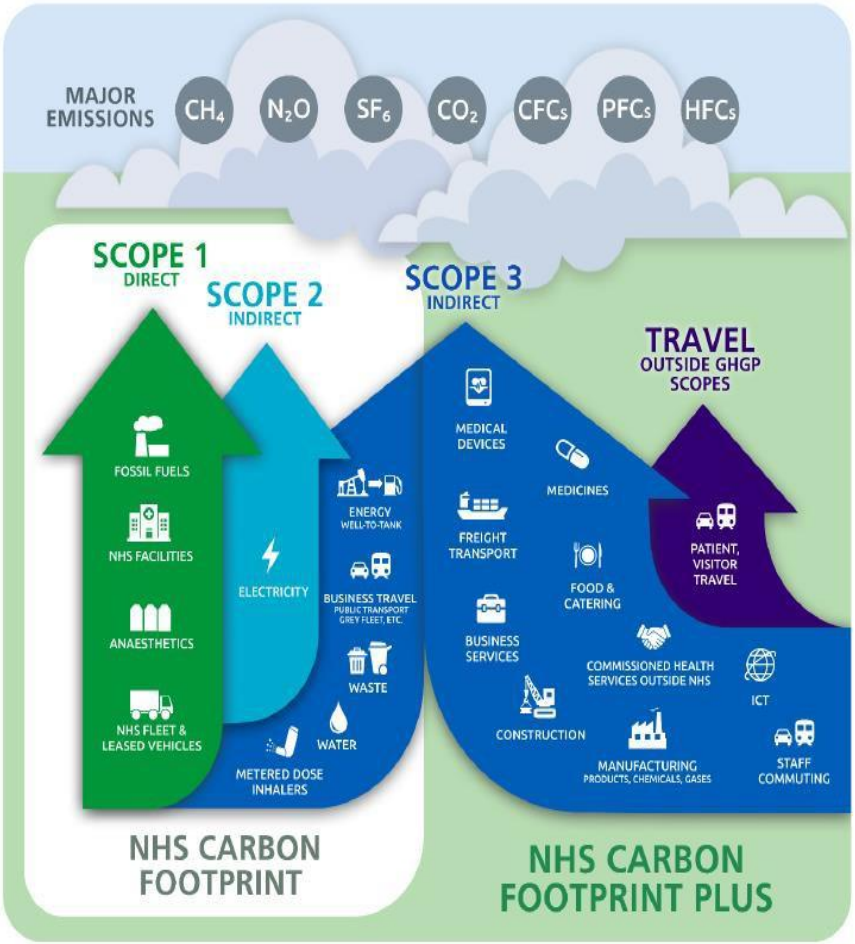
"For a Greener NHS" campaign was launched in January 2020. This set out an ambitious, evidence-based route and date for the NHS to reach net zero. In October 2020, the NHS committed to two targets.

- Carbon Footprint: for the emissions we control directly, net zero by 2040.
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045

The Trust's sustainable priorities in this document reflect the long-term plan of the Greener NHS.

Our Green Plan considers both the national and local context of sustainability within the healthcare sector and considers the external drivers for the NHS.

The following graphic defines the different "scopes" of carbon emissions, and what makes up the NHS Carbon Footprint and Footprint Plus.



The Trust's engages with national and local Greener NHS groups, and with other organisations such as local councils and other stakeholders.

We will continue our work with patients, staff and students to embed sustainability awareness throughout the Trust and reduce the impact on public health and the environment, save money and reach net carbon zero.

The Tavistock & Portman's Green Plan 2024 – 2027 is a refresh to our first plan and is our guide to enable the Trust to becoming truly sustainable. The document aims to set out a clear strategy, to ensure continued progress against carbon reduction targets and other sustainability objectives.

Throughout the transition to becoming Net Zero by 2040, this document will be reviewed and updated to ensure we monitor and impact on those activities which have a negative impact on the environment. This will require the Trust be responsive to opportunities, working with our partners, to determine the success of our ability to meet the objectives set by NHSE.

The associated actions identified are intended to be organic, changing and developing, reflecting the achievements and progress that is made.

Success in the actions will demonstrate The Trust's commitment and achievements towards being an environmentally responsible organisation, contributing to the minimisation of climate change and increased protection of natural resources.

2. About us

We are a specialist NHS mental health trust with a focus on training and education as well as providing a full range of mental health services and therapies for children and their families, young people and adults.

