



The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

**Wednesday
13th December
2023**

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

**Please refer to
the agenda for
timings.**

**MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON WEDNESDAY, 13 DECEMBER 2023 AT 2.00PM – 5.00 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL**

AGENDA

23/	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
004	Service Presentation - Camden Whole Family Team	Discussion	Chair	V	2.05 (20)	
005	Minutes of the Previous Meeting held on 11 October 2023	Approval	Chair	E	2.25 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.30 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.35 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.40 (10)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
Comfort Break (10 minutes) 3.00pm – 3.10pm						
DELIVER HIGH QUALITY CLINICAL SERVICES which make a significant difference to the lives of the people & communities we serve.						
009	Quality And Safety Committee Assurance Report	Assurance	Quality Committee Chair	E	3.10 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
010	Guardian of Safer Working Report	Information	Chief Medical Officer	E	3.15 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/>

						Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
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.						
011	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	3.20 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
012	Education and Training Committee Assurance Report	Assurance	Education & Training Committee Chair	E	3.25 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
013	Green Strategy	Discussion	Interim Chief Finance Officer	E	3.30 (10)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
014	Vision, Mission and Values	Approval	Chief People Officer/Director Communication & Engagement	E	3.40 (10)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
DEVELOP & DELIVER A STRATEGY & FINANCIAL PLAN that supports medium & long-term organisational sustainability & aligns with the ICS.						
015	Performance, Finance and Resources Committee Assurance Report	Assurance	PFR Committee Chair	V	3.50 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
016	Finance Report – Month 7	Discussion	Chief Finance Officer	E	3.55 (10)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
WELL-LED AND EFFECTIVELY GOVERNED						
017	Integrated Audit and Governance Committee Assurance Report	Assurance	Audit Committee Chair	E	4.05 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
018	Scheme of Delegation	Approval	Chief Finance Officer	E	4.10 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
019	Integrated Governance Action Plan Progress	Assurance	Chief Executive Officer	E	4.15 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
020	Fit and Proper Person Test – Policy and Procedure	Approval	Director of Corporate Governance	E	4.20 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
021	Board and Board Committee Meeting Dates 2024/25	Approval	Director of Corporate Governance	E	4.25 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>

022	Board Service Visits	Discussion	Director of Communication and Engagement	E	4.30 (10)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
CLOSING ITEMS						
023	Board Forward Planner	Information	Chair	E	4.40 (5)	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>
024	Questions from the Governors	Discussion	Chair	V	4.45 (10)	
025	Any other business (including any new risks arising during the meeting): <i>Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting</i>	Discussion	Chair	V		
026	Questions from the Public	Discussion	Chair	V		
027	Reflections and Feedback from the meeting	Discussion	Chair	V	4.55 (5)	
DATE AND TIME OF NEXT MEETING						
028	Wednesday 21 February 2024 at 2.00pm – 5.00pm					

**UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO
HELD IN PUBLIC
WEDNESDAY, 11 OCTOBER 2023 AT 2 P.M.
LECTURE THEATRE 5th FLOOR, THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
AND VIRTUALLY VIA ZOOM**

PRESENT:

John Lawlor	Chair of the Board of Directors	JL
Deborah Colson	Non-Executive Director and Vice Chair	DC
Aruna Mehta	Non-Executive Director, Chair of the Performance, Finance and Resources Committee and Joint Chair of the Audit Committee	AM
David Levenson	Non-Executive Director and Joint Chair of the Audit Committee	DL
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 Committee	CJ
Sal Jarvis	Non-Executive Director and Chair Education and Training Committee	SJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality Committee	JJ
Michael Holland	Chief Executive Officer	MH
Sally Hodges	Deputy Chief Executive and Chief Clinical Operations Officer	SH
Caroline McKenna	Previous Interim Chief Medical Officer	CMcK

IN ATTENDANCE:

Kathy Elliot	Stakeholder Governor and Lead Governor	KE
Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Rod Booth	Director of Strategy and Transformation	RB
Clare Scott	Chief Nursing Officer	CS
Jane Meggitt	Interim Director of Communications and Marketing	JM
Gem Davis	Chief People Officer	GD
Peter O'Neill	Interim Chief Finance Officer	PON
Elisa Reyes-Simpson	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	ERS
Mike Smith	Head of Communications and Engagement	MS
Reni Aina	Corporate Governance Officer (Minutes)	RA
Jenny Jones	Executive Assistant	JJS
Claire Kent	Clinical Lecturer and PPI (Patient and Public Involvement) Lead	CK
Marcy Madzikanda	PPI Officer	MM

APOLOGIES:

Chris Abbott	Chief Medical Officer	CA
--------------	-----------------------	----

MINUTE NO.	ACTION (INITIALS)
23/001	WELCOME AND APOLOGIES FOR ABSENCE
The Chair, JL welcomed all in attendance. Apologies for absence were received from Chirs Abbott.	

23/002 CONFIRMATION OF QUORACY

JL confirmed that the meeting was quorate.

23/003 DECLARATIONS OF INTEREST

There were no declarations of interest that related to business discussed at the meeting.

The Board received and noted the Register of Directors' Interests 2023/24, as of 8 September 2023.

23/004 PATIENT/ SERVICE USER EXPERIENCE

JL welcomed Claire Kent, PPI Lead and Marcy Madzikanda, PPI Officer to the meeting. The Board watched a video recording of an interview with a parent whose son had been a patient at the Tavistock CAMHS, Bounds Green.

The parent gave an outline of their experience of the service, setting out what worked well and what could improve.

Compliments included:

- It was good to work with a clinical social worker and staff in the family team.
- It was easier to attend appointments at a local outreach centre.
- The service user felt valued and listened to by taking part in patient interviews, forums and panels.
- Ideas and suggestions on how to improve the service were taken seriously and appeared to be actioned.

Suggestions for improvement included:

- Care ending at age 18 was too abrupt, the offer of help should continue for 18 - 25-year-olds.
- In cases where there is a family, the family unit should be looked at as a whole. If help is needed, this should be offered until the youngest child reaches 18 years old.
- There should be better liaison with GP's (including University GP's).

At the end of the video CK and MM joined in the discussions. The Board agreed that:

- there needs to be an improvement in following the protocols for transitioning from the Children's service.
- The feedback about University GP's is one that can be taken up with Commissioners.
- Further work is being explored to improve the Trust's level of engagement with younger patients.
- The use of peer support groups and recovery colleges is something that the Trust should consider.

On behalf of the Board JL thanked the CK and MM for attending the meeting and for the useful feedback provided in the video. JL also requested that the service user be informed of the Board's discussion.

23/005 MINUTES OF THE PREVIOUS MEETING HELD ON 27 July 2023

The minutes of the previous meeting held on 27 July 2023 were agreed as an accurate record.

23/006 MATTERS ARISING FROM THE MINUTES AND ACTION LOG REVIEW

It was noted that there were no matters arising.

The Board reviewed the action log and noted the progress made on all items.

Action points:

- **It was agreed that the due dates for Actions 11.23, 14.23 and 15.23 should be by the next Board meeting on 13 December 2023.** RA
- **It was agreed that all actions proposed for closure be updated as completed.** RA

23/007 CHAIR AND CHIEF EXECUTIVE'S REPORT

MH, the Chief Executive Officer introduced the report which covered the period since the last Board meeting on 27 July 2023. The report was taken as read and highlights included the following points:

- All the newly appointed members of the Executive Team have now taken up their roles.
- The week of 18 September marked the 90th anniversary of the Portman Clinic seeing its first patient. The CEO attended a presentation given by the Forensic CAMHS team.
- The Chief People Officer is in the process of consolidating the actions arising from the 2022 staff survey. Feedback on the 2023 survey is likely to be in January 2024.
- Throughout the summer, the People Team along with colleagues from the Communications team held over 30 sessions with groups of staff, patients, service users and students to help in reshaping our vision, mission and values.
- The Care Quality Commission (CQC) carried out a planned inspection of the Gender Identity Development Service (GIDS) on 6 and 7 September.
- The final accounts and external audit process was completed at the end of August, with a reported deficit of £3,418k.

In addition to the CEO's report JL, the Chair advised that he had a meeting with Mike Cooke, Chair of the North London Integrated Care System to discuss the Trust's merger proposals.

23/008

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

SH, Chief Clinical Operations Officer presented the Integrated Quality and Performance Report. The Board received and noted the Trust-wide Integrated Quality & Performance Report, an amalgamation of all the local IQPRs that have taken place across the Trust in September, with DET and quality data added.

The Board noted the review of the report by the Performance, Finance and Resources Committee, observations included:

- The report is going in the right direction, with better detail and thus it allows NEDS to triangulate data.
- The report is still too fragmented and data heavy without enough direction for NEDS to know where to focus. We agreed to organise a seminar for the committee to work through together where the focus should be.
- The plan on a page for the key strategic areas will also help, this will be visible in the reports in the next couple of months. The focus will be on waiting times.
- Although waiting times are the key concern, a number of metrics, particularly in the GIC report raised questions for the committee and it was agreed that these would be shared with the board.
- It was also agreed that a brief report on GIC issues with a summary on what actions we are taking will be brought back to the next PFRC.
- The fire at our Bounds Green site and the Care Notes outage report raised questions about how well embedded our Business Continuity Plans are. Clare Scott, CNO reported that there is a training on this being rolled out. The committee asked for an update in 6 months post this training.
- The contracts update highlighted significant risks to about 14 million of our income in 24-25. This will be escalated to board, and with the development of the IQR better link between contracts, activity and workforce.
- Job Planning continues to be a challenge, and it was recognised that this is required for clarity on capacity across our services.

The Board noted that RB and SH will be working together on how the IQPR relates to the key strategic priorities. JL thanked SH for the report and advised that the next report should be more concise for the purpose of the Board meeting.

Action point:

The Integrated Quality and Performance Report for the next Board meeting will be shorter and include an executive summary. **SH**

23/009 **ANNUAL OBJECTIVES AND STRATEGIC PRIORITIES REPORT**

RB, the Director of Strategy and Business Development presented the Annual Objectives and Strategic Priorities Report. The report was taken as read and highlights included the following points:

- The five strategy ambitions and the plans to deliver the 3-year strategic plan for the Trust.
- The Executive Team participated in three planning days in September followed by a Board Seminar discussion to develop objectives and priorities for the next twelve months.
- The delivery of actions will be tracked weekly via a Strategy Delivery Room with Microsoft Teams used to map progress against each individual action to enable a focussed discussion each week.

The Board approved the Executive Team delivery plan and the priorities as set out in the report.

23/010 **QUALITY COMMITTEE ASSURANCE REPORT**

The Board noted the key discussions and assurances provided at the Quality Committee meeting held on 7 September 2023.

JJ, the Deputy Chair of the Quality Committee presented the report which was taken as read. The highlights included:

- An update to the Complaints improvement plan, plus a summary of complaints received in Quarter 1 2023/24.
- An update on the plan for 23/24 vaccinations.
- A comprehensive summary of the work undertaken by the named safeguarding leads during 2022-23,
- An update about the procurement of the Trust's Risk & Safety system (currently called the Quality Portal). The tender process for a new system has now been completed and a provider has been appointed.
- The Committee approved the Trust's Patient Safety Incident Response Plan (PSIRP).
- The Committee approved its updated Terms of Reference.

23/011 **ANNUAL INFECTION PREVENTION AND CONTROL PLAN AND STATEMENT**

CS, Chief Nursing Officer presented the Annual Infection Prevention and Control Plan and Statement 2022-2023. The report included a summary of the gaps identified through the National Infection Prevention Control Board Assurance Framework (NIPC BAF) which was completed in the current financial year.

The report was taken as read and highlighted the key risks and gaps in assurance relating to:

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

The Board approved the Annual Infection Prevention and Control Plan 2022-2023 and the plans to reduce or remove the risks and gaps in assurance contractors.

Action Point:

The Annual Infection Prevention and Control report should be included on the agenda at the next meeting of the Performance, Finance and Resources Committee.

RA

23/012

RESPONSE TO NHSE LETTER ABOUT THE LUCY LETBY CASE

CS, Chief Nursing Officer presented the response to the NHSE Letter about the Lucy Letby Case. The report provided assurance on the points outlined in the letter from NHS England (NHSE) regarding the Lucy Letby case. Highlights included:

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. The Trust are working to ensure that all staff know the correct escalation routes for raising concerns.

The Trust reviewed its guardianship resource and is advertising for a second FTSUG.

All current Board directors have passed the Fit and Proper Person 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.

The Executive Team considered patient safety and the services provided at the Trust. It also reflected on whether an equivalent event could occur at the Trust.

The Board noted the assurances provided in the response and also noted that that the review of service-users had enabled the Trust to address any

gaps in the service. The Board also noted that plans are underway to appoint a second Freedom to Speak Up Guardian (FTSUG).

AK

Action Point: The Fit and Proper Person Policy is to be updated.

23/013

PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE ASSURANCE REPORT

The Board noted the key discussions and assurances provided at the People, Organisational Development, Equality, Inclusion and Diversity Committee meeting held on 7 September 2023.

SS, the Chair of People, Organisational Development, Equality, Inclusion and Diversity Committee presented the report which was taken as read. The points highlighted included:

- The Committee will receive updates as to the uptake and feedback on the leadership and management development training programme.
- The Committee received an update from the newly elected chairs of the Disability and Long-Term Health Condition network, now called Purple Circle.
- The Committee agreed to train recruiting managers in inclusive recruitment and to create a comprehensive debiasing toolkit/checklist.
- The Committee approved its updated Terms of Reference.

23/014

EDUCATION AND TRAINING COMMITTEE ASSURANCE REPORT

The Board noted the key discussions and assurances provided at the Education and Training Committee meeting held on 21 September 2023.

SJ, Chair of the Education and Training Committee presented the report which was taken as read. The points highlighted included:

- The Student Survey for 22/23 had an increased response rate (35%). It is very pleasing that student overall satisfaction increased to 85% (from 76%). Specific areas of concern include Student Support and Engagement, Assessment, Organisation and Management, and EDI. Enhancement work is underway.
- Work is ongoing between Finance, HR and the directorate to ensure that the budget reflects the Electronic Staff Record (ESR) status, and that ESR accurately reflects the post strategic review position, but this has been challenging.

- It is hoped that the budget position will soon be stabilised so that work can commence on the forecast out-turn.
- The Committee approved the recommendations from the Annual Student Survey 2022-23
- The Committee approved the change to the Higher Education Classification of subject (HECoS) codes for the University of Essex validated courses.
- The Committee approved its updated Terms of Reference.

The Board also noted the following risks identified in the report and that plans are ongoing to address these:

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

**PON &
ERS**

Action Point: PON to speak to the Director of Education and Training about the 2023/24 budget and financial viability work.

23/015

EXECUTIVE APPOINTMENT AND REMUNERATION COMMITTEE CHAIR'S ASSURANCE REPORT

The Board noted the key discussions and assurances provided at the Executive Appointment and Remuneration Committee meeting on 13 September 2023. JL, the Chair introduced the report which was taken as read. The points highlighted included:

- The Committee approved changes to the Trust Constitution to add further voting members of the Board.
- The Committee approved the appointment of a secondment to the post of Chief Financial Officer at the conclusion of the current Interim Chief Financial Officer's contract.
- The Committee agreed to discuss Succession Planning at the next meeting.

23/016

ANNUAL MEDICAL REVALIDATION REPORT

CMCK, the previous interim Chief Medical Officer and the Appraisal Lead presented the Annual Medical Revalidation Report. The Board approved the report and noted the following:

- All medical staff in the Trust have been informed that revalidation requires them to have a full appraisal which has to be recorded on the electronic system

of SARD (Strengthened Appraisal and Revalidation Database).

- There are no areas of concern, all doctors within the Trust are engaging with the revalidation process in keeping with GMC guidelines. No doctors within the Trust have restrictions on their practice and no doctors are undergoing formal fitness to practise investigations.

23/017 **PERFORMANCE, FINANCE AND RESOURCES COMMITTEE ASSURANCE REPORT**

The Board noted the key discussions and assurances provided at the Performance, Finance and Resources Committee meeting on 26 September 2023.

AM, Chair Performance, Finance and Resources Committee presented the report which was taken as read. The highlights included:

- The fire and the Carenotes outage report raised questions about how well embedded our Business Continuity Plans are. The committee asked for an update in 6 months of the training being rolled out.
- The committee highlighted issues with GIC staffing and morale, as well as the finance risks to contracts in 2024-2025 for escalation to the Board.
- The Committee reviewed the Integrated Quality and Performance report:-
- Although waiting times are the key concern, a number of metrics, particularly in the GIC report raised questions for the committee and it was agreed that these would be shared with the Board.
- It was also agreed that a brief report on GIC issues with a summary on what actions we are taking will be brought back to the next PFRC.
- Contract update highlighted significant risk of c.£14m to our income in 24-25, £10m of which is GIDS. This will be escalated to board, and with the development of the IQR establishing a better link between contracts, activity and workforce.
- The GIC operational risks (including waiting times) were agreed to be separated out as a specific set of new risks on the Risk Register.

Action. It is important that learning is shared across the organisation, this will be included in a clinical service newsletter.

SH

23/018 **FINANCE REPORT**

PON, Interim Chief Finance Officer presented the Finance Report for Month 5 (cumulative position to August 2023). The report was taken as read, the points highlighted included:

Income and Expenditure

The Trusts planned deficit of £2.5m requires the delivery of a £3m efficiency to achieve this. This is to be delivered by £2m of non-recurrent income and identified non-pay schemes of £1m.

Capital Expenditure

The agreed capital spend for the year is £2.4m, is a reduction from the previous year of £0.9m and will require robust management to ensure the Trust stays within plan.

Cash

The agreed plan includes a reduction in cash over the year to an outturn of £3.1m, which reflects the expected deficit position.

23/019 **AUDIT COMMITTEE ASSURANCE REPORT**

The Board noted the key discussions and assurances provided at the Audit Committee on 28 September 2023.

DL, Joint Chair of the Audit Committee presented the report which was taken as read. The highlights included:

Mazars additional fees are being challenged and a response from the External Auditors is expected. The intention is that the process should be concluded as quickly as possible, so as to not hinder the appointment and initial engagement with new External Auditors.

There are 12 outstanding management actions to be followed up to ensure progress on this key control weakness.

Analysis of the 22/23 Single Tender Waiver indicated that all bar 11 were due to contract extensions so should have been classified as STW's, the Standing Financial Instructions (SFIs) have been updated to reflected this.

The Board having considered the updated SFI approved the amendments.

23/020 **BOARD ASSURANCE FRAMEWORK (BAF)**

AK presented the Board Assurance Framework (BAF) report. The Board noted the key assurances and the latest position of the BAF.

The Board Assurance Framework has enhanced over the past eight months in terms of content and detail, with most risks included now identifying all key controls along with populating assurances received.

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

There are currently seven risks within the Board Assurance Framework for which we receive no independent assurance over the effectiveness of controls.

The Board noted the next steps:

- The Governance Team will continue to work with Executive Leads to further identify actions to address gaps in control and assurance.
- Targeted reporting to Board Committees will continue on a bi-monthly basis and this process and feedback will be reported through the Audit Committee and back to the Board.
- The Governance Team will work with the Executive Directors to re-evaluate the current format and context of the Board Assurance Framework in line with the agreed strategy developments.
- A report on developments with the Board Assurance Framework will be brought back to the next Board meeting in December having considered the current format and context and also further considered and developed our assurance programme.

Action Point: Risk management training will be provided to all teams, to ensure that BAF is key to Committee agenda and reports.

23/021 **CONSTITUTIONAL CHANGES ON BOARD MEMBERS' VOTING STATUS**

JL presented the report on Constitutional Changes on Board Members' Voting Status. The Board received the proposal to change the Trust Constitution to address the Board's balance between Non-Executive Directors and voting Executive Directors, in order to comply with the NHS England (NHSE) Code of Governance for NHS Provider Trusts (2023).

The Board approved the following:
 A change to section 20.2.3 of the Trust's Constitution; and addition of sub-sections 20.2.3.1 to 20.2.3.6 to the Trust's Constitution:

- 20.2.3 to increase by two (from five to seven) the number of voting Executive Directors on the Board of Directors to enable a more effective unitary Board;
- 20.2.3.1 to 20.2.3.5 to specify five voting Executive Directors; and
- 20.2.3.6 to refer to the two other voting Executive Directors.

That a resolution is laid to the Annual Members' Meeting on 11 October 2023, to approve the change to section 20.2.3 of the Trust's Constitution; and addition of sub-sections 20.2.3.1 to 20.2.3.6 to the Trust's Constitution.

23/022 **REVIEW OF COMMITTEE TERMS OF REFERENCE**

JL presented the report with revised Terms of Reference (ToR) to six Board sub-committees. All Board sub-committees received and approved the proposed revisions to their Terms of Reference during the September cycle of meetings and recommended them to the Board of Directors for ratification.

Cross Committee summary of key changes:

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

The Board approved the revised Terms of Reference of the six Board sub-committees as set out in Appendices 1 - 6 of the report.

23/023 BOARD FORWARD PLANNER

The Board received and noted the contents of the Forward Planner.

23/024 QUESTIONS FROM THE GOVERNORS

There were no questions from the Governors.

23/025 ANY OTHER BUSINESS

There was no other business.

23/026 QUESTIONS FROM THE PUBLIC

	There were no questions from the public.
23/027	REFLECTIONS AND FEEDBACK FROM THE MEETING
	Feedback received included: <ul style="list-style-type: none">• The quality of reports at the meeting had improved.• The patient/service user video was good and feedback was useful,• It was difficult to see those persons who had joined the meeting online.• The seating arrangement should not have all NEDs sitting together.
	Close
	The Chair closed the meeting at 4.40 p.m.

Date of Next Meeting in public: Wednesday 13th December 2023 at 2pm (time and venue to be confirmed).

Signature _____ Date _____

DRAFT

Board of Directors Part 2 - Public Action Log (Open Actions)									
Action Ref.	Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Open - New action added	To Close - propose for closure	Action owner (Name and Job Title)	Status (pick from drop-down list)	Next yet due - Action still in date
									Progress Note / Comments (to include the date of the meeting the action was closed)
11.23	27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	To Close - propose for closure	Adewale Kadiri, Director of Corporate Governance	In progress	Assistance being given as required. AK working with Chair to get NEDs up to date.
14.23	27.7.23	14	ETC Chair's Assurance Report	Chair of the Tavistock and Portman Charity to be invited to a future meeting to discuss bursaries for students	13.12.23	To Close - propose for closure	Elisa Reyes-Simpson, Interim Director of Education & Training	In progress	
15.23	27.7.23	16	Gender Pay Gap Report	A further report on the Gender Pay Gap will be considered by the Board later in the year.	13.12.23	To Close - propose for closure	Gem Davies (GD) Chief People Officer	To Close - propose for closure	No further gender pay gap reporting will be done till our next submission so the due date for this is now next year.
19.23	11.10.23	6	Matters arising and action log	The due dates for Actions 11.23, 14.23 and 15.23 should be updated to 13 December 2023 (the next Board meeting).	13.12.23	To Close - propose for closure	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	Task completed after Board meeting 11.10.23
21.23	11.10.23	6	Matters arising and action log	All actions on the log proposed for closure should be updated to actions completed.	13.12.23	To Close - propose for closure	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	Task completed after Board meeting 11.10.23
22.23	11.10.23	8	Integrated Quality & Performance Report IQPR	The Integrated Quality and Performance Report for the next Board meeting will be shorter and include an executive summary.	13.12.23	To Close - propose for closure	Sally Hodges, Chief Clinical Operations Officer	To Close - propose for closure	Action completed
23.23	11.10.23	8	Integrated Quality & Performance Report IQPR	IQPR should be included on the Agenda for a future Board Seminar.	15.11.23	To Close - propose for closure	Adewale Kadiri, Director of Corporate Governance	In progress	IQPR to be added to the updated Board development programme to be circulated to all Board members
24.23	11.10.23	11	Annual Infection Prevention & Control Plan	The Annual Infection Prevention and Control report should be included on the agenda at a future meeting of the Performance, Finance and Resources Committee	12.12.23	To Close - propose for closure	Clare Scott, Chief Nursing Officer	In progress	To be added to a future agenda
25.23	11.10.23	12	Response to NHSE letter about the Luct Letby Case	The Fit and Proper Person Policy is to be updated	13.12.23	To Close - propose for closure	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	The policy has been updated and the new version is on today's agenda for ratification
26.23	11.10.23	12	Response to NHSE letter about the Luct Letby Case	Information on freedom to speak up and performance data should be promoted in all public areas and online.	13.12.23	To Close - propose for closure	Jane Meggitt, Interim Director of Communications & Marketing	In progress	There is a poster informing staff of the FTSU process, and including contact information, by the lift doors on each floor of the Tavistock Centre, as well as in each staff kitchen and common room. These posters are being refreshed to make them more accessible, and new versions are being rolled out across all Trust sites. Further information will be provided as the recruitment process for a 2nd Guardian commences in the next few days.

Action Ref.	Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Action Due date	Action owner (Name and Job Title)	Status (pick from drop-down list)	Progress Note / Comments (to include the date of the meeting the action was closed)
27.23	11.10.23	14	Education & Training Committee Assurance Report	PON to speak to the Director of Education and Training about Estates, the 2023/24 budget and financial viability work.	13.12.23	Peter O'Neill CFO & Elisa Reyes-Simpson Interim CETO	In progress	Estates - issues are being picked up with DET. Finance - A small working group has met and has identified a number of actions in order to identify potential routes for income generation for the purposes of bursaries. The working group is due to report on progress against actions in the W/C 18th December.
28.23	11.10.23	17	Performance, Finance & Resources Committee Assurance Report	It is important that learning recommendations on Carenotes is shared across the organisation, this can also be included in a clinical service newsletter.	13.12.23	Sally Hodges, Chief Clinical Operations Officer	In progress	In progress within clinical services
29.23	11.10.23	20	Board Assurance Framework	Risk management training will be provided to all teams.	13.12.23	Adewale Kadiri, Director of Corporate Governance	In progress	Risk management training for teams has commenced, but the team member delivering it has now left the organisation. The training roll out will re-commence once a new member of staff is in place.

MEETING OF THE BOARD OF DIRECTORS PART II – PUBLIC – Wednesday, 13 December 2023					
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:	None				
Executive Summary:					
Action Required:	Approval <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information <input type="checkbox"/> Assurance <input type="checkbox"/>				
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 11 October 2023.				
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against leadership responsibilities within the CEO's portfolio.				
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input checked="" type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input checked="" type="checkbox"/>	Responsive <input checked="" type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/> All BAF risks		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
Legal and Regulatory Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
Resource Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	Yes <input checked="" type="checkbox"/>			No <input type="checkbox"/>	

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

Chief Executive's Report – 13 December 2023 Public Board

Purpose

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

2. Black History Month

As you know, October was Black History Month, and some activities took place here at the Trust just after my last report to the Board. The theme for the month was 'Saluting our Sisters' – highlighting the crucial role that Black women have played in shaping history, inspiring change and building communities. A highlight of the month was a well-attended event featuring poetry readings, an art exhibition and some very interesting UK and Caribbean history lessons. There was also an in-depth conversation with the inspiring nurse, educator and administrator, Professor Dame Elizabeth Anoniwu – one of the pioneers of the treatment of sickle cell anaemia and thalassaemia in the UK, who went through the various ups and downs of her eventful life and career. My thanks go to the EDI team and the Race Equality Network for putting on what was a thought provoking and inspirational event.

3. Camden Local Authority event

During November, the Chair and I both attended an event with the local authority and other providers from Camden. We met with local health champions from one of the local estates and discussed with them some of the issues that they saw within their community. I also spent some time hearing from a parent of two of the children who use our services. All the champions raised the issue of children's mental health and how they saw this as a priority for the borough and the need for stronger co-production across the system. As a group, through the Camden Integrated Care Executive, we will both be looking at how our plans address the issues raised around mental health and how we can strengthen co-production with local communities across Camden.

4. Writing our Case for Change

At the recent all-staff meeting I shared an update with staff on our Trust's future options. We are now working with NHSE and the ICS on our next steps, and Tor Jeffries, Head of Intensive Support for London, has joined us to support this phase. We know that the right merger partner has the potential to strengthen and increase the reach of our unique and ground-breaking clinical, educational, and academic services.

To ensure our merger results in a stronger Trust and improved care and education, we have started the process of developing a 'Case for Change' that

clearly articulates the challenges to be addressed, along with the potential benefits.

We want to hear from everyone across our Trust, about what benefits we can unlock by partnering with another organisation and will be hosting two drop-in 'Case for change' sessions that will be open to all staff. This will be followed by visits to teams, services, staff networks and taking advantage of existing meetings to engage as many stakeholders as possible in this foundational work as we look towards a future merger.

5. Delivery of High-level Clinical services

GIC Improvement Event

A 3-day event based on the Kaizen philosophy of continuous improvement was held last week, focussing on the range of actions that the Trust and its partners need to take to make the service more responsive to the needs of its patients.

In addition, the terms of reference for the invited review of the service have now been agreed. The review team is being pulled together with the aim that the work will start in the New Year.

Mandatory Learning Disability and Autism Training

The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. The Oliver McGowan Mandatory Training is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff.

The Trust is working with the ICB on the delivery of the training plan.

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

Purple Circle relaunch event



Last Tuesday, we celebrated the relaunch of Purple Circle, the staff network formerly known as Disabilities and Long-Term Health Conditions (DLTHC).

Colleagues were encouraged to (and mainly did) wear something purple as the day is a celebration of diversity and inclusion. There was a panel discussion with Lisa Tucker and Patience Akande, Co-Chairs of the Purple Circle staff network, Clare Scott, Chief Nursing Officer and Executive Sponsor of the network and Thanda Mhlanga, Associate Director of Equality, Diversity and Inclusion. A key aim of this relaunch is to encourage all staff who may have a disability or a long-term condition to feel confident to declare this and to receive the support that they need within the workplace.

GIDS Closure

Consultation has commenced with staff affected by the closure of the GIDS service. The consultation runs from 20 November to 20 December with an outcome paper to be published the following week.

Staff Survey

The 2023 NHS Staff Survey is now closed for responses, and I am pleased to announce that over half of our staff completed the survey, a significant increase on last year's completion rate. This is a marked improvement on the response rate of the previous survey and will ideally allow us to gain a much richer picture of how our people feel about the organisation. Results are likely to be provided (in an embargoed format) in late January / early February 2024.

Industrial Action

We are aware of further trade union ballots (in particular the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA)) requesting members to vote on additional strike action. We have been notified that the potential strike dates are 20th to 23rd December and 3rd – 8th January. We are also aware that the HCSA has successfully balloted their membership and would therefore be legally allowed to plan action.

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

We have developed a draft Medium Term Financial Plan in line with the ICS planning process.

The reported financial position at 31 October (reporting month 07) was a deficit of £2,252k in the period, against a planned deficit of £2,128k

8. Partnership – Within the ICS and Nationally

Phill Wells is now the Acting CEO for NCL ICB whilst Frances O'Callaghan is taking a career break. Sarah Mansuralli will be Deputy Chief Executive during this period with Bimal Patel interim CFO.

10. Well-led and Effective Governance

The Trust has now received the draft report from the Care Quality Commission (CQC) following the planned inspection of the Gender Identity Development Service (GIDS) on 6 and 7 September. The factual accuracy response has been submitted by the Trust and the report is expected to be published shortly.

The CQC continues to update providers on the changes they are making to the way they work. They announced that from 21 November they were starting the new single assessment framework in the South Region. They will then expand

their new assessment approach to all providers based on a risk-informed schedule and will be in touch with providers in other areas of the country, although it is likely to commence in January 2024 for London region.

Preparation for a Trust-wide inspection against the CQC's Well Led domain is continuing. This is being led by the Chief Nursing Officer, and an experienced consultant has been recruited to provide expert support in this area. A preparation session was held at the all-staff meeting on 28 November and the staff handbook is due to be published once the Trust mission, vision and values have been approved at Trust Board.

Board Assurance Framework

As we have now agreed our new Strategic Ambitions, it is important that the Board keeps abreast of any risks that may prevent us from achieving these, and how these are being managed. The process of updating the Board Assurance Framework (BAF) to better reflect the new strategy has commenced, with a very helpful seminar to look specifically at the people-related risks being held last week with members of the POD EDI Committee. Following this template, further work will be done by the Executive Team, and a fully updated BAF will be presented to the Board in the New Year.

National and Political Context

11. Patient and Carer Race Equality Framework (PCREF) launch

NHS England launched the Patient and Carer Race Equality Framework (PCREF), a mandatory anti-racism framework for mental health trusts and providers in England. The PCREF was a key recommendation of the Independent Review of the Mental Health Act 2018. All mental health trusts must have their PCREF in place by the end of the financial year 2024/25 and progress towards delivering the framework will be assessed as part of Care Quality Commission (CQC) inspections. Each trust's PCREF must be fully coproduced with local racialised and ethnically and culturally diverse communities, with mental health providers responsible for the delivery of PCREF in collaboration with partners including local authorities, commissioners, communities, patients, and carers. PCREF will support trusts to become actively anti-racist organisations by reducing racial inequalities within their services and applies to all mental health services and pathways and all patient age cohorts. PCREF will support improvement across three core domains: leadership and governance, national organisational competencies, and patient and carer feedback mechanisms.

[NHS England » Patient and carer race equality framework](#)

12. Ethnic inequalities in IAPT access

A landmark review by the NHS Race and Health Observatory published *Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)*, an independent review of services provided by NHS Talking Therapies undertaken in partnership with the National Collaborating Centre for Mental Health. The report is based on 10 years of anonymised patient data and finds that while there is no evidence that talking therapies are unsuitable or ineffective for ethnic minority groups, people from Black and ethnic minority groups experience worse access to, and outcomes from, NHS talking therapies compared to White British groups. Other key findings include:

- 1) In comparison with White British people, with the exception of Chinese people, people from minoritised ethnic groups (including non-British White people):
 - experienced worse outcomes, although this gap is narrowing.
 - waited longer for assessment.
 - were less likely to receive a course of treatment following assessment.
- 2) Inequalities in outcomes for people from minoritised ethnic groups are associated with:
 - increased symptom severity at initial assessment.
 - living in areas with higher levels of deprivation, and higher unemployment.
 - waiting longer for assessment and waiting longer between treatments.
- 3) The IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide (PPG) published in 2019 was well received by services, but:
 - does not appear to be used consistently across services
 - commissioners did not report knowledge of the PPG's recommendations when compared with IAPT staff and leads.

8 recommendations were made and the report can be found here [Ethnic Inequalities in Improving Access to Psychological Therapies \(IAPT\) - NHS – Race and Health Observatory \(nhsrho.org\)](https://www.nhs.uk/publications/ethnic-inequalities-in-improving-access-to-psychological-therapies-iapt-nhs-race-and-health-observatory/)

13. Young Carers and Young Adult Carers Inquiry

An inquiry by the All-Party Parliamentary Group on Young and Young Adult Carers has revealed the devastating impact caring has on the life opportunities of the UK's young people. The inquiry was led by Duncan Baker MP and heard evidence from over 70 organisations/stakeholders and more than 400 young carers and young adult carers.

Key findings from the Inquiry Report include:

- Some young carers have to wait 10 years before being identified. The average waiting time to be identified for support was three years.
- Being a young carer has a knock-on effect on school attainment and attendance, with young carers missing 27 school days per year on average.

- Young adult carers are substantially (38%) less likely to achieve a university degree than their peers without a caring role. Those caring for 35 or more hours a week are 86% less likely.
 - Young adult carers are less likely to be employed than their peers without a caring role.
 - Young people with caring responsibilities have a higher prevalence of self-harm. Of children who do self-harm, young carers are twice as likely to attempt to take their own life than non-carers. The Inquiry Report makes a series of recommendations including:
 - A cross-government National Carers Strategy with a dedicated section and resourced action plan relating to young and young adult carers.
 - The Government should commission an independent 10-year review of the difference the Children and Families Act 2014 and Care Act 2014 have made for unpaid carers.
 - The Government should work with young and young adult carers to set out its immediate plans to improve early identification, increase access to support for young carers and reduce the numbers providing inappropriate or excessive levels of care.
 - The Government should formally support the development and implementation of the first UK-wide Covenant for Young Carers and Young Adult Carers.

The report can be found at [appg-for-young-carers-and-young-adults-carers-reportlr.pdf](#)

14. Children and young people's mental health

NHS Digital published the latest follow-up report to the 2017 Mental Health of Children and Young People (MHCYP) survey. The mental health of children and young people aged 8 to 25 years living in England in 2023 is examined, as well as their household circumstances and their experiences of education and services and of life in their families and communities.

Key findings include:

- In 2023, about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder.
- After a rise in prevalence between 2017 and 2020, rates of probable mental disorder remained stable in all age groups between 2022 and 2023.
- Among 8- to 16-year-olds, rates of probable mental disorder were similar for boys and girls, while for 17- to 25-year-olds, rates were twice as high for young women than young men.
- 26.8% of children aged 8 to 16 years with a probable mental disorder had a parent who could not afford for their child to take part in activities outside school or college, compared with 1 in 10 of those unlikely to have a mental disorder.
- 17- to 25-year-olds with a probable mental disorder were 3 times more likely to not be able to afford to take part in activities such as sports, days

out, or socialising with friends, compared with those unlikely to have a mental disorder.

- Children aged 11 to 16 years with a probable mental disorder were 5 times more likely than those unlikely to have a mental disorder to have been bullied in person. They were also more likely to have been bullied online.
- Just over half of young people aged 17 to 25 years reported being worried about the impact of climate change.
- In 2023, eating disorders were identified in 12.5% of 17- to 19-year-olds, with rates 4 times higher in young women (20.8%) than young men (5.1%).

15. Public Accounts Committee highly critical of New Hospitals Programme

Parliament's Public Accounts Committee (PAC) has published a highly critical report of no confidence the Government will deliver on new hospitals programme.

[New Hospital Programme: Inquiry finds no confidence Government will deliver on promises - Committees - UK Parliament](#)

16. Autumn Statement

Chancellor Jeremy Hunt presented his Autumn Statement to the House of Commons this week, setting out the Government's tax and spending plans for the year ahead. Sadly, announcements that were hoped for relating to mental health were not included.

Key announcements include:

- There were no new major funding announcements for healthcare, and existing settlements will remain the same in cash terms:
 - £200 million of new funding announced in September 2023 to boost NHS resilience.
 - Funding the non-consolidated payment for 2022/23 for Agenda for Change equivalent staff.
 - More medical places starting in September next year in line with the NHS Long Term Workforce Plan.
- There will be increased support to help those who have mental health issues to find work, including by digitising the NHS Health Check. Building on the announcement from the Spring Budget, the government announced support for an additional 100,000 people to access Individual Placement Support over the next five years.
- NHS Talking Therapies (previously IAPT) will also be expanded so an additional 384,000 people can access psychological therapies within five years.
- Main rate of National Insurance cut from 12% to 10% from 6 January.
- Legal minimum wage - known officially as the National Living Wage - to increase from £10.42 to £11.44 an hour from April. The new rate will apply to 21 and 22-year old workers for the first time, rather than just those 23 and over.

- Universal credit and other working-age benefits in England and Wales to increase by 6.7% from April, in line with September's inflation rate.
- Claimants in England and Wales deemed able to work who refuse to seek employment will lose access to their benefits and extras like free prescriptions.
- State pension payments will increase by 8.5% from April, in line with average earnings.
- The independent Office for Budget Responsibility (OBR) forecasts that inflation will fall to 2.8% by the end of 2024, before reaching the Bank of England's 2% target rate in 2025. 9 Overall page 29 of 172
- Living standards are not expected to return to pre-pandemic levels until 2027-28. The NHS Confederation has published a briefing analysing the implications of the Autumn Statement for the health and care sector.

17. The NHS Long Term Workforce plan

NHS Providers have recently published a briefing analysing the plan and gathering feedback members. [NHS Providers view: NHS England's Long Term Workforce Plan - NHS Providers.](#)

MEETING OF THE Board of Directors Part two 13 th December 2023					
Report Title: Integrated Quality and Performance Report				Agenda No. 08	
Report Author and Job Title:	Amy LeGood, Commercial Director	Lead Executive Director:	Sally Hodges, CCOO, Elisa Reyes Simpson CTEO, Clare Scott CNO, Gem Davies, CPO		
Appendices:	Trust wide IQPR Report				
Executive Summary:					
Action Required:	Approval <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>				
Situation:	This report covers progress on all the strategic priorities and performance across the organisation				
Background:	The quality and performance data reporting is evolving to ensure that the board is able to quickly identify and focus on key areas of risk and progress.				
Assessment:	This report gives a clear baseline on strategic priorities which will enable the board to more accurately track progress on these and identify areas of further risk.				
Key recommendation(s):	The Board is asked to note the contents of this report				
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input checked="" type="checkbox"/> 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.	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input checked="" type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input checked="" type="checkbox"/>	Effective <input checked="" type="checkbox"/>	Caring <input checked="" type="checkbox"/>	Responsive <input checked="" type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	All BAF risks are covered by this report .				
Legal and Regulatory Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no resource implications associated with this report.				
	Yes <input checked="" type="checkbox"/>			No <input type="checkbox"/>	

Trust-wide Integrated Quality and Performance Report

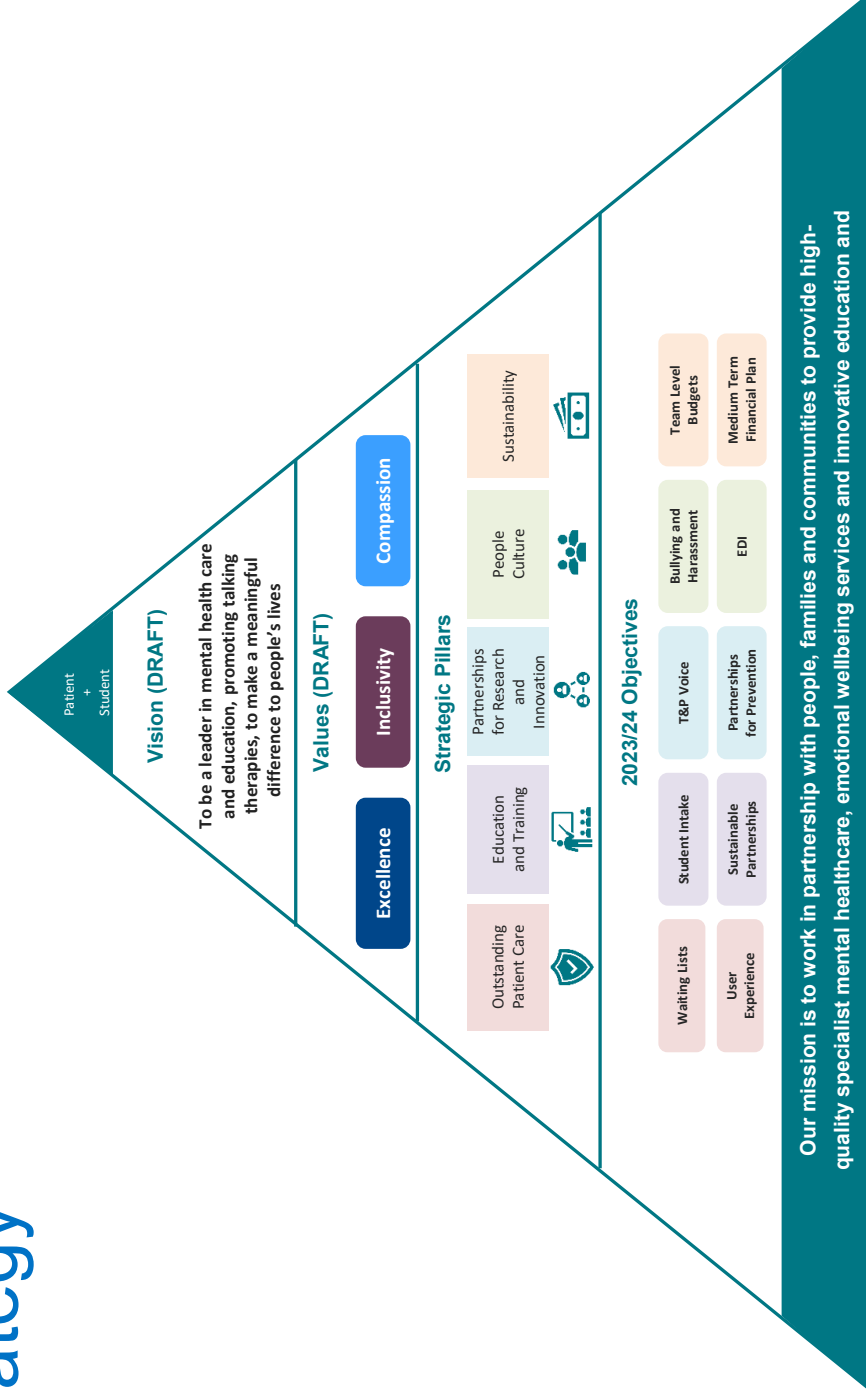
December 2023

1. Executive Summary

- This is the next iteration of our IQPR with our strategic A3's across the organisation now included
- This iteration also includes workforce data allowing for improved triangulation against activity thus giving clearer indication of performance.
- Service line detail is presented in a condensed form, with an emphasis on the key challenges and highlights.
- The key challenges remain the same and are represented in the strategic priorities

2. Values and Strategic Priorities

Tavistock and Portman – Our Values and Strategy



Waiting List Management – Summary A3 GIC

SRO: Sally Hodges

Problem Statement

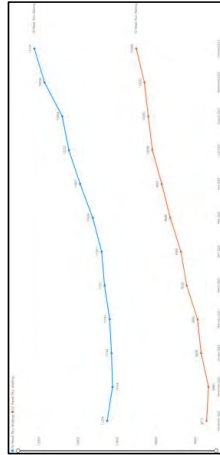
In at least 3 areas of the Trust patients are waiting longer than the NHS standard of 18 weeks for a first appointment (Adult Trauma/psychotherapy, Adult GIC and ASD). The Adult GIC pathway currently has significant demand/capacity constraints, with the waiting list currently holding ~14500 patients (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.

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

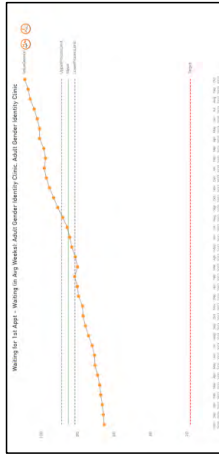
Goals:

1. Clear dormant caseload of patients waiting +36 Months the next 6 months
2. Complete Pathway mapping process
3. Enact DNA policy for consistent approach
4. Clear demand and capacity model identifying gaps so that they can be addressed by March 2024

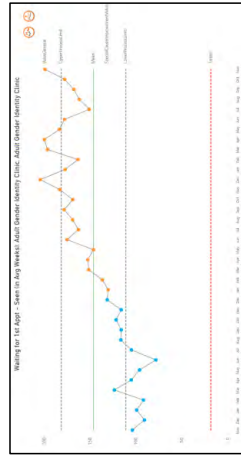
Current Situation



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

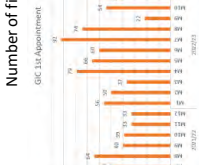


B) For patients that are still waiting on the last day of each calendar month, this shows the ave. time across the whole cohort

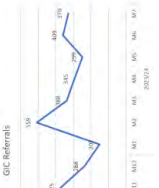


C) For patient who have been seen in the each calendar month, this shows on ave. how long they waited for this appointments

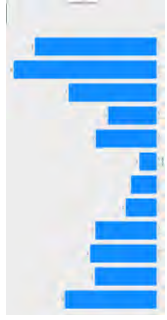
Root Cause / Gap Analysis



Number of first appointments conducted

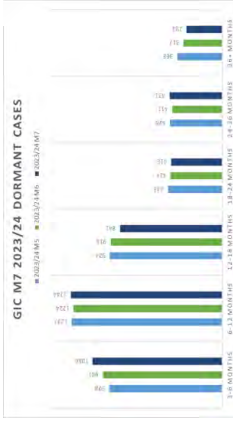
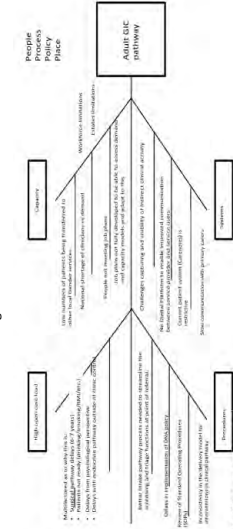


Number of referrals by month



Using the trends in the charts above, there are 4 opportunity areas to help impact the waiting list:

1. Increase number of 1st appointments
2. **Recruit to all clinical vacant positions**
3. Increase discharges per month (to reduce overall caseload)
4. Reduce dormant cases waiting over 36 months



Countermeasures / Next Steps

Concern	Cause	Countermeasure
There are patients that are dormant over 36 months that need review and/or discharge	In progress at the moment	- Review and discharge dormant cases from PTL
Average wait to first appointments are increasing	High amount referrals received	-Clinical Triage at point of referral to minimise unsuitable referrals being accepted
Number of 1 st appointments offered	Shortage of clinical staff	Revised job plans and clinical recruitments to be filled

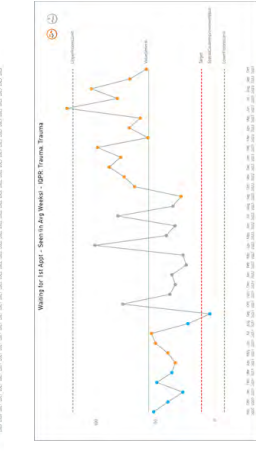
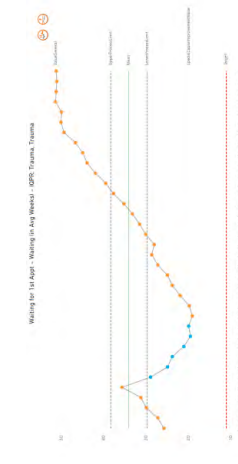
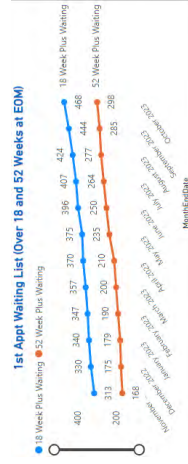
Waiting List Management – Summary A3 Adult Trauma

SRO: Sally Hodges

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 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.

Current Situation

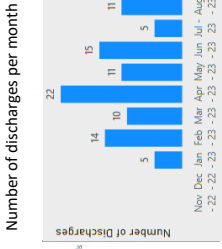
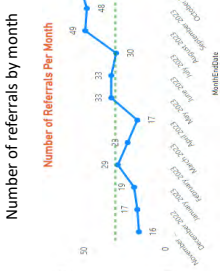
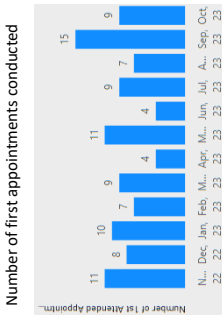


A) This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)

B) For patients that are still waiting on the last day of each calendar month, this shows the ave. time across the whole cohort

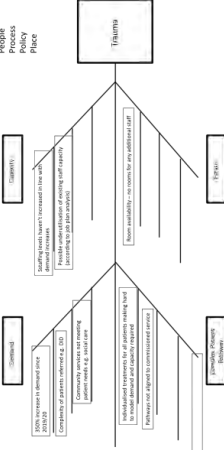
C) For patient who have been seen in the each calendar month, this shows on ave. how long they waited for this appointments

Root Cause / Gap Analysis



Using the trends in the charts & route cause analysis, there are 3 opportunity areas to help impact the waiting list:

1. Review the clinical the pathway including acceptance criteria, treatments offered and treatment lengths and then align it with commissioner expectations
2. Undertake demand & capacity modelling to identify staffing required to maintain steady state to keep up with demand & enablers required (likely a business case for additional staffing)
3. Agree a plan for backlog clearance & enablers required (likely a business case for additional staffing)



Countermeasures / Next Steps

- Working with ICS and NHSE colleagues to allocate additional resource via Elective Recovery Funding (ERF) to increase capacity to clear the backlog.

Waiting List Management – Summary A3 ASC

SRO: Sally Hodges

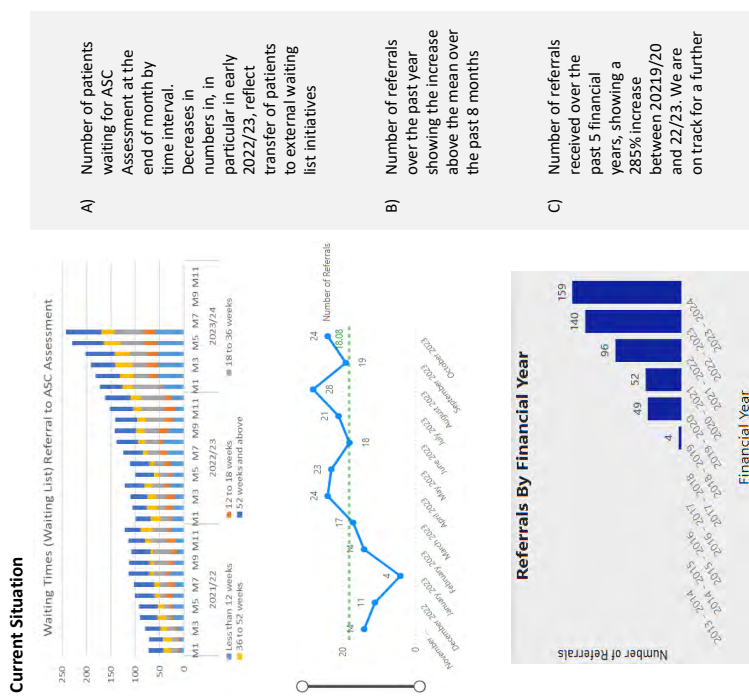
Problem Statement

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 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: No child or young person waits longer than 18 weeks to start their autism assessment from the date we receive their referral.

Goals:

- 1.1. Clearly defined and re-visioned pathways by the end of January 2024
2. To improve patient experience by reducing waiting times



User Experience Score – Summary A3

SRO: Clare Scott

Problem Statement

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

Current Situation

- 3 Service Lines – Community an Integrated, Complex Mental Health and Gender
- Community / GIC / Family and YA Service – managed by different coordinators
- There is variation in frequency, method and questions asked across service lines that impacts the services ability to respond to feedback.

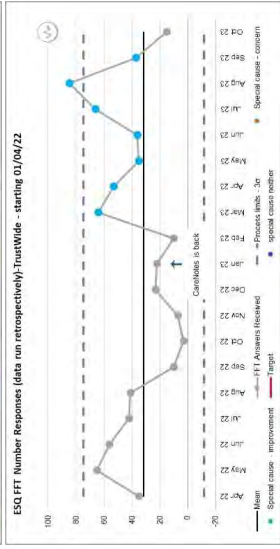
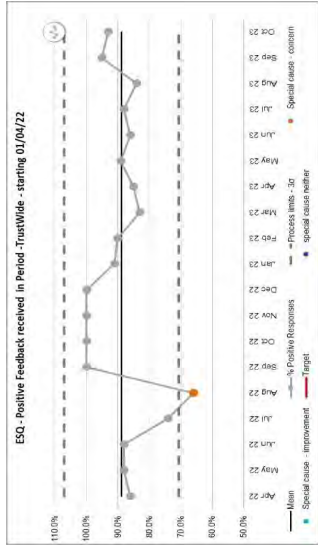


Chart 1 outlines the ESQ data showing positive user feedback scores trust-wide over the last 18 months.

This has remained relatively stable, with an increase in Sept/Oct 23.

This is relative to the number of responses received which is low, as per **Chart 2**

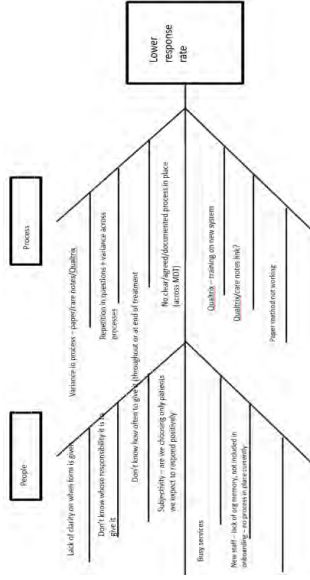
Vision & Goals

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

G1: To create benchmarks for each team for responses in the next 2 months

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

Root Cause / Gap Analysis



In line with our goals, our initial focus is to understand the root causes as to low response rates.

Our current understanding is that we have variation in process across different services/teams.

A best practice process will be validated with teams as part of the benchmarking activity.

Countermeasures / Next Steps

- Work on understanding and increasing response rate while monitoring positive responses
- Understand areas with largest opportunity to increase response rate and use targeted approach in this area

Bank of ideas:

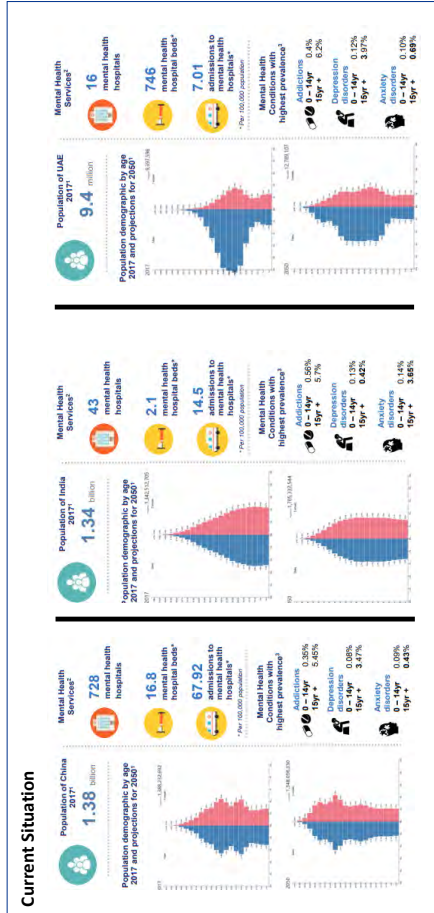
- Rapid improvement event with GM's etc. to work out process
- Establish consistent process for requesting feedback
- Align service reporting for consistency

Sustainable Partnerships – Summary A3

SRO:

Problem Statement
 As an organisation, we do not currently have incoming generating partnerships in place to help achieve £x financial impact. This is directly related to access to future student markets, and is an indicator of our influence and reputation both locally and globally. If successful, partnerships would allow us to expand our reach, grow our global student cohorts and solidify our reputation as a key MH education and training organisation.

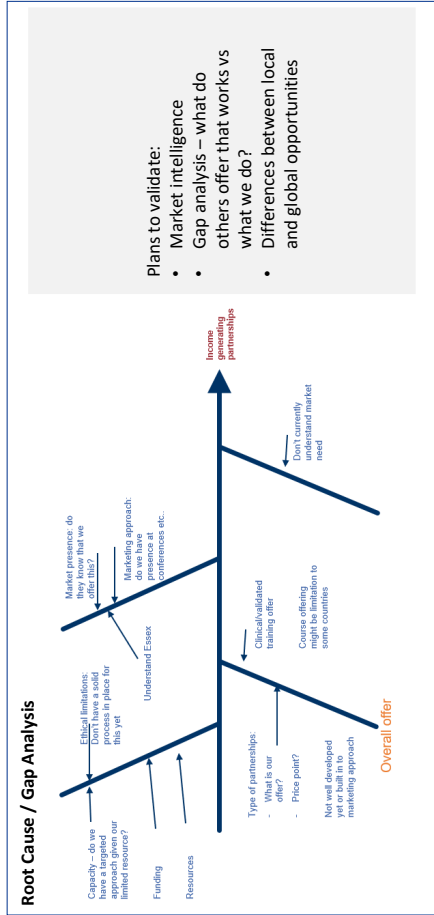
Vision & Goals
Vision: We have sustainable and mutually beneficial partnerships in place that generate consistent income for the trust
G1: Identify X number of partners (segregated into tiers by revenue value) per annum until 2030
G2: To generate income of £x in the next 12 months and by 2030



The Trust commissioned PA Consulting in 2018, to conduct a short review into the viability of developing a sustainable international education and training business.

The review considered three countries as potential initial focus markets (China, India, and the UAE) – as outlined in the charts above, with China demonstrating the greatest potential based on attractiveness (market size, potential growth and scale of opportunity), and accessibility (government policy, operating environment, and partner contacts known to the Trust).

The landscape for international partnerships and/or international student recruitment is likely to be different in 2023 (and beyond) when compared to 2018, with the HE sector seeing tangible growth opportunities in SE Asia (Vietnam and Indonesia) and East Africa (Kenya).



Countermeasures / Next Steps		
Concern	Cause	Countermeasure
Lack of market intelligence to identify new markets for sustainable student growth	Marketing function is not driven by longitudinal data in order to make evidence-led decisions for growth in student recruitment	Refocus the Marketing function to be data-led, utilising a more commercially focused approach alongside new CRM
Lack of data to identify key applicant audience on a regional and national level		

'Having a Voice' – Summary A3

<p>SRO: Chris Abbott</p> <p>Problem Statement As a Trust, we lack sufficient regional influence and representation in population health discussions. Despite X available opportunities, our current Y efforts fall short. This constrains our capacity to drive change, foster collaboration with partners, and influence neighbouring healthcare providers to align with population health drivers</p> <p>Vision & Goals Empower our organization to build and nurture essential relationships while providing compelling evidence of our contributions to drive meaningful advancements in regional healthcare discussions,</p>	<p>enabling us to play a pivotal role in shaping the future of population healthcare not only in the capital but also nationally.</p> <p>Goals:</p> <ul style="list-style-type: none"> • Work with colleagues and partners to identify population health priorities for the next 2 years • Agree on a framework for delivery and key partners to work with • Develop a 2-year action plan linked to Trust values and strategy incl. areas of research and EDI priorities • To have hosted an annual Regional Thought Leadership conference each year of the strategy to consider how best to meet the mental health and wellbeing needs of London 												
<p>Current Situation</p> <p>There are many potential partners who have a voice in the regional Population Health discussion and landscape of provision, and while we provide services in several of these categories of provision, we do not have connections to all elements of regional Pop Health, nor are we active in our Comms channels on the subject, and currently our National Media mentions are predominantly about GIDS.</p>	<p>Root Cause / Gap Analysis From: Media mentions weighted to Gender >>> To: Media mentioned re: Pop Health :: Active campaign to garner positive; pop health related media attention</p> <p>From: Not producing any media assets / trainings on topic >>> To: Producing quarterly videos :: Programme of monthly media development; videos, trainings, infographics</p> <p>From: Lack formal connections to partners >>> To: Build coalition with NCL-WR, Cavendish Sq. Grp.</p> <p>From: Lacking marketing channel for events >>> To: Exploiting coalition for event</p> <p>From: Barely currently presenting at conferences >>> To: Steppingstone presentations / webinars</p> <p>From: Lacking clearly defined 'pathways' >>>> To: Clarity of both our and others' interventions</p> <p>From: Do we research in this space currently? >>>> To: Now doing Pop Health specific research</p> <p>From: Little coordinated voice on "Prevention" >>>> To: Evidence of clear 'Prevention' work (See A3)</p> <p>From: Little engagement from staff grass roots >>>> To: Trained, mobilised + empowered staff group</p>												
<p>Countermeasures / Next Steps</p> <table border="1"> <thead> <tr> <th>Concern</th> <th>Cause</th> <th>Countermeasure</th> </tr> </thead> <tbody> <tr> <td>Media weighted to 'Gender'</td> <td>GIDS transfer / GIC waiting lists</td> <td>Programme of Pop. Health communications</td> </tr> <tr> <td>Lack of formal connections to partners</td> <td>Largely NHS focussed to date</td> <td>Campaign of engagement (+ NCL-WR)</td> </tr> <tr> <td>Where we fit in 'pop health' landscape</td> <td>Lack of understanding of all interventions</td> <td>Analysis of our pathways + partner's work</td> </tr> </tbody> </table>	Concern	Cause	Countermeasure	Media weighted to 'Gender'	GIDS transfer / GIC waiting lists	Programme of Pop. Health communications	Lack of formal connections to partners	Largely NHS focussed to date	Campaign of engagement (+ NCL-WR)	Where we fit in 'pop health' landscape	Lack of understanding of all interventions	Analysis of our pathways + partner's work	<p>enabling us to play a pivotal role in shaping the future of population healthcare not only in the capital but also nationally.</p>
Concern	Cause	Countermeasure											
Media weighted to 'Gender'	GIDS transfer / GIC waiting lists	Programme of Pop. Health communications											
Lack of formal connections to partners	Largely NHS focussed to date	Campaign of engagement (+ NCL-WR)											
Where we fit in 'pop health' landscape	Lack of understanding of all interventions	Analysis of our pathways + partner's work											

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

Prevention + Partnership – Summary A3

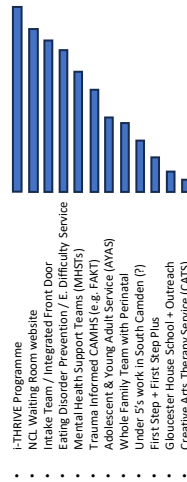
SRO: Chris Abbott

Problem Statement

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

- It is estimated that around 4,000 children and young people aged 5-16 years have a diagnosable mental health condition in Camden
 - It is estimated that around 6,000 young people aged 16-24 years have a diagnosable common mental health condition in Camden
 - More than 2,000 CYP (0-18 years) accessed support and treatment for mental health conditions, across the range of Child and Adolescent Mental Health Services (CAMHS) services offered in 2016/17
- Current initiatives in Camden:
- o Healing Together Camden School Offer
 - o Camden Council, Camden CCG and C&I
 - o Time to Change pledge
 - o Camden Early Help
- Healthy and ready for School
- o The Health and Wellbeing Board
- Camden partners:
- o Camden Early Help
 - o The Camden Health and Wellbeing Board
 - o Camden council
 - o Camden and Islington NHS Foundation Trust
 - o The Brandon Centre
 - o The Hive
 - o Fitzrovia Youth Action (FYA)
- The current process involves partners VCSE working on prevention initiatives which the Tav is not fully versed on and therefore we are missing opportunities to efficiently help with delivery and to align our efforts for maximum impact.

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



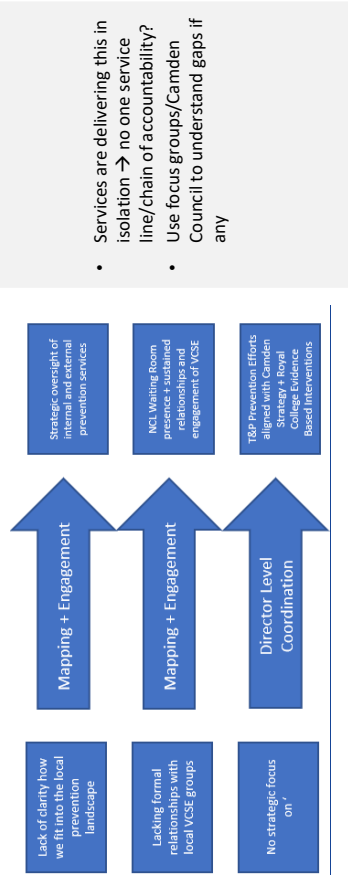
Vision & Goals

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

Goals:

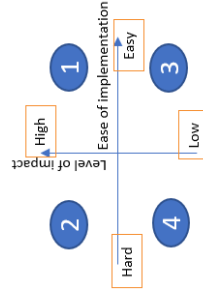
1. Understand what **provision** / activity is happening currently (next 2-3 months)
2. Identified target **populations** to work on and the **partners** to work with to deliver (next 3 months)
3. **Deliver** first round of interventions/countermeasures in the next 6 months

Root Cause / Gap Analysis



Countermeasures / Next Steps

Meeting with Camden Council on 17th November to plan service delivery in local pop health context.



EDI Score – Summary A3

SRO: Gem Davies

Problem Statement

The EDI score for the Trust is amongst the lowest scoring compared to our benchmark peers nationally. The score is currently 7.3, with the median score being 8.3 nationally and the best performing trust being 8.7. If we were to meet the median score, this shows an opportunity for the trust to improve the experience for staff and become an attractive employer going forward.

Vision & Goals

Vision: To consistently match or exceed the average score
G1: Improvement in indicative factors on pulse survey by 0.4 every 3 months
G2: Improve EDI from 7.3 to 8.3 by March 2025

Current Situation



Our diversity and inclusion score increased by 0.1 from 21/22 to 22/23 however our response rates also decreased in this period.

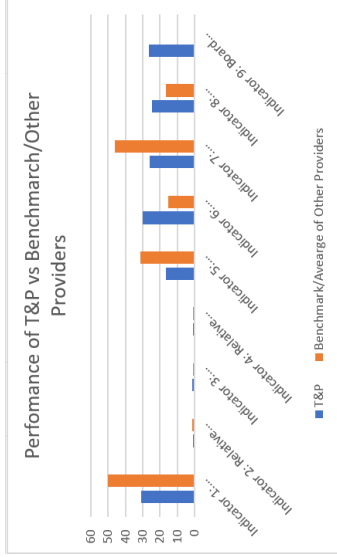
Other comments:

- Disclosure of issues is currently misaligned to the survey results, which means we may have an initial deterioration in EDI indicators, however, we expect this to improve over time.
- Workforce composition to improve over time as well

There are 9 indicators that contribute to EDI score from staff survey as per table:

Indicator	Description
Indicator 1	Percentage of staff in each of the 4C (Bones) 3 or Medical and Dental disciplines and 10M compared with the percentage of staff in the overall workforce
Indicator 2	Relative likelihood of White applicants being appointed from shortlisting compared to Black, Asian and minority ethnic applicants
Indicator 3	Relative likelihood of Black, Asian and minority ethnic staff entering the formal disciplinary process compared to White staff
Indicator 4	Relative likelihood of White staff receiving non-mandatory training and CPD compared to Black, Asian and minority ethnic staff
National NHS Staff Survey Indicators for each of the four staff survey indicators, comparing the experiences of the employees for white and BME staff	
Indicator 5	Percentage of Black, Asian and minority ethnic staff experiencing harassment, bullying and abuse from patients, colleagues or the public in the last 12 months
Indicator 6	Percentage of Black, Asian and minority ethnic staff experiencing harassment, bullying and abuse from staff in the last 12 months
Indicator 7	Percentage of Black, Asian and minority ethnic staff believing that their trust provides equal opportunities for career progression or promotion
Indicator 8	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues
National NHS Staff Survey Indicator for Board representation by ethnicity	
Indicator 9	Percentage difference between the organisation's board voting membership and its overall workforce

Root Cause / Gap Analysis



The EDI score is produced based on an overall assessment of the 9 indicator areas. Indicators 1, 5, 6, 7, 8 are our current priorities.

Countermeasures / Next Steps

Indicator	Root Cause	Countermeasures / Next Steps	Review Date
Indicator 1	Relative likelihood of White applicants being appointed from shortlisting compared to Black, Asian and minority ethnic applicants	Review recruitment process for bias	June 2023
Indicator 2	Relative likelihood of Black, Asian and minority ethnic staff entering the formal disciplinary process compared to White staff	Review disciplinary process for bias	September 2023
Indicator 3	Relative likelihood of White staff receiving non-mandatory training and CPD compared to Black, Asian and minority ethnic staff	Review CPD opportunities for all staff	September 2023
Indicator 4	Percentage of Black, Asian and minority ethnic staff experiencing harassment, bullying and abuse from patients, colleagues or the public in the last 12 months	Review reporting mechanisms and support for staff	September 2023
Indicator 5	Percentage of Black, Asian and minority ethnic staff experiencing harassment, bullying and abuse from staff in the last 12 months	Review reporting mechanisms and support for staff	September 2023
Indicator 6	Percentage of Black, Asian and minority ethnic staff believing that their trust provides equal opportunities for career progression or promotion	Review career progression opportunities	September 2023
Indicator 7	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues	Review reporting mechanisms and support for staff	September 2023
Indicator 8	Percentage difference between the organisation's board voting membership and its overall workforce	Review board composition	September 2023

Team Level Budgets – Summary A3

SRO: Peter O'Neill

Problem Statement

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

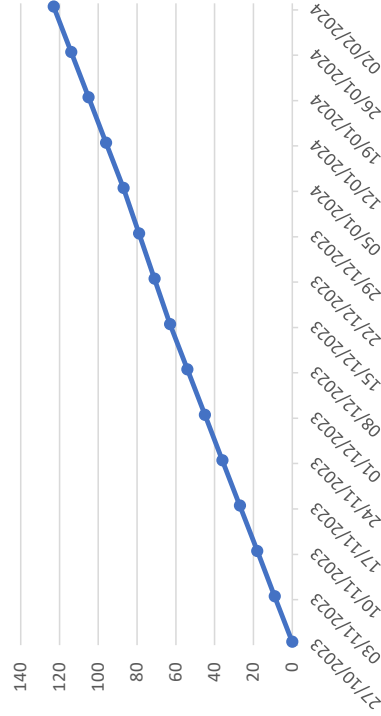
Vision & Goals

- G1: A complete set of team budgets by agreed date end of January 24
- G2: A robust team level budget maintenance process in place by January 24

Current Situation

- We have team level staff and non staff budgets identified that are consistent with the agreed financial plan for 23/24.
- We don't have any team level budgets signed off, as services don't recognise the outcome of the SR in some cases.
- We are working with individual teams to agree/update budgets as required.
- We are reconciling the ESR post list individual budget working papers
- There are currently ~65 team level staff structures to agree
- On a weekly basis, we will track the number of staff level statements that have been signed off and those outstanding
- We need to establish a realistic timescale to complete this
- Trajectory vs. current – reported weekly
- Each cost centre – review non-pay budgets set based on outrun spend

Cumulative Budgets Completed



Root Cause / Gap Analysis

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

Forward looking:

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

Countermeasures / Next Steps

Concern	Cause	Countermeasure
Risk of not maintaining papers for future budgets	Not BAU for Finance and HR to maintain budget working papers	<ul style="list-style-type: none"> - Put process in place - Put assurance process in place

MTEFP – Summary A3

SRO: Peter O'Neill

Problem Statement

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

Vision & Goals

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

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

Current Situation

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

Root Cause / Gap Analysis

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

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

Forward looking:

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

Countermeasures / Next Steps

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

3. Service Line Overviews

Education and Training

Successes

- Skills Fest – a new initiative launched in November 2023 to provide students with additional skills training
- 42% increase in international student recruitment
- Maintaining our broad geographic spread with over 71% of our short course students coming from outside of the London area.
- New project started to implement SOPs across all professional services relating to course administration
- 1074 prospective students have completed applications to our Postgraduate Courses surpassing the 1000 target

Challenges

- Flaws and risks highlighted in student record system (SITS)
- Impact of SITS on associated systems (eg proposed CRM)
- Outstanding student survey recommendations to be actioned and implemented
- Increased reporting and analysis requirements internally and externally without supporting systems

Current Situation

SHORT COURSES

PORTFOLIO	ANNUAL PLANS		PLAN		ACTIVITY (Q2)		Variance
	2021/22	2022/23	2023/24	Q2 Plan	Q2 Actual	Q2 Actual	
Perinatal	253	145	300	150	151	-19	
Psychiatric Applied	88	52	100	16	21	84	
Psychosomatic Clinical (Forensic)	82	36	33	16	17	1	
Psychological Therapies	96	96	-	-	-	-	
Social Care, Management and Leadership	950	1,111	693	325	270	-65	
Systemic	299	141	299	120	140	20	
Non-Portfolio	452	950	626	448	315	-133	
Digital Academy							
Grand Total	2,686	2,642	3,593	1,261	1,139	-122	

We remain slightly down in student numbers in this quarter against the annual workplan for this period. The Digital Academy and Social Care and Leadership portfolios are the main areas still showing a slight negative variance against workplan. In the Social Care portfolio, this should balance out in Q3 and Q4 as there are a number of bespoke projects in the pipeline in this portfolio that will be delivered by year end and their associated student numbers will therefore be reflected later in the year.

It has been noticeable in this quarter, which contains the start of the new academic year, that some of our courses have not recruited as well as they have in previous years and we may well be seeing some impact from the cost of living crisis on our student numbers going forward into Q3 as well. Anecdotally, we have been getting feedback from some prospective students, predominantly from other NHS Trusts and local councils, and particularly on our longer, more in-depth courses, that they are either struggling to get funding agreed at all or it is taking much longer for their employers to approve their funding and thus impacting their ability to enrol on time. We are keeping an eye on this trend and how it might impact our training delivery.

Long Courses

Enrolment for the new academic year has come to an end. As of the 23rd October 2023 we invited 1410 students to enrol. Of these 1014 students have enrolled, which is made up of 533 new students and 481 continuing students. We currently have 304 students who have been invited to enrol but have not done so yet. All those students whose enrolment is outstanding will be emailed and contacted by the Marketing Team and Admissions Team to ensure they are aware of the deadlines. The other 92 that haven't enrolled are students who have deferred, intermitted, been withdrawn, or who have outstanding fee queries. We expect the number of enrolled students to increase following contact from the team, and the processing of some late awards following the assessment boards.

Student numbers overall are slightly down on last year, but we have been pleased with how well recruitment has gone despite the cost-of-living crisis, and other factors which may have made applicants hesitant to apply. Detailed breakdown by course of applications can be found at Appendices.

DET Development Plan

The development plan in detail can be found in appendices.

Identified areas of concern

Data collected by HESA is used by the Office for Students (OfS) to understand the performance of an individual provider, such as the Trust, as such it is a regulatory requirement that the Trust must adhere to – with late or poor-quality data impacting funding and reputation (including existing and potential future university partnerships). Student numbers overall are slightly down on last year, but we have been pleased with how well recruitment has gone despite the cost-of-living crisis, and other factors which may have made applicants hesitant to apply. Our current SITS system is not fit for purpose and the following risks have been identified:

Risk A

- The current implementation of SITS – combined with the lack of staffing resource to manage ongoing tasks – outlines an urgent regulatory and reputational risk to 'business as usual' as well as a prohibiting factor to future growth.
- In order for the Trust to be competitive in an ever-changing HE landscape (e.g. adapting to new models of delivery), the underlying systems (SITS) need urgent redesign.
- Currently, there are 10 identified issues with our implementation and use of SITS – the majority of which are resulting in:
 - Loss of income
 - Poor data quality for regulatory data returns
 - Inability (at worst) / inadequate (at best) reporting of financial performance
 - Reputational risk (existing university partnerships)
 - Student experience

Risk B

- The Trust has adopted a staffing structure that is too lean to meet the ever-increasing regulatory burden imposed on higher education institutions (HEIs).
- There is a baseline of staffing need to meet the demands of data quality, reporting, planning and student systems within any higher education institution – irrespective of the number of students within an institution – which we do not currently meet.
- The Trust contracts the services of one HESA Data Futures Consultant, with the contract ending on 31st January 2024. We do not employ any other member of staff that have the knowledge or expertise to continue with the work required to meet the demands of HESA Data Futures.
- There is no capacity or resource within the Trust to redesign the SITS modules, and nor is there the expertise to train staff within Academic Registry on the full usage of SITS. At present, the current staff are not fully versed in the functionality of SITS – even in its limited functionality.

Next Steps

Concern	Cause	Countermeasure
Staffing shortage	Additional external reporting requirements	Review staffing structure
SITS inadequacy	Original implementation incorrect, doesn't allow for any changes, scaling up or accurate reporting	Comprehensive review followed by redesign

Complex Mental Health

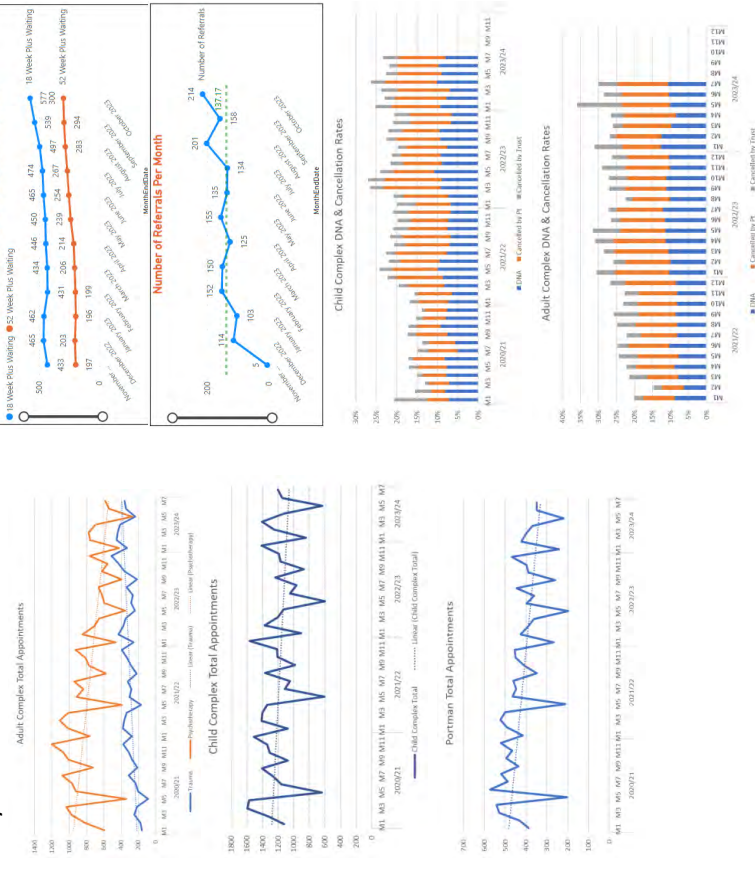
Successes

- 4.6% improvement on mandatory training compliance with initiative to encourage whole team training sessions for Oliver McGowan.
- Improvement measures in AVAS remain high at 80% for October.
- 58% reduction in missing assessment and summary reviews for AVAS since February 23. 8% across the rest of the service.
- Thematic analysis for Child Complex from EQ data highlights consistent kindness and compassion across all services.
- Therapy dogs project in AVAS widely considered as enhancing care & supporting staff engagement and wellbeing.
- Adult Psychotherapy embarking on new PPI initiative
- Care of waiters protocol drafted for Child Complex Services as well as Clinical Harm Protocol to support young people.
- Child Complex clear priorities for improvement set for Q3 and Q4 – performance against job plans showing improvement following focused review and action planning.

Challenges

- Out of hours duty trust wide needs discussion. Teams have fed back 95% of patients being seen within core clinical hours to prevent need for additional duty measure.
- Waiting times for ASC and Trauma interventions, implementation of new strategy underway
- Large number of posts to recruit to, for waiting list improvement, additional administrative burden
- Issues have arisen with payroll due to over and under payment (being investigated by the People team). Disproportionately affects junior staff
- FDAC reduction in cases, impacting on income and placement of team. Estates working closely with the team to work to a solution, ensuring the team have a private space and are closer in proximity to the main trust site.
- Training on A3 service improvement methodology and requirements needed at all levels of organisation to ensure plans are developed by teams and are not top down

Activity Overview



Analysis

Overall, Activity within the complex service line has reduced while referrals have increased. There has been a steady increase in appointments not completed due to non-attendance or cancellation which has also impacted on activity. Actions plans have been developed at team level to support Quality Improvement initiatives to increase activity by ensuring clearly mapped pathways, job planning analysis and complete data capture. Oversight of this work is held at IQPR meetings and escalations raised to PFR. Initial Job planning analysis for the service line:

Team	YTD	M1	M2	M3	M4	M5	M6	M7
FMH	92%	73%	84%	106%	75%	48%	78%	98%
FAKT	69%	47%	74%	59%	77%	35%	118%	123%
AVAS	81%	62%	89%	93%	83%	43%	84%	114%
EDAS	92%	84%	61%	110%	93%	91%	78%	109%
Autism & LD	83%	40%	78%	90%	58%	67%	116%	107%
Child Complex Total	85%	63%	80%	94%	77%	54%	89%	111%
Trauma	86%	64%	91%	89%	95%	48%	87%	126%
Psychotherapy	65%	45%	76%	73%	83%	28%	67%	83%
Adult Complex Total	74%	54%	83%	80%	89%	37%	75%	101%
Portman	81%	54%	93%	85%	90%	51%	103%	97%
FCANHS								
Returning Families								
Social Integration Total	81%	54%	93%	85%	90%	51%	103%	97%
Complex Mental Health Total	81%	58%	83%	88%	83%	49%	88%	106%
Cumulative Compliance	81%	58%	71%	76%	78%	72%	75%	79%

- The data provided relates to employed staff in post only whilst we ensure the honorary and trainee targets are correct. Vacancies are excluded.
- Job plan compliance of attended appointments is at 81% against the trust target of 90%.
- September and October has seen significant improvements in job plan compliance, with October being above target for the first time this year.
- This improvement is driven by a number of factors, including reduced leave in October and improvements in recording and increased caseloads following from actions plans being put into place
- More intensive support is being put into place for FAKT and Adult Psychotherapy to help understand and improve compliance with job plans.

Next Steps

Concern	Cause	Countermeasure
Waiting Lists for ASC Assessment	Increased demand above expected growth levels	Programme of QI work developed (see A3s)
Waiting Lists for Trauma Treatment	Increased demand above expected growth levels	Programme of QI work developed (see A3s)
Reduced Activity Levels	To be investigated	Review of Job plans
Inconsistency in record keeping	Different teams have developed SOPs in silos	Review and align SOPs across all service Lines

Community and Integrated

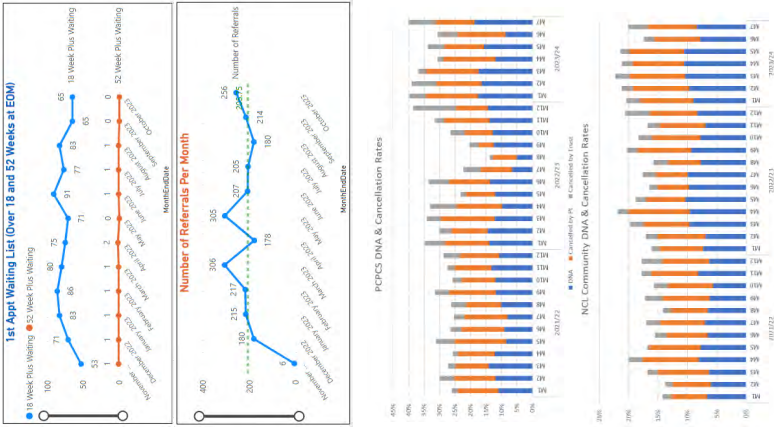
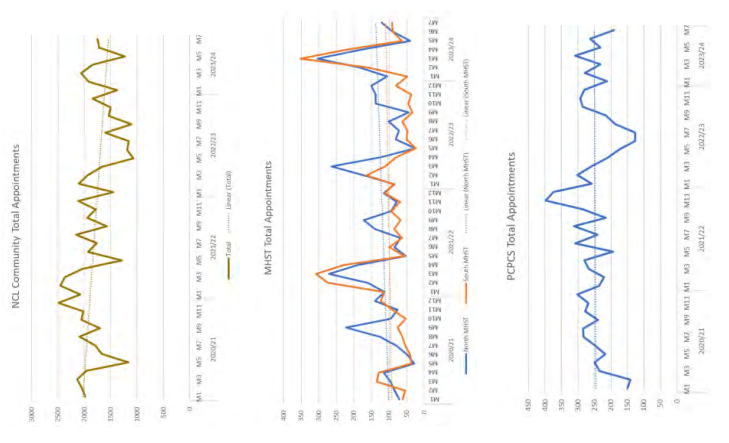
Successes

- Steady improvement in staff reported as having had clinical supervision, at 51% in October increased from 18% in August.
- 90% MAST compliance in service line
- Establishing & funding a mentoring programme for young people in Camden through Advantage Mentoring, via Arsenal football club. This will use the "core offer" underspend for Camden CAMHS. It will be in partnership with Islington CAMHS
- Waiting times remain low in all under 18s services with NCL community achieving a less than 3 week wait for a first appointment for the last 6 months. MHST have met our target of 2 appointments within 4 weeks for the last 5 months.
- Intake redesign has been effective ensuring cases are getting to the right place promptly and families are getting the information they need about the right place to access care.
- We have agreed, in principle, with Surrey commissioners new contract at £839,000 instead of the £500,000 requested by them

Challenges

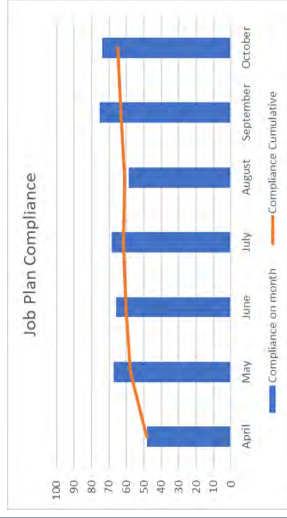
- Staffing levels remain problematic with most teams consistently having at least one vacancy. We currently have 45 vacant clinical posts and 3 admin posts. Admin roles are now to be filled by bank staff pending the GDS consultation.
- We have begun contract negotiations with PCPCS new commissioner regarding contract currency and clinical model for 23/24.
- Job planning review needs to be undertaken
- There have been repeated delays in moving treatment waiting lists onto Carenotes and reports not being fixed while other changes were made, this was not at the team's request. This means we are working between systems and people could fall through gaps.
- Some issues with intake redesign leading to around 20% of referrals being returned to intake, will cause some delay in booking appointments.
- SCCT team manager secondment has been agreed, will likely leave a gap in the service from late January 2024.