We are also a global centre of excellence in clinical practice, training and education, and innovation in the fields of mental health and emotional wellbeing. Our distinctive approach to mental and emotional wellbeing focusses on the importance we attach to developmental, psychological and social experience at all stages of people's lives across three key areas:

Education: the Trust is a pioneer in mental health, social work and leadership education. We train clinicians, social workers, nurses, teachers and many other professionals. Our clinician-tutor model and multidisciplinary approach ensures our courses are relevant, transformative and empowering.

Clinical services for children and adults: we provide over 30 specialist and community services in Camden, across London and nationally.

Research: our research and innovative approach began just after the First World War following successful recovery of military personnel using the Tavistock model, leading to extensive global trials and proven inquiry for a century. Since our inception, we have built a reputation as a testing ground for fundamental new ideas and practices. For decades our work has helped shape how we see ourselves, as people and as a society. Much thinking that has entered the mainstream emerged from its challenging interdisciplinary research and practice.

Our vision, mission and values

For 100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and emotional wellbeing.

Our vision

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

Our mission

Our mission is to work in partnership with people, families and communities to provide high-quality specialist mental healthcare, alleviate emotional distress and pioneer innovative education and research

Our values

We strive for **excellence**

We champion **inclusivity**

We place **compassion** at our core

We have **respect** for each other

3. Where are we now

The Tavistock and Portman has outlined a comprehensive three-step process designed to reduce its environmental impact:

1. **Measure our carbon footprint**: By thoroughly assessing our current carbon emissions, we aim to understand the full scope of our environmental impact and identify the areas where change will have the greatest effect.
2. **Reduce emissions**: Through strategic initiatives, we are actively working to decrease our carbon output across all aspects of our operation.
3. **Offset any remaining emissions**: For emissions that cannot be eliminated, we will engage in carbon removal projects, ensuring that our net impact is zero.

   As part of this strategy, the Tavistock and Portman has already begun implementing practical measures to drive down carbon emissions and promote sustainable practices within the organisation:

- **Energy reduction strategy**: We have initiated a programme to reduce overall energy consumption across our facilities. By improving energy efficiency, we aim to minimise waste and lower our carbon footprint.
- **Promoting sustainable transport**: we are actively encouraging our employees to participate in the cycle-to-work scheme. This not only reduces transport-related emissions but also supports healthier lifestyle choices.
- **LED lighting**: In a bid to cut down on energy usage, we have installed LED lighting across 70% of our estate, offering a significant reduction in electricity consumption.
- **Switching to NHSE utility suppliers**: In April 2025, we will transition to national NHS England utility suppliers once our current contract expires. This move is aligned with broader NHS sustainability goals and will ensure that we are sourcing our energy from greener, more sustainable sources.
- **Waste management**: We are currently trialling a new waste provider to gain better insights into our waste streams and consumption habits. Understanding these factors will help us reduce waste and promote recycling efforts.
- **Carbon assessment**: A thorough carbon assessment is underway, providing us with the data needed to make informed, impactful changes.
- **Recycling office furniture**: We are committed to extending the lifecycle of office furniture by recycling, which prevents unnecessary waste and reduces demand for new materials.
- **Recycling WEEE (Waste electrical and electronic equipment)**: A new contract is in place to ensure that electronic waste is properly recycled, preventing harmful environmental impacts from improper disposal.

To truly achieve our net zero ambitions, we need to take further, proactive steps. This includes making evidence-based, environmentally conscious decisions that go beyond the actions of the organisation.

We need to remain committed to continual improvement. This means assessing and adjusting our strategies regularly, incorporating new technologies and innovations, and remaining transparent about our progress toward our carbon-neutral and carbon-negative goals.

4. Areas of focus

Our People

Improved health and wellbeing and of our staff by encouraging healthy and sustainable behaviours

The health and wellbeing of our staff is integral to the sustainability of the Trust and the running of our services. We aim to support staff and students to make sustainable choices that their enhance well-being, support the health and wellbeing of our patient community and the reduction of health inequality.

Through our Green Plan we will seek to educate, inform and empower people to make different choices that will both reduce their impact on the environment while also improving health. We aim to embed sustainability training across the Trust and support staff by setting expectations at staff inductions.

Staff engagement is key to increasing knowledge and awareness of environmental and sustainability issues. We will develop a dedicated Trustnet section as well as more regular articles about sustainability progress that we will share with the wider community.

The Trust will continue to engage via sustainability surveys to highlight what staff believe are the most important actions for inclusion in the green plan, and how staff can help achieve targets.

We aim to increase the staff uptake of healthier active travel choices in their journeys to and from work and with business travel. The Trust carried out its first staff travel survey in the spring of 2024, this will be an annual exercise and used to monitor our aims on reducing emissions through staff commutes and business travel.

Key Actions

- Develop a staff engagement programme and an active communications strategy to raise awareness about sustainability at every level of the organisation.
- Aligning the wellbeing and sustainability agendas will add value and impact to the benefit of staff, patients and wider community.
- Reintroduce the staff environmental group.
- Include section on sustainability in induction, appraisals and job descriptions, with each individual PDP includes a reference to carbon neutral objective.
- Identify opportunities for training and e-learning modules that will help achieve sustainability objectives and improve general knowledge around sustainability

Measuring Progress

- Undertake an annual staff travel survey to monitor change in staff travel
- Sustainable behaviours will be considered in all staff personal development objectives.
- Monitor business travel to identify business mileages and emissions

Asset Management and Utilities

Proactively decarbonise and improve energy efficiency of our estate.

The Trust's estate is a significant consumer of energy (electricity and gas) and water, which contribute to a major proportion of the Trust's carbon dioxide emissions.

A key goal is to improve energy performance and management across all sites to reduce the carbon impact associated with utilities

We have in the last year's improved on the data gathering of energy usage for our sites and have installed automatic meter readings (AMR) for our electricity and gas meters. We have installed LED lighting across the Trust's (where feasible). We have switched to a greener energy tariff and all electricity is now from renewable sources.

Due to the size of the Trust, we do not employ a full time Energy Manager. We will work with suppliers to ensure savings are maximised and that innovative technologies are identified that can help us reduce energy. We have worked with water services consultants to manage improvements via the Aquafund grant to reduce wastage and ways to monitor our usage.

We are starting to use our Building Management System (BMS) to track temperatures and optimise efficiencies for heating.

Key Actions

- Monitor our energy and water use closely, across all our sites.
- Encourage behaviour change within the Trust in conjunction with a staff forum to proactively improve energy efficiency and identify energy wastages.
- Ongoing replacement of fluorescents with LED lighting and plant with more efficient equipment
- identify opportunities for external funding of energy efficiency measures
- At later stage - develop feasibility studies to electrify heating systems (including hot water) e.g. heat pumps and develop a Heat Decarbonisation Plan

Measuring Progress

- Undertake an annual carbon footprint for the Trust's activities to measure progress against carbon reduction targets
- Continue to record and monitor electricity, gas, and water consumption.

Travel & Logistics

To reduce the negative impacts from travel by supporting staff, students and patients to use more sustainable forms of travel.

Sustainable forms of travel, and the reduction in the number of journeys necessary, have a range of benefits. These dovetail with the need to reduce the negative environmental impacts of transport activities, such as carbon dioxide emissions, local pollution and congestion.

The Green Plan aims to promote sustainable travel at the Trust to improve air quality across our sites and reduce the impact of polluting transport on public health and the environment.

A key priority is to establish a baseline of how patients, staff and students travel to our facilities and how we can encourage more use of active travel and public transport through communications and engagement.

We have conducted a Trust-wide staff travel survey and this we be repeated annually, this will help establish a baseline on staff travel including improved detail on our business travel. Reducing single-person vehicle travel would help our sites that experience limits on nearby car parking and congestion, as well as easing late or missed appointments because of lack of parking availability.

The Trust offers Cycle scheme, an employee benefit that saves staff 25-39% on a bike and accessories. With nothing to pay upfront, payments are taken tax efficiently from your salary.

As part of the carbon reduction of our supply chain, a longer-term goal is to establish a baseline for our suppliers, this will include areas such as where suppliers source their materials from, and their travel impact.

Key Actions

- Explore how to obtain accurate data on business travel, patient travel and staff commuting.
- With staff consultation look to improve secure cycle facilities, including parking spaces, showers and lockers
- Provide users with links to existing walking and cycle routes around Trust sites, in line with the London Mayor's agenda to improve of air quality.