Activity Overview



Analysis

Overall, Activity within the complex service line has reduced while referrals have increased. There has been a steady increase in appointments not completed due to non-attendance or cancellation which has also impacted on activity. High vacancy levels have also impacted the service line. Actions plans have been developed at team level to support Quality Improvement Initiatives to increase activity by ensuring clearly mapped pathways, job planning analysis and complete data capture. Oversight of this work is held at IQPR meetings and escalations raised to PFR. Initial Job planning analysis for the service line:



- Compliance with job plans remains in the region of 70%.
- CWP and PCPCS are at or close to 90% compliance.
- This month we will be reviewing all plans and ensuring they are up to date as we have had significant staffing changes and new trainees joining which does impact the figures. We will also ID a team to pilot doing the plans adjusting each month for absence rather than doing a 44 week year.
- MHST and CWP plans are also being adjusted to increase admin time in recognition of the fact that their staff are more junior than those in other teams. Staff in band 4 and 5 roles will have increased admin time available to them which will reduce their number of contacts – these are quite high now.

Next Steps

Concern	Cause	Countermeasure
PCPCS patient non-attendance	Patient engagement complexity	Pathway and modality of treatment review
Vacancy Rates	To be investigated	Review of Job plans
Reduced Activity Levels	To be investigated	Review and align SOPs across all service Lines
Inconsistency in record keeping	Different teams have developed SOPs in silos	

Adult Gender Identity Clinic

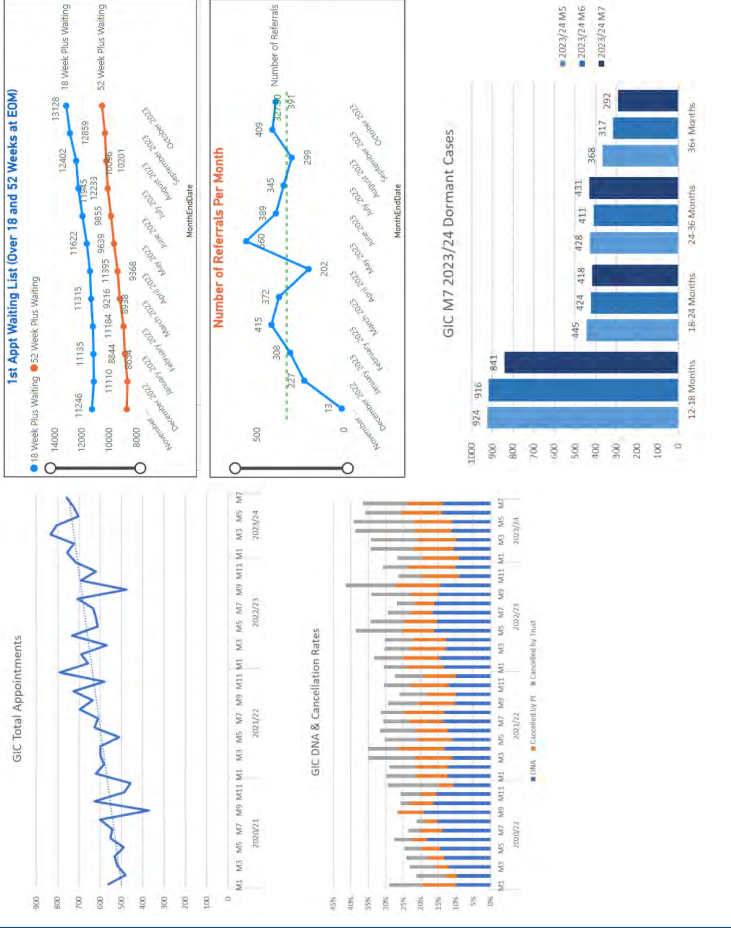
Successes

- Safe**
 - The Admin team are typing clinical letters in real time which results in patient treatment starting on time.
- Effective**
 - Gender Admin Away Day successfully took place in October 2023 and the focus was on staff wellbeing. The outputs will inform the Improvement Week 05 Dec 23 - 08 Dec 23
- Caring**
 - Comms Team have updated the GIC website accessibility preferences in response to user feedback
- Responsive**
 - Ongoing active clinical recruitment to ensure critical mass and improvement of waiting times. 2.6 WTE will be starting by January 2023.
- Well Led**
 - Focused approach on reduction of dormant cases in the PTL.

Challenges

- Staff morale and impact on productivity and activity. New job plans have been drafted and there is a more standardised approach which incorporates flexibility around Supported Professional Activities, subject to CMO agreement.
- Delays with job planning means that we are not able to have visibility and accountability for individual and service level activity.
- Open case discharges are delayed due to irregular notification of patients being discharged from the surgical pathway as well as long waiting times. The current service specification requires patients to complete the entire surgical pathway before they can be removed (circa 6 Years).
- Several Gender clinics have closed their waiting list. If this is not resolved by commissioners, we expect to see a significant rise in referrals.
- The Clinical notes function on Care notes has been used by the administrative team to record zoom appointments incorrectly. This has now been resolved where all appointments are placed in the correspondence tab.

Activity Overview



Analysis

- Activity within Adult GIC has increased steadily over the last few years, despite the challenges with recruiting to this specialist service. Referrals into the service continue to increase while numbers of first appointment remain steady (well below referral monthly figures). This is due to bottlenecks within the system, inability to discharge patients and high DNA and cancellation rates.
- This service line has been highlighted for strategic CI on waiting list management given the significant size and length of the waiting list. Oversight of this work is held at IQPR meetings and escalations raised to PFRC.
- Vacancy Rate in the service is high, plans are in place to manage recruitment effectively:

Department	Current Post WTE	Total Vacancy WTE
Speciality Doctor	9.2	6.2
Endocrinology	5.6	0
Counselling/Clinical psychology	5.6	2.6
SLT	3.6	3
CNS	0	3
Total	24 WTE	14.8 vacancy






- Sickness Levels within the team have been high, Staff sickness absence rate for October is 11.58%. This relates to long term sickness. The data translate to 148 days of sickness in October 23 which equates to approximately 250 lost appointments. All sickness is now being recorded to the ESR system and will support understanding of sickness rates better.
- Issues have been highlighted with record keeping and misalignment of processes vs trust policy.
- Risk highlighted with NHSE regarding the transfer protocol to the new clinics, with each clinic wishing us to transfer data in a different way. Working with commissioners to agree a single process.

Next Steps

Concern	Cause	Countermeasure
Waiting List	See priority area A3	
Vacancy Rates	To be investigated	
Transfer Protocol not being enacted by pilot GICs	New sites have not signed up to the transfer protocol	Meeting has been agreed with NHSE to resolve with all providers
Inconsistency in record keeping	Different teams have developed SOPs in silos	Review and align SOPs across all service Lines

Gender Identity Development Service

Successes

 <p>Safe</p>	<ul style="list-style-type: none"> Clinicians reviewing and updating patient management tracker on case-by-case basis to provide quality transfer of service.
 <p>Effective</p>	<ul style="list-style-type: none"> 95% of the 17+ waiting list have been referred to adult GICs. All over 18+ on open caseload adult referral form completed as necessary and awaiting to be picked up by the GICs.
 <p>Caring</p>	<ul style="list-style-type: none"> Continued support for young people whilst they await transfer of care to the New Providers. Case trackers have been used to identify young people who may get a referral to endocrine in the time remaining.
 <p>Responsive</p>	<ul style="list-style-type: none"> Increased regular communication with staff in response to notice of closure and decision to go to consultation. Additional reflective space groups scheduled for both clinical and admin staff groups.
 <p>Well Led</p>	<ul style="list-style-type: none"> Team managers/leads ensuring clear avenues for communication as well as links to HR and staff well-being, as extra support. Consultants working with new services to finalise an information sheet and transfer document.

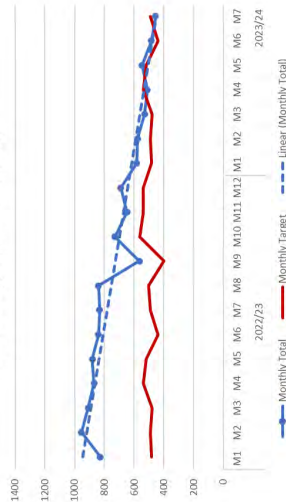
Challenges

<ul style="list-style-type: none"> Managing distress in patient group and realising that we will need to let some service users know that they will not complete the pathway to Endocrine in the service together with no information about what will be available in the new service.
<ul style="list-style-type: none"> Continued uncertainty and lack of engagement by New Services means essential tasks including patient consent for transfer are delayed. Consultation on redeployment/redundancy likely to result in loss of staff and the transfer of their caseloads to new clinicians.
<ul style="list-style-type: none"> 17+ on the Endocrine pathway not yet to be picked up by adult service. No information about what psychosocial care YP in Endocrinology will receive.
<ul style="list-style-type: none"> Closure announcement end of September 2023 has increased pressure on staff who are clearly feeling stressed and helpless. Focusing on clear and timely communications to staff as new information emerges.
<ul style="list-style-type: none"> Holding the maintenance of quality and safety of patient care and patient experience as the key priority of the service. Managing the impact of staff of negative and provoking media coverage with evident leaks of information from the new services.

Activity Overview

- Despite a 5% reduction in booked appointments recorded for October 2023, attended appointments were up 2% compared to September 2023.
- Weekly PTL tracking analysis continues to inform on number of YP awaiting appointment dates.
- DNA rate for October 2023 was 6%. This is within Trust target and a 4% reduction compared to September 2023.
- The review of the Cancellation and DNA Policy is still ongoing. Aim is to effectively support DNA processes and procedures to remain within the DNA national target.
- There was a 1% increase in appointments cancelled by YP in October 2023 compared to September 2023.
- Appointments cancelled by the Trust increased 0.4% from September 2023 to October 2023.
- The service continues to highlight cancellations in weekly PTL meetings.

GIDS Total Appointments - Monthly



GIDS DNA & Cancellation Rates



Analysis
Demobilisation of the service has been split into 3 workstreams, Clinical, Workforce and Infrastructure. Risks have been identified around lack of engagement by new providers and lack of clarity on the new service provisions, however the GIDS service continues to develop and monitor the caseload trackers and work closely with patients to ensure a safe handover of service.

Caseload Tracker Overview:

- Each clinician has an excel spreadsheet tracker with their open caseload (completed by clinicians) to track progress in preparing patients for discharge or transfer. The collated trackers provide service level data. These trackers were introduced in November 23, therefore at the time the initial data was shared, the work was incomplete.
- The tracker was developed to provide oversight of the open caseload and to enable managers to support staff with actions essential to safe transfer of patients. The data is not cut in the way that NHSE and stakeholders are requesting.
- To note, the parameters have changed since the tracker was developed. At the time the service was not aware that Endocrinology patient transfers were out of scope for the Phase 1 Providers.
- There is no mechanism on CareNotes at present to capture the level of detail being requested nor to cut the data as such, because the data we hold is qualitative and patient specific and would require a significant number of hours weekly to come even close to concrete/accurate figures.
- We have requested that IT support us to collate the data from individual trackers into a single database that can be updated as required, however this may take a few weeks to resolve.
- Individual case trackers are reviewed in monthly line management supervision to update on progress and identify issues in preparation for transfer of cases.
- The GIDS Closure Group have high level oversight of risks and emerging issues as the data is generated.
- This work will continue until the service closes as patients continue to receive input.

Next Steps

Concern	Cause	Countermeasure
Reporting on new requirements	Data not captured originally in a way that can be extrapolated easily	Working with informatics to develop an approach urgently to address needs
Demobilisation Timeline	Lack of clarity on new services and changing requirements	More frequent demobilisation meetings have been implemented with an urgent engagement taking place with new providers
Staff Consultation Impact	Closure of service	Team managers and leads to explain Consultation procedure to staff and support them to engage in procedure and to understand what the proposals mean for them. To closely liaise with HR for guidance on possible options and outcomes for staff.

4. Workforce Updates

Workforce

Overview

- Current vacancy Rate is at 17.16%
- Sickness rates are increasing as they are better recorded and more accurately reflect true absence, however our reported sickness rates remain much lower than other London providers. We continue to train managers on ESR supervisor self service
- Appraisal compliance is increasing

- There has been an increase in Occupational Health Referrals which is in line with the improved sickness reporting rates
- Specific strategic work has started to address identified issues around Bullying and Harassment, and EDI (See People Culture A3 Slides for detail)

KPIs - These workforce indicators could have a direct impact on the quality of all services (patient safety, patient experience, clinical effectiveness, student experience and satisfaction)

Key Performance Indicators	Trust Target	Jun-23	Jul-23	Aug-23	Trend (Against Previous Month)
Sickness Absence	3.07%	0.95%	1.18%	1.71%	↑
Mandatory & Statutory Training Compliance	95.00%	84.69%	90.73%	89.42%	↓
Appraisal (Rolling 12 months)	95.00%	77.51%	72.39%	78.38%	↑
Turnover	2.20%	1.32%	1.51%	2.57%	↑
Vacancy	15.00%	15.73%	17.03%	17.16%	↑

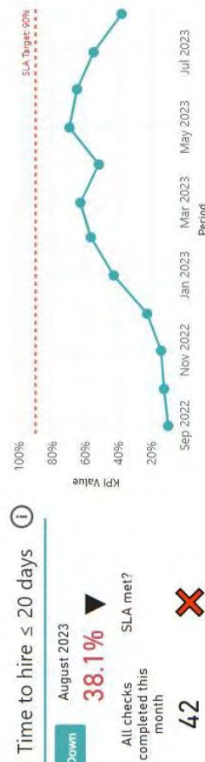
Band Aug-23	White	BME	Not Stated
Band 2	0.12%	0.24%	0.00%
Band 3	0.00%	0.24%	0.00%
Band 4	3.89%	6.20%	0.24%
Band 5	6.20%	5.72%	0.36%
Band 6	11.92%	5.60%	0.61%
Band 7	10.83%	4.26%	0.36%
Band 8 - Range A	11.80%	4.74%	0.24%
Band 8 - Range B	8.76%	1.58%	0.49%
Band 8 - Range C	3.65%	1.22%	0.12%
Band 8 - Range D	0.73%	0.36%	0.00%
Band 9	0.61%	0.24%	0.00%
Other	5.35%	2.92%	0.36%

The Trust BME headcount (self declared by individuals) currently stands at 262 staff which is 31.95% of the total headcount. Non-white colleagues continue to be under-represented in higher banded roles across the organisation

Countermeasures / Next Steps

Concern	Cause	Countermeasure
Impact of Merger on staff morale	Uncertainty around future	We have offered support through regular interventions (listening sessions, admin forum) and have signposted staff to the EAP service to minimise the impact on their morale and well-being following this news.
Inaccurate sickness reporting	Training and systems required Update	New policy developed and rolling training sessions have been developed for staff alongside a clear communications plan
Appraisal and MasT compliance	Period of uncertainty	Updated communications and support strategy to ensure all staff have access to all training
Disproportionate ethnicity representation across bandings	TBD - likely to be linked to perception of unfair development and career progression	Increase declarations of protected characteristics. Provide greater transparency of processes. Inclusive recruitment.

Recruitment

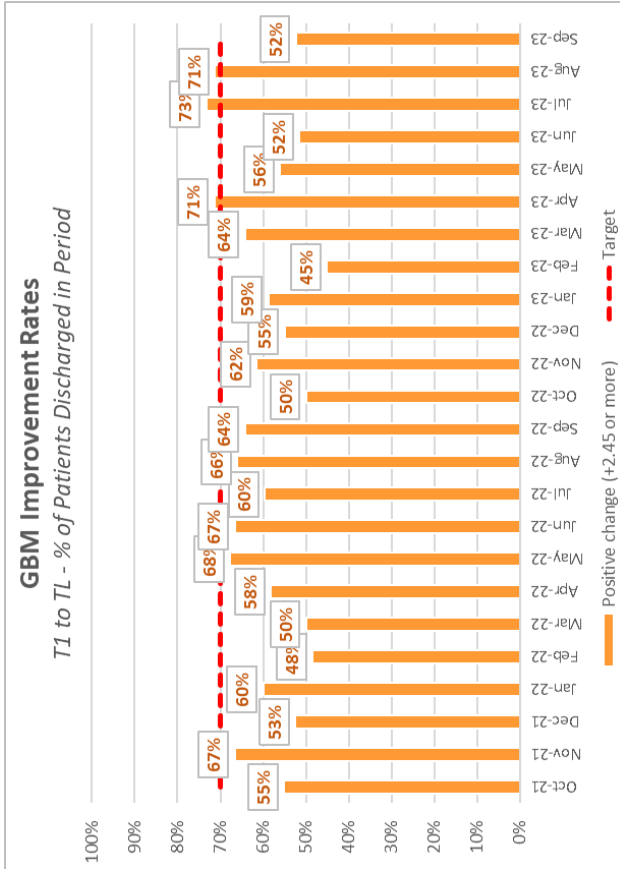


Measures from conditional offer sent to all employment checks completed. Excludes lapse time where Visa/COS required, honorary, non-routine recruitment and outliers where lapse time is < 4 days or > 100 days. The current KPI value has decreased from 55.0% in July to 38.1% in August. SLA= Service level agreement

5. Quality and Patient Safety

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

OMs - GBM (Goal Based Measure)

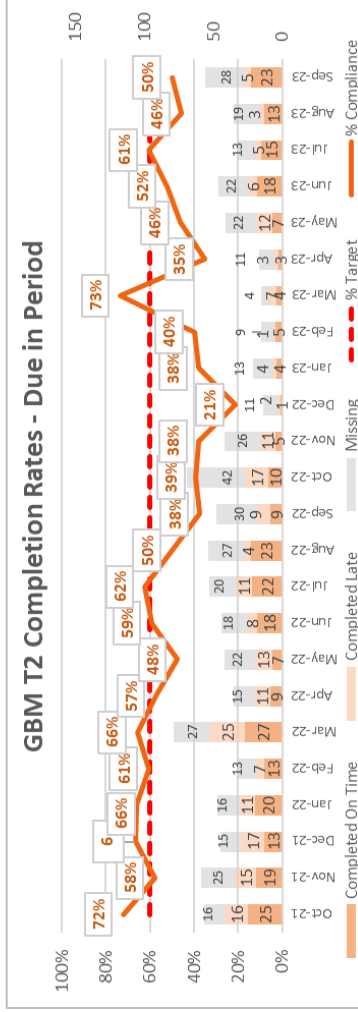
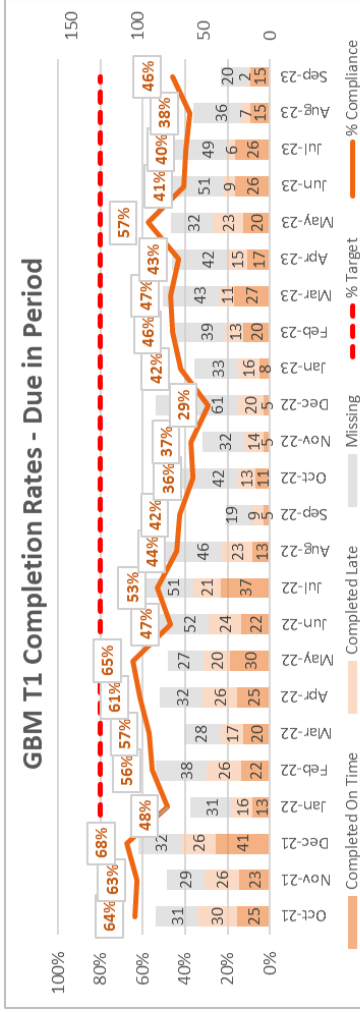


GBM OM is a way of evaluating progress towards goals in clinical work with children, young people, and their families and carers. Data includes: all contracts and age range under 18s. Teams excluded: Autism Assessment, First Step, First Step Rehab, Gloucester House, Gloucester House Outreach Service, Heallios Assessment, Heallios Treatment, Returning Families and Returning Families School Service.

The GBM improvement rates include all patients discharged in the period with a minimum of two completed forms. It compares scores from the first form (T1) completed to the last one (TL). GBM methodology considers an improvement only those scores that increase by 2.45 points or more an improvement.

The report has updated all previous months retrospectively for accuracy.

Data source: 06/10/2023 SRFS (Internal Reporting System) Reported by the Quality Team; Data was run with 97 unoutcomed appointments

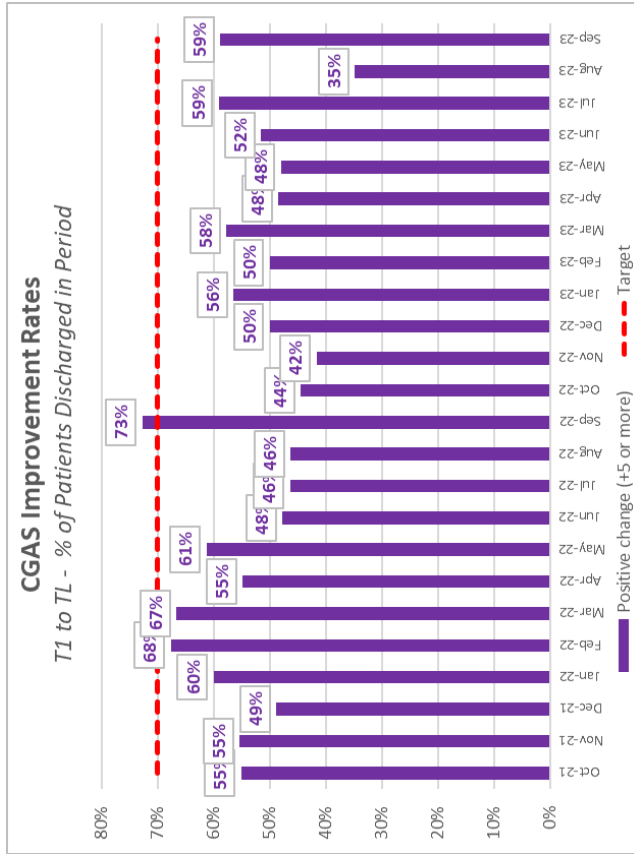


Completion rates include forms completed on time and late, under Thriving, Getting Help & Getting More Help Thrive categories. As we report 'due in period' the most recent months do not include late forms, as they are not created yet.

-GBM T1 -, with minimum 2 appointments are expected to have a GBM T1 completed. Those completed within 1 month of second appointment are deemed as on time.

-GBM T2 - expected 3 months after T1, deemed as on time if within 4 months of T1. We exclude discharged patients who were not seen after T1.

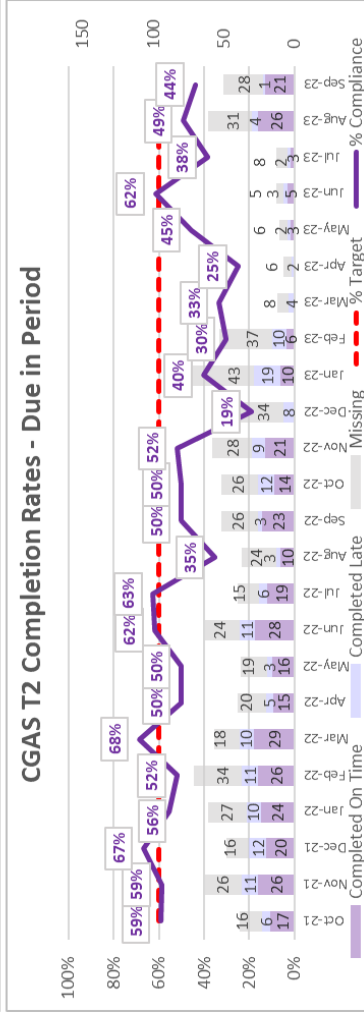
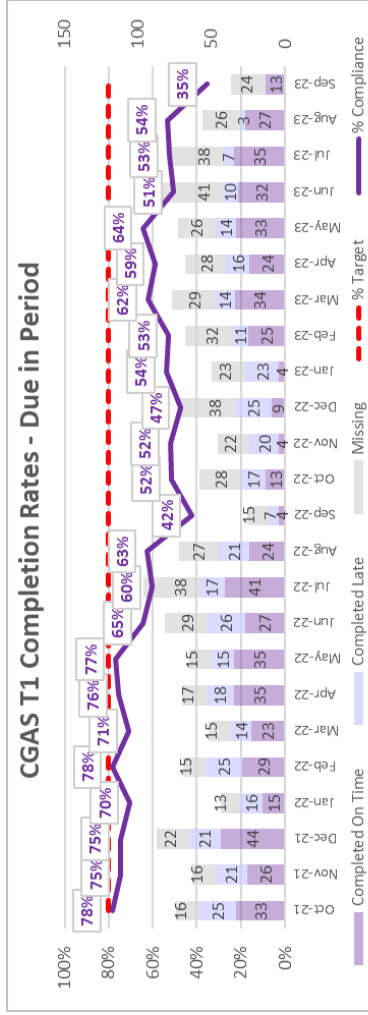
OMs - CGAS (Children's Global Assessment Scale)



CGAS OM a rating of functioning aimed at children and young people. Data includes: all contracts and age range 4 to 18. Teams excluded: Autism Assessment, First Step, First Step Rehab, Gloucester House, Gloucester House Outreach Service, Heallios Assessment, Heallios Treatment, Returning Families and Returning Families School Service.

The CGAS improvement rates include all patients discharged in the period with a minimum of two completed forms. It compares scores from the first form (T1) completed to the last one (TL). CGAS methodology considers an improvement only those scores that increased by 5 points or more as improvement. The report has updated all previous months retrospectively for accuracy.

Data source: 06/10/2023 SRFS (Internal Reporting System) Reported by the Quality Team; Data was run with 97 unoutcomed appointments

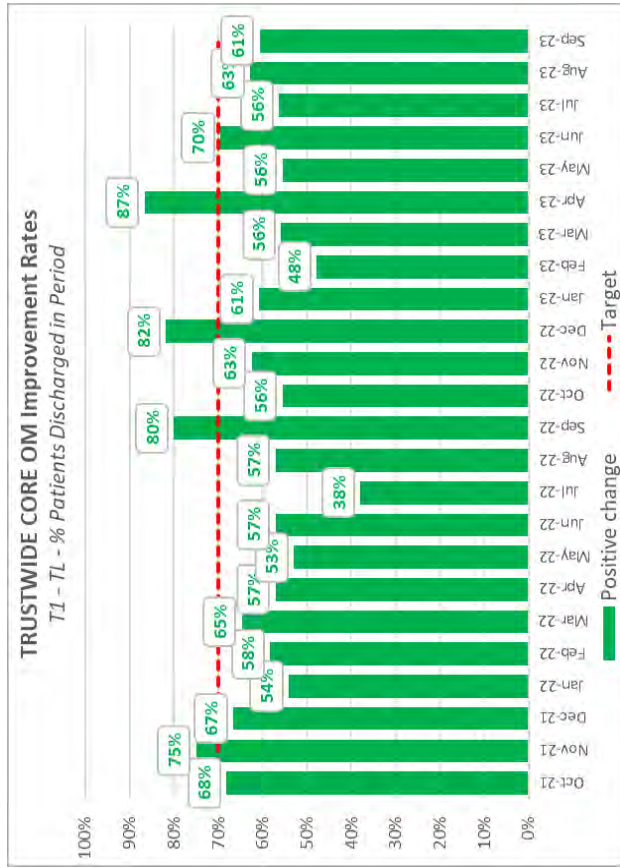


Completion rates include forms completed on time and late, under Thriving, Getting Help & Getting More Help Thrive categories. As we report 'due in period' the most recent months do not include late forms, as they are not created yet.

-CGAS T1 rates: Patients under Thriving, Getting Help & Getting More Help Thrive categories, with minimum 2 appointments are expected to have a CGAS T1 completed. Those completed within 1 month of second appointment are deemed as on time.

-CGAS T2 rates: expected 6 months after T1, deemed as on time if within 7 months of T1. We exclude discharged patients who were not seen after T1.

OMs - CORE OM (Clinical Outcomes in Routine Evaluation)

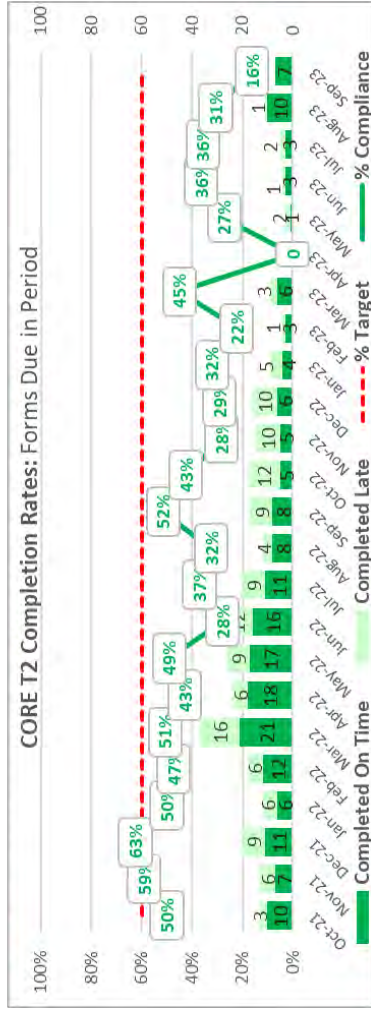
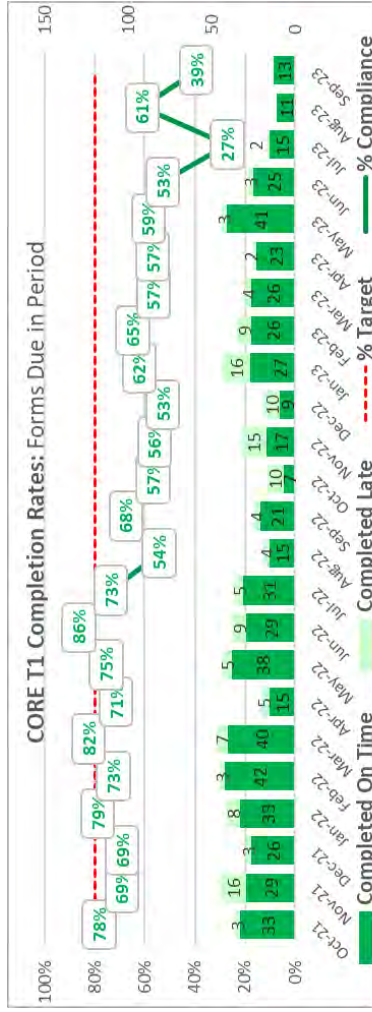


CORE OM, Clinical Outcomes in Routine Evaluation, is a session by session monitoring tool with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. Data includes: CORE 34, all contracts and age range over 18s.

The CORE OM improvement rates include all patients discharged in the period with a minimum of two completed CORE OM forms. It compares scores from the first form (T1) completed to the last one (TL).

PCPCS service is transitioning to CORE 10. T1 due cohort excludes newly referred patients, as they will be completing a CORE 10.

The report has updated all previous months retrospectively for accuracy.



Completion rates include forms completed on time and late. As we report 'due in period' the most recent months do not include late forms, as they are not created yet.

-CORE T1: expected after a second appointment, deemed as on time if within 1 month of that appointment.

-CORE T2: expected 6 months after T1, deemed as on time if within 7 months of T1. T2 forms are particularly challenging for teams that have a long waiting list.

Data source: 05/10/2023 SRRS (Internal Reporting System) Reported by the Quality Team; Data was run with 97 unoutcomed appointments

Clinical Notes Compliance

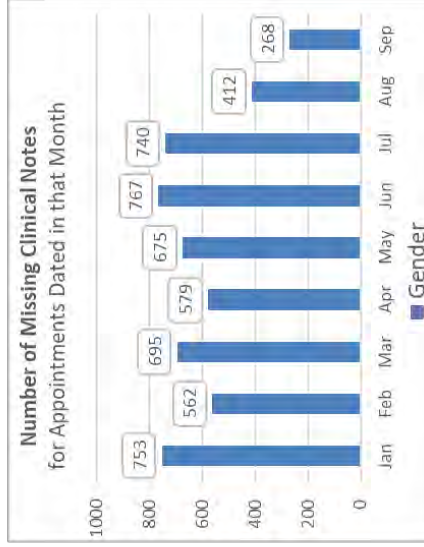
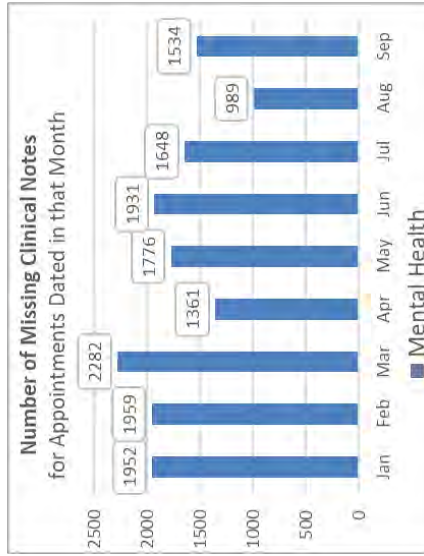
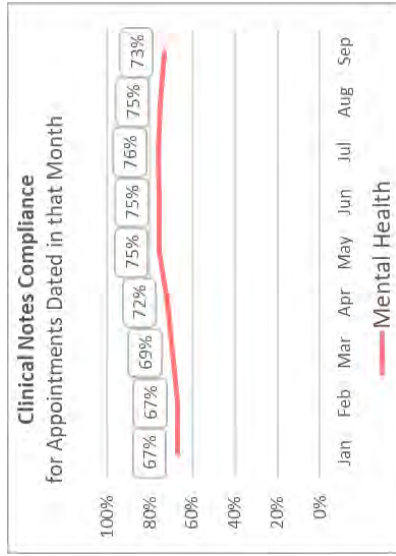


Trustwide Completion Rates YTD from Jan to Sep **70%**

The report refers to outcomed appointments that took place during that month. Unconfirmed clinical notes are included in this data. Compliance graphs show portion the appointments that took place during that month that have a valid clinical note.

Missing graphs show the number of appointments that took place during that month without a valid clinical note.

There has been a slight but constant improvement on Clinical Notes Compliance. YTD percentage in May was 65%, in July was 68% and current YTD is 70%. This improvement is likely to be a combination of several factors: raising awareness in the clinical governance meetings, email reminders, delivering new training sessions and improving SOPs.



Total MH Missing Notes from Jan to Sep **15432**

Total Gender Missing Notes from Jan to Sep **5451**

Data source: 05/10/2023 SRRS (Internal Reporting System) Reported by the Quality Team; Data was run with 97 unoutcomed appointments

Care & Crisis Plan Completion

Care Plan

Target	Detail of indicator	Target %	% Progress May 22/23
CAMHS Transformation Targets	80% initial completed care plans	80%	Latest monthly data compliance for Sep 64% -- out of 45 Initial Care Plans due, 29 were created Current Financial year completion rate 85% (last financial year we had 78%) The percentage of completed initial care plans has increased significantly over the last few months. Care Plans for under 18s are now being generated by admin when the assessment forms are marked as completed by clinician. This report updates all previous months retrospectively for accuracy.
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working)	80%	Latest monthly data compliance for Sep 63% -- out of 30 Review Care Plans due, 19 were created Current Financial year completion rate 73% (last financial year we had 44%) The percentage of completed review care plans has increased significantly over the last few months. Care Plans for under 18s are now being generated by admin when the review forms are marked as completed by clinician. This report updates all previous months retrospectively for accuracy.
	ESQ question 'How well are people you've seen here working together to help you?' [A Lot or A little or Not at All or Do Not Know]	70%	Sep compliance 95% -- we received 21 responses from CYAF patients to the ESQ question 'How well are people you've seen here working together to help you?' . 18 patients answered 'A Lot', 2 answered 'A Little', 0 'Not Good' and 1 'Don't Know' . Note the calculations methodology has been improved to include 'don't know' answers. This is in line with the method used nationally for FFT questions. We are pleased that we continue to receive positive feedback from CYPs and families. We will focus on increasing the number of ESQ's received to ensure that the data is robust.

Crisis Plan Completion

Target	Detail of indicator	End of Year Target %	Progress 22/23
Crisis Plan	CYAF	100%	Preliminary work completed. Adaptations to new strategic review structure are underway. Operational change has affected our reporting capacity, and we are working on a solution.
	AFS	100%	Preliminary work completed. Adaptations to new strategic review structure are underway. Operational change has affected our reporting capacity, and we are working on a solution.

Data source: 09/10/2023 SRRS (Internal Reporting System) Reported by the Quality Team; Data was run with 97 unoutcomed appointments

Incidents Reported by Risk Level – Trust wide	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Apr	2023/24 May	2023/24 June	2023/24 July	2023/24 August	2023/24 Sept
1-4	64	40	30	36	26	30	33	43	7	15	19	11	4	21
5-8	42	69	29	24	35	32	23	39	7	8	12	13	16	23
9-12	11	5	16	4	16	16	9	17	2	3	7	2	3	*9
15+	1	1	1	2	2	1	3	2	0	1	0	0	0	0
Total	118	115	76	66	79	79	68	101	16	27	38	26	23	53

*Ongoing loud Building works affecting patient sessions. reported to Estates

Incidents by Directorate

Adult Forensic Service (AFS)	24
Children Young People and Adolescent Service(CYAS)	14
Gloucester House	18
GIC	31
GIDS	9
Corporate and Trust wide	6

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

The Trust is in the final stages of replacing its Local Risk Management System (LRMS). Once a supplier has been appointed, a timeline for implementation will be confirmed. We are currently able to upload manually to LFPSE for all appropriate patient safety incidents.

Themes and trends of Incidents

Incidents by Category		Total
2023/ Q2		
Access to Treatment or Drugs		1
Appointments		8
Clinical		*23
Communications		5
Damage to Property		1
Facilities		8
Information Governance		*21
Medical		3
Other		3
Patient care		5
Physical or Verbal Abuse		*17
Privacy Dignity Wellbeing		2
Safeguarding		3
Slip Trip Fall		1
Trust Admin includes Policies, Procedures and Pt Record Mgmt		1
Total		102

Data source: Patient Safety/ Governance- CMO Office 12/10/2023. Previous data as reported in relevant earlier reports.

Below is a selection of some of the comments gathered from ESQ qualitative data during Q2 2023/24.

EXPERIENCE OF SERVICE QUESTIONNAIRE FEEDBACK Compliments (Q2 2023)

<p>The staff, from receptionist to therapist and people walking around the building are all friendly and relaxed. All information relating to my therapy were communicated in a prompt and organised manner.</p> <ul style="list-style-type: none"> - MFAS 	<p>Therapist is incredible. The space is calming and respectful. I'd like to pass on my gratitude to the staff at the Tavistock. I understand it has been very difficult, but I've found this place to be an incredibly healing place with which I have made profound positive changes to my life. Thank you.</p> <ul style="list-style-type: none"> - ADULTS PATH
<p>Validating and comforting. Fantastic therapist 10/10!</p> <ul style="list-style-type: none"> - ADOLESCENT YPCS 	<p>XXX, XXX's psychotherapist was really attentive and involved. She really cared a lot about XXX and was most kind and helpful.</p> <ul style="list-style-type: none"> - SOUTH Service
<p>They were nice. They did everything possible. They went above and beyond.</p> <ul style="list-style-type: none"> - Family Service 	<p>The service is good enough to be recommended. Family therapy was very wonderful and we enjoyed it as a family.</p> <ul style="list-style-type: none"> - Family Service
<p>This is an excellent service which I am extremely grateful for, thank you very much.</p> <ul style="list-style-type: none"> - PORTMAN Glasser 	<p>Thank you all for providing a truly fantastic service. Special thank you to XXX, XXX and XXX.</p> <ul style="list-style-type: none"> - ADOLESCENT Camden Team
<p>The sessions were very helpful for our XXX. They were person centered towards XXX's needs and we were consulted and given feedback of the progress. XXX was excellent at getting XXX to engage in session. We are very grateful for the service!</p> <ul style="list-style-type: none"> - SOUTH Service 	<p>XXX was fantastic for my son. She was very smiley and welcoming from the start. She engaged brilliantly with XXX and he really enjoyed each session. She was a great listener which helped XXX communicate his anxieties very easily and comfortably. Thanks you so much,</p> <ul style="list-style-type: none"> - Whole Family
<p>XXX has been amazing, very welcoming and accommodating. Great that setting appointments has so much flexibility.</p> <ul style="list-style-type: none"> - CWP North-South Camden Community Team 	<p>The people I worked with were amazing and so helpful, I am in a much better place now.</p> <ul style="list-style-type: none"> - SOUTH Service
<p>XXX listens to us and has lots of patience. Thank you very much.</p> <ul style="list-style-type: none"> - North MHST 	<p>I enjoyed the group it really helped, thank you</p> <ul style="list-style-type: none"> - CHPC Team A
<p>it was brilliant. I feel very lucky to have received this care.</p> <ul style="list-style-type: none"> - ADOLESCENT Camden Team 	<p>Excellent communication, very friendly staff, always listened to concerns and very knowledgeable. Keep up the good work XXX.</p> <ul style="list-style-type: none"> - Autism Assessment

Complaints

35 complaints were received Trust-wide in Quarter 2 2023/24.

This figure is slightly above the average number of complaints received per previous quarters.

The Quality Portal is currently still aligned to pre-Strategic Review structures and so reporting accurately by teams is not accurate, however a summary by division is reported below.

- GIC - 22
- GIDS - 3
- Mental Health – 9
- Corporate - 1

86% (30) of the complaints received in Q2 2023/24 were acknowledged within three days. This is below the target and will continue to be a key area of focus for the Complaints function.

4 complaints received in Quarter 2 were closed within the current 25 working day timeline – a compliance rate of 11%. It's important to note that not all complaints opened in the quarter will have been open for 25 working days at the end of the quarter. 2 of the 4 complaints were resolved informally

Themes of complaints are waiting times to first appointment, delays to communications including clinical letters, administration issues and disagreement with clinical decision making.

Complaints referred to the Ombudsman

We were not informed of any cases being referred to the Ombudsman in Q2 2023/24.

Key actions in the Complaints Improvement Plan to be taken in the next month

- Continue to work through open complaints and contact investigation leads where report is outstanding
- Approval of the refreshed Trust-wide Complaints process
- Analysis of Complaints & PALS data over previous 24 months to be completed to inform structure and resourcing discussions

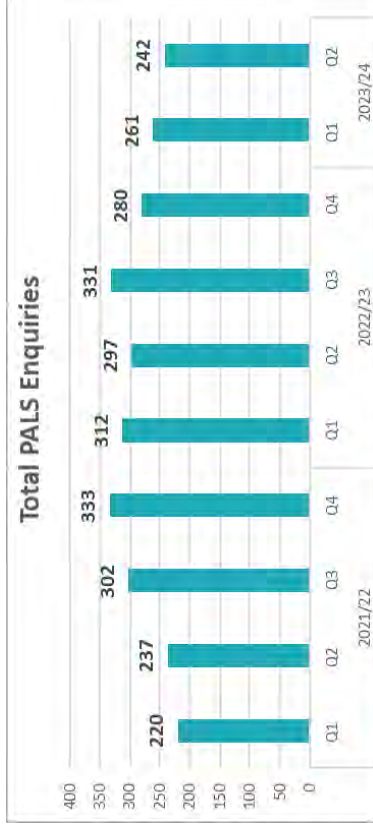
A detailed update on Complaints will be provided to the November 2023 Quality Committee.

Target	Monitoring	Target %	Q2 23/24
Complaints* - % Response to Complaints A - 90% of complaints acknowledged within 3 working days.	Quarterly	>90%	86%
B - 80% of complaints responded to within 25 working days (those received in the quarter). NB – recent open complaints might not have been open for 25 working days.	Quarterly	>80%	11%

PALS data for Q2 2023/4

242 Enquiries and follow ups:

- 188 via emails/portal
- 54 telephone calls/zoom meetings including follow ups



Main themes:

GIDS enquiries are often concerned with the change in service, wait times following these changes and not receiving adequate communications currently/historically (not always related to Tavi services).. PALS does acknowledge the distress, but it is difficult to know how to manage given the restrictions placed on GIDS.

Enquiries continue around : Access to Treatment/Drugs and Integrated Care (how to access services and what is available) e.g., types of therapy offered, wait times and referrals process, whether referrals have been received, other support services such as housing, benefits, financial support. We still receive a good number of enquiries about MBT/DBT despite these being unavailable at our Trust outside of the Portman.

Enquirers range from patients/service users themselves, to parents, partners, siblings and family friends and professionals seeking information about how to make referrals or learn more about our services.

Key themes are;

- Appointments (availability/waiting times)
- Communication issues (letters, notifications, getting through to teams)

Most involved services:

1. Adult Complex Needs
2. GIDS
3. C&F/Young People
4. GIC (that have a PALS involvement in addition to GIC PALS)

Patient FFT

FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks people "Would you recommend this service to friends and family?".