Measuring Progress

- Undertake an annual staff travel survey
- Include air quality date as part of the information gathering and monitoring exercises

Adaptation

To ensure that the Trust is prepared for the effects of climate change by clearly identifying the risks and responding to them

The effects of climate change pose a range of risks to the health of local populations and the ability of our services to operate effectively. By ensuring the resilience of our organisation through emergency preparedness, response and business continuity planning, we can be more prepared for unexpected situations.

To enable the long-term delivery of services and the continued safety of all patients, staff, students and visitors the Trust needs to be resilient against the impacts of climate change on our infrastructure, supply chain and resources.

The Trust has contingency plans in place for major incidents, including an adverse weather plan. However, the risks from climate change should be further integrated into the Trust's risk assessment process and adaptation planning.

Key Actions -

- Embed climate change risks into Emergency Preparedness and business continuity planning
- Continue to update the Trust Risk register to include climate change effects
- To consider and develop a Climate Change Risk Assessment (CCRA)
- To consider and develop a Climate Change Adaptation Plan

Measuring Progress

- Assess the financial impacts of climate change to our Trust and measure activities that lead towards carbon net zero.
- Number of climate change impacts recorded on the risk register

Capital Projects

To take a whole life costing approach that incorporates sustainability principles in all refurbishment and new building projects

The Trust will consider sustainable design principles that improve service users experience and contribute to the wellbeing of staff, students and all who use our spaces.

Our existing estate was not designed as low carbon assets. In recent years we have undergone renovation and refurbishments including work towards improvements on the energy efficiency and operational running of our buildings. We have recently moved out of inefficient buildings, consolidating the estate and improving estate management operations.

Our Capital Project teams have knowledge of the sustainability outcomes within their roles, including energy efficiency technologies, space utilisation and adaptation. We will educate and support staff to make energy efficiency decisions from the environment controls available.

We are committed to delivering the requirement of the NHS 2020/21 planning guidance that all new buildings must be designed to be carbon neutral.

Key Actions

- Review design briefs to ask for low carbon, low environmental impact proposals and solutions from suppliers and partners.
- Create a sustainable capital projects process to ensure sustainability is maximised on major refurbishments
- Create a set of scalable sustainability aims for all capital projects and major refurbishment
- Design our capital projects and major refurbishments to be usable during future projected weather profiles such as extreme heat

Measuring Progress

- Agree a set of sustainability certifications to monitor the performance of existing buildings
- Undertake occupancy surveys to ensure we maximise the value of our estate by delivering services in the most efficient manner

Green space and biodiversity

To manage the Trust's green spaces in a way that reflects the importance of the natural environment for people's health

The Trust is responsible for the maintenance and preservation of its green spaces around its estate. These areas provide an important role in providing habitats for many species and contribute to the wider biodiversity in the surrounding environment.

There is significant evidence that demonstrates the health and well-being benefits of being in green space. The use of green space is often limited in London and the Trust's green spaces are valued by all who access them. Our garden areas are used by patients for a therapy gardening group, staff and students.

To protect the environment outside of our control, we will ensure all timber and paper products we use meet the government guidelines such as FSC and recycled paper.

Key Actions

- Maintain our greenspaces to protect biodiversity and enhance where possible
- Promote and enable the use of our green space to our staff, students, patients
- Consider biodiversity and habitat protection in any construction projects
- Ensure all timber and paper products meets government guidelines
- Assess the levels of air pollution, based on the London Mayor's map of pollution options could include fume absorbing plants considering local biodiversity.

Measuring Progress

- Assess whether our green spaces are safe, clean and accessible
- Assess the impacts of our services on local biodiversity
- Monitor how garden waste is composted on or off site.

Sustainable Care Models

Pathways that deliver excellent quality and safety of care for patients whilst ensuring efficient use of resources

The Trust aims to improve patient, staff and student experience by moving to more sustainable workplace practices. We are committed to delivering sustainable models of care and embedding sustainability across all departments within our organisation

The Trust continues to collaborate with the Integrated Care Board (ICB) on sustainable models of care. Engagement with clinical teams will be essential to develop and enable lower carbon, more sustainable models of care.

We aim to use of every opportunity to minimise health inequalities, and to support wellbeing for all. We will streamline process and pathways to reduce waste and duplication within our systems and ensure delivery of safe and effective care.

Where the Trust procures products, suppliers, technologies, and use processes and pathways that aim to reduce our carbon, environment and health impacts.

Key Actions

- Explore where our sustainability programme can most effectively support our work around health inequality, with a particular focus on the areas set out by NHSE: fuel poverty, air quality and access to green spaces
- Include sustainability as a part of the quality of care we provide
- Integrate sustainable principles into the Trust quality improvement (QI) programme and policy.
- Consider opportunities to educate and inform our patients on the choices they can make to improve health and wellbeing beyond their time in our care

Measuring Progress

- Analyse staff, patient and student surveys
- Monitor success of our carbon footprint

Sustainable Use of Resources

To improve the Trust's use of resources, to reduce waste through better procurement decisions and improved waste management

NHS organisations can use their individual or collective purchasing power and decisions to reduce carbon embedded in supply chains.

- Since April 2022 all NHS procurements have had to include a 10% net zero and social value weighting.
- All new contracts from April 2024 requires suppliers to publish a Carbon Reduction Plan for their UK scope 1 and 2 emissions and a subset of scope 3 emissions as a minimum.

The Trust will follow guidance from NHSE through its PTOM (Procurement Target Operating Model) programme. We will align with the ICS and seek out joint procurement services where possible.

NHS England's stated policy objective is to meet its Net Zero carbon targets while achieving its wider Social Value priorities. Looking beyond the financial cost to how services procured could improve economic, social and environmental well-being factors, et promoting a circular economy, provide training opportunities and job creation as well as reduction carbon and waste. Our work with the catering and gardening services is an example of this working in practice. The Trust has moved considerably towards using recycled paper and a paper light organisation

The social value question will need to be specific to each contract and how impact can be measured and monitored. The Trust needs to be mindful of these mandatory requirements around procurement, especially with some our smaller suppliers to ensure they are not disadvantaged.
The Trust's Carbon reduction plan will be part of its Selection Questionnaire submission (SQ) regardless of the value of the contract and will require an annual update.

Key Actions

- Develop processes to ensure environmental and social value considerations are embedded within the tendering processes through to contract management stage.
- Where applicable we query suppliers' approaches to equality and diversity
- We will take circular economy principles to reduce waste and reuse/recycle what we can
- Consider alternative arrangements of paper communication with the majority of patients
- Commit to a zero to landfill policy, improve segregation of waste as WEE waste was introduced in 2024 and recycling of furniture.
- Create a sustainable products inventory for frequently purchased items
- Include energy efficiency in the procurement criteria for ICT appliances

Measuring Progress

- Environmental and social value outcomes monitoring will be embedded in each contract with clear lines of reporting.
- Report how the Trust approach is leading to a continual reduction in our levels of waste types
- Monitor and report reduction of CO2

Carbon & Greenhouse Gases

Carbon and sustainable development should be explicit and accounted for in every aspect of NHS life

Since October 2020, the NHS committed to two targets around carbon emissions

- Carbon Footprint: for the emissions we control directly, net zero by 2040.
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

We recognise that the Trust contributes to carbon emissions and acknowledge our responsibility to minimise this impact by decarbonising our estate. We will work towards the overarching NHS net zero carbon target of 2040. Data gather and reporting on emissions to NHSE are in accordance with PPN 06/21–21 and associated guidance and reporting standard for Carbon Reduction Plans.

See appendix one for detail on category definitions.

Significant inroads have been made on building energy where improvements have been made in the region of 12%. Focus is required on the collection of business and patient travel as well as staff commuting. Currently the Trust's largest emissions sit within the Trust's other supply chain and commissioned health services, this will be a priority area and provides a substantial potential for reduction.

Key Actions

- Develop a Carbon Reduction Plan
- Procurement will develop a sustainable procurement policy, to ensure carbon emissions and sustainability performance are embedded in procurement and contract management.
- Finance will focus on categorising spend data for the NHS Carbon Footprint plus and improve accuracy of our data reporting.

Measuring Progress

- Create granular assessment with carbon emissions for the other supply chain category
- Monitor greenhouse gas emissions from energy use, water, waste and transport
- Produce an annual carbon footprint and track progress

5. Stakeholder Involvement /communication

The Trust's manifesto was developed by staff and is a statement of how many people feel within the organisation and who are committed to making change happen.

For the Green Plan to succeed the Trust will need a structured and engaging approach to communications so that we can effectively drive sustainable development across the Trust. We need to ensure a collaborative environment is created and maintain on these issues through a variety of communication platforms.