The data in the first table is published on the NHSE Statistics website and it includes forms recorded at the time of submission. Updated published data has not been made available on the NHS Statistics website since February 2023 data until June 2023. July's data have been made available recently.

The data on the second table comes from internal reporting. This data might include forms inputted after submissions to the national data and therefore numbers may differ slightly.

Published Data - National Submissions	Target	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Sep 23 to Jan 23	Feb 23	July 23	Aug 23
FFT patients' responses – % NEGATIVE	7%	0%	8%	5%	9%	7%	5%	14%	0%	0%	2%	8%
FFT patients' responses – % POSITIVE	86%	96%	84%	84%	85%	91%	89%	64%	96%	86%	85%	83%
Total Responses		49	104	43	34	57	55	28	55	7	55	83

* Due to the CareNotes outage no FFT data was collected for September 22 to December 22..

For those months where the national data has not been published see below internal data	Target	Mar-23	Apr-23	May-23	Jun-23	Jul-23
FFT patients' responses – % POSITIVE	86%	83%	85%	88%	85%	84%
Total Responses		63	53	34	33	51

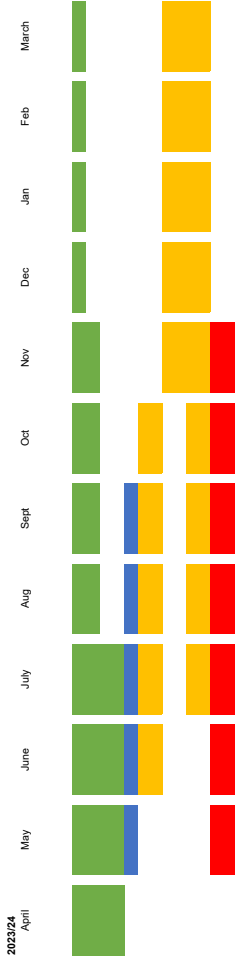
Data source: 10/10/2023 NHS England publications and SRRS (Internal Reporting System) Reported by the Quality Team

Appendices

Date: 31/03/2023

SETTING OUR FOUNDATIONS

- Assessment Boards
- Student Admissions
- Student Disability Support
- Trainee Clinical Governance
- Exhausting Circumstances
- Intermission and Withdrawal
- SOP reviews and workflows - by each prof service team
- Growth targets/fee setting over 3 years, following course viability/work



Status	Delivery Lead
In flight	Lisa Harris
In flight	Mike Whitcombe
In flight	Rebecca Bouskey
Scheduled	Isabelle Bratt
To be scheduled	AO Lead (vacant)
To be scheduled	Lisa Harris
To be scheduled	Heads of services
Behind schedule	Training Exec

SYSTEMS DEVELOPMENTS

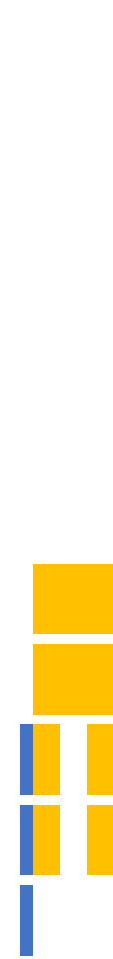
- PowerBI student data phase 2
- SITs readiness for HE SA Data Futures
- Customer Relationship Management tool (CRM)
- Student Enquiry Management System
- SITs portfoliomapping and curriculum building
- Module SITs integration



Status	Delivery Lead
In flight	Will Fitzmaurice
In flight	Lisa Harris
Requires approval	Rosalind Wright
Requires approval	Will Fitzmaurice
Requires approval	Lisa Harris
Scheduled	Matt Lingard

BAU PERFORMANCE REPORTING

- KPI setting for DET Prof Services teams
- Faculty KPIs and reporting (IQPR)
- Integration of Prof Services reporting into Trust IQPR
- Reporting financial performance against budgets - at service level (IQPR)



Status	Delivery Lead
Scheduled	Will Fitzmaurice
Requires approval	Ella RS Paul D
Requires approval	Will Fitzmaurice
Requires approval	Heads of Service

STUDENT VOICE AND ENGAGEMENT PLAN

- Confirming governance arrangements for student voice
- Annual Student Survey - revise plan
- Student voice plan for regular feedback loops throughout academic year



Status	Delivery Lead
Scheduled	Will Fitzmaurice
In flight	Isabelle Bratt
In flight	Isabelle Bratt

OPERATIONAL ENABLERS

- Budgets for 2023/24
- Course Financial Viability Review
- Visiting Lecturer Framework - to include fee rates
- Educational Governance Review
- Business Review



Status	Delivery Lead
In flight	Will Fitzmaurice
Behind schedule	Isabelle Bratt
To be scheduled	Isabelle Bratt
To be scheduled	Isabelle Bratt

Course	22/23	23/24	Difference
Introduction to Counselling and Psychotherapy (D12)	48	57	+18.75%
Introduction to Counselling and Psychotherapy (ED12 – Online)	39	26	-33.33%
Psychodynamic reflective practice in mental health (D65)	1	14	+1300%
Foundations of psychodynamic psychotherapy (D58)	56	65	+16.07%
Foundations of psychodynamic psychotherapy (BD58)	38	24	-36.84%
Foundations of psychodynamic psychotherapy (D58L, Leeds)	12	11	-8.33%
Inter-cultural psychodynamic psychotherapy (D59)	34	39	+14.71%
The Tavistock adult psychoanalytic psychotherapy training (M1)	8	20	+150%
Psychoanalytic studies (M16)	11	17	+54.55%
Developing a diverse child and adolescent workforce (CPD64)	7	25	+257%
Emotional care of babies, children, young people and families (E1)	22	33	+50%
Child, adolescent and family mental wellbeing: multidisciplinary practice (D24)	29	31	+6.9%
Perinatal, child, adolescent and family work: a psychoanalytic observational approach (M7 - Day)	88	82	-6.81%
Perinatal, child, adolescent and family work: a psychoanalytic observational approach (M7 – Evening)	25	23	-8%
Perinatal, child, adolescent and family work: a psychoanalytic observational approach (M7 - Saturday)	39	32	-17.94%

Psychodynamic psychotherapy for child and adolescent psychiatrists (M14)	6	6	+0%
Psychological therapies with children, young people and families (M34)	41	40	-2.44%
Child and adolescent psychoanalytic psychotherapy (M80)	47	67	+42.55%
Child and adolescent psychoanalytic psychotherapy (M80N, Leeds)	11	22	+100%
Systemic approaches to working with individuals, families and organisations (D4F – Foundation)	61	67	+9.84%
Systemic approaches to working with individuals, families and organisations (D4I – Intermediate)	55	69	+25.45%
Systemic Psychotherapy (M6)	81	106	+30.86%
Systemic family therapy supervision, consultation and training (M21)	18	20	+11.11%
Advanced practice and research: systemic psychotherapy (M10)	8	9	+12.5%
Advanced practice and research: social work and social care (D55)	12	9	-25%
Consulting and leading in organisations: psychodynamic and systemic approaches (D10)	29	30	+3.45%
Consulting and leading in organisations: psychodynamic and systemic approaches (ED10 – Online)	20	25	+25%
Tavistock qualification in consultation (D10C)	4	4	+0%
Advanced practice and research: consultation and the organisation (D10D)	13	6	-53.85%

<p>The Committee received an update in respect of the Trust’s work to address past recommendations from inspections, and the preparation for any future inspections.</p> <p>A review of all must and should do recommendations issued since the last Trust-wide inspection in 2018 has been undertaken to, firstly, ensure that the actions marked as completed have been embedded to full effect, and to review themes of recommendations to ensure that issues are not being inadvertently replicated in different services. The actions in place to address the themes will be reported into the new CQC Improvement Group.</p> <p>A successful Learning Lessons ‘CQC Demystified’ event was hosted by the Committee in October 2023. The event was developed in collaboration between the Chief Nursing Officer (CNO) team and clinical services to understand how staff are feeling in relation to past and future inspections and to share some valuable experiences of past inspections. The event also included an interactive session with members of the services that were inspected in January 2023 (The Portman and Camden Child and Adolescent Mental Health Services) to share what they felt went well, and what could be improved for future preparation. Building on the feedback received during the event, the team has devised a ‘you said, we did’ action plan.</p>	<p>Adequate <input checked="" type="checkbox"/></p> <p>N/A <input type="checkbox"/></p>
<p>4. Quality & Safety metrics</p> <p>Building on the content of the existing Quality Report, the new set of quality and safety metrics has been drafted to ensure the Trust’s reporting of quality data is robust, transparent and accountable in line with internal and external requirements.</p> <p>The metrics will be the agreed way in which the Trust’s Quality function reports on key areas of quality via existing Trusts governance processes including the IPQR and the Quality Report</p> <p>The Committee approved the list of metrics.</p>	<p>Limited <input type="checkbox"/></p> <p>Partial <input type="checkbox"/></p> <p>Adequate <input type="checkbox"/></p> <p>N/A <input checked="" type="checkbox"/></p>
<p>5. Local Risk Management System (LRMS) replacement</p> <p>The Committee received an update in relation to the new Local Risk Management System (LRMS). It was noted there were some current delays to the finance and contractual paperwork which is being prioritised with urgency. A high-level timetable for implementation will be presented to the next Committee in January 2024.</p>	<p>Limited <input type="checkbox"/></p> <p>Partial <input checked="" type="checkbox"/></p> <p>Adequate <input type="checkbox"/></p> <p>N/A <input type="checkbox"/></p>
<p>6. Service User Experience Group Terms of Reference</p> <p>A new sub-group of the Committee has been established to focus on service user experience. Historically the Trust had a similar group called Patient Experience and Care Quality, but that had been stopped at the beginning of the financial year in line with a review of governance structures.</p> <p>The new group will be responsible for oversight and challenge on all patient engagement and experience activity. Importantly, it will also be responsible for driving improvements and initiatives to further strengthen the Trust’s focus on experience and engagement. Healthwatch and</p>	<p>Limited <input type="checkbox"/></p> <p>Partial <input type="checkbox"/></p> <p>Adequate <input type="checkbox"/></p> <p>N/A <input checked="" type="checkbox"/></p>

<p>service user representatives will be members of the group to enable a collaborative and transparent approach to this programme of work.</p> <p>The Committee approved the new group's Terms of Reference (ToR).</p>		
<p>Summary of Decisions made by the Committee:</p>		
<ul style="list-style-type: none"> • The Committee APPROVED the new quality & safety metrics • The Committee APPROVED the PSIRF Transition Group's Terms of Reference • The Committee APPROVED the Service User Experience Group Terms of Reference 		
<p>Risks Identified by the Committee during the meeting:</p>		
<p>There were no new risks identified by the Committee during this meeting.</p>		
<p>Items to come back to the Committee outside its routine business cycle:</p>		
<p>None.</p>		
<p>Items referred to the BoD or another Committee for approval, decision or action:</p>		
Item	Purpose	Date
N/A		

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Thursday, 27 July 2023						
Report Title: Report from Guardian of Safe Working Hours				Agenda No.: 10		
Report Author and Job Title:		Dr Gurleen Bhatia, Guardian of Safer Working Hours		Lead Executive Director:	Dr Chris Abbott, Chief Medical Officer	
Appendices:		None				
Executive Summary:						
Action Required:		Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>				
Situation:		The Guardian of Safe Working Hours at each Trust, is a role independent of the management structure of the Trust, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by that Trust.				
Background:		This is the report for Q2 period 2023/24.				
Assessment:		The Guardian of Safe Working Hours provides a report for the Trust Board on a quarterly and annual basis. The rate of exception reporting in the Trust is very low.				
Key recommendation(s):		The Board is asked to NOTE the contents of the report. The Trust will continue to monitor the impact of the junior doctors strikes and on the exception reports.				
Implications:						
Strategic Objectives:						
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input type="checkbox"/> Ensure we are well-led & effectively governed.		
Relevant CQC Domain:		Safe <input checked="" type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input type="checkbox"/>
Link to the Risk Register:		BAF <input type="checkbox"/>	CRR <input type="checkbox"/>		ORR <input type="checkbox"/>	
		None				
Legal and Regulatory Implications:		Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
		There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:		Yes <input checked="" type="checkbox"/>		No <input type="checkbox"/>		
		The report relates to the resolution of issues associated with working hours for the junior doctors employed by that Trust				

Diversity, Equality and Inclusion (DEI) implications:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>			
	There are no equality, diversity and inclusion implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required	

Guardian of Safe Working Hours Q2 report 2023/24

1.1 Introduction

The Guardian of safer working hours provides a report for the Trust Board on a quarterly and annual basis.

2. Exception reports

Total exception reports:	Total reports	Toil	Fine	NFA
Month				
July	1	0	1	0
August	7	0	7	0
September	10	0	8	2

2.1 Work schedule reviews

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

2.2 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.3 Locum

The NROC is currently being staffed by Trainees and occasionally an external locum. The trainees do 1 locum shift/month in addition to their normal working schedules and on call rota (1 in 9.8)

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

Extra hours worked	Total fine	Amount paid to trainees	Fine Remaining		
Normal hrs	Enhanced hrs	£	£		
July	0	1hr 16min	201.07	75.411	125.66
August	5hr98min	6hr	1663.42	623.83	1039.59
September	18hr23 min	4hr10min	3017.15	1131.55	1885.593
Total	24hr 21min	11hr 26min	4881.96	1830.79	3050.84

3. Junior Doctors Forum (JDF)

New Trainee representatives in post. JDF meeting on 11th October 2023.

4. Conclusions and Recommendations

We will be monitoring the impact of the junior and senior clinicians' strikes on the exception reports.

This report will be shared with the LNC chair Dr Sheva Habel.



CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS' (BoD) MEETING ON 13 DECEMBER 2023					
Committee:	Meeting Date	Chair	Report Author	Quorate	
People, Organisational Development, Equality, Diversity and Inclusion Committee	December 2023	Shalini Sequeira, NED	Gem Davies, Chief People Officer	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Appendices:	None		Agenda Item: 11		
Assurance ratings used in the report are set out below:					
Assurance rating:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required	
The key discussion items including assurances received are highlighted to the Board below:					
Key headline			Assurance rating		
1. Health and Wellbeing <ul style="list-style-type: none"> It was noted that NHS Charities Together funding has been awarded to us in the form of £22,000 towards Health and Wellbeing for our staff. These funds have been allocated to be used to repurpose a space at the main site, Tavistock Centre, as a wellbeing space for staff. Additionally, to run weekly yoga classes for staff including online classes to ensure staff at our other sites can benefit. The new supporting health and wellbeing policy has launched, training sessions have started with support from the HRBP team, and these are being well received. 			Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		
2. FTSU <ul style="list-style-type: none"> The committee welcomed Sarah Stenlake who gave a verbal presentation. The information provided echoed that of the presentation recently received by the board. In terms of the last six months from July to October 2023, there have been 38 cases within this period. SaS touched on some of the key figures around this. <ul style="list-style-type: none"> 40% of cases are racism related. 8% involves some other form of discrimination. 55% of cases raised in the last six month involved something to do with bullying from colleagues or management culture. 5% involved concerns that things that were raised previously and not affectively investigated or addressed by the trust. 8% involved some form of detriment. 13% involves staff welfare not relating to bullying or management culture. 13% related to patient safety. <p>In this context, detriment means individuals feeling that they will be punished if they speak up. There are a lot of individuals coming to SaS</p>			Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		

<p>saying that they are concerned to speak up because they are worried how they will be mistreated afterwards. SaS is doing proactive work in some of the upcoming investigations.</p> <ul style="list-style-type: none"> The advert and job description for the new FTSU Guardian have been drafted and will be issued shortly. 	
<p>3. EDI considerations</p> <ul style="list-style-type: none"> TM highlighted the achievements since the last meeting. The Reciprocal Mentoring programme that has been launched and 19 pairs are meeting. Two key events for celebrating Neurodiversity were held, the anti-bullying campaign posters are now up around the building and the team has had a successful black history month including celebrating the REN network. The paper also looked at the eclectic merger of the EDI provision across the organisation and raised the question of governance around how we pull together the work EDI experience in relation to patients and students. SS has requested TM to look at some of the good practices in DET and see what we could learn from this as well as sharing further good practice occurring around the organisation. The Committee was concerned that the People Delivery Group and the EDI Programme Board had not met since the last POD EDI meeting. They have been asked to meet regularly as originally planned in between POD EDI meetings as they are the key assurance mechanism for the People Plan and the EDI Plan. 	<p>Limited <input type="checkbox"/> Partial <input checked="" type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/></p>
<p>4. Accommodation Strategy</p> <ul style="list-style-type: none"> BM gave an update to the committee on the current demand for space within the Tavistock centre. What we are finding is that as the trust is trying to get more individuals into the building there is a sense of increasing need for considering how space can be utilised more effectively. There is an imbalance of space, and space utilisation need to be managed differently whilst realising that this may well involve ways that both clinical rooms and others can be bookable spaces, those bookings are fairly distributed, and that they are promptly cancelled when no longer needed. Also looking at ratios for hybrid arrangements, understanding how many individuals come into the office, what the expectations are for people to come in and balancing out provision of space so that it is not disproportionate in one team or another. Finally, looking at how teams use the scheduling system. BM is aiming by the end of this year to be looking for different arrangements for booking space on the 3rd floor. 	<p>Limited <input type="checkbox"/> Partial <input checked="" type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/></p>
<p>Summary of Decisions made by the Committee:</p>	
<p>The Committee did not make any approvals during this meeting.</p>	
<p>Risks Identified by the Committee during the meeting:</p>	
<p>There was no new risk identified by the Committee during this meeting.</p>	
<p>Items to come back to the Committee outside its routine business cycle:</p>	
<p>There was no specific item over those planned within its cycle that it asked to return.</p>	
<p>Items referred to the BoD or another Committee for approval, decision or action:</p>	
<p>Item</p>	<p>Purpose</p>
<p>Date</p>	

None		
------	--	--

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	16 November 2023	Sal Jarvis, Non-Executive Director	Elisa Reyes-Simpson, Interim Chief Education & Training Officer/Dean	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Appendices:	None	Agenda Item: 12			
Assurance ratings used in the report are set out below:					
Assurance rating:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> 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 Performance Report (ETC Finance & Performance update): <ul style="list-style-type: none"> The Committee received a first draft full year forecast of the education and training budget including income. The forecast will be refined over the coming months to give a good base for budget setting for 24/25. The Committee was concerned that the Trust was unable to submit the Annual Financial Return to the Office for Students by the extended deadline. The Committee was reminded of the importance of the OfS and its role as the regulator for education and training. There is an increase in students requesting to pay off old debt in a staged manner to enable them to enrol for the new year. The Committee noted the requirement for additional resource to take forward the work of the Visiting Lecturer task and finish group. 			Limited <input type="checkbox"/> Partial <input checked="" type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>		
2. Student Debtors: <ul style="list-style-type: none"> The Committee noted the concern regarding the level of student debt, particularly old debt (over 365 days) not being addressed. The Committee was updated on processing issues which have resulted in an unclear level of inaccuracy in historic invoices which would require additional resource to investigate. Addressing the inaccuracy of data in student records is a high priority for Academic Registry. Steps have been taken to reduce error levels in invoicing. There has been insufficient capacity to address debt related queries. The new Student Records and Finance Lead will facilitate invoice query resolution in a more timely, efficient manner resulting in better debt management and improved student experience going forward. The Committee noted the need for additional resource to investigate old debt, before proposing to write off true debt deemed unrecoverable. 			Limited <input type="checkbox"/> Partial <input checked="" type="checkbox"/> Adequate <input type="checkbox"/> N/A <input type="checkbox"/>		
3. CETO/Dean's Report:			Limited <input type="checkbox"/> Partial <input type="checkbox"/>		

<ul style="list-style-type: none"> • The Committee was pleased by the positive start to the academic year with good feedback and engagement from students. • The Committee agreed that the contractual position of visiting lecturers remains a challenge and area of risk. • We have continued our staff and student engagement events, which have been well attended with staff and students making good use of this space to share their thoughts and concerns. • We continue the Moodle consolidation project with the aim of having one Moodle site, one Moodle web address, and one aesthetic from Summer 2024. • Focused work is underway to deliver DET's objectives to achieve our 3-year improvement plan and Trust strategic objectives. 	Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>4. Workforce Innovation Unit Update:</p> <ul style="list-style-type: none"> • The Committee was assured that National Workforce Skills Development Unit 23/24 portfolio projects are progressing well, however, as the 23/24 portfolio is still not fully finalised with NHS England Workforce Training and Education directorate, £250K of the contract value remains unallocated. • Unfortunately, we have received formal notification that NHSE WT&E plan to decommission the NWSDU at the end of this financial year. NHSE WT&E have also indicated that they wish to recall the £250k funding that they have failed to allocate in the 23/24 contract year. This all presents a significant financial risk to the Trust. • The I-Thrive team in Tavistock Consulting remains on track to meet and possibly exceed its budget target in year and more work is in the pipeline. • The wider Tavistock Consulting team continues to face unforeseen challenges but is at 50% of its target at mid-year. The Director of WIU and Acting Director of Tavistock Consulting are working collaboratively to address the difficulties. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>5. DET Development Update:</p> <ul style="list-style-type: none"> • The Committee received an update on relevant DET developments. was assured by progress of developments and the need to identify resource to undertake due diligence. • The appointment of an experienced business development lead with specific focus on education and training is a much-needed resource that should have a significant impact on the Trust's capacity to engage in horizon scanning and respond to tenders. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>6. Annual Student Survey Action Plan Progress Report:</p> <ul style="list-style-type: none"> • The Committee was assured as to progress against the Action Plan. • Key progress since the last meeting includes the first Skills Fest at the end of November, work to re-design webpages to make information clearer and more accessible, developments to the Reasonable Adjustments process, and commencing work to re-write the Student Charter. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>7. Academic Outcomes from Academic Year 2022-23:</p> <ul style="list-style-type: none"> • The Committee noted the qualifications awarded by the Trust in academic year 2022/23 for long courses by type and award. • The overall picture is positive in terms of qualifications awarded, with the percentage increasing from 2021/22 to 2022/23 by over 6%. There has been a rise in Pass and Merit awards, whilst Distinctions have declined, and further analysis is required to understand this. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>

<ul style="list-style-type: none"> The Committee requested further analysis of the data, and context, to be provided at the next meeting. 	
<p>8. Review of Student Recruitment:</p> <ul style="list-style-type: none"> Overall, we recorded higher numbers of incomplete applications (a 23% increase) and complete applications (a 13% increase). We have recorded slightly higher numbers of enrolments for 23/24. For 22/23, total enrolments came to 451; for 23/24, the equivalent total was 472 – a 4.65% increase. The Committee noted that in order to significantly grow our student numbers in the coming 24/25 cycle and beyond, we need to also upscale our marketing and admissions resource and activity – by investing in systems that are fit for purpose and in the resource needed to drive and maintain activity throughout the cycle. We also need to get greater clarity on our finances – including the nuances of break-evens and profitability for all our courses, to inform our strategy and where the greatest efforts and investment should be placed – and on our recruitment data during and after each cycle, ensuring that this is available and accurate. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>9. Nominations for Honorary Doctorates</p> <ul style="list-style-type: none"> The Committee requested due diligence be carried out on the nominations as some of these are historical nominations, prior to making a decision on recommended nominees for Graduation 2025. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>10. Marketing Strategy</p> <ul style="list-style-type: none"> The Marketing team have relocated to DET Professional Services (from the Communications team) for a six-month pilot. There is a need to be more data- and intelligence-led in both our marketing and fee setting. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>11. Sub-Committee Terms of Reference</p> <ul style="list-style-type: none"> The Committee discussed and approved the updated terms of reference for the four Sub-Committees (Learning & Teaching, Academic Governance & Quality Assurance, DET Development, and Student Experience). 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input type="checkbox"/> N/A <input checked="" type="checkbox"/>
<p>12. Board Assurance Framework and Corporate Risk Register (ETC Risks) and/ or ETC 12+ Risks:</p> <ul style="list-style-type: none"> The Committee was assured as to the maintenance of an operational risk register within the directorate and the effective reduction and mitigation of risk. The Committee noted the need to develop an education and training risk for the Board Assurance Framework as this has been missing. 	Limited <input type="checkbox"/> Partial <input type="checkbox"/> Adequate <input checked="" type="checkbox"/> N/A <input type="checkbox"/>
<p>Summary of Decisions made by the Committee:</p>	
<ul style="list-style-type: none"> The Committee APPROVED the Terms of Reference for the education and training Sub-Committees within the new governance structure. 	
<p>Risks Identified by the Committee during the meeting:</p>	
<p>The Committee identified the following risks for escalation to the Board of Directors:</p> <ul style="list-style-type: none"> There is a significant financial risk to the Trust due to the decommissioning of NWSDU and recall of unallocated funding from the 23/24 contract year. The ongoing risk regarding the paused work of the HR Task and Finish Group for Visiting Lecturers contracts and associated issues. 	

- There remain capacity pressures in the credit control area within the Finance Directorate.
- Staffing, vacancies, and resource across the directorate are a barrier to achievement in a number of areas.

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

The Committee asked the Academic Outcomes for 2022-23 to return with further context around the data.

The Committee requested that Partners be added to a future meeting.

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

Item	Purpose	Date
Student Debtors: The need for additional resource to investigate old debt, then proposal to write off true debt deemed unrecoverable.	Action	To FIRM To Audit Committee

Board of Directors Part 2 (Public) – 13 December 23					
Report Title: Sustainability - Green Plan/ Net Zero				Agenda No.: 13	
Report Author and Job Title:	Benita Mehra – Estates Consultant	Lead Executive Director:	Peter O’Neill, Chief Financial Officer		
Appendices:	Green Plan Action Plan				
Executive Summary:					
Action Required:	Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>				
Situation:	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> A Paper to demonstrate the Trust’s commitment to Sustainability and the NHS target 2045.				
Background:	The purpose of this report is the update the Green plan in support of the Trust’s sustainability agenda. Green plan was developed in 2021 for 5 years to 2026. With a new leadership team, the green plan has been updated with some minor amendments.				
Assessment:	The paper provides a direction of travel for the Trust and a set of actions to support the plan.				
Key recommendation(s):	The Board is asked to note the paper.				
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input checked="" type="checkbox"/> 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.	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input checked="" type="checkbox"/>	Effective <input checked="" type="checkbox"/>	Caring <input checked="" type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	Risk Ref and Title: BAF 14: Effective Performance and Risk management arrangements, there are no specific linked risks.				
Legal and Regulatory Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no legal or regulatory implications.				
Resource Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	

	There are no specific resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
	There are no equality, diversity and inclusion implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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 report was produced as an action from the Board.				
Reports require an assurance rating to guide the discussion	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required	

Report Title: Update to the Green plan.

1. Purpose of the report- Executive Summary

The purpose of the report is update of the Green plan in support of its sustainability commitment, to meet NHS 2045 target around net zero. There are limitations to the Estate as most buildings are pre- 1970 and would require significant investment to enable a reduction in utilities and an improved environment. Appendix 1

2. Sustainability - Action plan

2.1 Attached is a copy of the sustainability action plan. The focus for 22-23 was around consolidation of utility suppliers and sourcing a green electricity. For 23-24 the focus has been around data gathering and upgrades around LED lighting.

For 24-25, the focus will be further sharing, as kitchens are now shared, and there has been a significant reduction in printers and printing. Equally behavioural changes will come into play from 24-25 as more teams consider space sharing and reducing waste as data is being gathered for 23-24, with the aim of increasing recycling of waste.

Also in 24-25, a travel survey will be undertaken to assess patient, student, and staff travel, with the aim of reducing car travel, Appendix 2



The Tavistock and Portman
NHS Foundation Trust

The Tavistock and Portman NHS Foundation Trust

Green Plan 2021 - 2026



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 because 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.

This manifesto is an opening statement for the development of a new Board-approved Green Plan. Once developed the Green Plan will provide full details of the Trust's environmental aims and objectives, including the specific actions and timeframes required to achieve the broad principles described above.

Contents

Our Manifesto	2
1. Introduction	4
2. Climate Change & Healthcare	7
3. Delivering 'Net Zero' – Our View	8
NHS Carbon Footprint and Footprint Plus	9
Scope 1: Reduce and Decarbonise	10
Scope 2, 3 and Travel: Measure & Reduce	11
Once Minimised: Offset	12
4. Drivers for Change	13
5. Our Mission and Values	17
6. Areas of Focus	18
Corporate Approach	19
Asset Management and Utilities	20
Travel & Logistics	21
Adaptation	22
Capital Projects	23
Biodiversity	24
Sustainable Care Models	25
Our People	26
Sustainable Use of Resources	27
Carbon & Greenhouse Gases	28
7. Tracking Progress	29
8. Governance	36
9. Reporting	36
10. Communication	37
11. Risk	38
12. Finance	39
Glossary	40

1. Introduction

The Tavistock and Portman NHS Foundation Trust is a specialist mental health trust with a focus on training and education alongside a full range of mental health services and psychological therapies for children and their families, young people and adults.

With circa 1,000 staff across several sites, we are committed to improving mental health and emotional wellbeing, believing that high quality mental health services should be available for all who need them. We bring a distinctive contribution based on the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the promotion of health and the prevention and treatment of mental ill health.

We contribute to the pool of ideas through our own research and development but are also committed to bringing together the best ideas of the time, old and new, from inside and out, together with the most gifted and able professionals in our fields of endeavour. We aim to share our ideas and practice through as many routes as possible.

As a Trust we aim constantly to be evolving in nature and form in relation to the environment in which we work, to ensure that our contribution remains relevant.

This Green Plan is a new, living document that will help guide the Trust to becoming truly sustainable.

Throughout the transition to becoming Net Zero by 2045, this document will be reviewed and updated to set out a clear strategy, with assigned responsibility to ensure continued progress against carbon reduction targets and other sustainability objectives. This will lower business risk, improve resilience, reduce the resources impact, and improve wider health outcomes.

The associated sustainability action plan is intended to be organic, changing and developing, reflecting the achievements and progress that is made. Success in the action plan 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. The Trust realise this cannot be done alone and so will be encouraging participation from all employees, patients, and visitors. As well as internal stakeholders, the Trust will work in conjunction with other organisations such as other parts of the NHS and local councils, as they will be key to achieving some of these goals.

What do we mean by Sustainability?

'Development that meets the needs of the present without compromising the ability of future generations to meet their own needs'

In practice, this means taking decisions which consider the 'triple bottom line' by balancing economic (financial), social and environmental factors. The Government's refreshed vision and commitments for sustainable development build on the principles that underpinned the UK's 2005 sustainable development strategy, by recognising the needs of the economy, society, and the natural environment, alongside the use of good governance and sound science. The five principles of sustainability are expanded below.

Living within Environmental Limits

Respecting the limits of the planet's environment, resources, and biodiversity, whilst improving our environment. Ensuring that the natural resources needed for life are unimpaired and remain so for future generations.

Ensuring a Strong, Healthy & Just Society

Meeting the diverse needs of all people in existing and future communities. Promoting personal wellbeing, social cohesion, and inclusion, and creating equal opportunities for all.

Achieving a Sustainable Economy

Building a strong, stable and sustainable economy which provides prosperity and opportunities for all, and in which environmental and social costs fall on those who impose them (Polluter Pays) and efficient resource use is incentivised.

Using Sound Science Responsibly

Ensuring policy is developed and implemented based on strong scientific evidence, whilst considering scientific uncertainty (through the Precautionary Principle) as well as public attitudes and values.

Promoting Good Governance

Actively promoting effective, participative systems of governance in all levels of society engaging people's creativity, energy, and diversity.

Five pillars of sustainable development

What are the Sustainable Development Goals?

In 2017, Public Health England declared its support for the UN’s Global Goals for Health. These goals form a global action plan to end extreme poverty, inequality, and climate change by 2030, and have been signed by every member of the UN, including the UK.

The 17 goals have been agreed globally as a framework for sustainable development. Research undertaken by PwC suggests five of the goals are a priority for the Health and Care Industry as a whole: Good Health & Wellbeing, Decent Work and Economic Growth, Gender Equality, Quality Education and Industry, Innovation, and Infrastructure.

At delivery level The Trust believe other goals are also relevant, including Reduced Inequalities, Sustainable Cities and Communities, Climate Action, and Responsible Production & Consumption.



2. Climate Change & Healthcare

Climate change is widely regarded as one of the greatest challenges facing society today and in the future. In the UK temperatures have been increasing by around 0.25°C per year. Projections indicate that by 2050 what we currently consider as an extreme heat wave may well become the norm. Patterns of rainfall will change with reduced rainfall in the summer exacerbating water shortages and increased rainfall in winter months leading to increased rates and intensity of flood events.

This will have implications for public health including heat stress, reduced productivity, poorer air quality and the direct and indirect impact of flooding.

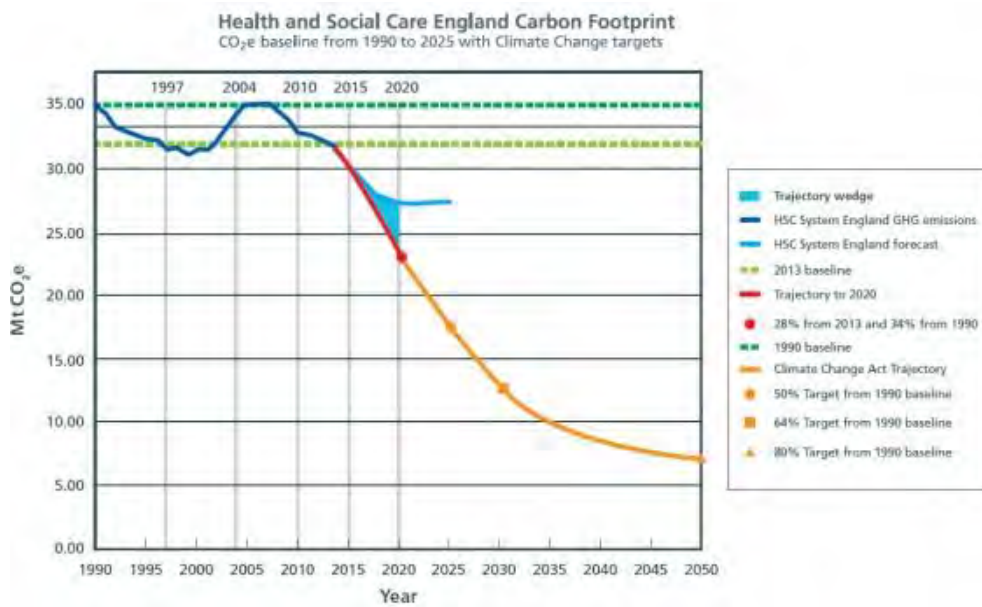


Figure 1: Graph showing the carbon footprint of health and social care in England

The UK Climate Change Act 2008 set out ambitious targets to reduce emission of greenhouse gases by at least 80%, compared to 1990 levels, by 2050. The Trust’s carbon footprint in section 7 of this document shows the Trust’s progress against this target.

3. Delivering Our ‘Net Zero’

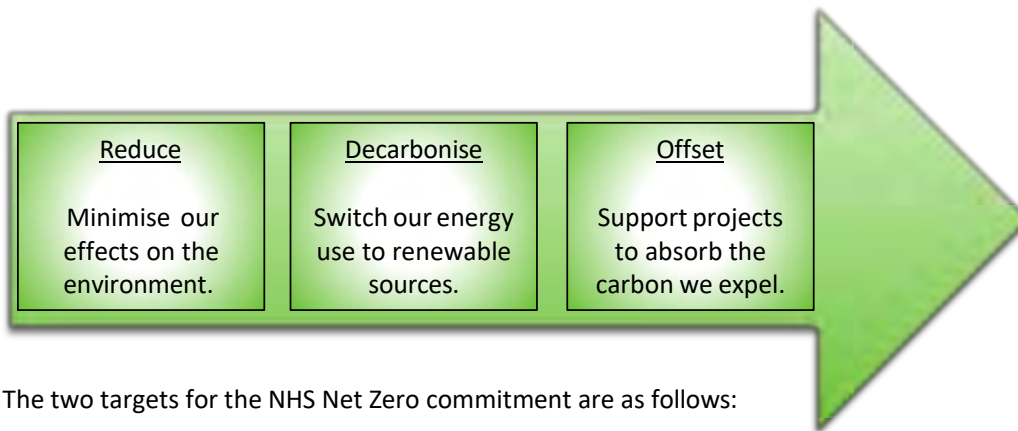
Following the new announcement of the NHS becoming “Net Zero” by 2045, the Trust will look to ensure our Green Plan covers the challenges that this target sets for the NHS.

What do we mean by Net Zero?

Net zero refers to the balance between the amount of greenhouse gas produced and the amount removed from the atmosphere. We reach net zero when the amount we add is no more than the amount taken away.

Net zero means achieving a balance between the greenhouse gases put into the atmosphere and those taken out.

Net Zero can be achieved using three strategies:

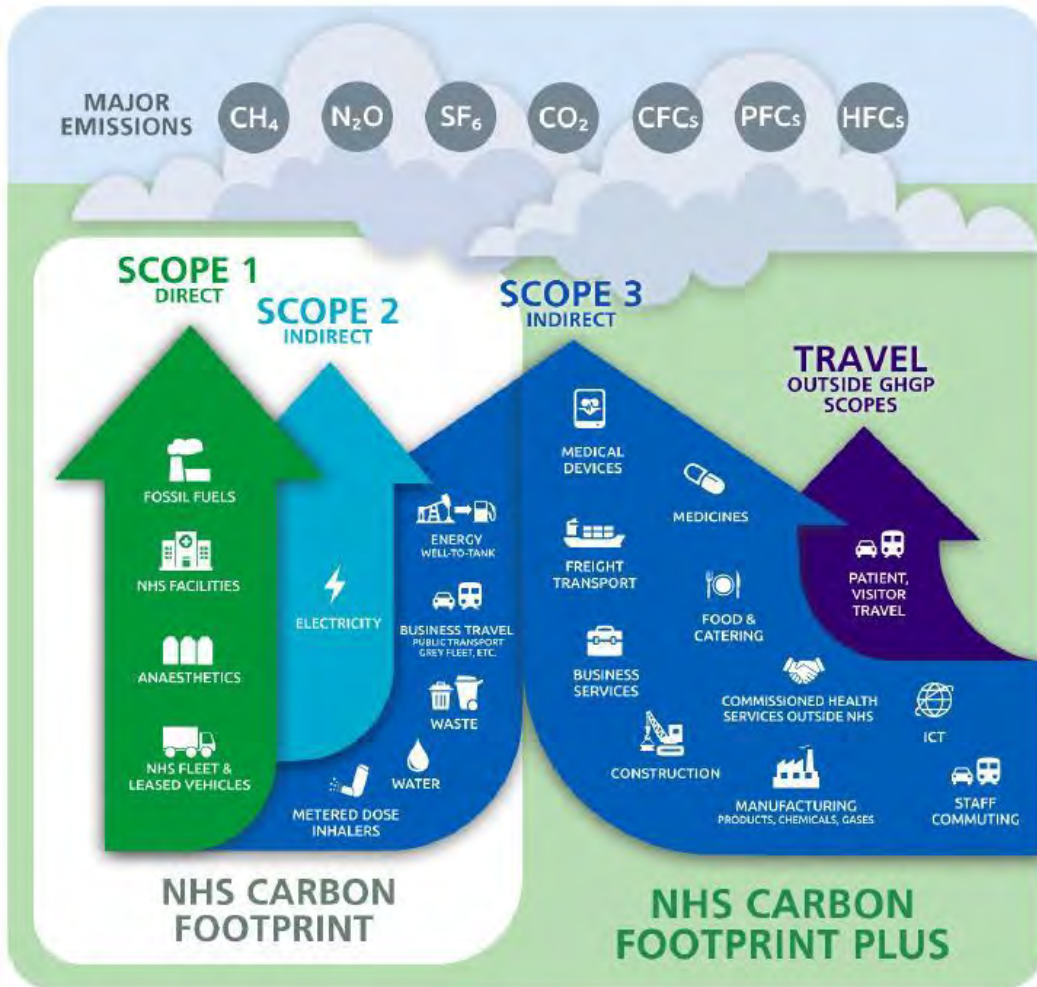


The two targets for the NHS Net Zero commitment are as follows:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

NHS Carbon Footprint and Footprint Plus

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



Scope 1: Reduce and Decarbonise

To use this Green Plan to identify our emissions and reduce as far as we can to ensure that decarbonisation is achievable.

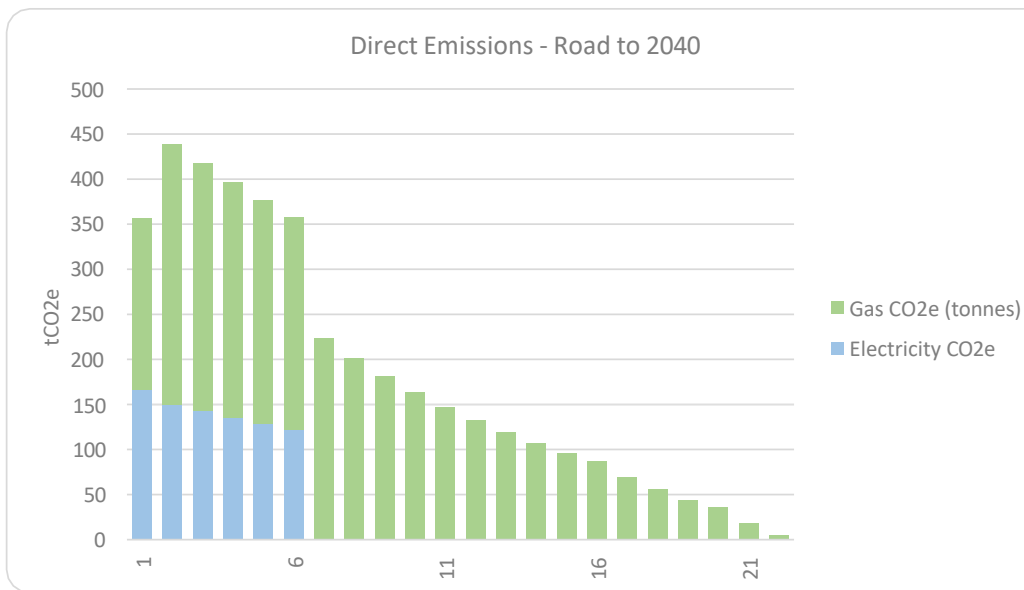
Across our sites, we use fossil fuels to provide heating and domestic hot water. Over the next five years, we will assess our equipment to inform a new decarbonisation plan. This will involve using new heat pump technology and high efficiency electric boilers to reduce, and eventually eliminate, our dependence on fossil fuels for heat generation.

Alongside this, we will be embarking on an energy reduction strategy that will reduce our overall consumption by 10%, so that when we switch to a low carbon solution, we will not need as much capacity.

On imported electricity, we will switch to renewable electricity sources whilst reducing through operational changes and engagement with our staff, students, patients, and visitors.

At all our sites, we are in the process of investigating where heating can be switched to low carbon technologies, or to electricity once we have a renewable supply.

This part of our Net Zero challenge depends on the final specification of our new site, so in the next two years, we will generate a new baseline for reduction and decarbonisation to realise our goals whilst we modernise.



- ### Key Actions
- Renewable electricity tariffs achieved in 2022
 - Catering facility gas has been removed in 2022

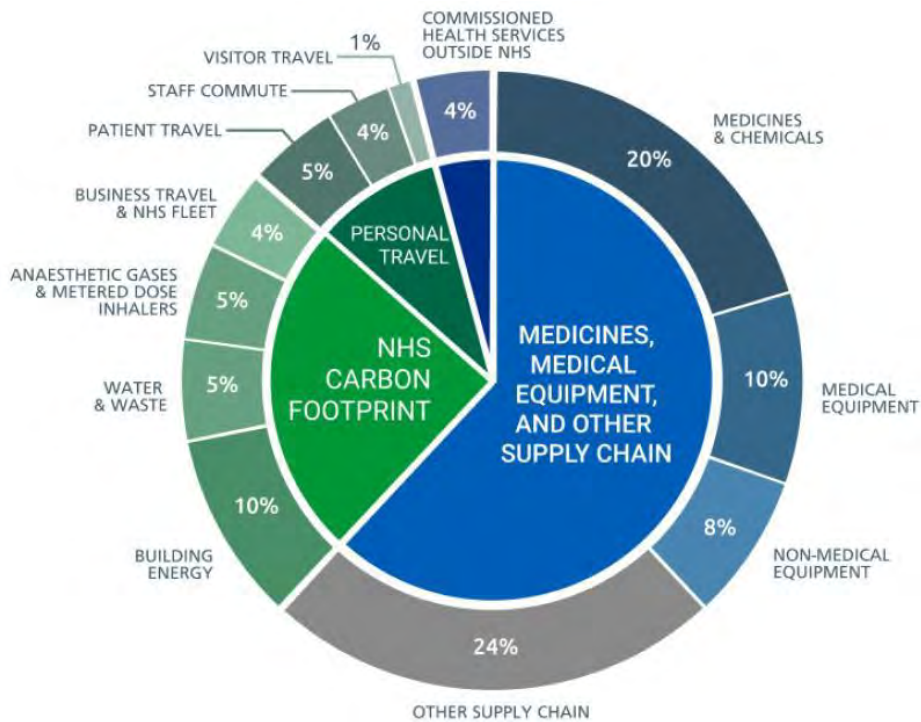
Scope 2, 3 and Travel: Measure & Reduce

To use new, recognised tools to measure our emissions to produce a plan for reduction

Following the HOTT and P4CR tools becoming available from the Greener NHS, the Trust now has access to reliable tools to measure, report and analyse our carbon footprint outside of fossil fuels and water use.

By ensuring we have a set of baseline data in place in the next year, we will be able to set targets and create actions to reduce and decarbonise as much as possible.

We have already started to reduce our impact, as detailed in later sections of the plan.



Key Actions

- Utilise new tools to measure our emissions.
- Monitor patient and visitor travel- with a staff survey planned for 2024, the Trust does not operate any fleet
- Set targets for reduction and decarbonisation to include waste reduction

Once Minimised: Offset and Remove

To work with accredited organisations and use our own green spaces to absorb carbon that we must emit to deliver our services

The Trust recognises that to provide a world class healthcare provision, there are some resources that we must use, such as water. This means that the Trust are always going to have some form of carbon emission. The final step to becoming Net Zero is to recognise those emissions we have and adopt programmes such as tree planting that can help absorb at least the same amount of carbon the Trust's activities emit.

We will soon be forming relationships with accredited organisations and our local community so that once we get to Net Zero, we can stay there.

Key Actions

- Create relationships with recognised teams, and are part of the NCL climate group, extend to LA and charities
- Incorporate offsetting into our green spaces' strategy

4. Drivers for Change

There are a range of national and international policies, legislative requirements and healthcare specific guidance driving sustainable healthcare in the NHS:

- **NHS Long Term Plan - NHS published its first ever long-term plan on 7 January 2019.**
The plan includes the NHS' commitments towards sustainability:
 1. A commitment to the carbon targets in the UK government Climate Change Act (2008), reducing carbon emissions (on a 1990 baseline) by 34% by 2020; 51% by 2025 and 80% by 2050.
 2. The NHS is committed to improving air quality by cutting business mileage by 20% by 2023/24; ensuring that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultralow emissions) by 2028; and phasing out primary heating from coal and oil fuel on NHS estates.
 3. The NHS will ensure that all trusts adhere to best practice efficiency standards and adoption of new innovations to reduce waste, water, and carbon, in addition to reducing single-use plastics.

The plan outlines the idea of the NHS as an '**anchor institution**', which is an important concept to promote an understanding of the NHS' contribution to the local economy, society, and environment.

The idea of prevention and more efficient working is threaded throughout the plan, e.g. by promoting earlier detection of illness. Preventing illnesses from happening in the first place is the best possible way for the NHS to become the most sustainable health and care system it can be.

- **Shared Vision for London** - The Mayor of London launched in October 2019
This is a wider partnership of NHS England and Improvement, Public Health England and the London Councils organisations.

The London Vision identifies 10 priorities that, through collaborative and innovative working, will address the capital's key health issues and ensure that quality of life and life expectancy will match the aspiration to make London the world's healthiest global city.

The 10 priority areas are:

1. Reducing childhood obesity
2. Improving the emotional wellbeing of children
3. Improving mental health and progress towards zero suicides
4. Improving air quality
5. Improving tobacco control and reduce smoking
6. Reducing the impact and prevalence of violence
7. Improving the health of the homeless
8. Improving services and prevention for HIV and other STIs
9. Supporting Londoners with dementia to live well
10. Improving care and support at end of life.

- **Collaboration and partnerships**

Local councils – Camden Climate Change Alliance network
Global Action Plan
Local NHS Trusts

These drivers provide legal context and policy frameworks for improving sustainability and are outlined below in 5 key groups.

Legislative

Civil Contingencies Act 2004
Climate Change Act 2008 including 2050 target amendment
Public Services (Social Values) Act 2012
Environmental Protection Act 1990
The Waste (England & Wales) Regulations 2011

Mandatory

Standard Form Contracts requirements for Sustainable Development 2017-19
HM Treasury’s Sustainability Reporting Framework
Public Health Outcomes Framework

UK Guidance

National Policy and Planning Framework 2012
Department for Environment, Food and Rural Affairs (DEFRA): The Economics of Climate Resilience 2013
Department for Environment, Food and Rural Affairs (DEFRA): Government Buying Standards for Sustainable Procurement 2016
The Stern Review: The Economics of Climate Change 2006
Health Protection Agency (HPA) Health Effects of Climate Change 2012
The National Adaptation Programme 2013: Making the Country Resilient to the Changing Climate
Department for Environmental, Food and Rural Affairs (DEFRA) 25 Year Plan Health Specific Requirements
The Marmot Review 2010: Fair Society, Health Lives NHS Long Term Plan 2019
Sustainable Development Strategy for the Health and Social Care System 2014-2020
Adaptation Report for the Healthcare System 2015
The Carter Review 2016
National Institute for Clinical Excellence (NICE) Guidance: Physical Activity, Walking and Cycling 2012 Health Technical Memoranda (HTMs) and Health Building Notes (HBNs), specifically HTM 07-02 Making Energy Work in Healthcare 2015 and HTM 0701 Management and Disposal of Healthcare Waste 2013
Sustainable Transformation Partnerships (STP) Plans
Local strategies and plans
The health and care vision for London, October 2019
London Environment Strategy
The Mayor's Ultra Low Emission Zone for London (ULEZ)
The Mayor's Transport Strategy
Camden's Clean Air Action Plan 2019-2022

International Guidance

Intergovernmental Panel on Climate Change (IPCC) AR5 2013
EU Waste Directive 2008
United Nations (UN) Sustainable Development Goals 2016
World Health Organisation (WHO) Toward Environmentally Sustainable Health Systems in 2016
World Health Organisation (WHO) Health 2020: European Policy for Health and Wellbeing
The Global Climate and Health Alliance. Mitigation and Co-benefits of Climate Change

Healthcare Specific Requirements

The Marmot Review 2010 Fair Society, Healthy Lives?

Sustainable Development Strategy for the Health and Social Care System 2014-2020

Adaptation report for the Healthcare System 2015

The Carter Review 2016

Health Technical Memoranda (HTMs) and Health Building Notes (HBNs)

Local Sustainable Transformation Partnership plans

Delivering a 'Net Zero' National Health Service

Greener NHS Guidance that replaces the NHS Sustainable Development Unit tools

5. Our Mission and Values

Our mission

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. Working with children and families and adults, our approach brings together psychoanalytic, psychodynamic, and systemic theory and practice and other approaches and seeks to understand the unconscious as well as conscious aspects of a person's experience and places the person, their relationships and social context at the Centre of our practice.

Our creative and skilled staff continue to build on these approaches, welcoming new ideas and developing innovative interventions, services and models of care which respond to contemporary challenges.

Our goal is that more people should have the opportunity to benefit from our approach. We seek to spread our thinking and practice through devising and delivering high quality clinical services, the provision of training and education, research, organisational consulting and influencing public debate.

Our Aims

The Tavistock and Portman will:

- continue to deliver and develop high quality and high impact patient services.
- offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care, and other sectors.
- develop its presence as a Centre of excellence in research.
- lead the development and evaluation of new models of care and innovative approaches to addressing systemic issues in the delivery of care and other services.
- use its insights and expertise to contribute to the development of national debate and public policy.

Our values

As an organisation:

- we work with people with lived experience to co-create and improve our services and inform our decision making.
- we are caring and compassionate.
- we are passionate about the quality of our work and committed to openness, the use of evidence and the application of improvement science.
- we value all our staff, are concerned for their wellbeing, and seek to foster leadership, innovation, and excellence in our workforce.
- we embrace diversity in our workforce and work to make our services and training as accessible as possible.
- we work with others, in the UK and internationally, who share our values and can enable us to achieve our mission.

6. Areas of Focus

The Green Plan is divided into ten areas of focus. These ten areas are selected as they are the standard 10 recognised by the Sustainable Development unit in their sustainable development assessment tool (SDAT). Using these areas of focus allows us to benchmark our progress against others and against SDU best practice. These sections layout a clear pathway to achieve improved sustainability outcomes, by highlighting the key objectives and actions required to make progress in each area. The actions are summarised in the Sustainable Action Plan, with responsibility and timeframes assigned for each.

Corporate Approach

To embed sustainability into our organisation, improving our financial stability and health and wellbeing of patients, staff, students, and our local community

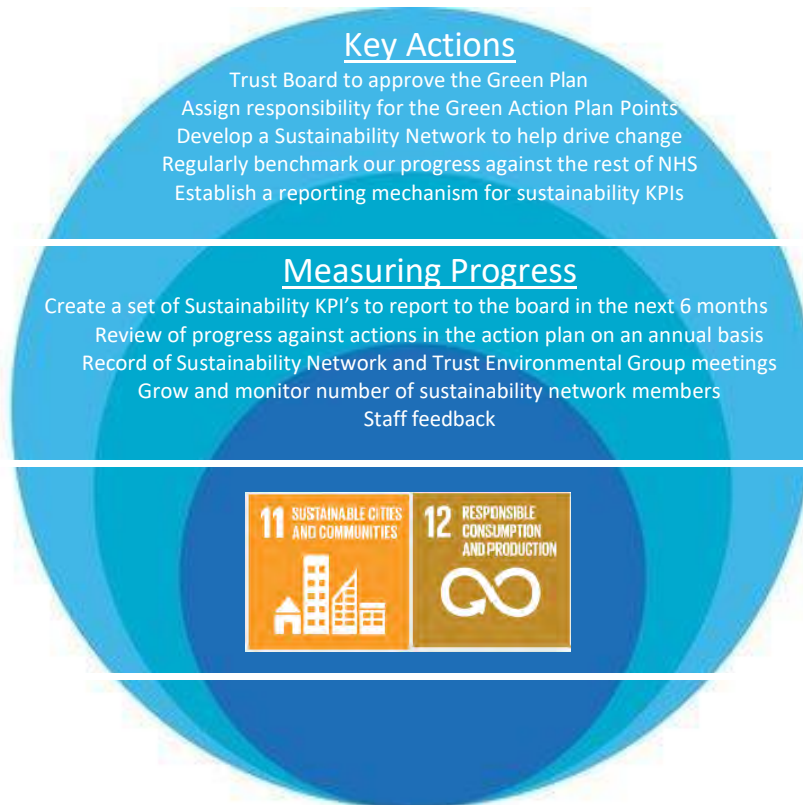
The Trust is in the midst of updating its vision, mission and values and has developed 5 strategic pillars, within the 5th pillar, sustainability is aligned to the economic and financial position of the Trust. This plan will be embedded to provide a clear strategy for the delivery of sustainability objectives and assign responsibility for different workstreams.

We have created our Trust Environment Group to help guide our sustainability and have produced our Manifesto to highlight our objectives moving forward.

However, we recognise that we cannot be sustainable on our own. So far, we have engaged third parties to help us design our Green Plan, as well as reaching out to our community and other NHS institutions for advice and ideas.

Given the size of our Trust, our executive team are also involved in operations, which allows us to affect change in sustainability without relying on a single point of access to the directorate.

However, we are in the process of naming a Sustainability Lead, who will be supported by the rest of our team and the Trust Environment Group.



Green Plan: 2021 - 2026

⚡ Asset Management and Utilities

To work with the staff, students, and estate teams to reduce costs and energy usage, limiting the environmental impact of the Trust’s estate

Our Trust operates from several sites, with the aim of consolidating and driving a more efficient space model, that complements energy usage on our main sites, we do not yet have a full set of energy data for all of them.

We are creating our strategy for energy reduction and decarbonisation, which includes making sure we know what we’re using and where, but we’re also looking to develop our thinking to help drive reductions.

On our electricity, we switched to a greener tariff so that 10% of our energy is now from renewable sources, and we will increase this until we have zero carbon emissions from the electricity we use. However, as we know we can do more, we will be looking to submeter our electricity to allow for greater control and efficiency.

On our fossil fuel use, we are undertaking audits of our heat generation equipment, as in line with the newest NHS guidelines, we’ll need to decarbonise our heat in the future to get to Net Zero.

The Trust doesn’t employ a full time Energy Manager, but even so we are looking to ensure savings are maximised. We will be working with suppliers to ensure that innovative technologies are identified that can help us reduce energy and water on our sites.



Travel & Logistics

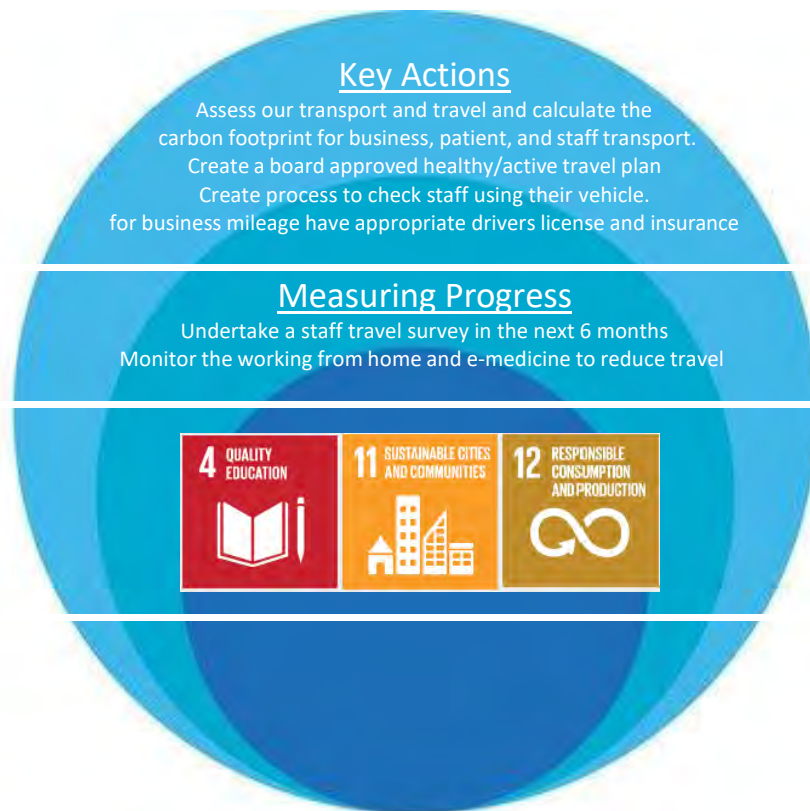
To reduce the negative impacts from travel by supporting staff and patients to use more sustainable forms of travel to our sites

Sustainable forms of travel, and the reduction in the number of journeys necessary, have a range of benefits including improving health from reduced air and noise pollution, as well as being able to treat a commute as exercise. Reducing single-person vehicle travel can 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 coronavirus pandemic has helped us, along with the rest of the NHS, to increase the use of telemedicine. Combined with our staff working from home whenever they can, our aim is to keep these positive sustainable steps in the future.

We already have our cycling to work policy, which allows our staff to use a bicycle with a value of up to £1000 and pay through a salary sacrifice scheme. We also have details on our site on how to get to us via underground, overground and buses. We also make clear that parking can be challenging, and we do not have our own site parking. Building on these steps, we will be producing a green travel plan to ensure that we have a clear hierarchy on how our staff, patients and visitors can get to us sustainably.

We will evaluate the impact of using the Health Outcomes of Travel Tool (HOTT) to reduce our emissions even further.



Green Plan: 2021 - 2026

Adaptation

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

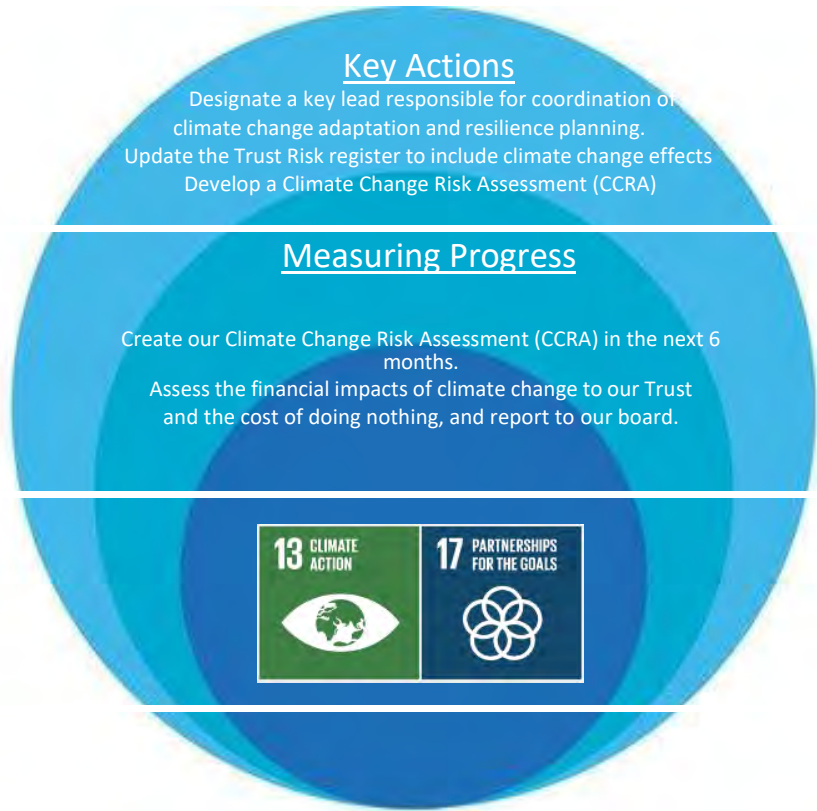
The effects of climate change pose a range of risks to the health of local populations and the ability of our services to operate effectively.

The COVID-19 pandemic has prompted a change in how we deliver our services, with any services switching to telemedicine in the short term.

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.

With being connected to a school, the Trust have had to put plans are in place to ensure the children are supported in the event of major and extreme events and have trained our workforce to deal with different extreme weather scenarios.

- Flooding and coastal change
- Risk from high temperatures
- Risk of water shortages
- Risk to natural capital
- Risk to food production and trade
- New and emerging pests and diseases



Green Plan: 2021 - 2026

Capital Projects

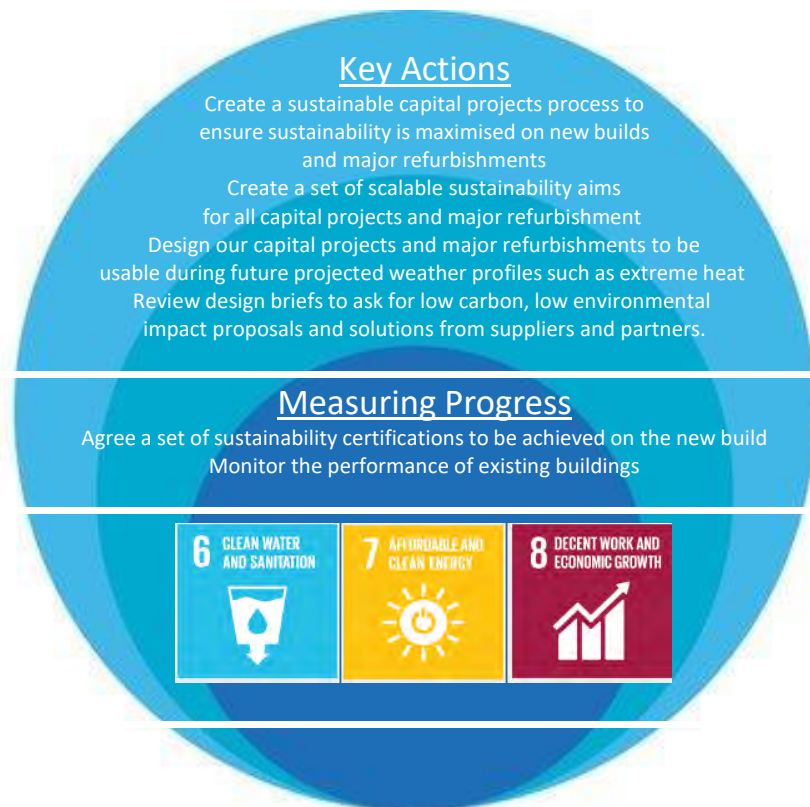
To take a whole life costing approach that incorporates sustainability principles in all refurbishment and new building projects

The Trust’s estate is pre 1970 and has been upgrading its existing building and system infrastructure, as consolidation and improved space utilisation plays a part in improved efficiency. Once approved, this capital project will need to encompass all the sustainability features expected of new facilities, from LED lighting to the use of sustainable materials.

Our Capital Project teams will be trained in how they can develop sustainable outcomes within their roles, such as understanding energy efficiency technologies, use of space, space utilisation and adaptation. On occupation of our new buildings, we can train staff on the way it works and support them to make energy efficiency decisions from the environment controls available.

Our current buildings were not designed as low carbon assets, but where possible design will consider better energy efficiency.

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



Biodiversity

To manage out Trust in a way that reflects the importance of the natural environment for people’s health

Biodiversity is the complex network of all living things on our planet. To ensure that we are sustainable, we must do all we can to complement the plant and animal life in our communities and reduce any negative impacts we have.

We will look to utilise green spaces for our staff and patients, and the new site will give us the opportunity to assess our impact on biodiversity in that area and create a plan to sustain and maintain it.



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.



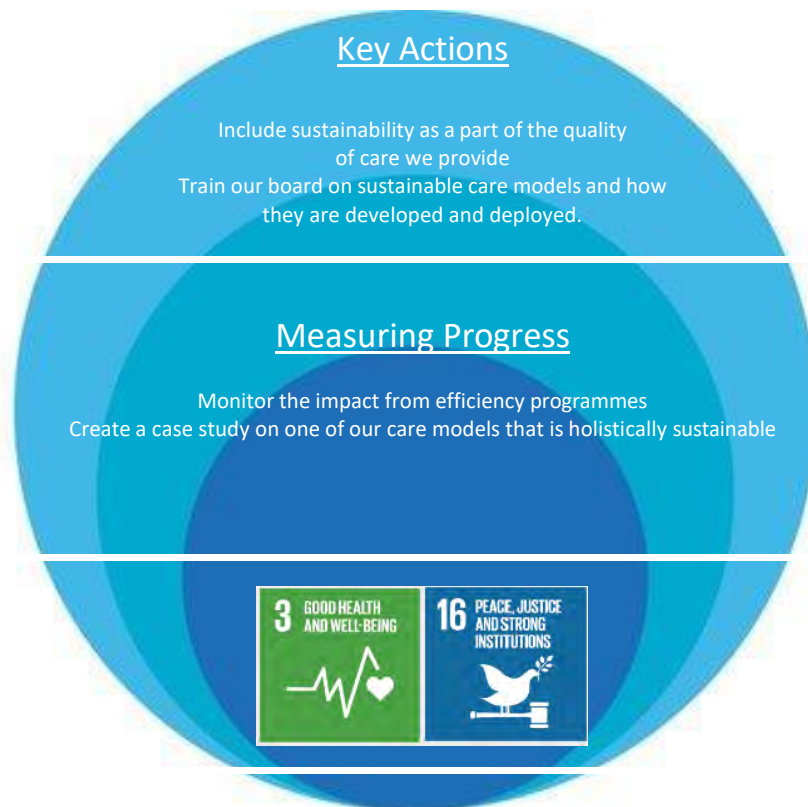
♥ Sustainable Care Models

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

Given our Trust specialises in mental health and wellbeing, we actively engage with our staff in service design, asking staff to place themselves as the patient, so that our care models we provide are realistic and appropriate, as well as sustainable.

Our approach was tested over the last year as we had to port our care towards telemedicine, and given the success of that, we are now integrating telemedicine into our care models.

We capture and share our learning internally, and will externally in the future, so that our care models are truly future proof, but also are willing to adapt as the future of the NHS becomes clearer.



Our People

Improved wellbeing and productivity 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. The Trust is committed to finding innovative ways to drive efficiency and productivity through our workforce including delivering new agile ways of working that improve staff experience and maintain staff productivity.

We understand that a good experience at work leads to overall wellbeing. Because of this, we have worked hard to incorporate flexible working, eliminate smoking form site, and pay a fair living wage to give our staff the best chance to feel well at work.

There are significant opportunities to encourage sustainable behaviour among our staff, and we are already incorporating these into our new “people plan”. Many of the actions in this area will be covered in our people plan to ensure that wellbeing is not only a mainstay for our patients or students but also for our staff.



Green Plan: 2021 - 2026

Sustainable Use of Resources

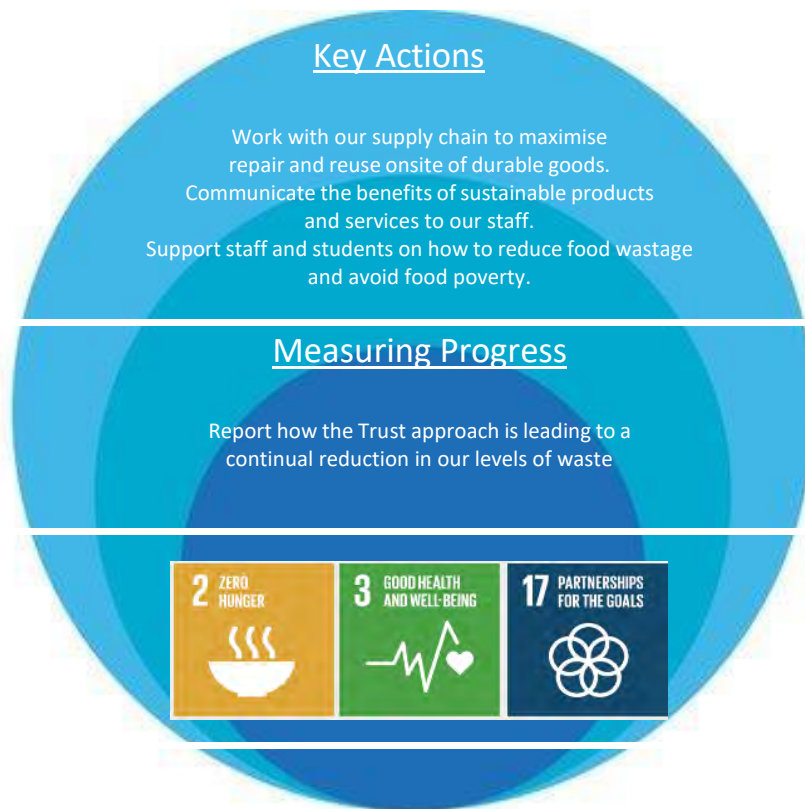
To improve the Trust’s use of resources to reduce waste through better procurement decisions and improved waste management

The Trust has a minimal amount of goods that are purchased compared to other NHS Trusts, as we are not an acute Trust. However, one type of goods we do use is very important to sustainability: Food.

Existing Vending machine contracts are in place and when the contract is renewed Healthy Living Vending machines will be considered to reduce the less nutritional choices our staff, students and visitors have. However, for the most sustainable and healthy choices, our catering team excel.

Throughout the pandemic, where lunchtime meals reduced from 300 meals to less than 30, our catering took it upon themselves to source ingredients locally instead of buying in bulk and risking increased waste. Including wild mushroom soup, our team ensures that whether visitors are staff, students, patients or the public, the Trust is using food to promote wellness.

The Trust has introduced food waste bins and correct measurement of waste and further improving recycling rates is a key aim for the Trust.



Green Plan: 2021 - 2026

☁ Carbon & Greenhouse Gases

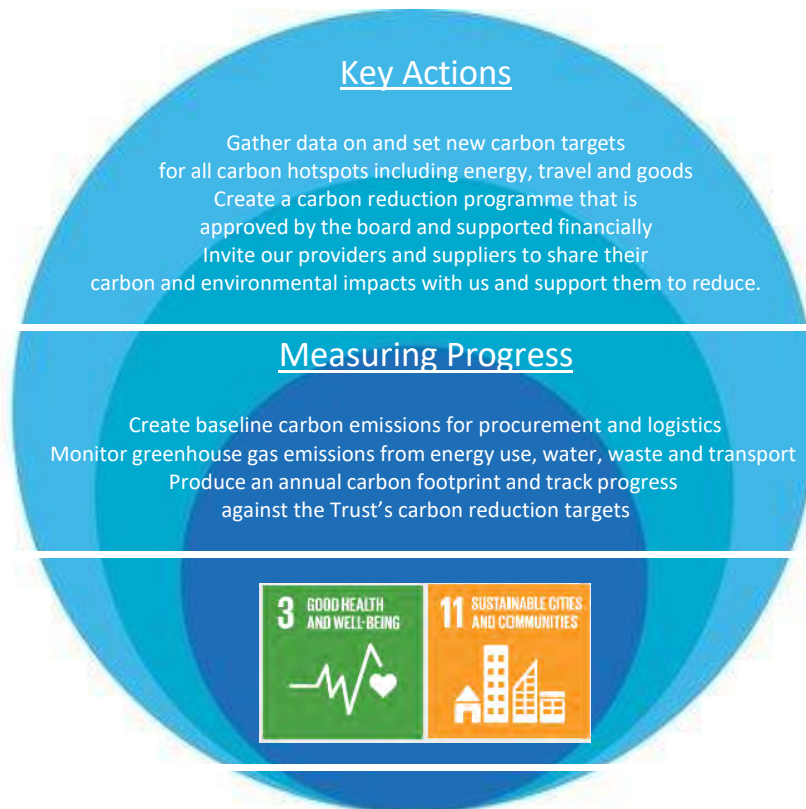
Carbon and sustainable development should be explicit and accounted for in every aspect of NHS life

The Trust currently reports on our energy usage in the yearly NHS ERIC system, but do not yet have an ongoing carbon reduction programme. Our first aim is to identify our direct emissions from gas, oil, electricity and water across all our sites, whilst exploring what can be switched to low carbon or zero carbon solutions.

We will also need to measure our indirect emissions using new technology and tools, such as P4CR and HOTT created by the Greener NHS. The Trust’s annual carbon footprint in section 7 shows the scale of our emissions so far, but once we have captured all our data, we can move forward to set targets to reduce and decarbonise.

We will measure the carbon impact of each of our activities and the progress we are making towards set targets to reduce emissions. We will include emissions from:

- | | |
|---|---|
| 1. Building energy use | 5. Procurement and logistic activities |
| 2. Building water use | 6. Information Technology (ICT) |
| 3. Waste generation and treatment | 7. Clinical service lines |
| 4. Travel, transport and logistics activities | 8. Other gases e.g. inhalers and air-conditioning gases |



Green Plan: 2021 - 2026

7. Tracking Progress

The following table shows our energy emissions for the last two years. Whilst our electricity has increased slightly, our emissions from electricity use has decreased. More concerning is the amount of gas we used due to weather, which has informed our decision to produce an energy reduction plan. Following our move to the new building, this data will change considerably, but we are aware we must act now to reduce.

Description	2018/19	2019/20
Gross internal site floor area (m ²)	10,973	11,478
Occupied floor area (m ²)	9,849	8,388
NHS estate Occupied Floor Area (%)	81	73
Site Heated Volume (m ³)	23,796	24,363
Electricity Consumed - Utility (kWh)	553,549	586,427
Electricity CO ₂ e	166	150
Electricity costs - green energy tariff	9,100	9,356
Electricity consumed - green energy tariff	66,277	61,318
Gas Consumed - Utility (kWh)	1,036,012	1,573,147
Gas CO ₂ e (tonnes)	191	289
Oil Consumed - Utility (kWh)	0	0
Oil CO ₂ e	0	0
Total Energy Cost (all energy supplies, utility, local & renewable) (£)	119,335	140,226
Total Energy CO₂e (tonnes)	357	439
Kg CO₂e/m² GIA	32	38
Water volume (including Borehole) (m ³)	5,250	4,048
Water and Sewage Cost (£)	18,367	13,200

The following tables display our waste in tonnes for the last two years, which influences changes and improvements the Trust can target. We now have to work to increase recycling and reduce overall waste.

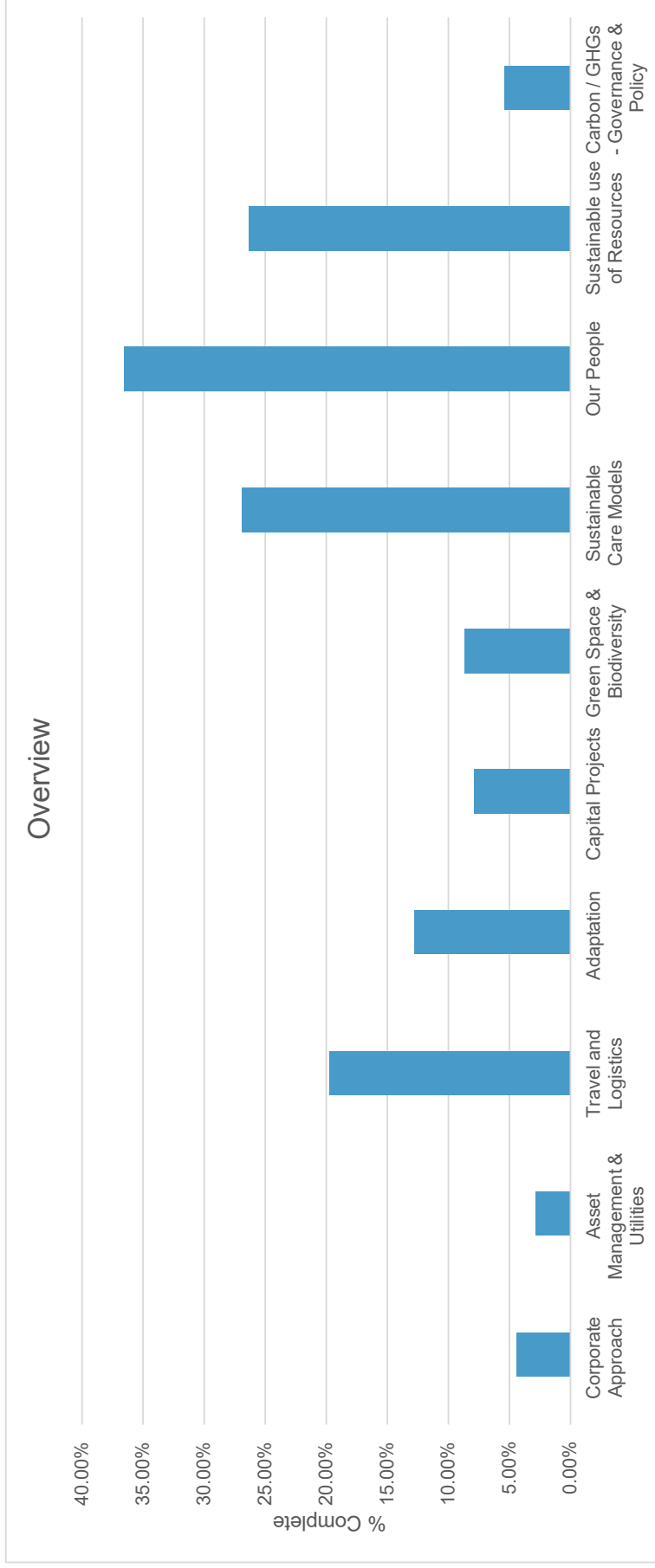
Waste 2019	Volume (Tonnes)	Cost	CO ₂ e	Share
Offensive waste	1.58	4,142	379.28	kgCO ₂ e 3%
Domestic waste (landfill)	20.29	7,686	11900.37	kgCO ₂ e 92%
Domestic waste (recycling)	28.59	16,663	610.49	kgCO ₂ e 5%
Domestic waste (food)	0.07	227	0.71	kgCO ₂ e 0%
Confidential waste	0.02	2,472	0.43	kgCO ₂ e 0%
Total waste	50.55	31,190	12891.28	kgCO₂e 100%

Waste 2020	Volume (Tonnes)	Cost	CO ₂ e Emissions	Share
Offensive waste	1.17	4,373	280.86	kgCO ₂ e 2%
Domestic waste (landfill)	28.08	11,119	16469.31	kgCO ₂ e 95%
Domestic waste (recycling)	5.69	4,907	121.50	kgCO ₂ e 1%
Domestic waste (food)	6.63	872	67.65	kgCO ₂ e 0%
Confidential waste	22.60	22,363	482.60	kgCO ₂ e 3%
Total waste	64.17	43,634	17421.92	kgCO₂e 100%

Green Plan: 2021 - 2026

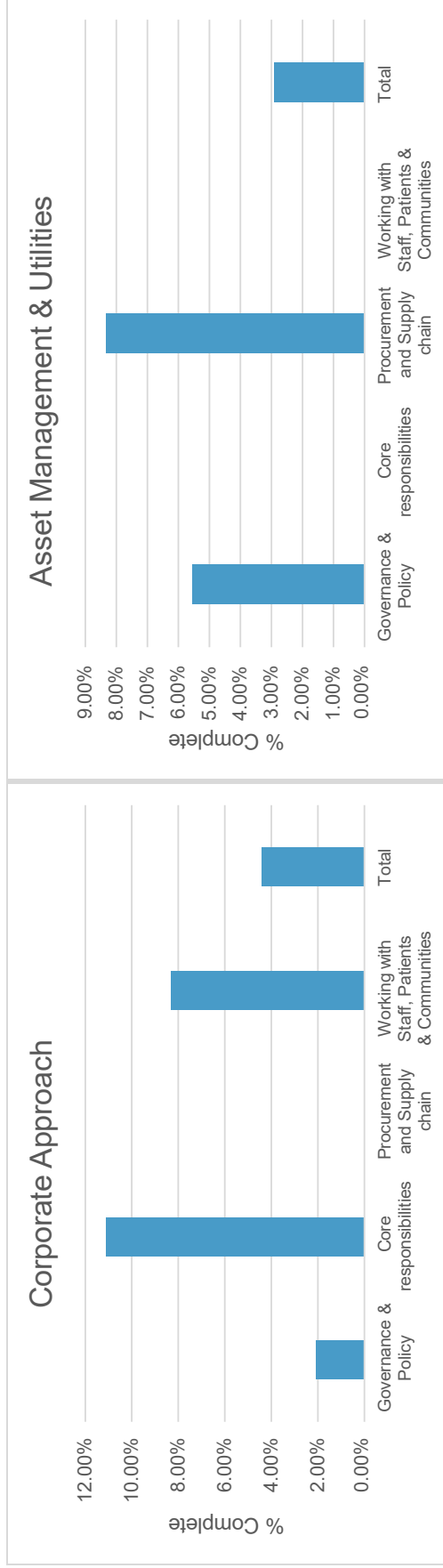
As part of this Green Plan, the Trust have benchmarked themselves against the NHS SDU using the Sustainable Development Action Tools, the results of which are below. Moving forward, the Trust will be able to compare scores with other Trusts to take advantage of progress other NHS institutions have made.

The scoring is based on sustainable actions that the Trust can undertake in order to become sustainable healthcare providers. The scoring is based on three points for a completed action, and one point for an action the Trust has started but not yet completed.

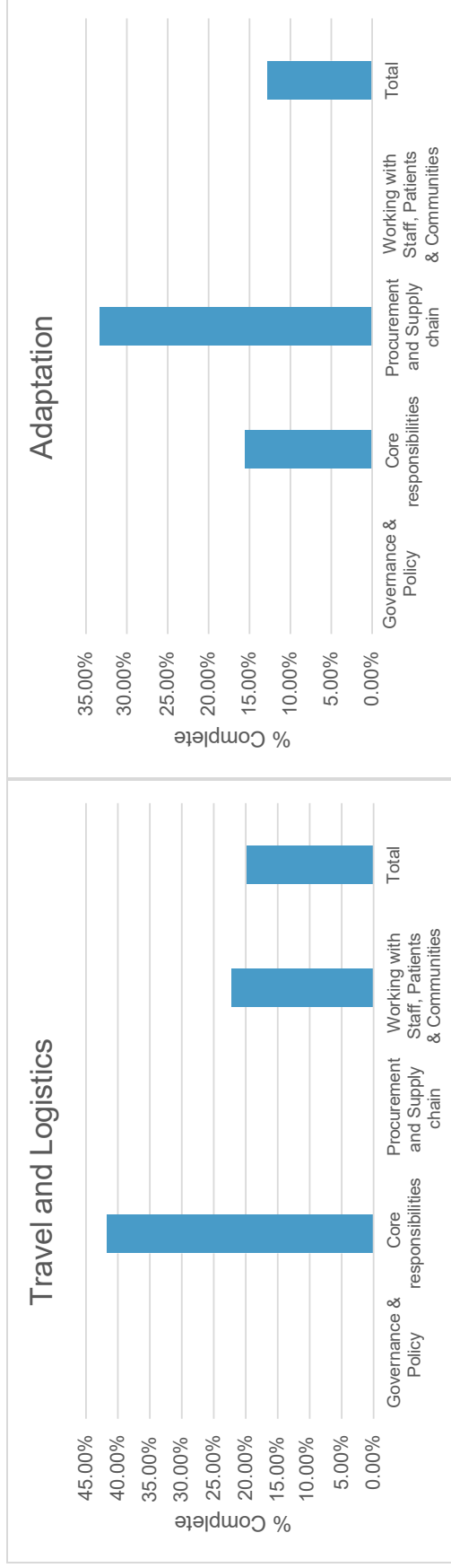


For each of the sections in the above scoring and benchmarking, there are four cross-cutting themes: Governance and Policy, Core responsibilities, Procurement and Supply Chain, and Working with Staff, Patients and Communities.

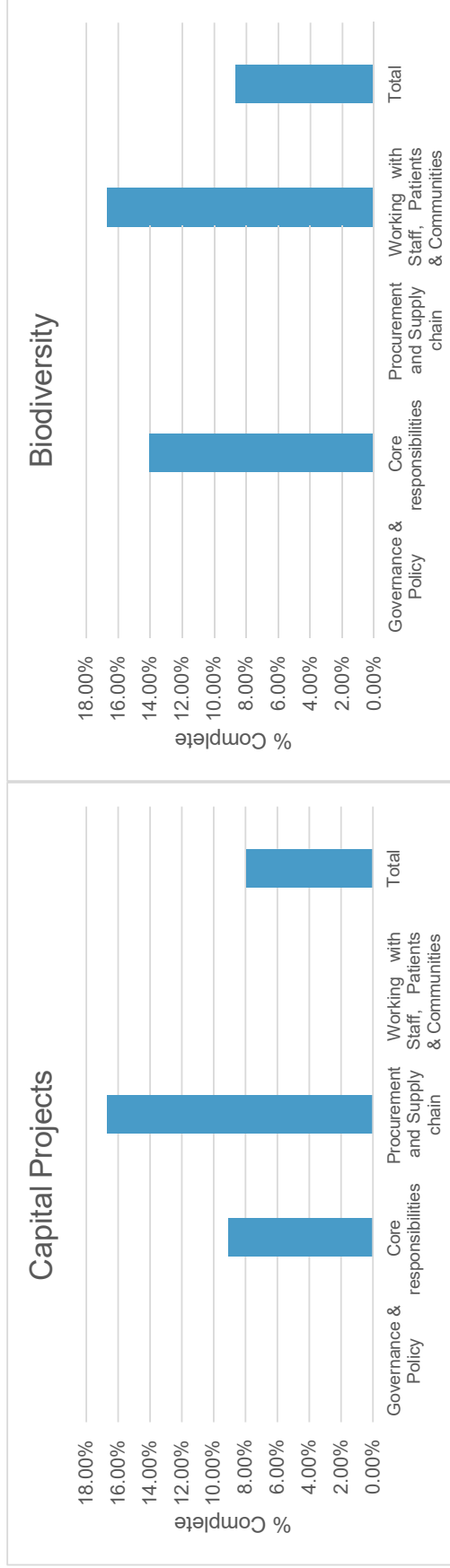
The following graphs show the Trust's progress in each area across these themes:



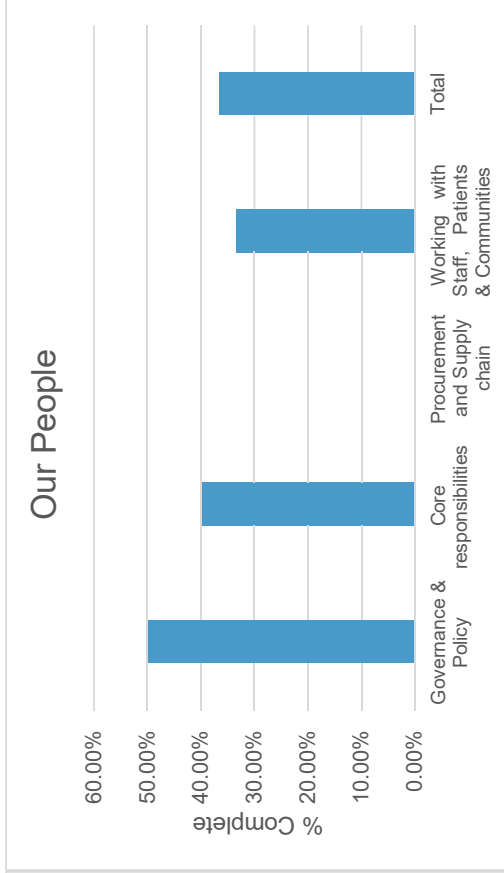
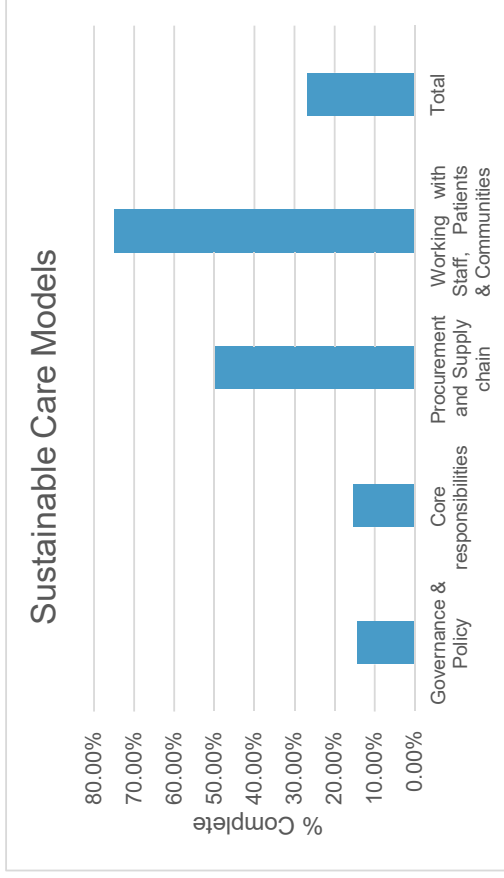
The above graphs show that as a Trust we need to refocus our procurement on sustainable themes, including engaging our suppliers to work sustainably, as well as needing to monitor our energy use clearly and develop ways to reduce.