Ideas for a local sustainability champions across the Trust and staff interest groups would provide a space for feedback and engagement. An intranet page will publicise achievements and priorities, publicise national and international events and aim to encourage participation.

The Trust will continue to collaborate with service providers and partners, and other Greener NHS and other organisations locally and nationally.

Trust will continue to engage with staff, students and service users. Key communications and engagement activities will include developing materials as an aid to behavioural changes, walking travel and sustainability map links to improve awareness of sustainability initiatives.

The Trust will work with established organisations in sustainable healthcare, and with partners such as Greener NHS and the wider community through a variety of communications platforms

6. Governance

All employees working for the Trust will be required to adhere to all legislative duties outlined within the Green Plan, and are expected to actively engage with, this plan and actions tailored towards their specific areas of work.

A sustainability lead will report to the Board regularly on key actions and measurable outcomes. The Board will retain responsibility for reviewing and approving the produced and submitted Green Plan, along with providing strategic oversight and support where necessary. This Board will be responsible for the progress of the actions within the Green Plan.

Directors and Leads will ensure their department or team is able to implement key actions and policies related to this Plan. They will be responsible for managing the input required to achieve targets and providing necessary strategic direction and support to their staff.

The Trust will explore reinstating a Green Plan / Environmental Group to help support wider engagement and provide a space for feedback and ideas for sustainability initiatives across the Trust and wider community.

7. Monitoring and Reporting

The Greener NHS Programme will use a unified approach to collection of data, monitoring and

reporting of progress against targets at national, regional and system level to support delivery of the programme's commitments.

The Green Plan will be used to support reporting in relation to energy usage and environmental impacts.

The Trust currently reports on the below platforms for performance relating to Estates and Facilities management. The Estates Returns Information Collection (ERIC) is completed annually and includes performance relating to energy, water and waste, and is benchmarked against similar types of organisations.

Estates Returns Information Collection (ERIC)	Mandatory reporting for all NHS Trusts. Comprises information relating to the costs and figures for operating the NHS estate including buildings, maintenance, equipment, provision of services and utilities
Premises Assurance Model (PAM)	Management tool used to provide NHS organisations with a method for assessing the safety and efficiency of their estates and facilities services.
Trust Annual Report	Sustainability is reported on in the Trust's annual report in a dedicated section. This publicly details the Trusts sustainability achievements and communicates the Trust's carbon footprint
Sustainability KPI reporting	There is a need to implement a mechanism for reporting on sustainability KPIs at board level. This is a key action identified in the Action Plan

8. Risk

There are numerous risks posed by failing to respond to climate change or not complying with associated regulations and legislation. In order to ensure that the Trust is sufficiently prepared for the effects of climate change and increased local demand on services, the likelihood and severity of the risks identified below should be identified and an adaptation plan developed in response to the scale of the risk. Several key areas of risk are summarised below:

Health	Climate change will increase the health risk from higher temperatures and extreme weather events including the mental health impacts of flooding on local communities.
Environmental	Although the environmental risks are difficult to quantify, it is clear that the effects of pollution and climate change will have a profound impact on our organisation and the health of our communities.

Financial	Increasing energy prices and waste disposal costs underline the need to continue to improve efficiency. Even though price increases may cancel out some of the efficiency savings, improving efficiency can help to mitigate against future price rises.
Legislative	There is a risk to the Trust from not complying with legislation, including financial penalties and reputational damage. This risk is mitigated through monitoring systems, auditing and training
Inequalities	Widening inequalities of access and outcome for individuals and communities because of extreme weather events, reduced food security and increased food prices, the impact of sir pollution etc.
Organisational	Sustainable development is not only important in becoming a resource efficient organisation and managing the risks associated with climate change, but it also affects public perceptions of the Trust. Therefore, it is important we take a leading approach with a comprehensive strategy and strong reporting structures.

The Trust recognises the important of sustainability (net carbon) and the risk to the environment as it looks to drive for a Greener NHS

Appendix 1- Categories within each scope and relevance to the Tavistock & Portman NHS FT

Scope 1	Anaesthetic gases	The Trust's services do not require the need for such gases, this data has been consistent with the measures since 1990, with no suggestion that this will change in the foreseeable future
Scope 1/2/3	Building energy	There has been a marked reduction, 12% since 2019 and has been attributable to a larger percentage of LED lamps having been installed across the Estate, circa 60%. Upgrades to electrical infrastructure. As there has also been a drive to reduce consumption by introducing more shared amenities. The next stage is around behavioural change where data is shared with users to encourage further efficiencies
Scope 1	Business travel and fleet	The Trust does not operate a fleet, with business travel accounting for the bulk of the carbon. Further analysis is required as there may be further opportunities through behavioural change as the baseline in 2019 may have been miscalculated.
Scope 1	Metered Dose Inhalers	The Trust's services do not require the need for such gases, this data has been consistent with the measures since 1990, with no suggestion that this will change in the foreseeable future
Scope 3	Waste	A 52% reduction in waste having taken place since 2019, primary gains have been around reviewing food waste, increasing recycling and incremental changes around reducing the amount of printing
Scope 3	Water	Water measures have been introduced with further opportunities in considering the use of grey water and harvesting and will be considered when undertaking infrastructure development
Scope 3	Medical equipment	The types of medical equipment is very small in number with little impact on carbon.
Scope 3	Medicines and chemicals	No pharmacies or medicines are delivered through the Trusts sites, there is further analysis around the chemicals to see if there are opportunities through the other supply chain
Scope 3	Non-medical equipment	The granularity of the data is still be assessed as opportunities may arise from the other supply chain as the level of equipment used by the Trust is small in nature and may lead to a redistribution from the other supply chain
Scope 3	Other supply chain	The bulk of carbon production is through the extended supply chain. With a 6% increase, the focus of this Trust is to review and work with its supply base to consider further recycling, renewal and reduction in carbon as the Trust is committed to working with its partners and in find alternative opportunities.
Scope 3	Patient and visitor travel	The Trust does not operate a patient transport service, however patients and students will be surveyed over the coming year to determine the travel methods used to attend appointment or training events
Scope 3	Staff commuting	Surveys have taken place in Spring 2024
Scope 3	Commissioned health services	The commissioned health services, greater granularity will allow the Trust to seek more information from its partners including UCL, GOSH and ICB

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 14 November 2024			
Report Title: Board of Directors (Public) Schedule of Business 2024/2025			**Agenda No.: 23**
Report Author and Job Title:	Fiona Fernandes, Business Manager Corporate Governance	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Board of Directors (Public) Schedule of Business 2024/2025		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	This report provides the Public Board of Directors Schedule of Business for 2024/2025.		
Background:	It is good corporate governance practice for the Board and its Committees to agree a forward Schedule of Business of its activities ahead of a new financial year. **Process undertaken:** The process of producing the Board schedule of business is conducted annually (ahead of the March/ April cycle of meetings) and it is facilitated by the Corporate Governance team function in consultation with the Chief Executive and /or the Chair.		
Assessment:	The Board is asked to note that the Schedule of Business is a live document, and it may be updated overtime depending on the Trust's priorities and other external/ regulatory factors. The Board Schedule of Business will be presented at each meeting of the Board for information highlighting any changes to the planner. Diary appointments for the 2024/2025 meetings have been issued to members. Any future changes to dates will be reflected in the Forward Planner.		
Key recommendation(s):	The Board is asked to **NOTE** the Public Board of Directors Schedule of Business for 2024/2025.		