These graphs show that we need to incorporate policies that cover business, patient and staff travel, and work with everyone to inform how the Trust operates as the climate changes. This includes our need to produce our Climate Change Risk Assessment, to sit alongside a board approved Adaptation Plan once our future building stock is set.



The above graphs show that we need to incorporate sustainable specifications into our procurement during capital works, particularly regarding our new site. We will also need to incorporate biodiversity into our procurement, such as buying responsibly sourced consumables and furniture.



These graphs show that we need to quantify the benefits of our sustainable care models and promote them within our Trust. Using our new people plan, we will ensure that our people's wellness is given centre stage within our organisation, not just our patients.

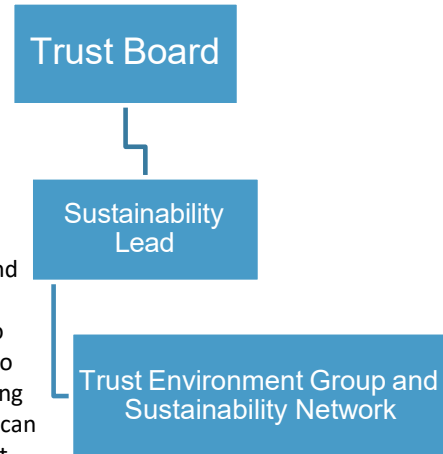


The above graphs highlight a lack of engagement surrounding our use of resources. Rectifying this will reduce waste, improve recycling rates and cut costs. We will also produce a carbon reduction plan that works for our sites, staff and procurement to ensure we are doing all we can to emit less.

8. Governance

Clear leadership, strategic direction and the support of senior staff, stakeholders and other decision makers will ensure we successfully deliver the actions outlined within the Action Plan. This will require clear assigned responsibility for undertaking actions and a mechanism for reviewing progress against the Action Plan on an annual basis.

The Trust Environment Group will be reintroduced, and development of the Sustainability Network is a key priority. Gaining input from representatives for key work areas will help to provide a platform for a holistic and proactive approach to sustainable development in the organisation. By holding sustainability network meetings for our staff and community, we can have groups that deliver on many parts of the plan at once, whilst harnessing the passion our members have for a sustainable future.



9. Reporting

The Trust reports figures relating to energy, water, waste and transport through Estates Returns Information Collection (ERIC) allowing for the Trust’s performance to be benchmarked against similar types of organisations. However, given our aim to understand our emissions, we will develop a mechanism for reporting sustainability KPIs at board level, including energy use not included in ERIC submissions.

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

10. Communication

The Trust has started on a structured and engaging approach to communications so that we can effectively drive sustainable development across the Trust.

We will create a collaborative environment by communicating with our staff, patients, visitors and local communities through social media outlets, giving everybody an opportunity to contribute so they will feel a part of our sustainability journey.

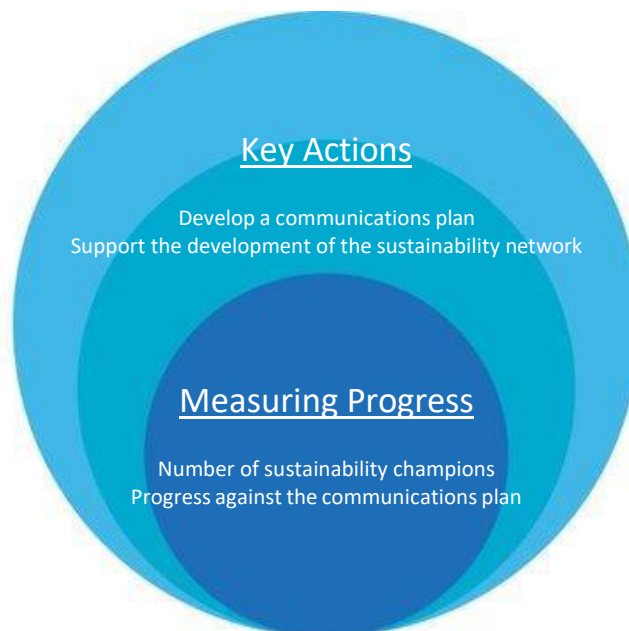
Our communications programme will involve local sustainability champions across the Trust and staff interest groups, with frequent updates and blogs on our intranet.

We will produce newsletters to highlight key achievements and priorities and to encourage our staff to participate in a range of events and activities. Our focus will be on national and international events such as NHS Sustainability Day, Clean Air Day and World Environment Day, all within the reality of Covid-19 restrictions.

We will also link with our service providers and partners to organise events to provide information and raise awareness of topical issues. These activities will be included on our Sustainability Calendar.

We will collaborate with our communications department to inform and engage our various departments to promote progress towards our sustainability targets.

We will continue to provide educational resources to staff through our intranet to enable change in the workplace as well as at home. We will also provide materials such as posters and stickers for staff to use in their own areas.



Green Plan: 2021 - 2026

11. 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 air 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.

We have identified risks to the Trust due to climate change and these are addressed through our adverse weather policies and procedures.

As new risks are identified, they will be assessed in line with the standard Trust risk assessment process using the Datix reporting system. All risks below a certain threshold value will be managed locally as appropriate. Risks which are deemed sufficiently high will be escalated through the appropriate group or board and ultimately to the corporate Trust risk register.

12. Finance

Sustainable development offers opportunities to see long term cost savings through a number of avenues such as reduced energy and water consumption, reduced waste production and increased resilience to the effects of climate change.

We should take the following steps to realise these savings:

1. Develop a clear understanding of our carbon emissions and embed carbon reduction in our financial mechanisms
2. Take advantage of local and national schemes which support investment in energy efficiency initiatives
3. Continue involvement in local strategic partnership arrangements and regional economic forums so that we may play a part in developing a sustainable and resilient health economy
4. Work in collaboration the Department of Health and the Greener NHS Unit to suggest and develop further incentives to support carbon reduction.

A number of public and private funds and loans are available in addition to Trust investment into sustainable development and carbon reduction. These are summarised in below:

- Guaranteed Savings Scheme (Energy Performance Contract) - The EPC provider guarantees that the improvements will generate energy savings sufficient to cover the cost of the investment over the period of the contract
- The Mayor of London's Energy Efficiency Fund (MEEF) - MEEF has been developed with the NHS as a core sector given its leadership in the low carbon sector
- The Public Sector Decarbonisation Scheme – Phased Scheme to assist the NHS to become Net Zero

Many of the workstreams discussed within this Green Plan will have a significant financial impact for the Trust and effective management of energy, water, waste and natural resource can bring financial benefits as well as improving environmental performance. In order for some of these actions to make a long-term difference, financial resource will be made available in the short term to facilitate change.

Glossary

BREEAM	Building Research Establishment Environmental Assessment Method
IWBI	International WELL Building Institute
CO ₂	Carbon Dioxide
CO ₂ e	Carbon Dioxide and equivalent Green House Gases
CQC	Care Quality Commission
CRC	Carbon Reduction Commitment
DECs	Display Energy Certificates
DH	Department of Health
EnCO ₂ de	NHS Energy Efficiency Guidance on healthcare facilities
ERIC	Estates Returns Information Collection
EU ETS	EU Emissions Trading Scheme
GBS	Government Buying Standards
HHM	Half Hourly Meters
HTM	Health Technical Memorandum
KPI	Key Performance Indicator
kWh	Kilowatt hours
NHS	National Health Service
Action Plan	Sustainable Development Action Plan
SDC	Sustainable Development Committee
SDU	Sustainable Development Unit
Greener NHS	New name for the NHS SDU
tCO ₂ e	Tonnes of Carbon Dioxide Emissions

MEETING OF THE BOARD OF DIRECTORS – 13 December 2023					
Report Title: Vision, Mission, and Values				Agenda No.: 14	
Report Author and Job Title:		Jane Meggitt, Interim Director of Communications (DOC) and Gem Davies, Chief People Officer (CPO)		Lead Executive Director: Jane Meggitt, Interim Director of Communications (DOC) and Gem Davies, Chief People Officer (CPO)	
Appendices:		VMV 01 Dec powerpoint			
Executive Summary:					
Action Required:		Approval <input checked="" type="checkbox"/> Discussion <input type="checkbox"/> Information <input type="checkbox"/> Assurance <input type="checkbox"/>			
Situation:		The Board of Directors are being presented with the final iteration of the trust's new vision, mission, and values.			
Background:		Starting in late June of 2023, the interim Director of Communications (DOC) and Chief People Officer (CPO), with the support of the communications team, undertook over 30 online and in-person sessions to hear staff, patient, student, governor, and board member views on refreshing our vision, mission and values.			
Assessment:		The task is now complete, and this paper provides an update to the Board of Directors on the work undertaken to refresh the trust's mission, vision, and values and to seek approval of the final versions.			
Key recommendation(s):		The Board of Directors is asked to approve the new vision, mission, and values for the trust.			
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.		<input checked="" type="checkbox"/> 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.		<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	
				<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	
				<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:		Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>
					Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:		BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>	
				ORR <input type="checkbox"/>	
		Risk Ref and Title: BAF 6: Lack of inclusive and open culture			
Legal and Regulatory Implications:		Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>	
		There are no legal and/ or regulatory implications associated with this report.			
Resource Implications:		Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>	

	There are no resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>	
	There are no specific equality, diversity and inclusion implications associated with this report. Due regard was given to ensure everyone had an equal voice when participating in the review. The implementation plan will also place due regard on the behaviours associated with new values and their inclusion within our approach to a just and learning culture.			
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input checked="" type="checkbox"/> Not applicable: No assurance is required

Report Title: Vision, Mission, and Values

1. Purpose of the report

- 1.1. To update the Board of Directors on the work undertaken to refresh the trust's mission, vision, and values and seek approval of the final versions.

2. Background

- 2.1 Starting in late June of 2023, the interim Director of Communications (DOC) and Chief People Officer (CPO), with the support of the communications team undertook over 30 online and in-person sessions to hear staff, patient, student, governor, and board member views on refreshing our vision, mission and values.
- 2.2 The process required multiple iterations of the vision, mission and values to be shared and tested, and generated hours of meaningful, insightful discussion.
- 2.3 The key stand out during the process was the passion and engagement from all stakeholders and the willingness to get the 'right' set of statements.

3. Vision

- 3.1 Our initial draft vision was:

"To make a positive difference in people's lives."

- 3.2 Many colleagues felt that this vision was too vague and generic and could be applied to a range of organisations. They felt we needed a vision that is more tailored to the work we do, referencing that we are a mental health Trust.

- 3.3 Some colleagues felt that referencing positivity seems reductive and simplistic given the difficult work we do.

- 3.4 Some people felt that this vision should be more ambitious and aspirational.

- 3.5 We went through further iterations including:

"to be a leader in mental healthcare and education, making a meaningful difference to people's lives"

- 3.6 Some colleagues felt that this statement could be more specific about what makes the Tavistock and Portman unique compared to other mental health Trusts.

- 3.7 By not directly mentioning our psychotherapeutic approach, it was felt that our vision could potentially be mistaken for any other Trust.

- 3.8 Following further iterations our final draft **vision** is therefore:

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

4. Mission

4.1 Our initial draft mission was:

“To deliver internationally renowned, high-quality training and education, underpinned by outstanding and innovative research, specialist clinical and partnership led community-based services for the populations we serve.”

4.2 Some felt that the mission was the wrong way round, as historically training came out of the practice of clinical work, rather than being "underpinned by".

4.3 Some colleagues felt that "internationally renowned" was unnecessary, as this is less important to service users.

4.4 Like the vision, staff had a range of views about how specific to our organisation the mission should be.

4.5 We went through further iterations including:

“To provide high-quality specialist mental health care and innovative education and research, in partnership with people, families and communities.”

4.6 Some felt that this mission didn't reflect the breadth of our work, as we don't exclusively provide mental healthcare. Some colleagues liked the inclusion of the word "specialist".

4.7 Following further iterations our final draft **mission** is therefore:

“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.”

All our staff are integral to making our mission a reality

5. Values

5.1 We previously had six values statements. It was felt that these were cumbersome and difficult to remember.

5.2 Our initial draft values were Excellence, Inclusivity and Compassion and these were contextualised as follows:

We strive for **Excellence** in everything we do. We are proud of our heritage and what the future offers for us all.

Inclusivity in how we provide care, educate future professionals and leaders and work together. We are united as one team.

Compassion is central to who we are, what we do and how we respect and treat one another.

5.3 Some felt these values were too long to remember and questioned whether the first two values needed a second sentence.

- 5.4 Staff liked the use of 'We', but felt the sentences should be structured in the same way.
- 5.5 Colleagues questioned whether we could be 'proud' of the future, and some mentioned that 'heritage' has negative connotations.
- 5.6 We had multiple conversations about the benefits and disadvantages of particular words, the importance of language and perceptions, and the cultural connection or dissonance we various words and contextual phrases.
- 5.8 Our final values therefore are **Excellence, Inclusivity, Compassion, Respect** and they are contextualised as follows:

We strive for **excellence**
We champion **inclusivity**
We place **compassion** at our core
We have **respect** for each other

6. Recommendation

- 6.1 Following the extension workshops and feedback it is recommended that the Board of Directors approve these final versions of the vision, mission, and values.



The Tavistock and Portman
NHS Foundation Trust

Vision, mission and values

Our final draft vision

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

Our final draft 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.

All our staff are integral to making our mission a reality

Our final draft values

We strive for **excellence**

We champion **inclusivity**

We place **compassion** at our core

We have **respect** for each other



MEETING OF THE Board of Directors (Public) 13 th December 2023			
Report Title: Finance Report - As of 31st October 23 (Reporting Month 07)			Agenda No. 16
Report Author and Job Title:	Udey Chowdhury, Deputy Chief Finance Officer	Lead Executive Director:	Peter O'Neill, Interim Chief Financial Officer
Appendices:	No Appendix		
Executive Summary:			
Action Required:	Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>		
Situation:	<p>The report provides a summary of the Month 07 (cumulative position to 31st October 23) financial performance against NHSE plan.</p> <p>Income & Expenditure The Trust incurred a net deficit of £2,252k in the period, against a planned deficit of £2,128k i.e., an adverse variance of £124k. This is a worsening from the previous month's negative variance of £45k against plan. This reflects some one-off costs paid in October and the ongoing industrial action and building rates additional costs. However, the distribution of the national funding for industrial action costs has now been confirmed and will offset these costs, bringing the trust back towards its planned deficit for the period. The trust still expects to achieve its year planned deficit of £2.5m.</p> <p>Capital Expenditure To date capital spend totals £942k, versus the plan total of £1,390k. Anticipated expenditure in the year being on plan at £2.2m.</p> <p>Cash The cash balance at the end of the period is £7.2m against the planned M07 figure of £9.9m. The negative variance reflects the impact of the variance to plan and a continued lower income receivables figure from NHS sources. It is anticipated that this position will move closer to plan in the coming months.</p>		
Background:	The Trust has a plan for a revenue deficit for 2023/24 of £2.5m, with Capital Expenditure of £2.2m and a year-end cash position of £3.1m.		
Assessment:	<p>Income and Expenditure The Trusts planned deficit of £2.5m requires the delivery of a £3m efficiency to achieve this. This is to be delivered by £2m of non-recurrent income and identified non-pay schemes of £1m. The Trust will decommission the GIDS at the end of March 24. The cost of decommissioning will fall partly in this financial year, with potentially significant redundancy costs falling into the next financial year. However, the likelihood is that we will be required to recognize the cost in this financial year by way of a provision. The working assumption by us and the ICB is this cost will be funded in total by NHSE. Thus the year end projection is unaffected for these costs at this point.</p> <p>Capital Expenditure The agreed capital spend for the year is £2.2m, is a reduction from the previous year of £0.9m and will require robust management to ensure the Trust stays within plan.</p>		

	<p>Cash The agreed plan includes a reduction in cash over the year to an outturn of £3.1m, which reflects the planned deficit position, but not the unknown impact of GIDS decommissioning.</p>				
Key recommendation(s):	The Committee is asked to NOTE the position outlined in the report.				
Implications:					
Strategic Objectives:					
<input type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organizational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	<p>BAF 8: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.</p> <p>BAF 10: Suitable Income Streams The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.</p>				
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>		No <input type="checkbox"/>		
	It is a requirement that the Trust submits an annual Plan to the ICS, and monitors and manages progress against it.				
Resource Implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
	There are no resource implications associated with this report.				
Diversity, Equality and Inclusion (DEI) implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
	There are no DEI implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input checked="" type="checkbox"/> Not applicable: No assurance is required

Board of Directors Part 2 (Public) – 13 December 2023				
Report Title: Integrated Governance and Audit Committee Highlight Report – Nov 23			Agenda No.17	
Report Author and Job Title:	Peter O’Neill, Interim Chief Financial Officer	Lead Executive Director:	David Levenson, Non Executive Director	
Appendices:	None			
Executive Summary:				
Action Required:	Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>			
Situation:	The report provides a summary of key matters arising at the Integrated Governance and Audit Committee of the 23rd November 23			
Background:	n/a			
Assessment:	<p>Scheme of Delegation</p> <ul style="list-style-type: none"> The committee received a proposed Scheme of Delegation that it agreed to send to the Board of Directors for approval. <p>External Auditor Appointment</p> <ul style="list-style-type: none"> The committee agreed to recommend to the Council of Governors the appointment of Grant Thornton as the Trust’s new external auditors. <p>Internal Audit</p> <ul style="list-style-type: none"> The committee received a report on waiting list management, that gave partial assurance. A trust wide action plan is being established to cover all services, with the committee particularly concerned about the long waits in GIC. The committee was advised that an improvement week was scheduled for early December, with improvements to be tracked via PFRC. <p>BAF Risks</p> <ul style="list-style-type: none"> The committee requested/agreed that the BAF Risks should be now updated to reflect the Trusts new strategic aims and to reflect any new issues generated by the merger process. A new training program is being established, with a view to reducing the number of BAF Risks and updating the processes for managing and using the risks as part of ‘normal business’. 			
Key recommendation(s):	Members of the Board of Directors are asked to: Note the report.			
Implications:				
Strategic Objectives:				
<input type="checkbox"/> Improve delivery of high-quality clinical services which make a	<input type="checkbox"/> Be a great & safe place to work, train & learn for everyone. A place	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium &	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally,	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.

significant difference to the lives of the people & communities we serve.	where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	long-term organizational sustainability & aligns with the ICS.	supporting improvements in population health & care & reducing health inequalities.		
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	<p>BAF 8: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.</p> <p>BAF 10: Suitable Income Streams The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.</p>				
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>		No <input type="checkbox"/>		
	Sub Committee of the Board of Directors.				
Resource Implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
	There are no resource implications associated with this report.				
Diversity, Equality and Inclusion (DEI) implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>		
	There are no DEI implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	Agreed at the Integrated Governance and Audit Committee.				
Reports require an assurance rating to guide the discussion:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input checked="" type="checkbox"/> Not applicable: No assurance is required	

Board of Directors Part 2 (Public) December 2023					
Report Title: Scheme of Delegation Update				Agenda No.: 18	
Report Author and Job Title:	Peter O'Neill Interim CFO/Adewale Kadiri DoCG	Lead Executive Director:	Peter O'Neill Interim CFO/Adewale Kadiri DoCG		
Appendices:	Scheme of Delegation				
Executive Summary:					
Action Required:	Approval <input checked="" type="checkbox"/> Discussion <input type="checkbox"/> Information <input type="checkbox"/> Assurance <input checked="" type="checkbox"/>				
Situation:	The Scheme of Delegation needs to be updated to reflect the new structure across the Trust.				
Background:	N/A				
Assessment:	The current scheme of delegation document is inadequate and doesn't reflect the current structure of the Trust.				
Key recommendation(s):	The Board is asked to: 1. Approve the revision of the Scheme of Delegation.				
Implications:					
Strategic Objectives:					
<input type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	Risk Ref and Title: BAF 8: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.				
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>			No <input type="checkbox"/>	
	The Trust should ensure that an adequate scheme of delegation is in place as part of it's conditions of license.				

Resource Implications:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>		
Equality, Diversity and Inclusion (EDI) implications:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>		
Freedom of Information (FOI) status:	<input type="checkbox"/> This report is disclosable under the FOI Act.	<input checked="" type="checkbox"/> 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:	Audit Committee then Board of Directors for approval.			
Reports require an assurance rating to guide the discussion:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required

1. Scheme of Reservation (Board of Directors)

All powers that have not been retained by the Board or delegated to a Committee of the Board shall be exercised on behalf of the Board by the Chief Executive. All powers delegated to the Chief Executive can be reassumed by him/her should the need arise. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Deputy Chief Executive or another nominated Officer after taking appropriate advice from the Chief Finance Officer.

The Board remains accountable for all its functions, included those that have been delegated. The Board may request, at any time, information about the exercise of delegated functions to enable it to maintain its monitoring role.

THE BOARD	DECISIONS RESERVED TO THE BOARD
THE BOARD	<p>General Enabling Provision</p> <p>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</p>
THE BOARD	<p>Regulations and Control</p> <ol style="list-style-type: none"> 1. Approve the Standing Orders (SOs) as set out in the constitution, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 3.2. 5. Approve a scheme of delegation of powers from the Board to Committees (SO 3.4). 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member of the Board may remain involved with the matter under consideration. 7. Require and receive the declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisational structures, processes, and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

	<ol style="list-style-type: none"> 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all Committees that are established by the Board. 14. Ratify use of the Trust seal. 15. Discipline members of the Board or employees who are in breach of statutory requirements or Standing Orders.
<p>THE BOARD</p>	<p>Appointments/ Dismissal</p> <ol style="list-style-type: none"> 1. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 2. Approve proposals on the appointment, appraisal, discipline and dismissal of Executive Directors made by the Remuneration Committee of the Board, subject to the Trust's Constitution. 3. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 4. Appoint, appraise, discipline and dismiss the Secretary. 5. Approve remuneration proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee. <p>Note:</p> <ol style="list-style-type: none"> (1) The Chief Executive is to be appointed (and removed) by the Non-Executive Directors, subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors. (2) The Executive Directors are to be appointed (and removed) by a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors, being the Remuneration Committee, acting in that capacity.
<p>THE BOARD</p>	<p>Strategy, Plans and Budgets</p> <ol style="list-style-type: none"> 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 3. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 4. Approve and monitor the Trust's policies and procedures for the management of risk. 5. Approve Outline and Final Business Cases for Capital Investment in excess of £250,000. 6. Approve budgets.

	<ol style="list-style-type: none"> 7. Approve annually the Trust's organisational development proposals. 8. Ratify proposals for acquisition, disposal or significant change of use of land and/or buildings. 9. Approve the introduction or discontinuance of any significant activity or operation. 10. Approve PFI proposals. 11. Approve the opening of bank or investment accounts. 12. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £5,000,000 over a 3-year period or the period of the contract if longer. 13. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance (for losses and special payments) previously approved by the Board. 14. Approve individual compensation payments made outside of legal/ statutory or mandatory requirements over £100,000. 15. Approve proposals for action on litigation against or on behalf of the Trust. 16. Review use of NHS Resolution risk pooling schemes (LTPS/PES/CNST/RPST).
THE BOARD	<p>Policy Determination</p> <ol style="list-style-type: none"> 1. Approve Trust's management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
THE BOARD	<p>Audit</p> <ol style="list-style-type: none"> 1. To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Integrated Audit and Governance Committee meetings and take appropriate action. 2. Receive the annual management letter prepared by the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Integrated Audit and Governance Committee.* 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Integrated Audit and Governance Committee. <p>*Note: The appointment or dismissal of the Auditor is reserved to the Council of Governors</p>
THE BOARD	<p>Annual Reports and Accounts</p> <ol style="list-style-type: none"> 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust. 3. Receipt and approval of the Trust's Quality Account.

THE BOARD	<p>Monitoring</p> <ol style="list-style-type: none">1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated or from Directors and Officers of the Trust.2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and/ or NHS England and the Charity Commission where Board certification is required shall be reported, at least in summary, to the Board.3. Receive reports from the Chief Finance Officer on financial performance against budget.
-----------	---

2. Decisions/duties delegated by the Board to Committees

COMMITTEE	DECISIONS/DUTIES DELGATED BY THE BOARD TO COMMITEES
INTEGRATED AUDIT AND GOVERNANC E COMMITTEE	<p>The Committee will advise and support the Board through:</p> <ul style="list-style-type: none"> (a) overseeing Internal and External Audit services; (b) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgments; (c) reviewing the establishment and maintenance of an effective system of corporate governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives; (d) monitoring compliance with Standing Orders and SFIs and the scheme of delegation; (e) reviewing schedules of losses and compensations and making recommendations to the Board; (f) Reviewing schedules of debtors/creditors balances over 6 months old and over a <i>de minimus</i> limit as defined by the Audit Committee and related explanations/action plans; (g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly. (h) Monitoring and reviewing the effectiveness of the Trust's internal audit function and ensuring that it meets any mandatory standards set by NHS England and any relevant UK professional and regulatory requirements; (i) Monitoring the independence and objectivity of the External Auditor; (j) Receiving reports from the Local Counter Fraud Service (LCFS) and monitor the work of the LCFS service.

<p>BOARD OF DIRECTORS REMUNERATION COMMITTEE</p>	<p>The Committee shall determine the appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other senior employees. They shall:</p> <ul style="list-style-type: none"> (a) advise about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other relevant senior employees), including: <ul style="list-style-type: none"> (i) all aspects of salary (including any performance-related elements / bonuses); (ii) provisions for other benefits, including pensions and cars. (b) determine arrangements for termination of employment and other contractual terms; (c) monitor and evaluate the performance of individual officer members (and other senior employees); (d) make such recommendations to the Board on the remuneration and terms of service of Executive Directors (and other relevant senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate; (e) decide on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate; (f) Monitor the skills and knowledge mix of the Board and make recommendations for future Executive and Non-Executive Director appointments; (g) The Committee shall report in writing to the Board its decisions and the basis for its recommendations; (h) The Board will consider and needs to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and Officers not covered by the Committee;
<p>QUALITY AND SAFETY COMMITTEE</p>	<p>The primary purpose of the Committee is to provide assurance to the Board of Directors that the Trust has a robust framework for the management of key critical clinical systems and processes and ensuring that patients receive safe, effective and appropriate care.</p>
<p>PEOPLE, ORG DEVELOPM ENT & EDI COMMITTEE</p>	<p>The purpose of the POD EDI Committee is to monitor actions being taken by the Trust to ensure the delivery of its duties under the people plan, that it is giving attention to the health and wellbeing of all staff, and achieve its goal to be an outstanding place to work where staff can flourish, and that plans to achieve the ambitions set out in the Race Equality and Inclusivity Plans are being delivered.</p>
<p>EDUCATION AND TRAINING COMMITTEE</p>	<p>The primary purpose of the Education and Training Committee is to oversee the implementation of strategies relating to the provision and training and education services.</p>

<p>PERFORMANCE, FINANCE AND RESOURCES COMMITTEE</p>	<p>The primary purposes of the Performance, Finance and Resources Committee is to oversee the financial and operational performance of the Trust, including:</p> <ul style="list-style-type: none"> • Considering relevant financial and operational strategies before these are submitted to the Board for approval; • Reviewing risks associated with the strategies and their mitigation; • Considering finance and other relevant reports; • Approving business cases with delegated authority from the Board; • Reviewing progress against the delivery of business plans previously approved by the Committee; and • Escalating appropriate matters to the Board.
---	---

3. Section 4 – Duties from the NHS Foundation Trust Accounting Officer Memorandum (IRG 24/15 5 August 2015)

REF	DELEGATED TO	DUTIES DELEGATED
7	ACCOUNTING OFFICER	<p>The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:</p> <ul style="list-style-type: none"> • there is a high standard of financial management in the NHS foundation trust as a whole; • financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; • financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.
8	ACCOUNTING OFFICER	<p>The essence of the accounting officer's role is a personal responsibility for:</p> <ul style="list-style-type: none"> • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts; • prudent and economical administration in line with the principles set out in Managing public money¹; • the avoidance of waste and extravagance; • the efficient and effective use of all the resources in their charge. <p>¹ www.gov.uk/government/publications/managing-public-money</p>

9	ACCOUNTING OFFICER	<p>The Accounting Officer must:</p> <ul style="list-style-type: none"> • personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by NHS England in accordance with the Act; • comply with the financial requirements of the NHS provider licence; • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonable accuracy, at any time, the financial position of the NHS foundation trust); • ensure that the resources for which he or she is responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official; • ensure that assets for which he/she is responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; • ensure that any protected property (or interest in) is not disposed of without the consent of NHS England; • ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, council of governors or in the actions or advice of the NHS Foundation Trust's staff, including himself or herself; • ensure that, in the consideration of policy proposals relating to the expenditure for which he or she is responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.
10	ACCOUNTING OFFICER	<p>Ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels:</p> <ul style="list-style-type: none"> • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

11	ACCOUNTING OFFICER	<p>Must make sure that the arrangements he/she puts in place for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills.</p> <p>Arrangements for internal audit should accord with the objectives, standard and practices set out in the <i>Public Sector Internal Audit Standards</i>²</p> <p>²www.gov.uk/government/publications/public-sector-internal-audit</p>
12	ACCOUNTING OFFICER	<p>See that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as accounting officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.</p>
13	ACCOUNTING OFFICER	<p>Set out in writing his/her objection to any proposal or course of action of the Council of Governors or the Board of Directors which may infringe the requirements of propriety or regularity, and the reasons for this objection.</p> <p>Inform NHS England should any decision to proceed be taken which infringes the requirements of propriety or regularity despite his/her objection.</p> <p>Inform the Trust's External Auditors and NHS England if the decision is taken and the Accounting Officers objections are overruled.</p>
14	ACCOUNTING OFFICER	<p>Inform the Board of Directors and Council of Governors, of any issue relating to the wider responsibilities for economy, efficiency and effectiveness, and provide advice to the Board of Directors and Council of Governors on a recommended course of action. If the Accounting Officer's advice is not taken, he/she should seek an instruction to proceed in writing from the Board or Council before proceeding.</p>
16-20	ACCOUNTING OFFICER	<p>The Accounting Officer may be required to appear before the Public Accounts Committee and will furnish the information and evidence required by the Committee.</p>
22	BOARD OF DIRECTORS	<p>Appoint an acting Accounting Officer (normally the Director of Finance) if an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more.</p>

Section 5 – Authorities/duties delegated from Standing Orders

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
2.1.1	CHAIR	Call meetings.
2.1.2	CHAIR	Chair all Board meetings.
2.16.1	BOARD	Suspension of Standing Orders
2.16.5	INTEGRATED AUDIT AND GOVERNANCE COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.3.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Board.)
3.2	CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within the Standing Orders and this scheme of reservation and delegation may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
3.5.1	CHIEF EXECUTIVE	Functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Board, shall be exercised by the Chief Executive on behalf of the Board.
3.6	CHIEF EXECUTIVE	The Chief Executive shall prepare a scheme of delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.1.1	THE BOARD	Declare relevant and material interests.
7.4	DIRECTOR OF CORPORATE GOVERNANCE	Maintain Register(s) of Interests of members of the Board upon receipt of new or amended information.
7.1.1	ALL STAFF	Comply with the Directors' Code of Conduct and any guidance and best practice advice issued by NHS Improvement.
7.9	ALL	Disclose relationship between self and candidate for staff appointment. (Board of Directors' Secretary to report the disclosure to the Board.)
8.1.1	DIRECTOR OF CORPORATE	Keep common seal of the Trust in safe place and maintain a register of sealing.

	GOVERNANCE/ NOMINATED OFFICER	
9.1	CHIEF EXECUTIVE	Sign all documents which will be necessary in legal proceedings.



Appendix 1: Authorisation Limits

Revenue Authorisation Limits – values include VAT

Role	Purchase Orders and Invoices	Credit Notes
Board of Directors	500,000	
Chief Executive	500,000	500,000
Chief Finance Officer	250,000	250,000
Chief Clinical Operations Officer	150,000	150,000
Other Executive Directors	150,000	150,000
Associate Directors of HR, IT and Facilities	50,000	50,000
Divisional Clinical and Operational Directors	50,000	50,000
General Managers	25,000	
Team Managers	10,000	

MEETING OF THE BOARD OF DIRECTORS PART 2 – PUBLIC – 13 December 2023			
Report Title: Integrated Governance Action Plan Progress – November 2023			Agenda No. 19
Report Author and Job Title:	Dorothy Otite, Governance Consultant	Lead Executive Director:	Michael Holland, Chief Executive Officer
Appendices:	Appendix 1: Integrated Governance Action Plan – High Level Summary Report		
Executive Summary:			
Action Required:	Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input type="checkbox"/> Assurance <input checked="" type="checkbox"/>		
Situation:	This report provides the latest progress of the Integrated Governance Action Plan (IGAP) at 10 November 2023 recommended to the Board of Directors for assurance by the Integrated Audit and Governance Committee.		
Background:	<p>The IGAP consolidates recommendations from the 2021/22 Office of Modern Governance (OMG) board and leadership review, the outstanding governance actions with the Single Oversight Framework (SOF 3) 2022/23 exit criteria, two significant outstanding actions from internal audit recommendations and key actions associated with the preparations for a CQC Well-Led inspection.</p> <p>The Integrated Governance Task & Finish Group (the Group) chaired by the Chief Executive Officer continues to meet monthly to oversee the delivery of the IGAP.</p> <p>The Group has adopted a risk-based approach to identifying areas for potential deep dives. It has so far conducted deep-dives on the SOF 3, Corporate Governance; Workforce; Clinical Governance; Education and Training; and Finance workstream elements of the IGAP.</p> <p>In September 2023, the Group agreed a process for final sign-off of the IGAP at the end of March 2024, which involves requiring completion of majority of the milestones on the IGAP by end January 2024 to enable Lead Executive Directors and relevant Board sub-committees review and receive assurance, ahead of final sign-off by the IGAP Task and Finish Group at the end of 2023/24.</p>		
Assessment:	<p>Summary and assessment of overall progress of the full IGAP:</p> <ul style="list-style-type: none"> In relation to the 25 OMG recommendations – 14 are complete; 5 are on track for implementation by 31st January 2024; 4 are in progress with implementation dates by 31st March 2024; 1 is no longer required; and 1 is archived as duplicated. In relation to the 8 SOF 3 (2022/23) recommendations - 3 are complete; 2 are on track for implementation by 31st January 2024; 2 are in progress with implementation dates by 31st March 2024; and 1 in relation to the Estates Strategy, is at risk of non-completion by end March 2024 as it is linked to the Trust’s future plans. 		

	<ul style="list-style-type: none"> The milestone in relation to the Well-led preparation is on track for implementation by 31st January 2024. The two milestones in relation to Annual Report and Accounts 2022/23 and two internal audit recommendations in relation to procurement are complete. Overall, the IGAP Task & Finish Group consider that good progress has been made in delivering key milestones since the last report to the Committee. A key focus for the Executive Leadership Team in 2023/24 is to fully implement the IGAP and to ensure the delivery of strengthened and sustained improvements in leadership and governance arrangements. 				
Key recommendation(s):	The Board is asked to receive ASSURANCE from the content of the report.				
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input checked="" type="checkbox"/> 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.	<input checked="" type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input checked="" type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	BAF 15: Ineffective senior leadership arrangements - A prolonged period of instability across the Trust Executive and senior management could impact on the effectiveness of governance, performance and engagement across the Trust, resulting in poor outcomes, levels of compliance, and staff performance.				
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>			No <input type="checkbox"/>	
	The IGAP contains regulatory actions.				
Resource Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no resource implications associated with this report.				
Equality, Diversity and Inclusion (EDI) implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no EDI implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.			<input type="checkbox"/> 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:	Integrated Audit and Governance Committee – 23 November 2023; and Integrated Governance Task & Finish Group – 31 October 2023			
Reports require an assurance rating to guide the discussion:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required

Workstream/ Milestone (including Recommendations)	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach *Root causes identified *Project plan in place *Capacity/ Capability in place	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
INITIATION							
Set up task and finish group to oversee delivery of the project	Chief Executive Officer	N/A				Complete	Complete - Task and Finish Group in place and meeting fortnightly with clear Terms of Reference.
GOVERNANCE REVIEW							
KLOE 1: Leadership, Capacity and Capability							
R1: The Chair should oversee the design and commence the early stages of implementation of a structured Board development programme aimed at improving Board impact and effectiveness. This should reflect the development areas identified throughout this report, including those related to increasing Board impact and providing effective scrutiny and challenge; and improving the effectiveness of Board member contributions	Chair/ Chief People Officer/ Director of Corporate Governance	Nov-23				On track	Director of Corporate Governance working with the Chair, CEO and CPO to develop a robust Board Development Programme. Meeting held on 5/10/23 to progress this work. Director of Corporate Governance to take a list of options to the Board Development Session in November 2023 to allow for Board input on draft Programme. Following which the Programme will be finalised. The Board is currently working on a session by session basis.
R2: The COG should consider, in conjunction with the Chair, the possibility of co-opting on the Board NEDs with clinical and higher education backgrounds. This should include engagement with ICS partners around drawing on skills that may exist in the ICS already in these areas and should be a precursor to recruiting NEDs with these skills substantively, informed by a Board Skills Framework.	Chair	N/A				Complete	Complete - New Non-Executive Directors in post, appointments approved by the Council of Governors December 2022.
R3: The Chief Executive should consider ahead of completion of the Strategic Review, the appointment of a substantive Director of HR, which needs to be accompanied by a clear focus on OD and bring forward proposals to enhance the corporate governance function, including the appointment of a substantive Director of Corporate Governance (drawing on skills that may exist in the ICS. This includes the substantive appointments of a Chief Medical Officer, Chief Nursing Officer, Director of Strategy, Transformation and Business Development, Chief People Officer and Director of Corporate Governance.	Chief Executive Officer/ Chief People Officer	N/A				Complete	Substantially Complete - All substantive appointments made and now in post, except Chief Education and Training Officer which is underway. Interim Chief Education and Training Officer still in post. Review of the Corporate Governance Team now complete. Agreed in principle by the Executive Leadership Team. Recruitment into gaps to be prioritised and progressed. The must-do milestones are now complete. The other milestones still outstanding are: 1. Appointment of the substantive Chief Education and Training Officer - to be progressed in due course 2. Source external facilitator to deliver executive director and senior leadership team (Triumvirate) development programme (this is duplicated as it sits under another recommendation).
R4: The Chair, working with the Corporate Governance team should lead the development of a robust NED induction programme	Director of Corporate Governance	N/A				Complete	Complete - Picked up by the Governance Consultant from mid-July 2023. Robust Board Induction handbook developed that includes all the relevant information about the Trust, Board members, governance structure, training, contact details etc. Rolled out to 4 new NEDs and placed in Board of Directors Reading Room. To roll out to new Executive Directors.
R15: The Chief Executive should reflect on ongoing actions and behaviours aimed at promoting team building and influencing multi-disciplinary executive working, with a view to incorporating this within a formal programme of development Covered in SOF 6.4 - propose to archive	Chief Executive Officer/ Chief People Officer	Jan-24				On track	Linked with SOF 3 - 6.3. Executive Team away days held in September and agenda included ways of working and priority setting. Procurement for 3c+ learning and management development training still being worked through with procurement. Sessions for 5- 5b are booked and applications are being received. Specification for OD programme written and being worked through with Procurement. Once commissioned it will be for a six months period. Evidence required to close is award of contract for the OD work and commencement of the development programme. Then this will move to BAU for 2024/25.
KLOE 2: Vision and Strategy							
R5: The Chair should consider what further work needs to be undertaken by the Board as part of a structured programme of Board development to agree a common understanding of the vision and long-term strategy for the Trust to provide direction and further meaning to the Strategic Review LINKED TO R1 ABOVE	Chair	Dec-23				On track	On track - Strategy discussion planned at Joint Board & CoG in November 2023 and formal Board sign-off in Dec 2023
R6: The Board should ensure that the Strategic Review is accompanied by a clear investment and implementation plan and the development of a quality impact process to assess costs reduction and transformation schemes in the SR and which has clear Board visibility	Chair/ Chief Executive Officer	N/A				Complete	Complete - After action review (AAR) Paper to Private Board on 11/10/23 to ensure lessons are learnt (in relation to Workforce).
R16: The Board should ensure that ICS partners are actively engaged to understand the Trust strategy, vision and how it fits within the overall ICS Refer to 5b above	Director of Strategy & Transformation	Dec-23				On track	Linked to R5 above - Draft strategy shared with the ICB and as part of SOF 3 meetings. Strategy discussion at Joint Board & CoG in November 2023 and Board sign-off in Dec 2023
KLOE 3: Culture							
R7: The Board should consider developing an engagement plan aimed at improving perceptions regarding the level of organisational engagement and visibility. This should give consideration to improve physical presence as well as refinements to the Trust approach to digital media and corporate communications SEE R5 ABOVE	Director of Communications and Marketing	TBC				In progress	Engagement plan has been approved by Board and is being implemented at pace. Outstanding milestones in relation to developing a membership and engagement strategy in conjunction with the Council of Governors. A draft strategy was developed in 2022/23 and was being consulted on with the CoG. At the time of writing, a follow-up discussion on progress was being had with the Director of Communications and Marketing.
R17: The Board should ensure a review of the FTSU: Raising Concerns and Whistleblowing Procedure in the light of the recent Employment Tribunal and use this as an opportunity to ensure the new policy is communicated to staff across the Trust PROPOSE TO ARCHIVE AS DUPLICATED IN SOF 3 7 BELOW	Chief People Officer	N/A				Complete	Linked with SOF 3 - 7 Complete: Revised Freedom to Speak Up Policy and Procedure in place and signed off by POD EDI in September 2022 FTSU NED Champion (Deborah Colson) agreed by Board in February 2023 Staff Drop in sessions held in October 2022. In Sight briefing held in October 2022.
R21: The Board should commence as part of the SR a piece of work to develop a cohesive Trust culture. This should include programme of work that address clinical and management relationships within the organisation	Chair/ Chief Executive Officer/ Chief People Officer	Mar-24				In progress	This is linked with the Organisational Development work in R15 above. ToR being refreshed in 2023/24 following outcome of effectiveness reviews presented to POD EDI in July 2023. Increasing staff engagement channels: Admin forum introduced - inaugural meeting held in August 2023. Two new tasks added are: (i) Each Executive Director has an EDI objective (ii) Each NED to agree an EDI objective. The other milestones still outstanding are: *Refreshing People Policies: Policies are being phased and as each policy is ratified there will be associated training as part of the implementation process. This is still in progress.
KLOE 4: Roles and Governance							
R8: The Board should more closely align its Committee structure with its strategic priorities, potentially to include a refocused Audit and Governance Committee and a new Quality, Finance and Performance & People Committees. Alongside this work, plans need developing to address gaps and issues we have already identified around the Committee structure at the Trust as a whole PROPOSE TO ARCHIVE - DUPLICATED IN SOF 6.2 BELOW	Chair/ Director of Corporate Governance	N/A				Complete	Complete and linked with SOF 3 - 6.2 Committee structure and Terms of Reference signed off by Board and operating. ToR being refreshed in 2023/24 following outcome of effectiveness reviews. Forward Planners produced in consultation with the Executive Leads and NED Committee Chairs; and signed off by each Board Committee during the March cycle of meetings. Committee effectiveness review process is complete. Outcome of effectiveness reviews reported to Board Committees during the May cycle and to Board at the June meeting. Board Forward Planner produced and presented to Board in April 2023. All Board Committee ToRs reviewed and being presented to Committees during the September cycle and to Board in October.
R9: The Board should seek to revisit the structure and format of the ELT, Operations Delivery Board and divisional accountability arrangements in light of our findings.	Chief Executive Officer	N/A				Complete	Complete. ELT Terms of Reference revised and agreed. Forward Planner developed for 2023/24. Introduced new Operations Delivery Board and refreshed the Clinical Leadership Group Terms of Reference. Terms of Reference of the Change Board has recently been revised. DET incorporated into Operations Delivery Board ToR.
KLOE 5: Risks and Performance							

Workstream/ Milestone (including Recommendations)	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach *Root causes identified *Project plan in place *Capacity/ Capability in place	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
R10: The Board should consider the various observations made within our review regarding refinements to the BAF and ORR and that there is greater consistency in practices across the Trust, including frequency of reviewing the BAF and ORR at Board, Committee and at the operational management level. LINKED TO 6.5 BELOW PROPOSE TO ARCHIVE - DUPLICATED IN SOF 3 6.5 BELOW	Director of Corporate Governance	Mar-24				In progress	Milestone substantially complete and Linked with SOF 3 - 6.5. Revised BAF presented to the Board Committees and Trust Board during the January and March cycles. Substantial assurance received from the Audit Committee. Internal Audit review of the Trust's risk management arrangements and BAF informed the Head of Internal Opinion for 2022/23. Operational Risk Registers now refreshed and to commence reporting to Board sub-committees in the September cycle. Outstanding actions in respect of procurement of a replacement risk management and incident reporting tool - decision made on tool. Roll-out planned; policy being refreshed to go to PAG for approval; and development of the CRR in progress. Risk training for managers being prioritised to happen independently of the roll-out of the new system.
R11: The Board should consider accelerating work underway to implement the Trust wide accountability and performance frameworks and increase executive focus on this area. This recommendation should be implemented in conjunction with the roll-out of a consistent suite of performance reports across the Trust	Chief Clinical Operating Officer	N/A				Complete	Milestone complete and Linked with IQPR work (which is reported under R12 below) Actions in relation to Terms of Reference of Tier 2 Committees to include scrutiny of performance metrics now complete. ToR have been refreshed in 2023/24 following outcome of effectiveness reviews.
R1b: The Board should explore as part of a structured development session how it could make far more effective and meaningful use of the BAF/ORR to drive debate, provide assurance, and ensure a clear and consistent understanding of the key risks and issues facing the Trust LINKED TO RECOMMENDATION 1 ABOVE	Chair/ Director of Corporate Governance	N/A				Complete	Linked with R1 above Complete: Risk session focused on the BAF facilitated by RSM took place on 14 March 2023. Session was well received by the Board. A Board Appetite development session facilitated by RSM took place in April 2023. A further session took place on 10 May and will result in a refreshed appetite statement and position on the treatment and acceptance of risk across the Trust.
KLOE 6: Information R12: The Board should fundamentally revisit its approach to reporting throughout the organisation to promote a more integrated, focused, consistent, less fragmented and streamlined format of reporting at all levels of the organisation. The current Quality Dashboard should be used as the consistent suite of reports across the Trust 'anchor point' from which to design, develop and ultimately role out a consistent suite of reports across the Trust	Chief Executive Officer/ Chief Clinical Operating Officer	Mar-24				In progress	Roll out of A3 training being progressed by KPMG - Methodology around standardising projects also being rolled out. Iterative improvements being made to the IQPR. Assurance that the IQPR is fit for purpose by end 2023/24.
R18: The Board should reintroduce service user and staff stories to the Board, and consider widening this to include Student Stories	Chief Nursing Officer	N/A				Complete	Complete: Service user and staff stories added on Board Forward Planner for 2023/24 In addition, Service User / Staff stories are currently being received at the respective Board Committees (i.e. Quality - Service User; POD EDI - Staff Stories). Interim CNO agreed to co-ordinate to ensure there is a programme of stories in place for the year.
KLOE 7: External Partners Engaged R13: The Board should explore a programme of support to the Trust from ICS partners for a range of back office and support functions and draw on intensive support around demand management and capacity modelling from NHS England for GIDS	Chief Executive Officer	N/A				No longer required	No longer applicable. Intensive support previously brought in to work with GIDS
R1c: The Board should explore as part of a structured development programme stakeholder perceptions of the Trust and how comments and feedback in our review can be built upon positively LINKED TO RECOMMENDATION 1 ABOVE Reputational audit superseded by SOF 3 and the new strategy work focus on internal stakeholders	Chief Executive Officer	N/A				Complete	Complete: Communication and Engagement Strategy and implementation plan have been approved by the Board. Implementation is being progressed at pace by the Interim Director of Communications and Marketing. *Note interdependency with Trust Strategy - RS above.
R19: The Board should in collaboration with the CoG, commission a programme of development for the CoG	Director of Corporate Governance	Dec-23				On track	On track. Director of Corporate Governance progressing this with the Lead Governor and Chair. Revised date of December 2023 to finalise and present to CoG.
R22: The Board should develop a plan for member engagement, in conjunction with the CoG LINKED TO R7 ABOVE (ARCHIVED ON 03/03/23)		N/A					Archived as duplicated
KLOE 8: Learning Improvement and Innovation R14: The Board should establish as a sub-committee of the Education and Training Committee a student experience group that enables the Committee to directly hear the experience and voice of students	Director of Education & Training	N/A				Complete	Substantially complete - Work of the Educational Governance Working is now complete. Governance structure proposals were presented to the Education & Training Committee on 20 July and recommendations approved. Student Experience Sub-Committee agreed as one of the sub-committees of ETC. Draft ToR to be presented to ETC for approval in Nov-23.
R20: The Board should enhance the 2023/24 internal audit programme and within that include a substantial element of audit activity focused on independent assurance around education and training	Chief Finance Officer/Director of Education & Training	N/A				Complete	Complete - Audit Committee agreed the 2023/24 Internal Plan that includes Education and Training.
R23: The Board should undertake a detailed gap analysis around the Trust attaining Degree Awarding Powers, draw on the experience of external education partners	Chief Executive Officer/Director of Education & Training	N/A				Complete	Complete - The IGAP Task & Finish Group agreed to close this milestone following the deep-dive into the DET milestones on 26 July. It was felt the work done by the Educational Governance Working Group had sufficiently covered any future work required to attain degree awarding powers if that was the strategic path the Trust wished to follow.
SOF 3 EXIT CRITERIA (NEW CRITERIA AGREED FOR 2023/24 - group to decide if these should be replaced without evidence of completion)							
GIDS Service Safe legal transfer of the GIDS service	Chief Clinical Operating Officer	Mar-24				In progress	NHSE have informed the Trust of the new transfer date of March 2024. Trust commissioned for 2023/24. Board is sighted on measures including safety, interim exit plan/ operational running/ ongoing management and staffing.
Longer Term Strategy 2. Estates strategy in place, signed off by the board and agreed with the ICS.	Chief Finance Officer	Mar-24				At risk	Linked to Trust future plans. Interim estates strategy is in place. Future state work will impact on timescales and ability to complete. Updated date to March 24.
Financial Recovery 3. Financial Recovery plan in place, signed off by the board and agreed with the ICS. Track record of delivery at the system level. See R ^a above	Chief Finance Officer	Dec-23				On track	Part of the Medium Term Financial Plan (MTFP) work. Recovery plan process, assumptions and high level plans form part of the MTFP. MTFP is going to PFRIC in November 2023 and then to Board in December 2023. Version already done, being updated in line with ICS timetable and process.
4. The trust and system have an agreed understanding of risks to the financial plan	Chief Finance Officer	N/A				Complete	22/23 budget agreed with ICS, plus 23/24 plan. This forms part of 3.2.
Finance 5. Robust financial controls and processes are in place and overseen through appropriate financial governance procedures	Chief Finance Officer	Dec-23				On track	Payroll audit and HFMA progress update meeting being held with RSM during the week of 6 November and reported to IAGC in November. Some outstanding evidence against some actions but progress is being made.
Leadership and Governance							

Workstream/ Milestone (including Recommendations)	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach *Root causes identified *Project plan in place *Capacity/ Capability in place	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
6. Strengthened Leadership and Governance at Board Level	Chair/ Chief Executive Officer / Director of Corporate Governance	N/A				Complete	Milestone substantially complete. Outstanding actions in relation to Tier 3 meetings and rollout of templates. Needs to be split out as did not form part of the original SOP 3 recommendations. Should do rather than Must do. Outstanding actions for Workforce are in relation to recruitment into the Executive positions and the Executive leadership development plan. Progress - Chief Executive Officer and Chief People Officer in post. Interims in place prior to substantive appointments. 4 Substantive appointments made. CETO in progress. Committee structure and Terms of Reference signed off by Board and operating. TOR being refreshed in 2023/24 following outcome of effectiveness reviews. Forward Planners produced in consultation with the Executive Leads and NED Committee Chairs, and signed off by each Board Committee during the March cycle of meetings. Committee effectiveness review process is complete. Reports drafted. Outcome of effectiveness reviews to reported to Board Committees during the May cycle and Board in June. New templates produced and are being rolled out.
7 Strengthened organisation wide governance processes LINKED TO R17 ABOVE	Chief Executive Officer	N/A				Complete	Milestone substantially complete - Outstanding action for Workforce is in relation to the appointment of the FTSU Champions/ Ambassadors in each division of the Trust. Ongoing discussions around progressing the appointment of the FTSU Champions/ Ambassadors. FTSU recently moved to the DoCG Portfolio. Completed - Revised Freedom to Speak Up Policy and Procedure in place and signed off by POD ED in September 2022. FTSU NED Champion (Dorothy Colson) agreed by Board in February 2023. Staff Drop in sessions held in October 2022. In Sight briefing held in October 2022. Approval of change to the Trust Constitution taken to CoG on 14 September 2023 ahead of the 2022/23 AGM. Governance handbook to be produced.
Quality							
8 Trust has implemented an updated Quality Framework	Chief Nursing Officer	Mar-24				In progress	Three milestones outstanding. A Quality Framework improvement plan has been produced and progress is reviewed bi-monthly by the Quality Committee. Outstanding milestones: *Patient Safety Incident Response Framework (PSIRF) implementation: PSIRP (patient safety incident response plan) has been developed, presented and approved at Quality Committee in Sept 2023. Training delayed until January 2024. 3, 6 and 9 month plan being presented to QSC on 2 November. Engagement events with Service Lines being progressed with After Action Review planned. Implementation will take a number of months. It requires a change in culture and the new incident and risk system needs to be in place as well. PSIRF is a longer term implementation which will be through a QI approach. *Incident and Risk System procurement - New tool agreed and procured. Contract signed with provider during the week of 16 Oct 2023. IT working with current provider on transition plans (contract end date is June 2024). Early stages of agreeing time frame with new provider. Two weekly meetings to oversee progress. *Tier 3 Groups ToR. Outstanding Tier 3 ToR being produced for sign off by QSC in Jan-24.

WELL-LED SELF REVIEW

Well Led Self Review	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
Implement a well-led self assessment review	Chief Nursing Officer	Jan-24				On track	The CNO met with the CQC during the week of 16 Oct 2023. Discussed the new ways of working. Plans to introduce this to London Trusts from January 2024 (earliest opportunity for a Well-led). Document library being developed and placed on Virtual Board Room using the KLOE headings. Next Board seminar in November 2023 to discuss new ways of working and progress. CQC Improvement Group has been re-established. Review of Must Dos and Should Dos progressed and gaps identified. Each service line to update on evidence around that, and sharing of lessons learned planned. Revised handbook being produced. Revised timeline of January 2024 to coincide with contract end date of CQC Lead.

ANNUAL REPORT AND ACCOUNTS 2022/23

Annual Report and Accounts	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
Deliver a timely Annual Reports and Account process for 2022/23	Director of Corporate Governance, Chief Finance Officer	N/A				Complete	Complete: Extra-ordinary meetings held for Audit Committee (21 June) and Board (28 June) to sign off the Annual Report and Accounts. These have been signed off subject to completion of the External Audit and any changes that arise as a result. Production Timetable for the Annual Report and Annual Governance Statement met. Milestones in relation to submission of ARA to NHSE, Laying before parliament; and Annual Members Meeting now complete. The Audit Committee to receive a full post-mortem report with observations regarding the Finance Team and the External Auditor's performance; including what actions need to be taken to mitigate in 2023/24

INTERNAL AUDIT OVERDUE ACTIONS

Internal Audit Overdue Actions	Executive Lead	Final Revised Delivery Date (current)	Exit Criteria Agreed	Delivery Approach	Monthly Improvement	Milestone RAG	Workstream Update to include any risks to delivery, mitigations
Two actions in relation to Procurement: Implementation of a Procurement Risk Register and review of the Procurement Policy	Chief Finance Officer	N/A				Complete	Complete: The Task & Finish Group agreed to close the Procurement Internal Audit actions as these were being monitored by IAGC. Evidence of Procurement risks and Procurement Policy reviewed.

Milestone RAG key:
Complete - Evidence TBC or Added to Evidence library
On track - not at risk of failure/ delays to achieve revised timeline (by end Jan-24)
Progress is being made - moderate risk of failure/ delays to achieve revised timeline of end Mar-24
Deadline not met (Final revised timeline not met)
At risk of meeting deadline of 31 Mar-24

19a App 1 - IGAP High level summary report November 2023

MEETING OF THE BOARD OF DIRECTORS PART 2 – PUBLIC – 13 December 2023			
Report Title: Fit and Proper Person Test Policy and Procedure			Agenda No.: 20
Report Author and Job Title:	Dorothy Otite, Governance Consultant	Lead Executive Directors:	Adewale Kadiri, Director of Corporate Governance; and Gem Davies, Chief People Officer
Appendices:	Appendix 1: Fit and Proper Person Policy Appendix 2: Fit and Proper Person Procedure Appendix 3: Fit and Proper Person Implementation Plan 2023/24		
Executive Summary:			
Action Required:	Approval <input checked="" type="checkbox"/> Discussion <input type="checkbox"/> Information <input type="checkbox"/> Assurance <input type="checkbox"/>		
Situation:	This report sets out the new Fit and Proper Person Policy and Procedure, recommended by the Executive Appointment and Remuneration Committee (EARC) for approval by the Board of Directors.		
Background:	<p>The amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which took effect from 27 November 2014 resulted in a new <i>'Directors Fit and Proper Persons'</i> test. This applies to all NHS organisations and includes Executive and Non-Executive Directors (NEDs) appointed to the Board.</p> <p>NHSE published a new Fit and Proper Person Framework for Board Members on 2 August 2023 alongside guidance for Chairs and staff on implementation. NHSE expect elements of the framework to be used from 30 September 2023 for new appointments, with full implementation by 31 March 2024.</p> <p>Following the FPPT Audit in 2022/23, it was agreed a new FPPT Policy would be developed for the Trust during 2023/24.</p>		
Assessment:	<p>The drafting of the new FPPT policy and procedure for the Trust coincided with the publication of NHSE's Fit and Proper Person Framework for Board Members.</p> <p>Despite the Trust not previously having a FPPT Policy, the fundamental elements of the FPPT processes were already in place within the Trust as recognised by the FPPT Audit in 2022/23.</p> <p>The main changes to the existing processes introduced by the NHSE Framework have been incorporated into the new FPPT Policy and Procedure and are noted as follows:</p> <ul style="list-style-type: none"> • The framework introduces a new standardised board member reference. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role; and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT. The template has been included within the procedure. • The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record 		

	<p>and report compliance internally. The policy and procedure have incorporated the following:</p> <ul style="list-style-type: none"> ○ A new template for the self-attestation and this has replaced our current self-assessment template (which formed part of the Trust’s Gifts, Hospitality and Interests Policy). ○ The Chair’s responsibility has been included within the new policy to reflect the emphasis placed on this within the new framework and the role of the Senior Independent Director added in respect of the review linked to the Chair’s appraisal. ○ The requirement for an annual submission to the NHS England Regional Director (for 2024 the deadline is 31 March 2024 but going forward this is expected to align with appraisals in Q1 of the following year). ○ A number of additions have also been made to provide further clarity, including the respective requirements for joint appointments. <p>The full implementation of the framework is reliant on:</p> <ul style="list-style-type: none"> • National changes to ESR, which have now been implemented and are available for local use. • DPIA (data protection impact assessment), which has been completed by the NHS Business Services Authority (NHSBSA) who host ESR; and NHS England. • Publication of the forthcoming NHS Leadership Competency Framework (expected October 2023) and the Board Appraisal Framework (expected by March 2024). 				
Key recommendation(s):	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> - APPROVE the FPPT Policy and Procedure, as recommended by the EAR Committee at its meeting on 15 November 2023. - NOTE the FPPT Implementation Plan 2023/24. 				
Implications:					
Strategic Ambitions:					
<input type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>		No <input type="checkbox"/>		
	The amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all Trusts to ensure that all executive and non-executive				

	director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of FPPR.			
Resource Implications:	Yes <input type="checkbox"/>		No <input checked="" type="checkbox"/>	
	There are no additional resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes <input checked="" type="checkbox"/>		No <input type="checkbox"/>	
	The Leadership Competency Framework (still to be published) will support the recruitment and appraisal of NHS Board members. The Framework will cover six competence categories including equality; and creating a compassionate and inclusive culture. These will feed into job descriptions and the appraisal process.			
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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 Counter Fraud Specialist – 31 October 2023 (External Assurance) Executive Leadership Team – 6 November 2023 Executive Appointment and Remuneration Committee – 15 November 2023			
Reports require an assurance rating to guide the discussion:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required

Fit and Proper Person Test Policy

Version:	1.0
Bodies consulted:	Executive Leadership Team; Local Counter Fraud Specialist; Executive Appointments and Remuneration Committee; and Board of Directors
Approved by:	Board of Directors
Date approved:	TBC
Name and job title of author:	Dorothy Otite, Governance Consultant
Responsible Directors:	Chief People Officer; and Director of Corporate Governance
Date issued:	TBC
Review date:	October 2025 (or earlier subject to changes to regulation/ guidance/ good practice).

Version Control Summary

Version	Date	Status	Commentary/ Changes
1.0	05/10/2023	Final Draft	New policy outlining the Trust's approach to fit and proper person tests including scope; roles and responsibilities in line with guidance issued by the CQC in January 2018 and the Fit and Proper Person Test Framework for Board Members issued by NHS England on 2 August 2023. A separate Fit and Proper Person Test procedure has been produced which includes the process and prescribed templates. This policy should be read in conjunction with the procedure.

Contents

1. Introduction	4
2. Purpose.....	4
3. Scope.....	4
4. Definitions	5
5. Policy Statement	7
6. Roles and responsibilities.....	7
7. Outline Process for Assessing FPPT Compliance	10
8. Training and Implementation Requirements	13
9. Identified Issues or Concerns regarding FPPT compliance.....	13
10. Maintaining compliance with the Regulations	14
11. Breaches of the Regulation	14
12. Dispute resolution.....	15
13. Monitoring of implementation and compliance with the Policy	16
14. References.....	16
15. Associated documents	17
16. Equality Impact Analysis.....	18
Appendix 1 – Full FPPT Assessment	20

Fit and Proper Person Test Policy

1. Introduction

- 1.1. The 'Fit and Proper Persons' Test set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulation') came into force on the 27 November 2014 (updated 2022) and is aimed at making sure that those individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care, and as such can be held accountable if standards of care do not meet legal requirements.
- 1.2. The Regulations have been integrated into the Care Quality Commission's (CQC) registration requirements and falls within the remit of their regulatory inspection approach. Guidance issued by the CQC emphasises the importance of the Fit and Proper Person Test (FPPT) in ensuring the accountability of Directors of NHS bodies. NHS bodies have a responsibility to ensure the requirements are met, with the CQC's role being to monitor and assess how well this responsibility is discharged from the recruitment stage and subsequently throughout Directors' employment.
- 1.3. In August 2023, NHS England published a Fit and Proper Person Test (FPPT) Framework for Board Members in response to recommendations made by Tom Kark KC in the 2019 Kark Review. The framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC. This policy should be read in conjunction with the NHSE framework.

2. Purpose

- 2.1. The policy objectives are to:
 - Define the minimum standards for determining the fitness and propriety of individuals on appointment and on an ongoing basis to serve in their respective position within the Trust
 - Outline how the Trust complies with the Regulation, including the evidence that demonstrates statutory obligations
 - Outline how the Trust complies with the FPPT Framework for Board Members (the Framework), including the evidence that demonstrates compliance
 - Define the individuals and/or roles to which this policy applies
 - Describe the procedures in relation to the policy to help the Trust ensure that all Board Director-level appointments meet the FPPT, and that Directors continue to be fit to hold their position
 - Prioritise patient safety and good leadership
 - Promote stakeholder confidence in the Trust and its officers.

3. Scope

- 3.1. This policy applies to Directors and people performing the functions of, or functions equivalent or similar to the functions of a Director. It applies to Board Directors and

equivalents who are responsible and accountable for delivering care, irrespective of their voting rights, including interim and associate positions.

- 3.2. For the purpose of this policy, the following Director positions as defined in Section 4.1 below fall within the scope of this policy:
- Trust Chair
 - Non-Executive Directors (NEDs)
 - Chief Executive Officer (CEO)
 - Executive Directors
 - Equivalent positions.
- 3.3. For clarity, this FPPT policy does not apply to Governors of the Trust.

4. Definitions

4.1. Director

4.1.1. In this policy, “Director” refers to those covered within Regulation 5 and in this Trust, it means:

- 4.1.1.1. Non-Executive Directors (including Associate Non-Executive Directors)
- 4.1.1.2. Voting Executive Directors (Substantive; Interim or Acting)
- 4.1.1.3. Non-voting Executive Directors (Substantive; Interim or Acting)
- 4.1.1.4. Where Interim or Acting Executive Directors are in place, the requirement to comply with the requirements under this Policy applies if the position is likely to, or does, exceed six weeks.

4.2. Fit and Proper Persons can be defined under the Regulations as:

- 4.2.1. Being of good character as defined under Schedule 4, Part 2 of the Regulations;
- 4.2.2. Having the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;
- 4.2.3. Being able by reason of their health, after reasonable adjustments have been made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
- 4.2.4. Not having been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
- 4.2.5. Not being considered “unfit” as defined under Schedule 4, Part 1 of the Regulations, and set out in 4.4 below.

4.3. Good Character

4.3.1. “Good Character” is defined under Schedule 4 Part 2 of the Regulations in negative terms, so a person would not be deemed of good character if:

- 4.3.1.1. They have been convicted in the United Kingdom (UK) of any offence or been convicted of any offence which, if committed in any part of the UK would constitute an offence; and
- 4.3.1.2. They have been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

4.3.2. The CQC names the following as some features that are ‘normally associated’ with “good character” that should be taken into account when applying FPPT to an individual, in addition to those specified in Schedule 4, Part 2 of the regulations:

- Honesty
- Trustworthiness
- Integrity
- Openness / transparency
- Ability to comply with the law
- A person in whom the public can have confidence in prior employment history, including reason for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulation body
- Any breaches of the Nolan principles of public life
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the Trust
- Any other information which may be relevant, such as disciplinary action taken by an employer.

4.4. Unfit persons:

4.4.1. The “unfit persons test” is set out in Schedule 4, Part 1 of the Regulation. A person is deemed “unfit” if they:

- 4.4.1.1. are an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- 4.4.1.2. are the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- 4.4.1.3. are a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- 4.4.1.4. have made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- 4.4.1.5. are included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

4.4.1.6. are prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.4.1.7. are responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

4.5. Misconduct:

4.5.1. "Misconduct" means conduct that breaches a legal or contractual obligation imposed on the Director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

4.6. Mismanagement:

4.6.1. "Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision-making and actions of the managers falls below any reasonable standard of competent management.

5. Policy Statement

5.1. This policy document sets out The Tavistock and Portman NHS Foundation Trust's policy for assuring all Board Directors comply with the Fit and Proper Person Tests. The policy ensures alignment with the arrangements as detailed in the Regulations; NHS Employment Check Standards; Care Quality Commission (CQC) and NHS England's guidelines.

6. Roles and responsibilities

6.1. The table below outlines the roles and responsibilities in respect of this policy:

Role	Responsibilities
Trust Chair	Ultimate responsibility to discharge the FPPT placed on the Trust to ensure that all relevant post-holders (new and existing) meet the 'fitness' test and do not meet any of the 'unfit' criteria. As such the Chair's responsibilities are: <ul style="list-style-type: none"> • To ensure the Trust has proper systems and processes in place so it can make the robust assessments required by the FPPT. • To ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the Trust. • To ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

Role	Responsibilities
	<ul style="list-style-type: none"> • To ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member. • To ensure that an appropriate programme is in place to identify and monitor the development needs of board members. • On appointment of a new board member, consider the specific competence, skills and knowledge that they require to carry out their activities, and how this fits with the overall board. • To conclude whether the board member is fit and proper for the role. • To complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. • To confirm that all Board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in the Trust. • To ensure that for any Board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) why there has been a question whether a board member might not be fit and proper, and the measures taken to address this. A written record of this process should be retained, a summary of which should also be included in the annual FPPT submission form to the relevant NHS England regional director. • Overall responsibility for compliance with the FPPT. • Ensuring the fitness of all new and existing Directors has been assessed in line with the regulations on appointment and on an ongoing annual basis. • Ensuring the necessary action is taken to ensure existing Directors who no longer meet the FPPT do not continue in their role. • Accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture is maintained across the Trust to support an effective FPPT regime.
Senior Independent Director (SID)	<ul style="list-style-type: none"> • Annually, overseeing the outcome of FPPT on behalf of the Chair and ensuring that the Chair meets the FPPT requirements • Undertaking any investigations into any concerns raised about the Chair
Chief Executive Officer (CEO)	<ul style="list-style-type: none"> • Overseeing the outcome of the FPPT for all the Executive Directors
Chief People Officer	<ul style="list-style-type: none"> • Jointly overseeing the implementation of the FPPT policy • Ensuring any FPPT undertaken on appointment comply with the process detailed in this policy, bringing non-compliance to

Role	Responsibilities
	<p>the attention of the Chair and/or Senior Independent Director [SID] (as appropriate)</p> <ul style="list-style-type: none"> Supporting the Chair and/or SID with any investigations Ensuring that all appropriate documentation is completed, stored and available for inspection upon request
Recruitment Provider	<ul style="list-style-type: none"> Undertaking all pre-employment checks (including the component parts of the FPPT) for Directors and providing evidence to demonstrate assurance Ensuring the results (and evidence in the form of copies of certificates, etc) of the FPPT undertaken on appointment are recorded in ESR and within an individual's file Ensuring any recruitment agencies/executive search companies involved in the recruitment process understand their responsibilities and comply with the requirements of this policy, i.e., that all necessary pre-employment checks (including FPPT) have been undertaken and evidence to demonstrate assurance is made available for inspection and retention by the Trust
Director of Corporate Governance	<ul style="list-style-type: none"> Jointly overseeing the implementation of the FPPT Maintaining the Directors' register of interests including annual updates Ensuring the annual FPPT declarations are undertaken, recorded and evidenced on ESR and on individual files Ensuring annual submissions are made to NHSE Confirming compliance with the policy in the Trust's annual report Providing advice and support to the Trust Board and Council of Governors in respect of the administration of and compliance with the FPPT Preparing annual reports for consideration by the appropriate Committee as part of the appraisal process Identifying any changes to the Regulations or guidance, recommending to the Executive Appointments and Remuneration Committee and Council of Governors' Nominations Committee the appropriate policy amendments.
Executive Appointments and Remuneration Committee	<ul style="list-style-type: none"> Ensuring ongoing compliance by receiving an annual report on the application of FPPT in relation to Executive Directors (including the Chief Executive (CEO))
Council of Governors' Nominations Committee	<ul style="list-style-type: none"> Ensuring ongoing compliance by receiving an annual report on the application of FPPT in relation to Non-Executive Directors (NEDs) including the Chair. The removal of a Non-Executive Director will be a decision for the Council of Governors following a recommendation from the Nominations Committee.
Directors (individuals who fall within the policy)	<ul style="list-style-type: none"> Providing consent to the required checks as described in this policy Signing the declaration that they are a fit and proper person on appointment and on an annual basis

Role	Responsibilities
	<ul style="list-style-type: none"> • Providing evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position • Identifying any issues that may affect their ability to meet the statutory requirements on appointment and bringing any issues on an ongoing basis to the CEO (for Executive Directors) and the Chair (for NEDs). The Chair will raise any issues with the Lead Governor as appropriate.
Staff	<ul style="list-style-type: none"> • Raising any concerns via the appropriate Trust policies and procedures, e.g., through the Freedom To Speak Up policy.
Care Quality Commission (CQC)	<ul style="list-style-type: none"> • Powers to assess whether Directors are fit to carry out their role • Powers to assess whether providers have in place adequate and appropriate arrangements to ensure Directors are fit and proper persons both on recruitment and whilst in post • In undertaking inspections, will assess compliance as part of the well-led domain • Where appropriate will work alongside other regulators, e.g. professional bodies, to ensure that the correct processes are adhered to and information is shared when relevant and appropriate • Cannot prosecute for breach of the FPPT but can take regulatory action.
NHS England (NHSE)	<ul style="list-style-type: none"> • Able to use its enforcement powers to deal with a breach of a license condition by requiring the Trust to remove the unfit person from office or by taking such action itself. • It is likely that NHSE will rely on CQC's findings to take action under this licence condition.

7. Outline Process for Assessing FPPT Compliance

7.1. Recruitment:

- 7.1.1. Appointments of new Board members must be made through a robust, transparent and thorough recruitment process.
- 7.1.2. In order to confirm Directors are Fit and Proper Persons, all appointments to roles covered by this policy will be subject to the standard employment checks in line with NHS Employer's pre-employment check standards; the CQC recommended checks; and the three core elements of the Framework.
- 7.1.3. The selection process must, as a minimum, include an interview panel process and value-based interview/ assessment.
- 7.1.4. In assessing competence, skills, and experience as part of the recruitment process, reference must also be made to the NHS Leadership Competency Framework (LCF) for board level leaders (expected October 2023).

7.1.5. The prescribed forms for self-declaration, Board member reference requests and other applicable forms are detailed in the Trust's Fit and Proper Person Test Procedure.

7.1.6. No Board member should start in post until all FPPT checks have been completed and approved by the Chair.

7.2. **Full FPPT Assessment:**

7.2.1. A documented, full FPPT assessment will be carried out by the Trust in the following circumstances:

7.2.1.1. New appointments to board member roles, whether permanent or temporary, where greater than six weeks; this covers:

- a) Incumbent staff who have been promoted to a board level role within an NHS organisation
- b) temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
- c) existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
- d) individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

7.2.1.2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset).

7.2.1.3. Annually: that is, within a 12-month period of the date of the previous FPPT to review any changes in the previous 12 months. All Board members will be required to update their self-declarations by completing a 'Fit and Proper Persons' self-declaration in the prescribed form which can be found in the Fit and Proper Person Test Procedure.

7.2.1.4. For Sections 7.2.1.1.a, 7.2.1.1.b and 7.2.1.1.c above (new appointments) the full FPPT will also include a board member reference check.

7.2.1.5. For Sections 7.2.1.2. and 7.2.1.3. above, the board member reference check will not be needed.

7.2.1.6. A full FPPT assessment will consist of the checks listed in Appendix 1 of the policy.

7.2.1.7. Evidence of the checks and the Chair's approval will be documented on the individual's personal file and on the Trust's Electronic Staff Records (ESR) system.

7.3. **Board Member References:**

- 7.3.1. The NHSE Framework introduced a standardised Board Member Reference to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The template can be found in the Fit and Proper Person Test Procedure.
 - 7.3.2. When recruiting into a Board member role, at least one reference should be obtained on the standardised reference form wherever possible. Further details can be found in section 3.9.2 of the NHSE Framework. This applies to permanent and temporary appointments and internal appointments (unless the candidate is moving from one director position to another). It also applies where a board member from another organization joins the Trust in a non-board level role.
 - 7.3.3. References should cover a minimum of 6 years. Where this is not possible, additional character or personal references should be sought.
 - 7.3.4. When a Board member leaves the Trust, or a reference request is received for an existing Board member, a reference will be produced on the standardised reference form. This process will be led by the Director of Corporate Governance with input from the People Team. The draft reference will be shared with the Chair for approval before being issued (or the SID if the reference is for the Chair). Both the initial and final board member references will be retained locally on ESR.
- 7.4. **Governance - Trust Board of Directors /Council of Governors Assurance:**
- 7.4.1. Confirmation of ongoing fitness will be recorded as part of the appraisal process; and will be reported annually to the Executive Appointments & Remuneration Committee (for Executive Directors); Council of Governors' Nominations Committee (for Non-Executive Directors) and to the Board of Directors.
 - 7.4.2. Confirmation of compliance will be declared in the Trust's annual report.
 - 7.4.3. The Trust must also submit an annual report to NHSE using the prescribed template which can be found in the Fit and Proper Person Test Procedure.
- 7.5. **Joint appointments across different NHS Organisations:**
- 7.5.1. For joint appointments across different NHS organisations, the full FPPT will be completed by the Trust if the Trust is the designated host/employing NHS organisation and in concluding its assessment it will require input from the Chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.
 - 7.5.2. Where the Trust is not the designated host/ employing NHS organisation, they will request written confirmation if the FPPT checks from the other NHS organisation. This will be retained in accordance with Section 7.6 below.
- 7.6. **Personal Data:**

- 7.6.1. Personal data relating to the FPPT assessment will be retained in local records systems and specific data fields in the NHS Electronic Staff Record (ESR).
- 7.6.2. FPPT outcomes will be entered onto ESR, and an annual FPPT submission form will be generated in the prescribed form (as detailed in the Trust's Fit and Proper Person Test Procedure) for Chair's sign off and submitted to the NHSE Regional Director.

8. Training and Implementation Requirements

- 8.1. This policy will be provided to each individual in scope electronically or on appointment whichever is applicable.
- 8.2. A notification of any policy revisions will be provided via the Trust intranet to promote awareness of the policy.
- 8.3. This policy will be regularly monitored and reviewed and will be assessed annually with the intention of improving its effectiveness.

9. Identified Issues or Concerns regarding FPPT compliance

- 9.1. If a concern regarding a Director is brought to the attention of the Trust, an appropriate investigation will be carried out in a timely and appropriate manner by an appropriate person/body dependent on the particular circumstances.
- 9.2. If these concerns are substantiated through evidence, further investigation and action will be taken using the Trust's Resolution policy and procedure.
- 9.3. An investigation may take the format of an internal investigation; internal investigation including an independent element; or an external investigation undertaken by an entirely independent investigator.
- 9.4. Any subsequent action will be undertaken in line with procedures outlined in the Trust's Resolution policy.
- 9.5. In circumstances where there is a suspicion of fraud or bribery, action will be undertaken in line with the Anti-fraud and Bribery Procedure, and the Local Counter Fraud Specialist (LCFS) will be notified immediately.
- 9.6. When a Director who is registered with a professional regulator no longer meets the FPPT, the Trust may inform the regulator and also take action to ensure the position is held by a person meeting the requirements.
- 9.7. Where a Director's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users. This may

mean that a Director's duties are temporarily varied or closely supervised pending investigation, and, in some cases, suspension may be considered. Suspension or restriction from duties will be for no longer than necessary to protect the interests of Trust, patient safety, and public confidence and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

10. Maintaining compliance with the Regulations

- 10.1. In order to comply with the FPPT, the Trust must have systems and processes in place to ensure Director appointments meet the required standards and that Directors continue to meet the Fit and Proper Persons Requirements (FPPT).
- 10.2. The Trust's Fit and Proper Person Test Procedure stipulates the required checks to ensure Trust Directors are Fit and Proper Persons, together with suggested evidence to provide assurance that the requirements are met.
- 10.3. The Director of Corporate Governance will undertake an audit of the personal files and ESR records of those in scope on an annual basis and provide assurance through the Executive Appointments and Remuneration Committee (EARC) of the Trusts continued compliance. This will be reported to the Board through the EARC Chair report.
- 10.4. Where there are concerns about a person's fitness or continued fitness/ability to undertake their role after they have been appointed, and where concerns are substantiated, proportionate timely action must be taken. This may include support and development to assist the Director to reach the required competence level or standards of performance in line with the relevant Trust policies.
- 10.5. Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any potential risk to patients, staff or members of the public. Any interim measures will be agreed with the Chief People Officer.
- 10.6. If it is discovered that a person is not of good character after they have been appointed to a role, the Trust will take appropriate and timely action to investigate and rectify the matter. If the person is deemed suitable despite existence of information that suggests the person is not of good character, the reasons should be appropriately recorded for future reference and made available should the need arise.
- 10.7. Every three years, the Trust will commission a review to be conducted by its internal audit providers to assess the processes, controls and compliance supporting the FPPT assessments, and make recommendations for improvement as required.

11. Breaches of the Regulation

- 11.1. The regulation is breached if the Trust has in place someone who does not satisfy the FPPT. Evidence of this could be if:

- 11.1.1. A director is unfit on a 'mandatory' ground, such as a relevant un-discharged conviction or bankruptcy.
- 11.1.2. The Trust does not have a proper process in place to enable it to make the robust assessments required by the FPPT.
- 11.1.3. On receipt of information about a director's fitness, a decision is reached on the fitness of the director that is not in the range of decisions that a reasonable person would make.
- 11.1.4. A director has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.
- 11.2. An offence contrary to the Fraud Act 2006 may be committed if an employee provides false documentation, references, or experience in relation to pre-employment checks. Any such suspected conduct will be investigated in accordance with the Trust's Resolution Policy and will also be referred to the Local Counter Fraud Specialist, potentially resulting in a full investigation, appropriate disciplinary action and/or prosecution. Where it is found non-compliance constitutes a criminal offence, it will be subject to a criminal investigation and sanction as appropriate.
- 11.3. If fraud is suspected in relation to this policy, please report to the Trust's Local Counter Fraud Specialist (the up to date contact details can be found on the intranet) or by calling the NHS Counter Fraud Authority (NHSCFA) FREE 24 hour confidential fraud reporting hotline on 08000284060 or report via the online reporting form: www.cfa.nhs.uk/reportfraud. Please refer to the Trust's Anti-fraud and Bribery Procedure for further details.
- 11.4. Sharing of information by CQC:
- CQC will send all information it receives that falls under FPPT to the Trust in relation to the Director in question (if continued to be employed by the Trust) following consent by the person providing the information or if CQC decides to proceed without it
 - The Trust will be asked by the CQC to indicate the action it will take in response to the notification within 10 days. This response will need to satisfy CQC that the Trust has followed a robust process to ensure that the person in question is fit and proper for their role
 - CQC will also advise the Director in question of the actions to be taken.
- 11.5. Historic allegation:
- In line with CQC's national guidance, the Trust as the current employer has a duty to investigate historic allegations (not the employer at whose organisation the allegations took place)
 - The Trust will consider a level of proportionality and consistency in dealing with historic cases
 - There is no time limit for considering FPPT concerns.

12. Dispute resolution

- 12.1. Where a Director disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper', the Trust's local policies and constitutional arrangements should be followed in the first instance.

13. Monitoring of implementation and compliance with the Policy

- 13.1. Implementation and compliance with this policy will be monitored as follows:

For monitoring	Lead	Method	Frequency	Reporting
FPPT for newly appointed Directors	Chief People Officer	Audit of personal files and ESR to ensure pre-employment checks (including FPPT) undertaken for all new Director appointments	On appointment	Executive Appointments & Remuneration Committee/ Council of Governors' Nominations Committee
FPPT annual checks	Director of Corporate Governance	Audit of personal files and ESR to ensure annual FPPT declarations have been completed by Directors on appointment; and FPPT checks undertaken	At least annually	- Executive Appointments & Remuneration Committee/ - Council of Governors' Nominations Committee/ - Board of Directors - Annual Report - NHSE
Awareness	CEO Chair	Awareness of policy raised during recruitment process and included in main T&Cs of employment; also at local induction	On appointment	

14. References

NHSE, "The NHS Foundation Trust Code of Governance" July 2014:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327074/Summary_of_changes_to_code_of_governance.pdf

Care Quality Commission, Regulation 5: "Fit and Proper Persons: directors" January 2018:
<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors>

NHS Employers, NHS Employment Checking Standards, April 2015:
<http://www.nhsemployers.org/your-workforce/recruit/employment-checks/nhs-employment-check-standards>

NHS Confederation:

http://www.nhsconfed.org/~media/Confederation/Files/public%20access/Fit_proper_person_test_guidance_providers.pdf

NHS England Fit and Proper Person Test Framework for board members, August 2023:

[NHS England » NHS England Fit and Proper Person Test Framework for board members](#)

NHSE Guidance for Chairs on Implementation of the Fit and Proper Person Test for Board Members:

<https://www.england.nhs.uk/publication/guidance-for-chairs-on-implementation-of-the-fit-and-proper-person-test-for-board-members/>

15. Associated documents¹

- **Fit and Proper Test Procedure v1.0**
- Trust Constitution
- Anti-fraud and Bribery Procedure
- Gifts, Hospitality and Interests Policy
- Raising concerns and Whistle-blowing Policy
- *Resolution Policy*
- *Recruitment and Selection Policy*

¹ For the current version of Trust policies and procedures, please refer to the intranet.

16. Equality Impact Analysis

Completed by	Dorothy Otite
Position	Governance Consultant
Date	5 October 2023

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		x
Is it a major policy, significantly affecting how Trust services are delivered?		x
Will the policy have a significant effect on how partner organisations operate in terms of equality?		x
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		x
Does the policy relate to an area with known inequalities?		x
Does the policy relate to any equality objectives that have been set by the Trust?		x
Other?		x

If the answer to *all* of these questions was no, then the assessment is complete.

If the answer to *any* of the questions was yes, then undertake the analysis below:

	Yes	No	Comment
Do policy outcomes and service take-up differ between people with different protected characteristics?			
What are the key findings of any engagement you have undertaken?			
If there is a greater effect on one group, is that consistent with the policy aims?			
If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?			
Will the policy deliver practical benefits for certain groups?			
Does the policy miss opportunities to advance equality of opportunity and foster good relations?			
Do other policies need to change to enable this policy to be effective?			
Additional comments			

If one or more answers are yes, then the policy may be unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust’s Equalities Lead (for all other policies).

Appendix 1 – Full FPPT Assessment

As outlined in section 3.10.1 of the NHSE Framework a full FPPT assessment will consist of:

- First name*
 - Second name/surname*
 - Organisation* (that is, current employer)
 - Staff group*
 - Job title* (that is, current job description)
 - Occupation code*
 - Position title*
 - Employment history:*
- This would include detail of all job titles, organisation departments, dates, and role descriptions.
- Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
 - References:* (see section 7.3 of the policy)
 - Last appraisal and date
 - Disciplinary findings
- That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding. Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
 - Date DBS received* †
 - Disqualified directors register check
 - Date of medical clearance* (including confirmation of OHA)
 - Date of professional register check (eg membership of professional bodies)
 - Insolvency check
 - Self-attestation form signed (Appendix 3 of the NHSE Framework here)
 - Social media check
 - Employment tribunal judgement check
 - Disqualification from being a charity trustee check
 - Board member reference*
 - Sign-off by chair/CEO.

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

Fit and Proper Person Test Procedure

(To be read in conjunction with the Fit and Proper Test Policy)

Version:	1.0
Bodies consulted:	Executive Leadership Team; Local Counter Fraud Specialist; Executive Appointments and Remuneration Committee; and Board of Directors
Approved by:	Board of Directors
Date approved:	TBC
Name and job title of author:	Dorothy Otite, Governance Consultant
Responsible director:	Chief People Officer; and Director of Corporate Governance
Date issued:	TBC
Review date:	October 2025 (or earlier subject to changes to regulation/ guidance/ good practice).

Contents

1. Recruitment - New Director Appointments:	4
2. Ongoing Fitness:.....	6
3. Joint appointments across different NHS Organisations:	7
4. Personal Data:	8
5. Board Member Reference Request on initial appointment:	8
6. Board Member Reference Request on exiting the Trust:.....	9
7. Dealing with Concerns:	10
Appendix 1a - Fit and Proper Person Test self-attestation template	11
Appendix 1b – Chair’s Fit and Proper Person Test self-attestation template	12
Appendix 2 - The board member reference template.....	13
Appendix 3 - Letter of confirmation.....	19
Appendix 4 - Annual NHS FPPT submission reporting template.....	20
Appendix 5 - Board Member Fit and Proper Person Test Privacy Notice.....	24
Appendix 6 – FPPT checklist.....	27

Fit and Proper Person Test Procedure

1. Recruitment - New Director Appointments:

1.1. In order to confirm that the individual is a fit and proper person to perform a Board role, the Trust will undertake a Full FPPT assessment which will include the following:

1.1.1. Good character: All new appointments are subject to pre-employment checking in line with the NHS Employment Check Standards and NHS England's Fit and Proper Person Test (FPPT) Framework for Board Members ("The Framework") including:

- Search of the Companies House register to ensure that no Board member is disqualified as a director
- Search of the Charity Commission's register of removed trustees
- Disclosure and Barring Service (DBS) check
- Check with the relevant professional bodies where appropriate
- Employment tribunal judgements relevant to the board member's history
- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life
- The extent to which the board member has been open and honest with the NHS organisation
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately
- Any other information that may be relevant, such as an upheld/ongoing or discontinued investigation (including where a board member has left the NHS organisation prior to an investigation being completed), including:
 - disciplinary finding
 - grievance finding against the board member
 - whistleblowing finding against the board member
 - – finding pursuant to any trust policies or procedures concerning board member behaviour.

- 1.1.2. Qualifications, competence, skills required and experience: All new appointments are subject to pre-employment checking to ensure the candidate holds the required qualifications and has the competence, skills and experience required. These include:
- Professional registration and qualifications (where relevant to the post): Original certificates are required at appointment stage and professional registration sites are checked
 - Employment history and references: Employment history is provided at application stage. References are taken up for a **minimum of six years of employment** one of which must be the most recent employer. References are obtained using the Board member reference template (Appendix 2).
 - Formal training and development the Board member has undergone or is undergoing
 - Occupational Health Assessment (OHA) as relevant to the role.
- 1.1.3. Financial soundness: All new appointments are subject to robust checks in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This is to ensure that Board members do not meet any of the elements of the unfit person test. These checks include:
- Disqualified Directors' listings
 - Bankruptcy and insolvency registers
 - County Court Judgement (CCJ) or High Court Judgement for debt
 - Removed Charity trustee register
 - A check of any register held by the CQC, or any publicly available information collated by the Regulator (web-based search).
- 1.2. As the CQC expects Trusts to take account of some core public information sources when making Director-level appointments, the Trust will also consider whether the Director has ever breached any of the Nolan principles of public life by undertaking, but not limited to, a web and news search of the individual, but being mindful that not everything found on an internet search is factually accurate. "Core public information sources" includes information from:
- Public inquiry reports about the provider
 - Serious case reviews relevant to the Trust that employed the individual at the time of the allegations
 - Homicide investigations involving mental health Trusts
 - Criminal prosecutions against providers
 - Ombudsmen's reports relating to providers.
- 1.3. Where the Trust engages the services of a recruitment agency or executive search company to assist with the appointment, the consultants will be asked to carry out some or all of the checks, and documentary evidence that the checks have been completed satisfactorily must be provided.
- 1.4. Records of checks undertaken are maintained on the Trust's Electronic Staff Record (ESR) and the individual electronic staff file. Paper copies may be produced and kept for inspection purposes.

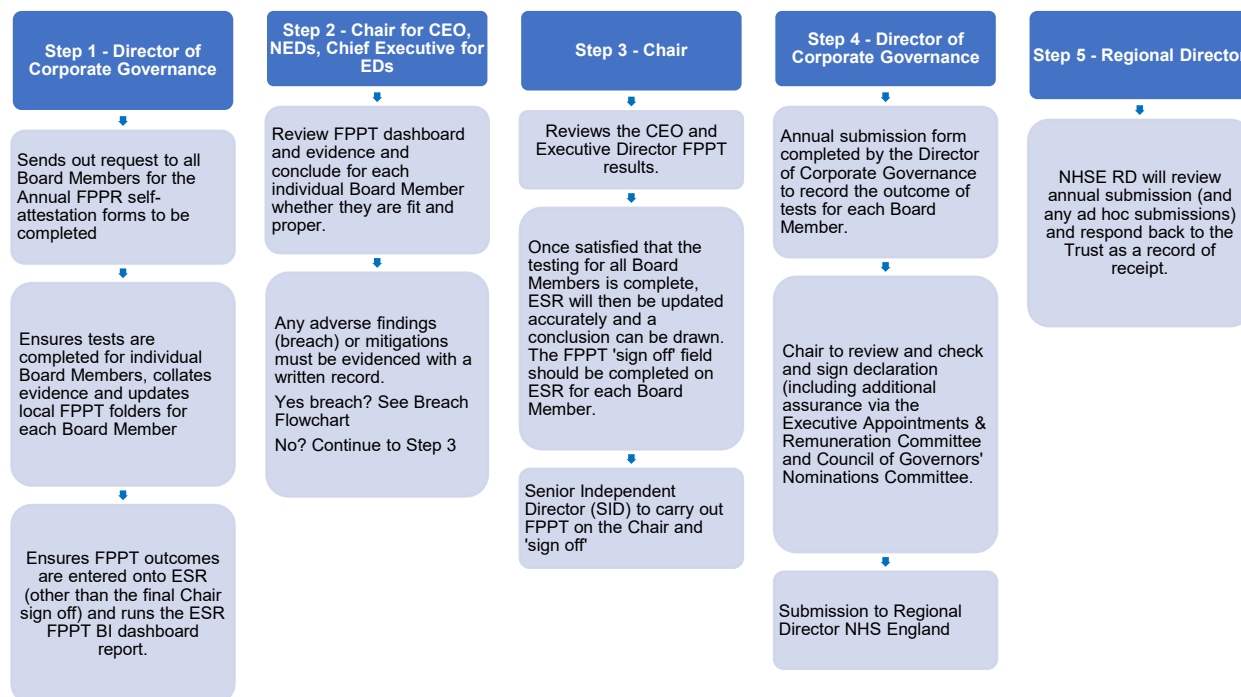
- 1.5. The Chief People Officer is responsible for ensuring compliance with FPPT check requirements with relevant support (Director of Corporate Governance) at the time of recruitment. The Chief People Officer will declare that appropriate checks have been made in reaching a judgement of a candidate's fitness.
- 1.6. The Council of Governors is responsible for the appointment of the Chair and Non-Executive Directors, drawing on recommendations from the Council's Nominations Committee. The Council will need to satisfy themselves that relevant employment checks, including checks which show compliance with FPPT, have been carried out and that the Board has adequate assurances on the robustness of procedures.
 - 1.6.1. In respect of Executive Directors, the Executive Appointments and Remuneration Committee is responsible for the appointment of Executive Directors including the CEO.
 - 1.6.2. All Board Director appointments will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be minuted.
 - 1.6.3. Where the Trust deems that the appointee is suitable following investigation despite not meeting the characteristics outlined in Schedule 4 part 2 of the Regulations (good character) the reasons will be recorded in the minutes of the relevant meeting and the information about the decision will be made available.
 - 1.6.4. Where specific qualifications are deemed necessary for a role, this will be made clear and included in the recruitment information pack; only those individuals who meet the required specification will be appointed including any requirements to be registered with a professional regulator.
 - 1.6.5. Disqualification: A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.
 - 1.6.6. Ineligibility of candidates: If the candidate fails to show that they meet the FPPT, the Trust will withdraw the provisional offer of employment/appointment.
 - 1.6.7. Concerns raised during pre-employment will be considered by the Chair and the Chief People Officer.

2. Ongoing Fitness:

- 2.1. The Trust is responsible for ensuring that relevant individuals continue to meet the FPPT. This is done through an annual review in March/April.
- 2.2. All Directors are required to complete the self-declaration form (Appendix 3); this declaration will be signed by the Chair (to confirm that the annual checks have been completed) and retained on the individual's personal file.
- 2.3. The annual appraisal process will provide an opportunity to discuss continued 'fitness' to ensure that the Director continues to have the appropriate level of skill, experience

and competence for the role. Discussions at appraisal will also cover how the Director displays the Trust's values and behaviour standard including the leadership behaviour expected.

- 2.4. Enhanced DBS checks will take place on appointment and will be repeated every three years in line with Trust policy. In line with recognised best practice, Directors will be required to join the online Disclosure and Barring (DBS) update service.
- 2.5. Checks on disqualification from acting as a Director, bankruptcy and insolvency will also be carried out annually.
- 2.6. Directors will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person.
- 2.7. Annual checks against the disqualified directors register, bankruptcy, and insolvency register, removed charity trustees register and relevant professional registers.
- 2.8. Formal appraisal process by the relevant line manager.
- 2.9. The flowchart below sets out the annual fitness test process:



3. Joint appointments across different NHS Organisations:

- 3.1. For joint appointments across different NHS organisations, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

- 3.2. The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.
- 3.3. The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.
- 3.4. For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.
- 3.5. If the FPPT assessment at one organisation finds an individual not to be a Fit and Proper Person, the Chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

4. Personal Data:

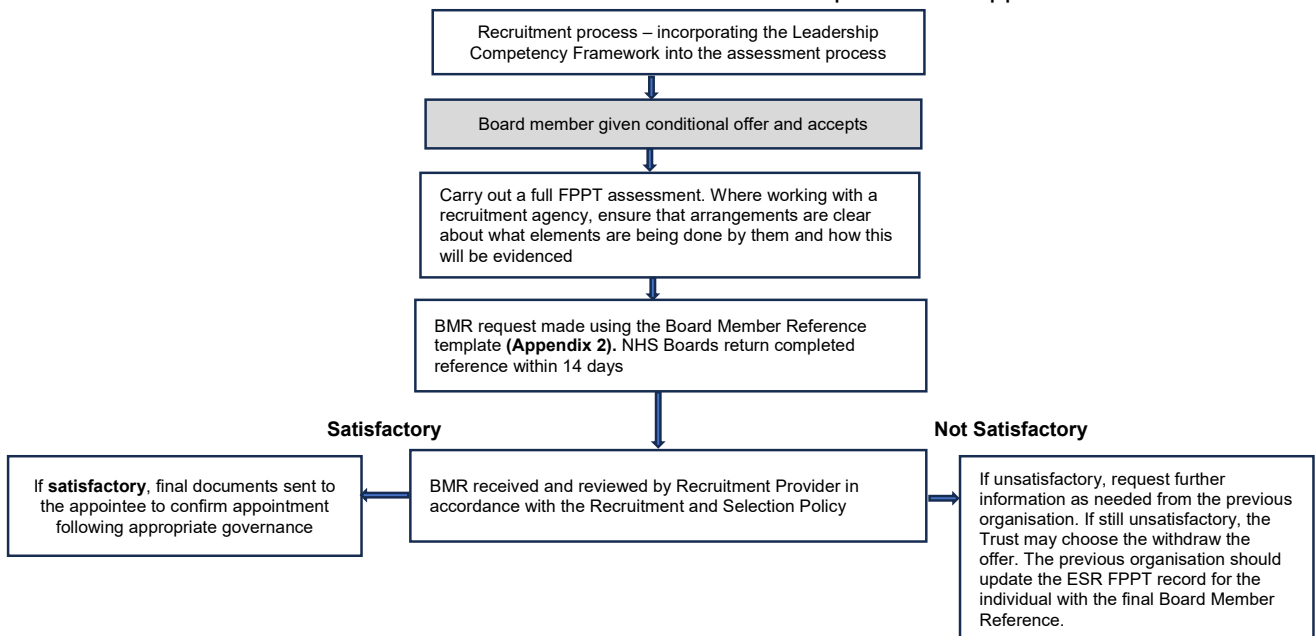
- 4.1. Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR).
- 4.2. FPPT outcomes must be entered onto ESR and ESR FPPT Dashboard generated for Chair review. Once satisfied with the test the Chair must update and sign off each Board member on ESR. An annual submission form will be generated for Chair sign off and submitted to the NHSE Regional Director. The NHSE FPPT central team will collate records from NHSE regions.

5. Board Member Reference Request on initial appointment:

- 5.1. The Trust will need to request board member references (Appendix 2), and store information relating to these references so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.
- 5.2. NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally on ESR.
- 5.3. Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:
 - a) New appointees that have been promoted within an NHS organisation.
 - b) Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
 - c) Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

- d) Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

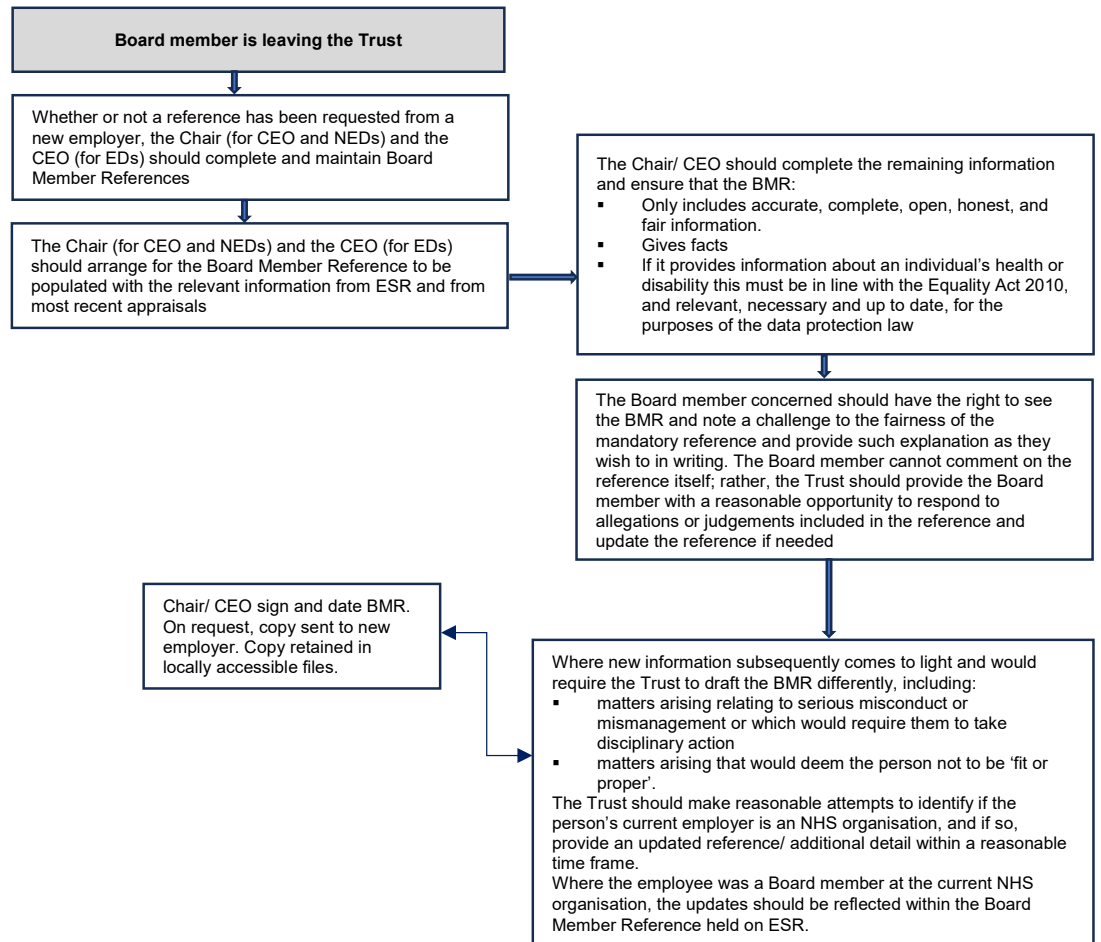
5.4. The flowchart below sets out the Board Member Reference process for appointments:



6. Board Member Reference Request on exiting the Trust:

- 6.1. The Trust will maintain complete and accurate board member references using the prescribed form (as detailed in the Trust's Fit and Proper Person Test Procedure) at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement.
- 6.2. Both the initial and final board member references will be retained locally on ESR.

6.3. The flowchart below sets out the Board Member Reference process for Board Members leaving the Trust:



7. Dealing with Concerns:

- 7.1. If the Trust discovers at any point, information that suggests an individual Director does not meet the 'Fit and Proper Persons' criteria, the matter shall be referred immediately to the Chair (or the Senior Independent Director if the concern relates to the Chair).
- 7.2. The Chair shall take appropriate and timely action to investigate and rectify the matter, taking expert advice as necessary and ensuring any issues are dealt with in accordance with the Trust's HR policies. Any concerns will be referred to the relevant Committee (i.e., EARC or CoG Nominations Committee). Where appropriate, findings in relation to a person's fitness may be referred to the relevant professional/regulatory body/bodies.
- 7.3. The Chair, in discussion with the relevant Committee, will put in place interim arrangements, if required, during any period of investigation. The removal of any Director will be in accordance with the Trust's Constitution, with decision to remove resting with the EARC (Executive); and CoG Nominations Committee for for Non-Executive Directors.

**Appendix 1a - Fit and Proper Person Test self-attestation template
THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST**

This attestation should be submitted to DOI@Tavi-Port@nhs.uk on behalf of the Chair.

Tick as appropriate:

New starter

Annual check

I declare that I am a fit and proper person to carry out my role.

- I am of good character
- I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- I, where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- I am capable by reason of health of properly performing tasks which are intrinsic to the position
- I am not prohibited from holding office (e. directors disqualification order)
- Within the last five years:
 - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
 - I have not been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
 - I am not on any 'barred' list.
- I have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

I confirm that the information provided above is complete and correct. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair. I am aware that if I do not make full, accurate and timely declarations then internal disciplinary, criminal, civil or professional regulatory, action may result. Should I provide false or misleading information, I understand that a referral may be made to the Local Counter Fraud Specialist.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For Chair to complete	
Signature of Chair to confirm receipt:	
Date of signature of Chair:	

**Appendix 1b – Chair’s Fit and Proper Person Test self-attestation template
THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST**

This attestation should be submitted to DOI@Tavi-Port@nhs.uk on behalf of the SID.

Tick as appropriate:

New starter - Chair

Annual check - Chair

I declare that I am a fit and proper person to carry out my role.

- I am of good character
- I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- I, where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- I am capable by reason of health of properly performing tasks which are intrinsic to the position
- I am not prohibited from holding office (e. directors disqualification order)
- Within the last five years:
 - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
 - I have not been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
 - I am not on any ‘barred’ list.
- I have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

I confirm that the information provided above is complete and correct. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the SID. I am aware that if I do not make full, accurate and timely declarations then internal disciplinary, criminal, civil or professional regulatory, action may result. Should I provide false or misleading information, I understand that a referral may be made to the Local Counter Fraud Specialist.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of Chair:	
Date of signature of Chair:	
For Senior Independent Director (SID) to complete	
Signature of SID to confirm receipt:	
Date of signature of SID:	

Appendix 2 - The board member reference template

Board Member Reference

STANDARD REQUEST: To be printed on Trust letterhead and used only AFTER a conditional offer of appointment has been made.

Date

Name of referee
Organisation Name
Address
Address
Address

Email:xxx@Tavi-Port.nhs.uk

Dear Referee's name

Re: Applicant's name – ref. number – Board position

The above-named person has been offered the board member position of [post title] at The Tavistock and Portman NHS Foundation Trust. This is a high-profile and public-facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

Recruitment officer's name
Job title

<p>Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.</p>		
<p>1. Name of the applicant (1)</p>		
<p>2. National Insurance number or date of birth</p>		
<p>3. Please confirm employment start and termination dates in each previous role <i>A: (if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)</i> <i>B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)</i></p>		
<p><u>Job Title:</u> <u>From:</u> <u>To:</u></p> <p>Job Title <u>From:</u> <u>To:</u></p> <p>Job Title: <u>From:</u> <u>To:</u></p> <p>Job Title: <u>From:</u> <u>To:</u></p> <p>Job Title: <u>From:</u> <u>To:</u></p>		
<p>4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): <i>(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)</i></p>		
<p> </p>		
<p>5. Please confirm Applicant remuneration in current role <i>(this question only applies to Executive Director board positions applied for)</i></p>	<p><u>Starting:</u> £</p>	<p><u>Current:</u> £</p>
<p>6. Please confirm all Learning and Development undertaken during employment: <i>(this question only applies to Executive Director board positions applied for)</i></p>		
<p> </p>		

<p>7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? <i>(only applicable if being requested after a conditional offer of employment)</i></p>	<p><u>Days Absent:</u></p>	<p><u>Absence Episodes:</u></p>
<p>8. Confirmation of reason for leaving:</p>		
<p>9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) <i>(This question is for Executive Director appointments and Non-Executive Director appointments where they are already a current member of an NHS Board)</i></p>		
<p>Date DBS check was last completed.</p> <p>Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)</p> <p>If an enhanced with barred list check was undertaken, please indicate which barred list this applies to</p>	<p>Date:</p> <p>Basic <input type="checkbox"/></p> <p>Standard <input type="checkbox"/></p> <p>Enhanced without barred list <input type="checkbox"/></p> <p>Enhanced with barred list <input type="checkbox"/></p> <p>Adults <input type="checkbox"/></p> <p>Children <input type="checkbox"/></p> <p>Both <input type="checkbox"/></p>	
<p>10. Did the check return any information that required further investigation?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>If yes, please provide a summary of any follow up actions that need to/are still being actioned:</p>		

<p>11. Please confirm if all annual appraisals have been undertaken and completed</p> <p>(This question is for Executive Director appointments and Non-Executive Director appointments where they are already a current member of an NHS Board)</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:</p>		
<p>12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)?</p> <p>(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>If yes, please provide a summary of the position and (where relevant) any findings and any remedial actions and resolution of those actions:</p>		
<p>13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to:</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

<ul style="list-style-type: none"> • Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS • Dishonesty • Bullying • Discrimination, harassment, or victimisation • Sexual harassment • Suppression of speaking up • Accumulative misconduct <p>(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)</p>		
<p>If yes, please provide a summary of the position and (where relevant) any findings and any remedial actions and resolution of those actions:</p>		
<p>14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)</p> <p><u>Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)</u></p> <p><u>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)</u></p>		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print):

Position Held:

Email address: Telephone number:

Signature:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 3 - Letter of confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[LEAD EMPLOYING ORGANISATION¹ LETTERHEAD]

[DATE]

Dear [CHAIR NAME²],

Fit and Proper Person Test

This confirmation letter is provided in connection with [name of board member, job title of board member, organisations that the joint board member post covers] for [year of test, eg 2023/24] as at [date of conclusion of annual³ FPPT for the individual] for the purpose of the Fit and Proper Person Test.

As Chair of [lead employer], I confirm that I have carried out the Fit and Proper Person Test for [name of board member].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [name of board member] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the [Fit and Proper Person Test Framework](#) requirements and in reaching my conclusion that [name of board member] is fit and proper as at [date of conclusion of test], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

..... (signature)

..... (chair of lead employer organisation)

Date.....

I confirm that I have received the outcome for the FPPT for [name of board member] and that I have provided any necessary information for you to reach this conclusion.

..... (signature)

..... (chair of lead employer organisation)

Date.....

¹ This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.

² This is the name of the chair of the other organisation that the joint board appointment is made with.

³ It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

Appendix 4 - Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
The Tavistock and Portman NHS Foundation Trust		

Part 1: FPPT outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST [year]				
For the SID to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:		
<i>As Chair of The Tavistock and Portman NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.</i>				
Chair signature:				
Date signed:				

For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 5 - Board Member Fit and Proper Person Test Privacy Notice

The Tavistock and Portman NHS Foundation Trust is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in the Electronic Staff Record (ESR) is commissioned by NHS England (NHSE).

Contact: Adewale Kadiri, Director of Corporate Governance and Senior Information Risk Owner (SIRO)
Address: 120 Belsize Lane, London NW3 5BA
Phone Number: 07849312244
E-mail: AKadiri@Tavi-Port.nhs.uk

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – This would include detail of all job titles, organisation, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.
10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.
11. DBS status.
12. Registration/revalidation status where required.
13. Insolvency check.
14. A search of the Companies House register to ensure that no board member is disqualified as a director.
15. A search of the Charity Commission's register of removed trustees.
16. A check with the CQC, NHS England and relevant professional bodies where appropriate.
17. Social media check.
18. Employment tribunal judgement check.
19. Exit reference completed (where applicable).
20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, e.g., CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHSE, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our Data Protection Policy and Records retention schedule.

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.
- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.

- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at SAR@Tavi-Port.nhs.uk if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at DPO@Tavi-Port.nhs.uk

You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

Helpline number: 0303 123 1113 ICO website: <https://www.ico.org.uk>

Appendix 6 – FPPT checklist

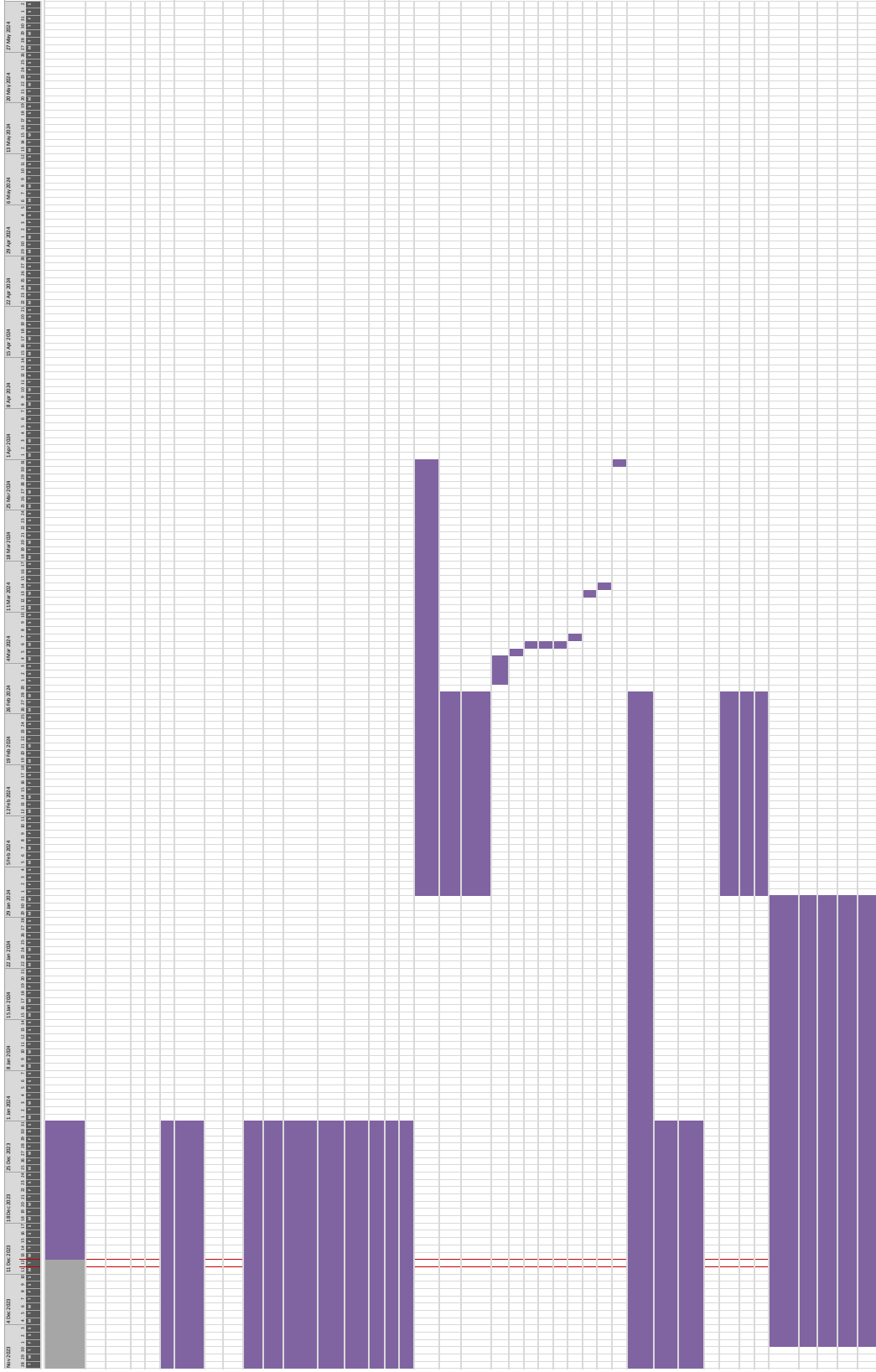
FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment Provider to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/ Surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (i.e. current employer)	✓	x	✓	N/A	✓	✓		
Staff Group	✓	x	✓	x – unless change	✓	✓		
Job Title	✓	✓	✓	x – unless change	✓	✓		
Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation Code	✓	x	✓	x – unless change	✓	✓		
Position Title	✓	x	✓	x – unless change	✓	✓		
Employment History Including: <ul style="list-style-type: none"> • job titles • organisation/ departments • dates and role descriptions • gaps in employment 	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development	✓	✓	✓	x	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, e.g. clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (e.g. professional
								period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
References Available references from previous employers	✓	✓	✓	x	✓	✓		qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
Last Appraisal and Date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	Including references where the individual resigned or retired from a previous role * For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	x	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT.
Grievance against the board member	✓	✓	✓	x	✓	✓		This question is applicable to board members recruited both from inside and outside the NHS.
Whistleblowing claim(s) against the board member	✓	✓	✓	x	✓	✓		
Behaviour not in accordance with	✓	✓	✓	x	✓	✓		

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
organisational values and behaviours or related local policies								
Type of DBS Disclosed	✓	✓	✓	x	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received	✓	✓	✓	x	✓	✓	ESR	
Date of Medical Clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of Professional Register Check (e.g., membership of professional bodies)	✓	x	✓	✓	✓	x	e.g. NMC, GMC, accountancy bodies.	
Insolvency Check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register Companies House	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register Check	✓	✓	✓	✓	✓	✓		
Disqualification from being a Charity Trustee Check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement Check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decision	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Social Media Check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 1a or 1b of the Policy
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	Appendix 2 of the Policy
Letter of Confirmation	x	✓	✓	x	✓	✓	Template	Appendix 3 of the Policy
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director – Appendix 4 of the Policy
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 5 of the Policy.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.



Implementation Theme/ Milestone	Executive Lead	Operational Lead	Expected Delivery Date	Milestone RAG	Milestone Update to include any risks to delivery, mitigations	Gantt Chart Summary															
						Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24							
1. Setting the tone																					
1.1. Establish new FPPT policy and procedure (including Stakeholder Engagement)	Director of Corporate Governance (DoCG)	Governance Consultant	31/12/2023	In progress	Milestone substantially complete. Consultation in progress prior to sign off of new policy																
2. System (ESR) readiness																					
2.1. Ensure ESR Readiness	Chief People Officer (CPO)	Associate Director of HR Operations (AD HRO)	31/12/2023	In progress	0																
3. Robust pre-employment checks for new appointments and promotions in line with new policy and procedure																					
3.1. Recruitment and selection processes from 30 September 2023 comply with FPPR including pre-Employment checks; completion of standardised Board Member Reference (BMR) and other requirements	Chief People Officer (CPO)	Associate Director of HR Operations (AD HRO)	31/12/2023	Not started	0																
4. Completion of annual assessments in line with new policy and procedure																					
4.1. Carry out Annual assessments and report on outcome to NHSE	DoCG	Governance Consultant or other Senior Member of Team	31/03/2024	Not started	0																
5. Complete Annual Appraisals																					
5.1. Carry out robust Annual Appraisal process	Chief People Officer (CPO)	CPO	28/02/2024	Not started	0																
6. Other related governance matters																					
6.1. In-life controls and Governance	DoCG/ CPO	DoCG / AD HRO	31/01/2024	Not started	0																

About this template

This template provides a simple way to create a Gantt chart to help visualise and track your project. Simply enter your tasks and start and end dates – no formulas are required. The bars in the Gantt chart represent the duration of the tasks and are displayed using conditional formatting. Insert new tasks by inserting new rows.

Guide for screen readers

There are 2 worksheets in this workbook.

ProjectSchedule
About

The instructions for each worksheet are in the A column starting in cell A1 of each worksheet. They are written with hidden text. Each step guides you to the information in that row. Each subsequent step continues in cell A2, A3 and so on, unless otherwise explicitly directed. For example, instruction text might say “continue to cell A6” for the next step.

This hidden text will not print.

To remove these instructions from the worksheet, simply delete column A.

RAG

Complete

Delay

In progress

Not started

Schedule of Business 2024/2025 draft v7

MEETINGS	AGM/ Board Extraordinary (ARA)	Board Meeting	Board Seminar	Council of Governors	Audit & Risk Committee	Quality & Safety Committee	Performance Finance and Resource Committee	Education and Training Committee	POD & Equality, Diversity and Inclusion	Remuneration Committee	Joint BoD and CoG	CoG Nom Committee
CHAIR/LEAD		Chair: John Lawlor	John Lawlor	Chair: John Lawlor Vice-Chair: David Levenson	Chair: David Levenson	Chair: Claire Johnston Exec Lead: Clare Scott	Chair: Aruna Mihta Exec Lead: Peter O'Neill/Sally Hodges	Chair: Sal Jarvis Exec Lead: Elisa Reyes-Simpson	Chair: Shalini Sequeira Exec Lead: Gem Davies	Chair: John Lawlor	Chair: John Lawlor	Chair: John Lawlor
APRIL			11 April 10.00 – 4.00							11 April 4:00 – 5:00	4 or 11 April 1.00-4.00pm	
MAY		9 May 10:00-5:30			21 May 10:00 – 1:00	23 May 10:00 – 12.30	16 th May 10:00 – 12.30	16 May 1:30 – 4:00	2 May 10:00 – 12:00			
JUNE			13 June 10.00 – 4.00	6 June 1.00 – 5.30	18 June (Ex-Ord for ARA) 10:00 – 1:00				27 June 10:00 – 12.30	13 June 4:00 – 5:00		
JULY		11 July 10:00-5:30				25 July 10:00 – 12.30	4 July 10:00 – 12.00	18 July 1:30 – 4:00				
AUGUST							29 August TBC 10:00 – 12.30					
SEPTEMBER	AGM: 19 September TBC	12 September 10:00-5:30			24 September 10:00 – 1:00	26 September 10:00 – 12.30		19 September 1:30 – 4:00	5 September 10:00 – 12:00			
OCTOBER			10 October 10.00 – 4.00	17 October 1.00 – 5.30			31 October 10:00 – 12.30			10 October 4:00 – 5:00		
NOVEMBER		14 November 10:00-5:30			26 November 10:00 – 1:00	28 November 10:00 – 12.30		21 November 1:30 – 4:00	7 November 10:00 – 12:00		28 November 1.00-4.00pm	
DECEMBER			12 December 10.00 – 4.00	5 December 1.00 – 5.30			19 December 10:00 – 12.30			12 December 4:00 – 5:00		
JANUARY		16 January 10:00-5:30				30 January 10:00 – 12.30		23 January 1:30 – 4:00	9 January 10:00 – 12:00			
FEBRUARY			13 February 10.00 – 4.00	20 February 1.00 – 5.30	25 February 10.00 – 1.00		27 February 10:00 – 12.30			13 February 4:00 – 5:00		
MARCH		13 March 10:00-5:30				27 March 10:00 – 12.30		20 March 1:30 – 4:00	6 March 10:00 – 12:00		20 March 1.00-4.00pm	

MEETING OF THE BOARD OF DIRECTORS (PUBLIC) 13 DECEMBER 2023					
Report Title: Board Service Visits				Agenda No.: 22	
Report Author and Job Title:	Jane Meggitt, Interim Director of Communications and Engagement	Lead Executive Director:	Jane Meggitt, Interim Director of Communications and Engagement		
Appendices:	Board and Governor service visits presentation				
Executive Summary:					
Action Required:	Approval <input type="checkbox"/> Discussion <input checked="" type="checkbox"/> Information <input type="checkbox"/> Assurance <input type="checkbox"/>				
Situation:	A programme of visits to clinical and non-clinical areas has been in place for some time, but steps are now being taken to enhance and broaden this to better include Non-Executive Directors and Governors. The programme will now be run by the Corporate Governance team and a 12-month schedule of visits that will cover all of the Trust's services is being created.				
Key recommendation(s):	The Board is asked to NOTE the contents of this presentation.				
Implications:					
Strategic Objectives:					
<input checked="" type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input checked="" type="checkbox"/> 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.	<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input checked="" type="checkbox"/>	Effective <input checked="" type="checkbox"/>	Caring <input checked="" type="checkbox"/>	Responsive <input checked="" type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	Risk Ref and Title: This item potentially impinges on all BAF risks as service visits should help surface issues that staff, patients and students across the organization.				
Legal and Regulatory Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
Resource Implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
Equality, Diversity and Inclusion (EDI) implications:	Yes <input type="checkbox"/>			No <input checked="" type="checkbox"/>	
	There are no equality, diversity and inclusion implications associated with this report.				

Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required

Executive, Non-Executive Director and Governor service visits



Jane Meggitt, Interim Director of Communications

Wednesday 13 December 2023



Service visits programme

- The programme serves to increase the visibility of our leadership, building relationships and trust with the services and staff
- It is a conduit for senior leaders to better understand the issues staff are facing, and empower them to resolve these at the most local level
- The visits are a strand of our strategy and Future Options engagement, offering an opportunity for discussion and feedback

Visits programme

Since the visits programme was established in late July, there have been 32 visits from Executives, Non-Executive Directors and Governors to teams across the Trust.

Since the last visits report, there have been visits to:

First Step + First Step Plus	Thursday, October 19, 2023	Sally Hodges
Gender Identity Clinic Executive meeting	Thursday, October 19, 2023	Clare Scott, Chris Abbott, Debbie Colson
Open Minded (N+S)	Thursday, October 19, 2023	Claire Johnston, John Lawlor, Talia Barry, Shalini Sequeira
Gloucester House Outreach	Monday, October 30, 2023	Debbie Colson
CAISS	Tuesday, October 31, 2023	Aruna Mehta, Elisa Reyes-Simpson
Portman	Friday, November 3, 2023	Sabrina Phillips, Shalini Sequeira, Aruna Mehta
Gloucester House Outreach	Monday, November 6, 2023	Michael Holland
IT Service Desk	Thursday, November 9, 2023	Michael Holland
Portman Clinic	Friday, November 17, 2023	Gem Davies, Shalini Sequeira
Tavistock Consulting and i-Thrive	Tuesday, November 28, 2023	Michael Holland
Portman Clinic	Friday, December 1, 2023	Sally Hodges, Elisa Reyes-Simpson
M7 course team	Wednesday, December 6, 2023	Michael Holland
Library joint meeting	Monday, December 11, 2023	Peter O'Neill

Feedback since the last service visits report

- There is impressive, innovative work going on across the organisation with exceptional clinical outcomes in some services
- There are ongoing issues with rooms, facilities and lack of space. Improved communications on Estates changes are needed
- Services not based at the Tavistock Centre do not always feel part of the Trust. Therefore, more collaborative and joined-up working across sites, sharing skills and resources would be valuable
- All-staff meetings and engagement sessions should accommodate clinical hours, for example, Gloucester House are unable to attend all-staff meetings before 3pm
- Reviewed outcome measures that are more engaging and reflect the work of the service would be helpful

Going forward

- The programme is now being managed by the Corporate Governance function
- In line with practice at other Trusts, we will draw up a 12-month schedule of NED and governor visits for 2024
- These visits will be scheduled outside of existing team meetings, to allow for deeper, richer discussions
- Following feedback from senior leadership, the service visits feedback form will be updated to allow for more open responses
- Leadership would like to engage with service users, and we are working with the PPI team to establish opportunities for this

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Wednesday, 13 December 2023					
Report Title: Public Board of Directors Forward Planner 2023/24				Agenda No.: 23	
Report Author and Job Title:	Amanda Hawke, Corporate Governance Manager	Lead Director:	John Lawlor, Trust Chair		
Appendices:	Appendix 1: Board of Directors (Public) Forward Planner 2023/24				
Executive Summary:					
Action Required:	Approval <input type="checkbox"/> Discussion <input type="checkbox"/> Information <input checked="" type="checkbox"/> Assurance <input type="checkbox"/>				
Situation:	This report provides the Board with the Public Board of Directors Forward Planner for 2023/24 (attached as Appendix 1) for information.				
Background:	<p>It is good corporate governance practice for the Board to agree a forward plan of its activities and be apprised of any changes to the planner during the year.</p> <p>The Public Board Forward Planner for 2023/24 was approved at the June 2023 meeting and is being presented to each meeting of the Public Board for information (highlighting any changes).</p>				
Assessment:	The Governance Manager administers the Board Forward Planner and there have been no updates to the planner since the last Public meeting of the Board.				
Key recommendation(s):	The Board is asked to NOTE the Public Board of Directors Forward Planner for 2023/24.				
Implications:					
Strategic Objectives:					
<input type="checkbox"/> Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	<input type="checkbox"/> 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.	<input type="checkbox"/> Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	<input type="checkbox"/> Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	<input checked="" type="checkbox"/> Ensure we are well-led & effectively governed.	
Relevant CQC Domain:	Safe <input type="checkbox"/>	Effective <input type="checkbox"/>	Caring <input type="checkbox"/>	Responsive <input type="checkbox"/>	Well-led <input checked="" type="checkbox"/>
Link to the Risk Register:	BAF <input checked="" type="checkbox"/>		CRR <input type="checkbox"/>		ORR <input type="checkbox"/>
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register.				
	However, the BAF is a standing item on the Board Forward Planner.				
Legal and Regulatory Implications:	Yes <input checked="" type="checkbox"/>			No <input type="checkbox"/>	
	The Board Forward Planner includes Statutory items for oversight by the Board.				

Resource Implications:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>			
	There are no additional resource implications associated with this report.				
Equality, Diversity, and Inclusion (EDI) implications:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>			
	There are no EDI implications associated with this report.				
Freedom of Information (FOI) status:	<input checked="" type="checkbox"/> This report is disclosable under the FOI Act.		<input type="checkbox"/> 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:	<input type="checkbox"/> Limited Assurance: There are significant gaps in assurance or action plans	<input type="checkbox"/> Partial Assurance: There are gaps in assurance	<input checked="" type="checkbox"/> Adequate Assurance: There are no gaps in assurance	<input type="checkbox"/> Not applicable: No assurance is required	

Agenda Item	Category	Sponsor / Lead	2023												2024	Board / Committee / Meeting Agenda Section	Frequency	Purpose	Author(s)
			Apr	Jun	Jul	Oct	Dec	Feb	2024	Previous committee/group	Onward approval								
Date of Meeting			19 Apr	14 Jun	27 Jul	11 Oct	13 Dec	21 Feb											
Paper Deadline			29 Mar																
Standard monthly meeting requirements																			
Opening / Standing Items (every meeting)																			
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P											
Confirmation of Quorum	Information	Chair	P	P	P	P	P	P											
Declarations of Interest	Information	Chair	P	P	P	P	P	P											
Patient/ Service User / Staff Story / Student Story	Discussion	ICMO / CPO	P	P	P	P	P	P											
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P											
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P											
Chair's Report	Information	Chair	P	P	P	P	P	P											
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P											
Closing Matters (every meeting)																			
Annual Board Forward Planner (For approval in Apr 23 and Feb 24)	Information	Chair	P	P	P	P	P	P											
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P											
Questions from the Public	Discussion	Chair	P	P	P	P	P	P											
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P											
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P											
Bi-monthly (6)																			
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P											
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	D	P	P	P											
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P											
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P											
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P											
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P											
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P											
Integrated Governance Action Plan Report	Assurance	CEO	P	P	D	P	P	P											
Quarterly (3 - 4)																			
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDCGG	P			P	P	P											
Audit Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P											
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P											
Guardian of Safer Working Report	Information	ICMO			P	P	P	P											
Six-monthly (2)																			
Mortality / Learning from Deaths	Assurance	ICMO			P														
Annual (1)																			
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (Audit, POD EDI, ETC; PFR, Quality, EAMR)	Discussion	Chair		P															
Review of Committee Terms of Reference	Approval	Chair				P													
Medical Revalidation	Discussion	ICMO				P													
Freedom to Speak Up Guardian Annual report	Discussion	CPO			P	R													
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Preparedness, Resilience and Response (EPRR)	Discussion	ICMO						P											
Quality Priorities 2023-2024	Discussion	ICMO																	
Staff Survey Results and Action Plan	Discussion	CPO		P															
Workforce Disability Equality Standard (WDES)	Approval	CPO						P											