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		

	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 Schedule of Business.			
Legal and Regulatory Implications:	Yes ☒		No ☐	
	The Board Schedule of Business 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 additional EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	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			2024					2025			Board / Committee / Meeting				
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**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)**	**Delivery ▼**
Date of Meeting			**09-May**	**11-Jul**	**12-Sep**	**14-Nov**	**16-Jan**	**13-Mar**							
Paper Deadline			**25-Apr**	**27-Jun**	**29-Aug**	**31-Oct**	**02-Jan**	**27-Feb**							
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			Verbal
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Verbal
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/ (	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Closing Matters (every meeting)															
Annual Board Schedule of Business (For approval in May 24)	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Enclosure
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Bi-monthly (6)															
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly			Enclosure (inc.FS)
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly			Enclosure (inc.FS)
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			High Quality Clinical Services	Bi-monthly			Enclosure (inc.FS)
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Develop & Deliver a Strategy & Financial Plan	Bi-monthly			Enclosure (inc.FS)
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Bi-monthly			Enclosure (inc.FS)
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			Enclosure (inc.FS)
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly			Enclosure (inc.FS)
Integrated Governance Action Plan Report	Assurance	CEO		P	P	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	Enclosure (inc.FS)
Quarterly (3 - 4)															
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDOCG	P			P	P	P			Well-led & Effectively Governed	Quarterly		Nadia Munyoro, Risk & Assurance Manager	Enclosure (inc.FS)
Audit Committee Chair's Assurance Report	Assurance	NED		P			P	P			Well-led & Effectively Governed	Quarterly			Enclosure (inc.FS)
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			Enclosure (inc.FS)
Guardian of Safer Working Report	Information	ICMO			P		P	P			High Quality Clinical Services	Quarterly			Enclosure (inc.FS)
Six-monthly (2)															
Mortality / Learning from Deaths	Assurance	ICMO			D	P		P			High Quality Clinical Services	6 monthly			Enclosure (inc.FS)
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			Enclosure (inc.FS)
Review of Committee Terms of Reference	Approval	Chair				P					Well-led & Effectively Governed	Annual		Dorothy Otite, Governance Consultant	Enclosure (inc.FS)
Medical Revalidation	Discussion	ICMO				P					Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Freedom to Speak Up Guardian Annual report	Discussion	IDOCG			D				POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
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			Enclosure (inc.FS)
Quality Priorities 2024-2025	Discussion	ICNO	P						Quality Committee		High Quality Clinical Services	Annual			Enclosure (inc.FS)
Staff Survey Results and Action Plan	Discussion	CPO	P				P		POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Workforce Disability Equality Standard (WDES)	Approval	CPO		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)

The Tavistock and Portman NHS Foundation Trust

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Date of Meeting			**09-May**	**11-Jul**	**12-Sep**	**14-Nov**	**16-Jan**	**13-Mar**							
Workforce Race Equality Standard (WRES)	Approval	CPO		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Gender and Race Pay Gap	Approval	CPO						P	POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Equality, Diversity and Inclusion Annual Report 2023/24 (including Department of Education & Training)	Approval	CPO		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Research and Development Annual Report	Discussion	ICMO			P						High Quality Clinical Services	Annual		Director of Research and Development	Enclosure (inc.FS)
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		P					Quality Committee		High Quality Clinical Services	Annual			Enclosure (inc.FS)
Annual Objectives and Strategic Priorities (Final)	Approval	CEO				P					Corporate Reporting	Annual			Enclosure (inc.FS)
Compliance Against Provider Licence	Approval	IDOCG		P					Audit Committee		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Financial Plan update 2024/25	Approval	CFO	P								Develop & Deliver a Strategy & Financial Plan	Annual			Enclosure (inc.FS)
Non-Executive Director Commitments 2025/26 (including Champions and Committee Membership)	Approval	Chair						P			Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Board and Board Committee Meeting Dates 2025/26	Approval	IDOCG		P							Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Honorary Doctorate Nominations	Approval	ICETO					P		Education & Training Committee		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
National Annual Patient Survey report (when available)	Discussion	ICNO							Quality Committee		High Quality Clinical Services	Annual			Enclosure (inc.FS)
Board Skills Review	Discussion	Chair							RemCo		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Fit & Proper Persons Test	Discussion	Chair		P					RemCo		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Board Development Programme	Discussion	Chair			P				RemCo		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Medium Term Financial Plan update	Approval	CFO	P						Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Annual			Enclosure (inc.FS)
Annual Plan 2025/26	Discussion	CEO						P			Develop & Deliver a Strategy & Financial Plan	Annual			Enclosure (inc.FS)
Board Service Visits	Discussion	CEO					P				Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Strategy / Policy Approval/Ratification (usually every 3 years)															
Year 1 (2023/24)															
Modern Slavery Statement	Approval	ICNO									Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Scheme of Delegation	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Standing Financial Instructions	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
People Strategy and Plan	Approval	CPO							POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Staff Engagement Strategy (Internal Communications Strategy)	Approval	DCE		P					POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Year 2 (2024/25)															
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly			Enclosure (inc.FS)
Green Plan/ Sustainability Strategy	Approval	CFO			D	P			Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly			Enclosure (inc.FS)
External Board Review (once every three years) Report	Discussion	Chair							RemCo		Well-led & Effectively Governed	3 yearly			Enclosure (inc.FS)
Year 3 (2025/26)															
Ad hoc/ As Appropriate															
Items to consider - Gloucester House	Approval	ICNO				P					Well-led & Effectively Governed				
Items to consider - Informatics Strategy	Discussion	IM&T				D			Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan				