NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Wednesday 21st February 2024

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

Please refer to the agenda for timings.

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON WEDNESDAY 21 FEBRUARY 2024 AT 2.00PM – 5.00 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

AGENDA

	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		Limited ☐ Partial ☐ Adequate ☐ N/A ☐
004	Service Presentation Mental Health in Schools Team (MHST)	Discussion	Chair	V	2.05 (20)	
005	Minutes of the Previous Meeting held on 13 December 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 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.45 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
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	2.55 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

010	Guardian of Safe Working Report	Information	Chief Medical Officer	E	3.00 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
011	Mortality/Learning from Deaths	Assurance	Chief Medical Officer	E	3.05 (5)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
012	Patient and Carer Race Equality Framework (PCREF)	Discussion	Chief Medical Officer	E	3.10 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
GREAT & SAFE PLACE TO WORK, TRAIN & LEARN for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.						
013	People, Organisational Development, Equality, Inclusion and Diversity Committee Assurance Report	Assurance	POD EDI Committee Chair	E	3.20 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
014	Education and Training Committee Assurance Report	Assurance	Education & Training Committee Chair	E	3.25 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Comfort Break (10 minutes) 3.30pm – 3.40pm						
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	3.40 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
016	Finance Report – Month 9	Discussion	Chief Finance Officer	E	3.45 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
WELL-LED AND EFFECTIVELY GOVERNED						
017	Integrated Audit and Governance Committee Assurance Report	Assurance	Audit Committee Chair	E	3.55 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
018	Emergency Planning Annual Report, Letter of Declaration and Self-Assessment against Core NHS Standards for Emergency Preparedness, Resilience and Response (EPRR)	Discussion	Chief Nursing Officer	E	4.05 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CLOSING ITEMS						
019	Board Forward Planner	Information	Chair	E	4.15 (5)	Limited ☐ Partial ☐ Adequate ☒

						N/A ☐
020	Questions from the Governors	Discussion	Chair	V	4.20 (10)	
021	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
022	Questions from the Public	Discussion	Chair	V		
023	Reflections and Feedback from the meeting	Discussion	Chair	V	4.30 (5)	
DATE AND TIME OF NEXT MEETING						
024	Thursday 9th May 2024 at 2.00pm – 5.00pm					

The Tavistock and Portman
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
WEDNESDAY, 13 DECEMBER 2023 AT 2 P.M.

TRAINING ROOM A&B, GARDEN WING,
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	AM
David Levenson	Non-Executive Director and 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
Chris Abbott	Chief Medical Officer	CA
Sally Hodges	Deputy Chief Executive and Chief Clinical Operations Officer	SH
Clare Scott	Chief Nursing Officer	CS
Rod Booth	Director of Strategy and Transformation	RB

IN ATTENDANCE:

Kathy Elliot	Stakeholder Governor and Lead Governor	KE
Paru Jeram	Staff Governor	
Sebastien Kraemer	Public Governor	
Michael Rustin	Public Governor	
Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Jane Meggitt	Interim Director of Communications and Marketing	JM
Gem Davis	Chief People Officer	GD
Udey Chowdhury	Deputy Chief Finance Officer	UC
Mike Smith	Head of Communications and Engagement	MS
Lloyd England	Communications Officer	LE
Amanda Hawke	Corporate Governance Manager (Minutes)	AH
Fiona Fernandes	Business Manager, Corporate Governance	FF
Antonia Carding	Associate Nursing Officer	
Elijah	PPI Expert by Experience	

APOLOGIES:

Elisa Reyes-Simpson	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	ERS
Peter O Neill	Interim Chief Finance Officer	PON

MINUTE NO.		ACTION (INITIALS)
23/001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL welcomed all in attendance. Apologies for absence were received from Peter O'Neill and Elisa Reyes-Simpson.	

23/002	**CONFIRMATION OF QUORACY**
	JL confirmed that the meeting was quorate.
23/003	**DECLARATIONS OF INTEREST**
	There were no new declarations of interest that related to business discussed at the meeting. The Declarations of Interest register has been circulated and members of the Board were asked to provide any relevant updates for the register.
23/004	**PATIENT/ SERVICE USER EXPERIENCE**
	Antonia Carding, Associate Nursing Director and Elijah Catley attended for this item. Elijah explained why he became an Expert by Experience and what such individuals can bring to the Trust. They will be looking at what the Trust does and what can be improved. It is hoped that a community of Experts by Experience will be created within the Trust. One of the key improvements to be made is to reduce waiting times. The question was raised as to how the voice of service users links in with the Trust-wide Forum and how it is represented across all services. Ms Carding advised that this is being discussed further, together with ideas as to how the local community can be included in discussions and how the voice of those on waiting lists can be included. Elijah was asked about the recruitment process to become an Expert by Experience. He advised that it was easy and once recruited he integrated smoothly into the role. Overall, he described the experience of being an Expert by Experience as 'pleasant and fun'. Ms Carding advised that the recruitment of the Patient Safety Partners (PSPs) was slightly more formal. There was a discussion on how both Expert by Experience and PSPs can be involved in areas of work in the Trust. It was suggested that they could be involved in strategy and development. A further suggestion was that Non-Executive Directors could join one of the meetings of the PSPs and Expert by Experience. **Action Point:** JL ask that Elijah come back to the Board in one year to talk about the developments made over the year.
23/005	**MINUTES OF THE PREVIOUS MEETING HELD ON 11th October 2023**
	The minutes of the previous meeting held on 11th October 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.

Matter Arising:

JL advised that he will be meeting with the new Chair of the Charity, Edward Harcourt to discuss how the Charity will be affected by the merger of the Trust with another organisation.

23/007	**CHAIR AND CHIEF EXECUTIVE'S REPORT**

The report was taken as read, JL highlighted the following points:-

- He attended a meeting of Chairs of NHS Organisations with the CEO of NHS Providers. The meeting set out the political context. They were advised that no increase in funding for the NHS was expected. The additional money allocated to the NHS has mostly been taken up with inflation.
- Henrietta Hughes suggested that Lived Experience Representatives should be on NHS Boards.
- Work is being done to understand why we have an expanded NHS workforce but do not have a corresponding increase in activity and productivity.

MH highlighted the following points:-

- A meeting is being held with staff to discuss the 'Case for Change'
- He had met with Caroline Clarke to discuss merger plans and it has been agreed that a merger partner will now be agreed by June 2024. Revised timelines are being worked on.
- The GIC improvement week had gone well and A3s have been developed from this to make improvements to the service. Terms of Reference for a review of GIC have been agreed and will be discussed with GIC staff.
- An Executive Sponsor has been appointed to each of the 3 Staff Networks
- Black History month activities had been well-received.
- The Disability Network has been re-launched under the new name of Purple Circle
- Patient and Carer Race Equality Framework (PCREF) – inequalities in access to services for ethnic minorities

JL suggested that the Staff Network Chairs should attend the Board to provide an update on work on inequalities and provide the necessary challenge.

Tor Jeffries from the ICB is working with us on 'Case for Change'. Drop-in session on this have been held for staff in order to engage with them on discussions on our culture, specialisms and identity. The passion that staff have for the Tavistock and

their work has come through at these meetings. Staff have also indicated that they are pleased to be consulted on this next stage for the Trust. The name 'Case for Change' has been discussed and may be refreshed.

The recruitment for the new Chief Education and Training Officer is progressing. The advertisement has gone out and a good response has been reported by the recruitment consultants. The deadline for applicants is in January 2024.

The Oliver McGowan Training, which is for all staff on engaging with people with learning disabilities, is now mandatory for all.

23/008 **INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)**

SH advised that the Integrated Quality and Performance Reports were discussed yesterday at the Performance, Finance and Resources Committee. Structured frameworks to address problems and issues, called A3s, have been provided for all improvement areas, it was noted that dates need to be added to these. We need to be clear which Board Committee has oversight for each area.

Under Performance a deep dive was held focussing on root causes in Adult Gender and Adult Trauma. We are working through the improvement plans for these services.

In the service line overview it was noted that job planning is improving and this is having a positive impact on services. Additional resources are being put into where they are needed. There continue to be issues in recording information on Carenotes which impacts the data coming to the IQPR reports. A Trust-wide Standard Operating Procedure is being written on adding information to Carenotes.

AM commented that it feels optimistic that progress is being made within services and that the A3s have been set out to address all issues, Thanks to all the Teams and members of the Executive Leadership Team for the progress that has been made.

It was noted that some staff may be slower to adapt to new ways of working, however there is enthusiasm within the teams. CA and CS are working closely with SH.

CS reported on Quality Improvements within the Trust. The new Incident Reporting system, RADAR, is being implemented. In Quarter 2, 35 formal complaints were received, response times are still slower than we would want, however the backlog of complaints is down from 85 to 55. It has been decided to merge our PALS and Complaints work.

Action Point: Our internal process on Quality and Performance to be looked at during a Board Development Session.

23/009 **QUALITY AND SAFETY COMMITTEE ASSURANCE REPORT**

The report was taken as read.

CJ advised that progress is being made on responding to formal clinical complaints. Litigation remains an area of concern, but AK is writing a report on these. Although

there are only a small number of legal claims these are serious. A new CQC Inspection model will be used from January 2024. Webinars are being held to ensure that staff are kept up to date on this process. Work is being done to address the 'must dos' identified from the last inspection, these include waiting lists and mandatory training.

The factual report from the GIDS CQC Inspection has been received. Significant improvements have been noted from the previous report. Four further areas have been identified for improvements. We were aware of these issues and plans were in place to address them. The high quality of care of our patients was acknowledged.

The Patient Safety Incident Reporting Framework (PSIRF) is being rolled out across the NHS. Training for staff on this new system is significant as it is for 3 full days. This will be commenced in January 2024. Staff are being informed of the new framework through internal sessions.

A new clinical reporting system, RADAR, for complaints and incidents is being implemented, the paper sets out the timetable for this. The Quality and Safety Committee will have oversight of this new system.

23/010 **GUARDIAN OF SAFE WORKING REPORT**

The report was taken as read.

CA advised that there was a slight peak in working hours during August and September which may be due to the Doctors rotation and the impact of strikes. The impact of the strikes is not a major issue in the Trust. Any issues that do occur will be highlighted to the Board as necessary.

23/011 **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, DIVERSITY AND INCLUSION ASSURANCE REPORT**

The report was taken as read. SS highlighted key points.

We have been given an award by NHS England for a project on staff well-being. This has been used to create a staff well-being space and provide yoga classes.

The reciprocal mentoring programme is going well, and further feedback is expected on this in due course.

Benita Mehra reported on how we are using our estate.

The Freedom to Speak Up Guardian has reported that staff are scared to speak up and cited worry about how they will be treated if they do. How to address bullying and harassment has been captured in the A3s. Another Freedom to Speak Up Guardian is being recruited.

Concern was expressed that staff do not feel able to speak up about bad behaviours which include bullying, harassment and racism. It was acknowledged that it takes time for a culture to change. It was suggested that we need to create safe spaces for staff to feel confident in speaking up and staff should be

	encouraged to call out poor behaviours. We are aiming to create a just and learning culture. GD advised that we have had more staff than previously complete the staff survey, however we are not expecting all responses to be positive. It does indicate, however that staff are starting to raise issues.
23/012	**EDUCATION AND TRAINING COMMITTEE ASSURANCE REPORT**
	The report was taken as read. SJ highlighted the key points. The budget for Education and Training will inform the decisions on the cost of courses. The Office for Students financial report is being submitted late. UCh advised that we are expecting to submit this today. With the merger plans for the Trust we will have to report this to the Office for Students as a notifiable event. The SITs configuration needs to be re-implemented. Capacity in the Registry Team is limited. The Visiting Lecturers' Task and Finish Group also has limited capacity. It was noted that we need to prioritise what work needs to be done due to limited capacity.
23/013	**GREEN STRATEGY**
	The report was received. This will be discussed in full in the January Board Development Session and an update will be provided at the February Board of Directors. **Action Point:** Green Strategy to be added to February Board of Directors agenda.
23/014	**VISION, MISSION AND VALUES**
	JL introduced the Vision Mission and Values Statement and it was noted that many views on this have been expressed by staff. GD noted the passion and engagement of staff on the Vision Mission and Values. This is the final version of the document for the Board to approve. All agreed to approve the Vision, Mission and Values statement. Work will now commence on this to roll it out across the Trust and bring it to life. JL acknowledged the work done on this statement and noted that it was not possible to reflect every individual comment in the statement.
23/015	**PERFORMANCE, FINANCE AND RESOURCES COMMITTEE ASSURANCE REPORT**
	AM advised that this committee met yesterday so a verbal report is being given.

The budget for next year is £61.3 million. Team level budgets are expected to be report on at the next PFRC Committee, there have been process issues with these.

There have been some overpayments to staff, this is being taken up with our payroll provider. GD advised that this has also been discussed at POD EDI and is being addressed through Shared Services.

Action Point: An update on overpayments should come to a future Board Meeting.

An issue with the Audit in 2021 has been referred to the Integrated Audit and Risk Committee. A deep dive into this is needed followed by a further internal audit.

Vacancies are now being included in the Integrated Quality and Performance reports.

23/016 **FINANCE REPORT – MONTH 7**

PON reported that we are behind plan due to industrial action costs. In month 8 we will have a reimbursement of these costs so expect to be back on plan. GIDS decommissioning costs may impact on the plan, however we are expecting NHSE to meet the costs associated with GIDS decommissioning.

23/017 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE ASSURANCE REPORT**

The report was taken as read.

DL advised that appointment of the new external Auditors, Grant Thornton, has been confirmed. They were the only auditors who came forward for this appointment, but a rigorous process was followed. The fees have increased significantly, £150,000 pa. PO'N received assurances from the Integrated Care Board that this fee was reasonable. The Council of Governors approved the appointment of Grant Thornton as our external Auditors at the meeting on 7th December 2023.

23/018 **SCHEME OF DELEGATION**

DL advised that the Scheme of Delegation needs to be correct ahead of the merger plans. It was discussed at the last Integrated Audit and Risk Committee and has been discussed as part of the Well-led Review of the Trust.

Changes to the Board Committees were based on the Well-Led Review of the Trust. Some final changes will be made to the Scheme of Delegation. These include confirming that the Chief Executive Officer is the Trust Accounting Officer, The Chief Financial Officer can be appointed as Acting Accounting Officer. Reference to Estates and IT should be included.

23/019	**INTEGRATED GOVERNANCE ACTION PLAN PROGRESS**
	JL advised that this report brings together the actions recommended by the Office of Modern Governance and the Single Oversight Framework 3. MH advised that we expect this process to be completed in March 2024. AK has been working on implementing the recommendations. It was noted that there are some Estates issues that are not within our control as to when they will be completed.
23/020	**FIT AND PROPER PERSON TEST – POLICY AND PROCEDURE**
	Following the Letby case our Fit and Proper Person Test (FPPT) process has been reviewed. The NHS have implemented recommendations from the Kark review that include a rigorous process for appointing people at Board level. We have signed up to the new regulations. We have written a FPPT Policy and have set out a framework for implementation of the policy. We will need to carry out annual FPPT declarations which will be a self-attestation process that should be completed when appraisals are conducted. Information on the FPPT self-attestation will be held within our Electronic Staff Record. GD advised that the first time this new process will be used will be for the appointment of the Chief Education and Training Officer. We will be writing to all existing Board members to complete this new FPPT process.
23/021	**BOARD AND BOARD COMMITTEE MEETING DATES 2024/25**
	The draft schedule of dates for 2024-25 was agreed. Any proposed changes to dates should be advised to AK.
23/022	**BOARD SERVICE VISITS**
	JM advised that the increased Executive Director visits to the teams are having a positive impact on staff. Visits are also being arranged for services outside the main Tavistock Building. It was noted that currently visits to the services are arranged during the Team meetings which does not leave very much time for discussions with the Executive Director. Visits at other times are being considered. Feedback on services is given at the weekly Executive Leadership Team meetings. A programme of visits is to be scheduled to include an Executive Director, a Non-Executive Director and a Governor. It was noted that these types of visits work well if time is spent prior to the meeting talking to those visiting so that they are familiar with the service.
23/023	**BOARD FORWARD PLANNER**

	The Board received and noted the contents of the Forward Planner. It was noted that the IQPR dates will be included in the Forward Planner.
23/024	**QUESTIONS FROM THE GOVERNORS**
	Kathy Elliott noted that it had been helpful to observe this meeting. She noted that that all basics now are in place which will help with the development programme for the Governors. Michael Rustin wished all a very Merry Christmas.
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**
	The timescale and process for the merger plans and the new CQC Inspection regime were discussed.
	Close
	The Chair closed the meeting at 4.40 p.m.

Date of Next Meeting in public: Wednesday 21st February 2023 at 2pm (time and venue to be confirmed).

Signature _____ Date _____

NHS
The Tavistock and Portman
NHS Foundation Trust

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

				Actions are RAG rated as follows: ->	Open - New action added	To Close - propose for closure	Overdue - Due date passed	Not yet due - Action still in date
Action Ref.	**Meeting Date**	**Agenda Ref.**	**Agenda Item (Title)**	**Action Notes**	**Action Due date**	**Action owner (Name and Job Title)**	**Status (pick from drop-down list)**	**Progress Note / Comments (to include the date of the meeting the action was closed)**
11.23	27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified
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	Elisa Reyes-Simpson, Interinm Director of Education & Training	In progress	
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	Adewale Kadiri, Director of Corporate Governance	To Close - propose for closure	IQPR added to the updated Board development programme with a recommendation that it be covered at the April seminar
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	Clare Scott, Chief Nursing Officer	In progress	To be added to a future agenda
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	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.
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 clincial services

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)
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	To Close - propose for closure	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. A new Risk Manager has now been appointed, and it is proposed that the training programe will be resumed in mid-March

MEETING OF THE BOARD OF DIRECTORS PART II – PUBLIC – Wednesday 21 February 2024				
Report Title: Chief Executive's Report				**Agenda No.: 7**
Report Author and Job Title:	Michael Holland, Chief Executive	**Lead Executive Director:**	Michael Holland, Chief Executive	
Appendices:				
Executive Summary:				
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐			
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.			
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Board of Directors should be sighted on.			
Assessment:	This report covers the period since the meeting on 13 December 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:				
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☐ Ensure we are well-led & effectively governed.
Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☐
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title: All BAF risks				
Legal and Regulatory Implications:	Yes ☐	No ☒			
Resource Implications:	Yes ☐	No ☒			
	Yes ☒	No ☐			

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

Chief Executive's Report 21 February 2024

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. Case for Change engagement sessions

The first of a series of Case for Change engagement sessions was held at the start of January. These highly interactive sessions, which are being held with Trust staff, service users and stakeholders, are an opportunity for attendees to think about and discuss the potential benefits and risks of a merger. They also allow participants to consider what we should look for in a potential merger partner, and what they would look for in us. Sessions for specific groups will continue to run into March.

3. The passing away of Isca Wittenberg

We were very sad to learn of the passing of Isca Wittenberg on 23 December 2023 at the age of 100. Isca had witnessed many of the 20th century's most turbulent periods, arriving in the UK from Frankfurt aged 16, her father, a rabbi, having already been briefly imprisoned and tortured at the Dachau concentration camp.

Isca trained as a child psychotherapist at the Tavistock, training under and working with some of the pioneers in that field, including Esther Bick, Anna Freud and John Bowlby. She later became Head of the newly developed Adolescent Department and continued to pioneer new approaches including the Young People's Counselling Service. Isca remained at the Tavistock for 25 years, ultimately rising to become its Vice-Chair. She was able to join us virtually last year for celebrations around the 75th anniversary of the NHS, and gave an interview reflecting on her work.

Providing outstanding patient care

4. PSIRF Training

30 members of Trust staff participated in a 3-day interactive training programme for the Patient Safety Incident Response Framework. The programme focused on four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents,
- Application of a range of system-based approaches to learning from patient safety incidents,
- Considered and proportionate responses to patient safety incidents, and
- Supportive oversight focused on strengthening response system functioning and improvement.

We know that full implementation of PSIRF will not be achieved by a change in policy alone, and it cannot be done in days or weeks, as it requires the design of a new set of systems and processes. Bringing together groups of staff from across the Trust to think collectively about how we can create a meaningful 'Just Culture' was inspiring and the next step will be to collectively role model and embed the compassionate engagement with and involvement of those affected by patient safety incidents, which is central to PSIRF.

5. Time to Talk Day 2024

1 February was national Time to Talk Day. The Trust's vision, to be a leader in mental health care and education by using talking and relational therapies to make a difference in people's lives, resonates with the day's intention – to encourage open conversations about mental health. The importance that we place on talking therapies and listening to our service users is what makes our clinical work and teaching so impactful and transformative. We should encourage everyone around us to continue to have open conversations about mental health.

6. Announced Special Educational Needs and/or Disabilities (SEND) Inspection

An announced SEND inspection took place across a range of services for school age children and young people in Haringey. The inspection was carried out jointly by Ofsted and CQC and was coordinated by the North Central London ICB; with sampling site visits to Tavistock and Portman on 31 January 2024. The outcome of the inspection will be communicated in due course.

7. Kaizen event at the City and Hackney primary care psychotherapy consultation service (PCPCS)

The PCPS recently held a Kaizen event (based on the Japanese philosophy of continuous improvement) with a focus on improving outcomes and experience for service users, and on supporting local General Practices. All those in attendance were well engaged in trying to understand and solve the issues facing the service.

8. Gender Identity Clinic Quality Improvement event

GIC also recently held a quality improvement event. Feedback received indicated that participants were fully engaged and positive energy flowing throughout. The 6 teams presented their 30-day plans in terms of the quality improvement work they have done and what they plan to complete over the next 60 and 90 days. Colleagues embraced the sessions, fostering a harmonious atmosphere that allowed for meaningful connections and a successful exchange of knowledge and experiences. Overall, the event was seen as a huge success, leaving everyone inspired and rejuvenated.

9. Gender Identity Development Service (GIDS) Update

The Trust has been working collaboratively with the new providers to safely transfer the care of those patients still under our care to them by the end of March. Our staff

are understandably distressed by the closure of GIDS, and we have provided significant resources to support them over this difficult time. Some staff have already been redeployed within the Trust.

10. Ongoing Industrial Action

Junior doctors are to be balloted for further industrial action once again with papers being sent out to BMA members in the second week of February. This comes after the announcement that Consultants have narrowly rejected the pay deal put forward by the government (51% rejected; 49% accepted) and it is now likely that further action will take place. All medical rotas in the Trust were covered during strike action in January which was the longest running period of strike action so far. Services continue to be monitored for safety during industrial action.

11. Relaunch of the Trust's Research & Development Group

The relaunch of the redesigned Research and Development Group, which will feed into the Quality & Safety Committee, was held on 9 January. Chaired by the Chief Medical Officer, it will include representation from clinical, DET and operations staff working together to provide better oversight of all the research taking place across the Trust. It will also set a vision for the research we take part in, ensuring that this is aligned with the Trust's vision, mission and values.

Enhancing our reputation as a provider of training and education

12. New senior medical appointments

Dr Myooran Canagaratnam took up the role of Director of Medical Education on 1 February 2024. He has significant experience in Medical Education and is currently the Child & Adolescent Tavistock Training Program Director, though he will be stepping down from that role in due course. We would like to thank Dr Jessica Yakeley, the previous Director of Medical Education, for the invaluable knowledge, commitment and leadership she has brought to the role over the past 15 years.

In January 2024, Sheva Habel was appointed as the Named Doctor for Safeguarding, and she will also provide clinical advice to the Prevent lead. Sheva takes over as Named Doctor for Safeguarding from Caroline McKenna who has held the role since 2018. Caroline will continue in her role as Deputy Chief Medical Officer, and we would like to thank her for the dedication and expertise that she brought to this important and sensitive area of work. Sheva first joined the Trust in 2009 and has been working as a consultant child and adolescent psychiatrist since 2015. She has a long-term interest in safeguarding and working across networks.

13. "Nurturing Natures" updated

Congratulations to Dr Graham Music, long standing Consultant Child and Adolescent Psychotherapist and lecturer at the Trust, on the publication of the third edition of his book, "Nurturing Natures". Graham has shared a video on the Trust website outlining

the new edition, and this includes the latest knowledge on children's emotional development, integrating research from attachment theory, neuroscience, development psychology and cross-cultural studies.

Great and Safe Place to Work, Train and Learn

14. Great Mental Health Day

26 January 2024 was the third Great Mental Health Day in London. The day forms part of efforts aimed at breaking the stigma that often surrounds discussions about mental health. Events took place across London, and three of our colleagues, John Lawlor, Gem Davies and Alisha Nurse, kindly shared their stories on our website and on our Trust's LinkedIn, Instagram, and X (Twitter) channels.

15. LGBTQI+ History Month and EDI Calendar

February is LGBTQI+ History Month, and this year's theme is celebrating LGBTQI+ peoples' contribution to the field of Medicine and Healthcare. We will be hosting a talk from activist Dr Ronx Ikharia as well as holding a LGBTQI+ History Month exhibition. We are also planning to have an organisational presence at London Pride in July.

We have published our first EDI calendar on the intranet. This new calendar is part of our work towards a culture where all our service users, students and staff feel visible, welcome and celebrated.

16. New Stuart Hall Foundation Scholars

Four students from the Trust's flagship M7 (perinatal, child, adolescent and family work) course are among the 20 new members welcomed into the Stuart Hall Foundation Scholars and Fellows Network. The Stuart Hall Foundation/Tavistock and Portman studentship aims to increase access to the Trust's courses and provide opportunities for students and academics from culturally diverse and disadvantaged backgrounds.

Well Led and Effective Governance

17. Integrated Governance Action Plan

In December 2022, the Trust set up the Integrated Governance Task and Finish Group to oversee and consolidate the implementation of actions emerging from the Office of Modern Governance board and leadership review, outstanding governance actions linked to Single Oversight Framework (SOF 3) exit criteria, internal audit and preparations for a CQC Well Led inspection. The Task and Finish Group worked closely with executive leads and the various Board Committees, taking a risk-based approach to the implementation of the actions.

The Group started with 113 actions and at the end of January 2024, 90 are complete, 6 were on track for completion by 31 January and a further 11 are in

progress with implementation expected by 31 March 2024. 5 actions are now no longer required and 1 will be dealt with as part of "business as usual."

Partnership – Within the ICS and Nationally

18. New Research Partnership with SOAS University of London

The Trust is partnering with SOAS University of London to develop a new research centre with the aim of understanding and addressing inequalities in access to mental health care, challenges in provision, and deficits in the experience and outcomes of care. The circa £8m funding for the centre comes from Research England's Expanding Excellence in England Fund. The Trust is excited to be a partner in this project to help reshape mental health care in London and globally.

Improving value, productivity, financial and environmental sustainability

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

The Trust's draft Medium Term Financial Plan has been developed in line with the Integrated Care System planning process. The latest iteration shows the Trust maintaining its current planned deficit in 2024/25 and moving towards a balanced plan in 2025/26. The closure of the GIDS service at the end of 2023/24 with the associated loss of income is the primary driver behind the two-year timescale to get back to a balanced plan position. This will be further developed as part of the ICS planning process in the coming weeks.

The reported financial position at 31 December 2023 (reporting month 09) was a deficit of £2,698k in the period, against a planned deficit of £2,781k i.e. positive variance of £83k. This is a continuing improvement against plan from the earlier part of the year, and reflects the stabilisation of the expenditure, after the series of one-off costs incurred in those earlier months. The Trust therefore expects to achieve its year planned deficit of £2.5m, still predicated on the assumption that GIDS decommissioning costs are funded separately.

National and Political Context

20. RCPsych reveals significant rise in urgent CAMHS demand

To mark Children's Mental Health Week, the Royal College of Psychiatrists is calling on the Government and ICBs to invest in targeted support for children and young people and turn the tide on the looming mental health crisis. Studies show that in just 4 years psychiatric teams have seen a 53% increase in the number of children in mental health crisis needing emergency support, rising from 21,242 referrals in 2019/20 to 32,251 in 2022/23.

The studies also show that many of these children have experienced deterioration in their mental health while on waiting lists, as overstretched CAMHS teams struggle to meet record levels of demand. Recently reported NHSE data shows that under-18s who are waiting for follow-up after a GP referral have already waited 5 months on average, and almost 2 years in the worst cases.

The Royal College had welcomed the Chancellor's announcement last year of an extra £5m to improve access to existing Early Support Hubs (for ages 11-25), but it cautions that an additional £125 to £205m is required to establish these hubs in every local authority.

21. National Review of Higher Education Suicides Announced

On 25 January, the Minister for Skills, Apprenticeships and Higher Education, Robert Halfon MP, wrote to all higher education providers setting out the steps that they need to take to participate in the National Review of HE Suicides, to be led by University of Manchester's National Confidential Inquiry into Suicide and Safety in Mental Health. Mr Halfon explained that that the aim of the Review was to ensure that lessons from past tragedies are learned in order that students are better protected in the future.

As well as announcing additional funding that was being made available to support providers in relation to student mental health and hardship, the Minister stated that NCISH would examine serious incident reports of suspected suicides and non-fatal incidents of self-harm, providing confidential feedback to providers and identifying common factors. He indicated that a report to the whole sector with anonymised findings would be published by Spring 2025 and encouraged all providers to take part in the review.

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – 21th February 2024			
Report Title: Integrated Quality and Performance Report			**Agenda No.: 8**
Report Author and Job Title:	Amy Le Good, Commercial Director	**Lead Executive Director:**	Sally Hodges COO, Clare Scott, CNO, Peter ONeill, CFO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☐ Assurance ☒		
Situation:	This is the January Quality and Performance Data report, The paper has already been reviewed by the PFRC on 13.2.24. Please note that while undertaking the new IQPR reporting data is pulled from the system on the third working day of the month following the previous month. We are aware that this will impact the activity performance data due to appointments not being outcome in time. Each report will have a year to date update to ensure all data is captured throughout the year.		
Background:	This data has been through local committees (DET and IQPR's) with the detail of areas of performance that need attention being brought to PFRC.		
Assessment:	There continues to be significant issues with waits in the key watch service areas. GIC have had a Kaizen week to focus on performance and PCPCS also had a Kaizen event on the 30/31st January. Both events have generated helpful areas to focus on, and staff have appreciated the supported time to focus on quality improvement. There are areas of very strong performance, Camden CAMHS has been outperforming other boroughs on the 4 week wait target in the ICS for the 4th consecutive month. Job planning is improving but there has been a slight dip in MAST, likely to be because of a previous approach to appraisals being done in designated time periods.		
Key recommendation(s):	The Board is asked to review the contents of this report for assurance on the quality and performance of our services.		
Implications:			
Strategic Objectives:			
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☒ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☒ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☒ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☒ Ensure we are well-led & effectively governed.

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	Risk Ref and Title:				

	RISK 1. Continued pressures resulting from limitations to Trust capacity and unwarranted variation in care pathways, is resulting in waiting lists and demand for some services continuing to increase. This could result in a deterioration of the quality and safety of services and impact on the service user experience. RISK 3. If standards of care to service users and students are not consistently met it could lead to poor clinical and educational outcomes and breaches of statutory and contractual obligations. RISK 4. A prolonged inability to have oversight, or understanding, of key quality indicators could lead to the organisation not being aware of patient safety, clinical effectiveness and/or patient experience concerns			
Legal and Regulatory Implications:	Yes ☐		No ☒	
	There are no legal and/ or regulatory implications associated with this report.			
Resource Implications:	Yes ☐		No ☒	
	There are resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	Delaying access to treatment can have disproportionate impacts on those already disadvantaged. The mitigation is to focus on reducing waiting times in a carefully managed way.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	The data has been through other committees eg local IQPR's but this is the first time the report in this form has been seen by the board.			
Reports require an assurance rating to guide the discussion: (tick)	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

NHS
The Tavistock and Portman
NHS Foundation Trust

Performance, Finance and Resource Committee
Integrated Quality and Performance Report

February 2024

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

Tavistock and Portman – Our Values and Strategy

The Tavistock and Portman NHS Foundation Trust

Integrated Quality and Performance Report — Month 9

Metric	Waiting List Management	SRO	Sally Hodges	Target		Measure	

Outstanding Pt Care | Education & Training | Partnerships for Research & Innovation | People Culture | Sustainability

Problem Statement

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

Vision & Goals

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

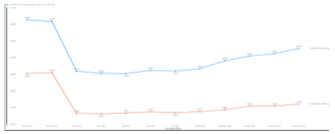
G1. Clearly defined pathways for patients within next 4 months

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

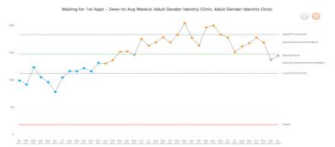
G3. Increase in patients in treatment vs on a waiting list

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

Historical Performance



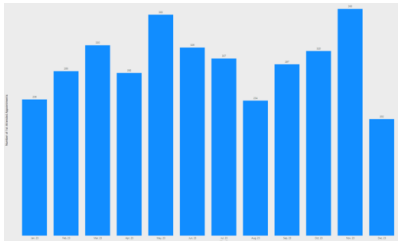
This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)



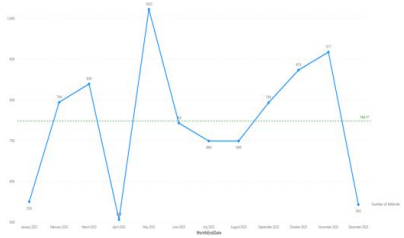
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

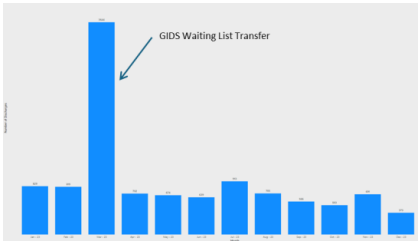
A. Number of first appointments conducted



B. Number of referrals by month



C. Number of discharges per month



Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
In some areas there is not enough resource for the numbers of patients being referred	Funding doesn't match demand	Negotiations with NHSE, we have received ERF funding that has doubled size of trauma and asd teams as well as increasing resources to GIC	Reduction in wait times due to taking more people from the waiting list	Hector and GM/s
Pathway Mapping has been developing or variable across the trust	Personalised or individualised care has driven care to patients already open	The mapping of 'as is' and 'to be' pathways is taking place across teams with a prioritisation of where there are longer waits	Having greater standardisation will prevent treatment drift, and with this create capacity which will enable waitlist reduction work	Sally Hector and ops teams
Data and metrics are inconsistent and not targeted	Lack of clarity about contractual requirements	IQPRs to flow team and service specific data that will allow better tracking of activity and improvement work	Team managers will have better resources to manage activity and with this greater accountability for team performance	Sally
Lack of clarity about actual capacity in teams	Lack of focused metrics to enable management to track and manage accountability	Job plans to be put in place for all staff and to be monitored on a regular basis	Clarity about capacity. Team managers better understanding of their team's performance fluctuations allowing them to adjust activity to compensate	Sally Rachel Hector

Integrated Quality and Performance Report — Month 9

Metric	User experience	SRO	Clare Scott	Target		Measure	

Outstanding Pt Care | Education & Training | Partnerships for Research & Innovation | People Culture | Sustainability

Problem Statement	Vision & Goals
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.	**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

Historical Performance

- 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.

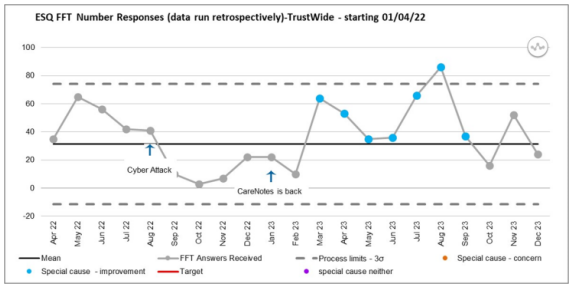


Chart A- Number of responses received which is low compared to the

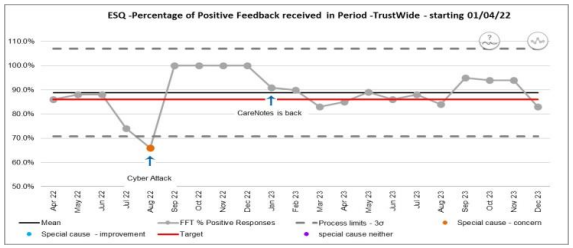


Chart B – ESQ data showing positive user feedback scores trust-wide from April 2022.

Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Low response rate – variance between touch points and number of responses	• Understand areas with largest opportunity to increase response rate and use targeted approach in this area • Develop benchmarks for each team	Report by service line and service by SPC chart and table (SP)	Sonia Perez
Lack of clarity on who is doing what by when	• Service user/Experts by Experience to be part of group • Include reception staff in group • Include team managers in the group • Include rep from IM&T/informatics • Develop understanding of the issues and agree PPI team identified lead • Process mapping has started with PPI and some clinical teams to understand current processes to collecting feedback • Review Platform that is being used – GIC mentioned their new platform • Consider how work already being done can be built into this.	Service lines to agree who will lead in their service line and update the PDSAs Process map of how we are collecting feedback, where it is collected and inputted into a system - Link with the outcome workstream and do a combined process map	Marcy Madzikanda and Service line leads Marcy Madzikanda and Antonia Carding-Wright
Extracting data and disseminating to the right areas	• Organograms developed and IT work programme to realign systems. • Interim - work with service lines to develop a feedback process for respective local teams	Clinical services seeing the feedback that has been collected. Learning from this and responding to improve services. Sharing positive feedback with staff	Sonia Perez and PPI
Uncertainty about what systems are in use to collect feedback	• Review what versions of ESQ are being used • Consider SU preferences for communication, various ways/multiple methods of providing feedback; making sure it is accessible • All see the standard ESQ, the one that GIC uses and the Trust wide ESQ • Consider what systems we use to collect the information	General managers to meet with PPI lead to collate what they are currently doing, bring back to next meeting	Aaron Horner Fiona Hartnett Gloria Leko
Share feedback from this group	• Is there a contractual requirement to feedback • Agree how work from this group is fed back through the service lines • Introduce a process for using the feedback , how it gets to teams to engage people and motivate them to encourage patients for feedback	Develop way of feeding back what we have done in response to feedback (e.g. you said we did)	Antonia Carding

Education and Training

Student Intake – Summary A3

SRO: Elisa Reyes-Simpson

Problem Statement

Without adequate market intelligence and financial viability modelling, it isn't possible to set meaningful and sustainable growth targets regionally, nationally or internationally.

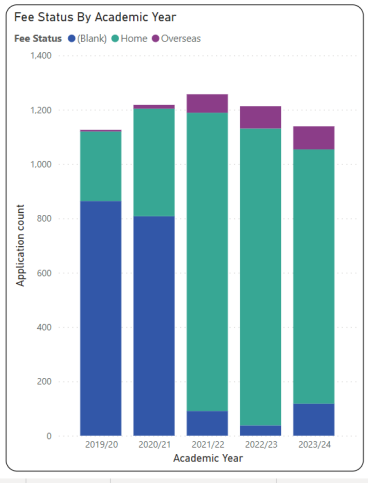
The number of applications for long courses was broadly similar in 2023/24 (1096) to 2022/23 (1098). The number of offers made to applicants in 2023/24 (813) fell by 1.5% from 2022/23 (825). However, the number of offers accepted has increased by 1.35% in 2023/24. As of 19/10/2023, 555 students had enrolled for 2023/24, compared to X at the same time in 2022.
Income from short courses has increased year on year from the pandemic (£1.2m in 2020/21 to £1.6m in 2022/23), as we moved to online delivery. We are currently forecast to see a slight decrease in income in 2023/24.

Vision & Goals

V1: Increase long course student population to 2000 students by 2023
G1: Increase student numbers by at least 40 additional students in 2024/25
G2: Scale growth to reach 5000 students by 2030, using a data-informed approach

V2: 60% increase in short course income by 2030
G1: Grow short course income by 15% for the 2024/25 cohort
G2: Implement a targeted marketing approach for 2025/26 recruitment cycle

Current Situation



The fee status differential has altered considerably between 2019 – 2023 (noting the effect of the pandemic on student recruitment in those years).

We experienced growth in certain international markets (China, India, Nigeria, Turkey) in 2023/24 compared to 2022/23, evidencing potential for growth in the coming years in the international student market – in traditional recruiting markets as well as new markets.

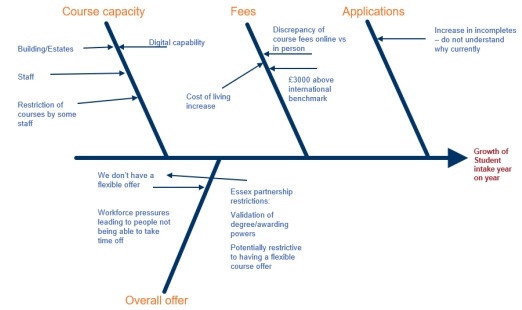
Top 10 Recruiting Countries (23/24)

Domicile	Applications
United Kingdom	614
England	395
China	17
(Blank)	16
Nigeria	8
India	7
Turkey	6
Northern Ireland	5
United States of America	5
Ireland	4
Pakistan	4

Top 10 Recruiting Countries (22/23)

Domicile	Applications
England	588
United Kingdom	511
Northern Ireland	15
United States of America	11
China	9
Ireland	9
Wales	7
Nigeria	6
(Blank)	5
Australia	4
India	4

Root Cause / Gap Analysis



Plans to validate:

- Include any learnings from current/previous student cohorts
- Course enquiry – reasons for not progressing application (c.1200 in 2023/24)
- Focus group with regional students
- Increasing our student numbers provides us with the opportunity to develop our brand and reputation which further supports the pipeline of students applying/wanting to train with us and supports the provision of MH services for the population going forward. We have identified an opportunity to increase student numbers to support this vision.

Countermeasures / Next Steps

#	Concern	Cause	Countermeasures in process/planned for next 30 days	Expected Impact	Owner	Status
1	Lack of flexibility in study modes	Restriction on validation from university partner	Discuss with existing partner/explore new partnership(s) SITS review awaiting commissioning with implementation post April 2024	Fit for purpose system allowing flexible modes of delivery	ERS (RSD)	Amber
2	Systems not suitable for long course and short course growth	Inadequate design and implementation of SITS and potential mismatch for short course offering	Scope improvement works required to SITS to facilitate new courses/study modes SITS review awaiting commissioning with implementation post April 2024 For short courses, commission and implementation of CRM	Flexibility of provision and increased number of students including those accessing LLE and competing with wider sector	ERS (RSD)	Amber
3	Lack of bespoke course commissions for high-revenue private entities	Lack of dedicated substantive staff in short-course portfolio	Explore alternative models similar to 'Department of Continuing Education' in HE settings Move from student marketing to student marketing, recruitment and admissions team based on marketing intelligence, data and conversion from enquiry to application	Increased student applications and new markets and reduce number of incomplete applications and increase number of complete applications	ERS (PD)	Amber
4	Lack of staffing resource across Professional Services teams	No investment in staffing in recent years – to match student growth	Proposal to be discussed at FIRM on 23rd January 2024, outlining substantial staffing increase (taking consideration of two ongoing consultations)	Increased resource to improve the student experience, minimise revenue loss and support student growth (= revenue growth).	ERS (RSD)	Amber
5	No diversification in type of student (i.e. degree apprentices)	Previous review outlined degree apprenceitships were not feasible	Collaborate with the Commercial team to re-review the feasibility of degree apprenticeships – using the Government Levy	Potential to diversify student intake in partnership with other entities; contribute to NHS Long-term Workforce Plan; leverage Degree Apprenticeship Levy	ERS	Amber

Education and Training

Sustainable Partnerships – Summary A3

SRO:

Problem Statement

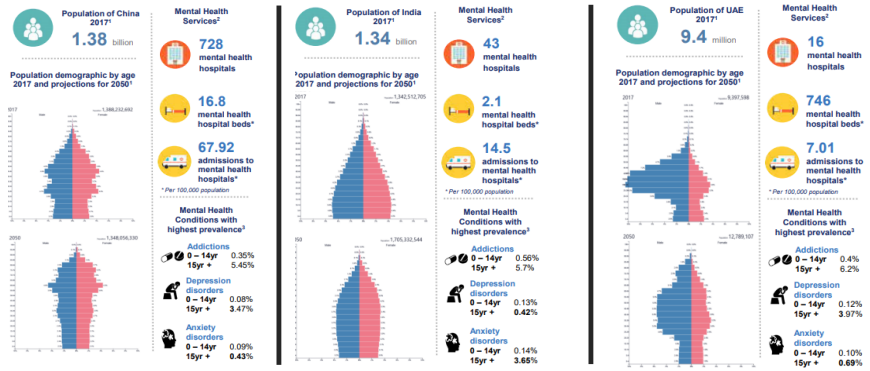
As an organisation, we do not currently have incoming generating partnerships in place to help achieve £x financial impact. This is directly related to access to future student markets, and is an indicator of our influence and reputation both locally and globally. If successful, partnerships would allow 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

Current Situation

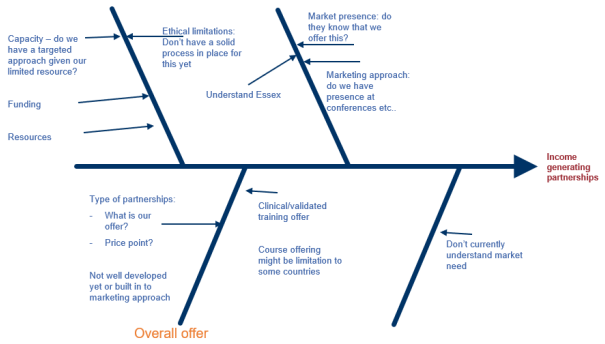


The Trust commissioned PA Consulting in 2018, to conduct a short review into the viability of developing a sustainable international education and training business.

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).

Root Cause / Gap Analysis



Plans to validate:

- Market intelligence
- Gap analysis – what do others offer that works vs what we do?
- Differences between local and global opportunities

Countermeasures / Next Steps

#	Concern	Cause	Countermeasures in process/planned for next 30 days	Expected Impact	Owner	Status
1	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 To take a transnational educational (TNE) approach to deliver in country T&P branded education and training; Identified countries: China, Philippines, Thailand and Vietnam, North Africa, Middle East, East Africa, South Asia. To adopt a pro-active approach using intelligence from existing interest to target specific countries and explore relationships with other HEIs. Meetings in place/being established with relevant organisations over next 4-6 weeks Digital delivery options to be developed	Marketing now moved into DET reporting to Director of Education: Operations Generation of new partnerships and student growth, increased revenue and promotion of T&P brand.	ERS	Amber
2	Lack of data to identify key applicant audience on a regional and national level					
3	Lack of breadth in student recruitment markets	Student recruitment has historically not followed a market intelligence/data-led approach	Continued horizon-scanning including engagement with potential partnerships via Department for Business & Trade trade missions (e.g. China in March 2024 – submitted on 19th January 2024) as well as the British Council's *Going Global Programme*	Increased potential for impactful revenue generating international partnerships for the medium/long-term	ERS	Amber
4	Lack of commercial focus on DET	No dedicated commercial/business development support for DET	Approval of an Associate Director of Business Development (DET) granted – advert going live in w/c 22 January.	Ability to develop ambitious and impactful revenue generating partnerships – with continual account management approach	ERS	Amber

‘Having a Voice’ – Summary A3

SRO: Chris Abbott

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

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, enabling us to play a pivotal role in shaping the future of population healthcare not only in the capital but also nationally.

Goals:

- 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

Current Situation

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	PCPCS	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

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.

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

From: Not producing any media assets / trainings on topic >>> To: Producing quarterly videos
:: Programme of monthly media development; videos, trainings, infographics

From: Lack formal **connections to partners** >>> To: Build coalition with NCL-WR, Cavendish Sq. Grp.

From: Lacking marketing channel for events >>> To: Exploiting coalition for event

From: Barely currently presenting at conferences >>> To: Steppingstone presentations / webinars

From: Lacking clearly **defined ‘pathways’** >>> To: Clarity of both our and others’ interventions

From: Do we research in this space currently? >>> To: Now doing Pop Health specific research

From: Little coordinated voice on ”Prevention” >>> To: Evidence of clear ‘Prevention’ work (See A3)

From: Little engagement from staff grass roots >>> To: Trained, mobilised + empowered staff group

Countermeasures / Next Steps

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

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.

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

- 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 estimate 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:

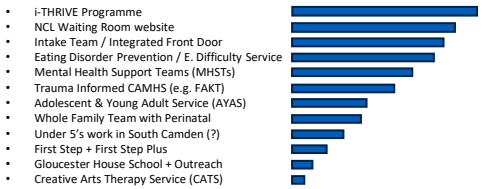
- Healing Together Camden School Offer
- Camden Council, Camden CCG and C&I
- Time to Change pledge
- Camden Early Help
- Healthy and ready for School
- The Health and Wellbeing Board

Camden partners:

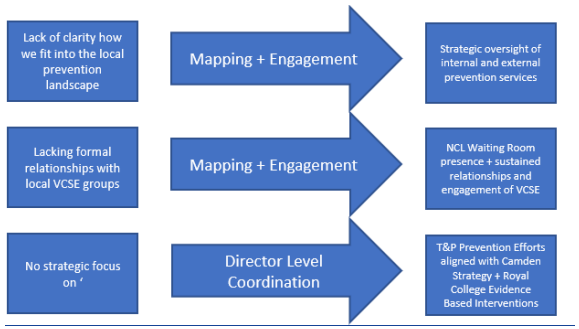
- Camden Early Help
- The Camden Health and Wellbeing Board
- Camden council
- Camden and Islington NHS Foundation Trust
- The Brandon Centre
- The Hive
- Fitzrovia Youth Action (FYA)

The current process involves partners VCSE working on prevention initiatives which the Tavi 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')



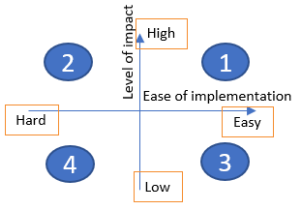
Root Cause / Gap Analysis



- Services are delivering this in isolation → no one service line/chain of accountability?
- Use focus groups/Camden Council to understand gaps if any

Countermeasures / Next Steps

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



Bullying and Harassment – Summary A3

SRO: Gem Davies

Problem Statement

WRES and WDES reflect an (%) increase in reported bullying and harassment and abuse disclosed within the staff survey and this is not reflected via other formal routes. This impacts culture, staff morale and the sense of inclusion.

Vision & Goals

Vision: for all reported incidents to match the WRES & WDES reported incidents

Goal for reported incidents to be more reflective of WDES/WRES incident levels

- Improvement based on reduction on difference between the reported incidents and WDES & WRES incidents:
- Year 1: 5% improvement/reduction in difference
- Year 2: 10% improvement/reduction in difference

Current Situation

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff

Table 9: Harassment, bullying or abuse in the last 12 months (staff)

WRES Indicator	Metric Descriptor		BME 2018/19	White 2018/19	BME 2019/20	White 2019/20	BME 2020/21	White 2020/21	BME 2021/22	White 2021/22
6 Staff Survey Q13c	Percentage of staff experiencing Harassment, Bullying or Abuse from staff in the last 12 months	Tavistock & Portman	27.8%	19.2%	25.7%	20.5%	23.4%	21.3%	30.8%	19.9%
		NHS Trusts	27.1%	21.2%	24.9%	21%	25%	19.6%	22.9%	18.1%

The WRES shows that harassment, bullying and abuse of BME staff from colleagues is increasing, and we are 7.9& worse than an average NHS Trust and have regressed from out position in 2018.

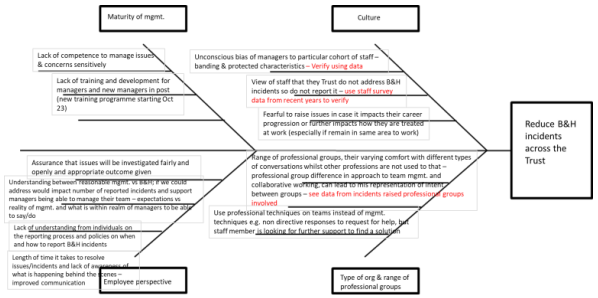
Metric	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying or abuse in the last 12 months from:	Disabled 2018/19	Non-Disabled 2018/19	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22
4 Staff Survey Q13a-d	(a) Patients/Service users, their relatives or other members of the public	27.6%	21.9%	30.9%	18.1%	21.2%	18.7%	17.6%	12.5%
	(b) Managers	21.1%	12.3%	21.0%	12.5%	32.1%	10.9%	25.3%	12.8%
	(c) Other Colleagues	14.0%	12.2%	21.0%	11.4%	24.7%	11.2%	24.2%	12.6%
	(d) Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	61.9%	47.8%	50.0%	60.6%	64.1%	63.5%	59.4%	52.2%

The WDES shows shows the proportion of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse from (a) patients, service users, or the public; (b) from managers, and (c) from colleagues in the last 12 months. Reports from colleagues has worsened compared to our 2018 performance. The percentage reporting B&H from managers has improved by 6.8%.

What does the data tell us?

- HR side → increase in reporting to people team in 6 months
- Some comms traffic
- Speak up – more to FTSUG than exec
- EDI – steady traffic
- Managers seeing increase in staff feeling B&H from managers and haven't raised elsewhere
- QP being revamped
- Exit interviews – leads to fact finding

Root Cause / Gap Analysis



Key next steps include interrogation of available data, assessment of the impact of L&MD training, implementation of and associated training for new just and learning culture policies, introduction of second FTSUG (and subsequently ambassadors), clearly explain processes to staff and communicate (anonymously) case studies of real claims.

Countermeasures / Next Steps

Concern	Cause	Countermeasure
Maturity and competence of managers		New training and leadership programme which started in October 23
Employee perspective	Lack of training for staff on policy and expectations & understanding the process	1. Updated resolution policy – will address the communication to staff and how we manage (use speak up policy to outline manager commitments) 2. Open forum for staff & managers when we launch resolution policy in January

People Culture

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

	2021	2022
Your org	7.2	7.3
Best	8.7	8.7
Average	8.3	8.3
Worst	7.2	7.3
Responses	411	335

Workforce indicators for each of the four workforce indicators, comparing the data for white and BME staff	
Indicator 1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM 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 accessing 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 outcomes of the responses for white and BME staff	
Indicator 5	Percentage of Black, Asian and minority ethnic staff experiencing harassment, bullying and abuse from patients, relatives 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

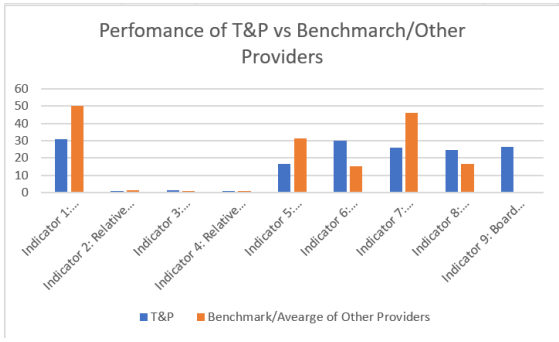
Our diversity and inclusion score increased by 0.1 from 21/22 to 22/23 however our response rates also decreased in this period.

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

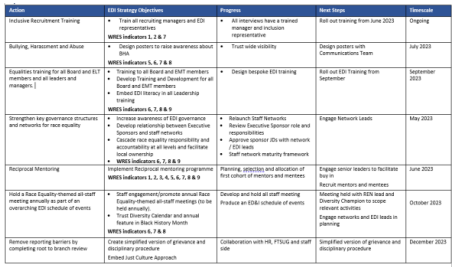
There are 9 indicators that contribute to EDI score from staff survey as per table:

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.
Key activities include implementation of our vision, mission, and values, including associated expected behaviours and how to 'call in' those not adhering to our values, as well a continual development of a just and learning culture.

Countermeasures / Next Steps



Action	EDI Strategy Objectives	Progress	Next Steps	Timescale
Inclusive Recruitment Training	• Train all recruiting managers and EDI representatives **WRES indicators 1, 2 & 7**	• All interviews have a trained manager and inclusion representative	Roll-out training from June 2023	Ongoing
Bullying, Harassment and Abuse	• Design posters to raise awareness about Bmk **WRES indicators 5, 6, 7 & 8**	• Trust wide visibility	Design posters with Communications Team	July 2023
Equalities training for all Board and ELT members and all leaders and managers. [	• Training to all Board and EMT members • Develop Training and Development for all Board and EMT members • Embed EDI literacy in all Leadership training **WRES indicators 6, 7, 8 & 9**	• Design bespoke EDI training	Roll-out EDI Training from September	September 2023
Strengthen key governance structures and networks for race equality	• Increase awareness of EDI governance • Develop relationship between Executive Sponsors and staff networks • Cascade race equality responsibility and accountability at all levels and facilitate local ownership • **WRES indicators 6, 7, 8 & 9**	• Relaunch Staff Networks • Review Executive Sponsor role and responsibilities • Approve sponsor JDs with network / EDI leads • Staff network maturity framework	Engage Network Leads	May 2023
Reciprocal Mentoring	Implement Reciprocal mentoring programme **WRES indicators 1, 2, 3, 4, 5, 6, 7, 8 & 9**	Planning, selection and allocation of first cohort of mentors and mentees	Engage senior leaders to facilitate buy in Recruit mentors and mentees	June 2023
Hold a Race Equality-themed all-staff meeting annually as part of an overarching EDI schedule of events	• Staff engagement/promote annual Race Equality-themed all-staff meetings (to be held annually). • Trust Diversity Calendar and annual feature in Black History Month **WRES indicators 6, 7 & 8**	Develop and hold all staff meeting Produce an EDI&I schedule of events	Meeting held with REN lead and Diversity Champion to scope relevant activities Engage networks and EDI leads in planning	October 2023
Remove reporting barriers by completing root to branch review	Create simplified version of grievance and disciplinary procedure Embed Just Culture Approach	Collaboration with HR, PTSUG and staff side	Simplified version of grievance and disciplinary procedure	December 2023

Key activities include implementation of our vision, mission, and values, including associated expected behaviours and how to 'call in' those not adhering to our values, as well a continual development of a just and learning culture.

Sustainability

Team Level Budgets – Summary A3

SRO: Peter O'Neill

Problem Statement

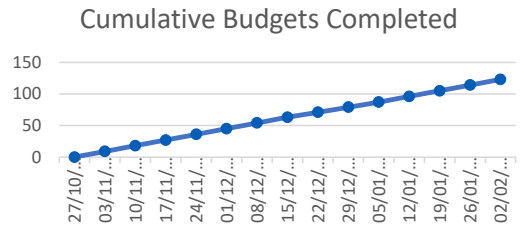
We don't have agreed team level budgets in place that are recognised to reflect the outcome of the strategic review across the Trust. We currently have 11 budgets updated and finalised out of a total of 123. The impact is the lack of team level accountability and an inability to produce service level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

Vision & Goals

1. A complete an initial set of team budgets by end of January 24
2. Ensure they are consistent with the agreed Trust Financial Plan, including updates for pay awards and assumed vacancy factors
3. Share with divisional managers and do initial cleanse for known movements of staff and/or posts
4. Provided actual spend to date and in month at same level/comparable format
5. Populate ledger with updated budgets
6. Prepare initial budget statements including the above as at M09.
7. Initial meeting with divisional reps to identify initial high level queries and agree specific improvement plan reflecting individual circumstances

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.
- ESR reconciliation process identified with input from HR and budget holders.
- Budgets will be drafted based on known plans and queries/cleansing done at cost centre level but reflecting whole divisional position, i.e. functional groups of services
- Budget working papers produced and updated based on tracked movements each month
- Recurrent and non recurrent additions to resources, eg ERF funding added and reflected in budget reporting going forward
- Monthly process in place, including scheduled meetings to pick up queries and budget variance issues, and feed into existing IQPR process
- Actual spend to be reviewed against budget, as part of the update and cleansing process.



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	- Put process in place - Regular dialogue/meetings HR/Finance and budget holders
Reporting Process not adequate to generate team level accountability	No budget reporting done routinely	Budget reporting being developed with adequate monthly budget management

Sustainability

MTFP – 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 MTFP 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 MTFP requires confirmation of the funding of the GIDS decommissioning before it can 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 MTFP 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.	MTFP 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

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Variation	Assurance	Mean	Sept 23	Oct 23	Nov 23	Dec 23
	Patient safety incidents	N/A				12	18	12	10
	Violence & aggression incidents	TBC				8	9	11	6
	Restraint incidents	TBC				1	1	0	0
	52-week+ dormant cases					2473	2380	2350	2366
	No of referrals (including rejections)	850				813	892	945	622
	No. of attendances	7046				5886	6079	7383	4665
	No. of discharges	730				566	505	693	382
	% of Trust led cancellations	<5%				4.09	5.54	3.84	6.39
	% of DNA	<10%				10.13	10.24	9.69	10.19
	Number of formal Complaints received	<10				7	5	7	3
	Formal complaints responded to within agreed timeline (%)	90%				42%	0%	0%	0%

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

CQC Measure	Metric	Target	Variation	Assurance	Mean	Sept 23	Oct 23	Nov 23	Dec 23
	Number of informal (local resolution) complaints	TBC				0	4	1	1
	ESQ positive responses (%)	90%				95%	94%	94%	83%
	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS	0				59	65	59	65
	18-week RTT breaches ASC	0				31	40	53	70
	18-week RTT breaches GIC	0				12851	13120	13232	13486
	18-week RTT breaches Trauma	0				438	461	491	527
	18-week RTT breaches PCPCS	0				61	50	51	90
	Mand and stat training	95%				56.33%	55.72%	75.78%	76.93%
	Appraisal completion	95%				79.70%	78.86%	79.57%	81.47%
	Staff sickness	3.07%				2.39%	2.23%	3.98%	3.17%
	Staff turnover	2.20%				1.88%	0.57%	1.07%	1.47%
	Vacancy rate (On Hold)	15%				15.41%	12.35%	12.46%	12.90%
	YTD savings								
	CIP								

Legal	All aspects of care provision is covered by the Health and Social care Act, this paper provides assurance on safe high quality care (Including mortality).
Regulation	The Care Quality Commission (CQC) regulates patient safety and quality of care and the CQC register and therefore license care services under the Health and Social Care Act 2009 and associated regulations.
Patient experience/ engagement	This paper includes significant detail on both patient experience and access to services.
Risk & performance management	This is the main Board assurance report for performance against quality and financial measures and is linked to risk management through the SRR.
NHS constitution; equality & diversity; communication	This report covers performance against access standards with the NHS Constitution.

NHS
The Tavistock and Portman
NHS Foundation Trust

Are we safe?

Delivering our vision – How are we doing?

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 10 Patient Safety Incidents in December The Patient Safety team have introduced a safety huddle to triage and review all incidents submitted, providing feedback to individuals and teams on recorded incidents, and to establish where further review and investigation may be needed. This will continue to be strengthened as part of the implementation of the Patient Safety Incident Response Framework (PSIRF). All incidents related to patient safety and with a clinical implication are currently reviewed through the reformed Clinical Incident & Safety Group (previously named Incident Panel). The November 2023 Clinical Incident & Safety Group (CISG) noted a theme in Gloucester House incidents of sexualised behaviour from pupils to staff and other pupils. It was recommended that a representative from Gloucester House join the Sexual Safety Charter group – this has been actioned.	**Pt safety incidents** **10**
The Trust reported 6 Violence & Aggression incidents in December The majority of the Violence & Aggression incidents are reported in the Gloucester House team (Community & Integrated service). As part of the implementation of PSIRF, the way in which the Trust learns from incidents of this nature is being strengthened. An after action review was recently undertaken following an incident of violence in a clinical setting. The AAR was reviewed at the January 2024 CISG, and will have an action plan developed to address the learning found. Escalating behaviours, or deteriorating mental health presentation, following appointments has been noted as a key area of action following it being identified as possible emerging theme of incidents. The Deputy Chief Medical Officer is leading a task and finish project to produce a supporting procedure for staff and patients in these instances. *Data as reported in the 'Physical & Verbal Abuse' category.*	**V&A incidents** **6**
The Trust reported 0 physical restraint Incidents in December Restraint incidents are predominantly reported in our specialist school team (Community & Integrated service). The way in which these incidents are recorded, reported and reviewed is being strengthened.	**Restraint incidents** **0**

The Tavistock and Portman
NHS Foundation Trust

Are we effective?

Education and Training

Successes

- **Staffing structure review completed – with proposal discussed at FIRM (23/01/2024)**
- **Comprehensive review of SITS commencing in February 2024**
- **367 applications received for M4 *Child, Community & Educational Psychology* doctorate (c.50% increase on 2023)**
- **73 applications received for M80 *Child and adolescent Psychoanalytic Psychotherapy* doctorate (c.16% increase on 2023)**
- **Accepted on Department of Business & Trade healthcare education mission to China in March 2024**

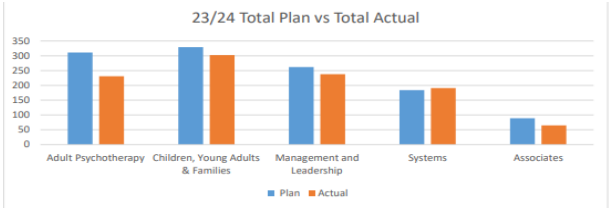
Challenges

- **Impact of SITS on associated systems (eg proposed CRM)**
- **Staffing resource – particularly in Academic Registry; Student Marketing, Recruitment & Admissions**
- **Lack of dedicated resource for staff CPD**
- **Increased reporting and analysis requirements internally and externally without supporting systems**

Current Situation

Short courses:

Long courses:



Although our enrolment numbers for long courses are lower than the target figures for the year, we have recorded slightly higher numbers of enrolments for 23/24 compared to the prior year. We have also seen a dramatic increase in the number of incomplete applications - marketing and admissions teams have worked together to increase conversion rates during this cycle. Target enrolments reflected a desire for growth, but application numbers remain unevenly spread across programmes, with many having application numbers broadly similar to the previous cycle. We saw a decline across portfolios for non-standard courses, which had resulted in significantly lower uptake of for online and evening versions of some of our more popular programmes. We have also seen a decline in applications and enrolments for our professional doctorate programmes, which has particularly affected the Management portfolio.
While these programmes are highly specialist, viability remains an ongoing concern. We have also secured a lower number of associate students across our courses. Several of our introductory courses maintained excellent recruitment numbers (particularly those relating to children and systemic modalities), which may bolster figures for more advanced programmes in subsequent years. We would expect Q4 to reflect continued enrolments in our Perinatal Mental Health module, although these numbers will decline in subsequent years due to changes in the funding associated with this programme. The following year will also see the launch of several new and revised programmes (including a specialist programme on Trauma and a revised version of our popular psychodynamic psychotherapy programme), which aim to increase the breadth and cohesiveness of our long course offering, particularly around adult psychotherapy

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.

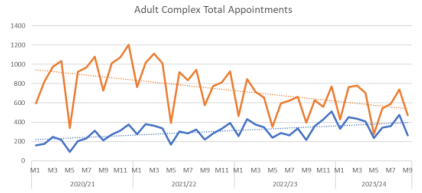
Next Steps

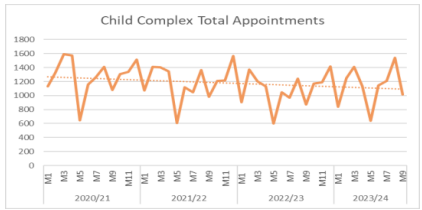
Concern	Cause	Countermeasure
Competing with HEIs able to deliver degree apprenticeships / flexible teaching modes	Lack of staffing resource; degree awarding powers; systems issues	Updated review needed looking into the feasibility of degree apprenticeships as well as degree awarding powers
Data quality and reporting issues	Issues relating to SITS as well as lack of staffing expertise to update and reconfigure Power BI dashboard (current data reporting is inaccurate for 2024)	Request for permanent staffing resource dedicated to data quality and reporting.

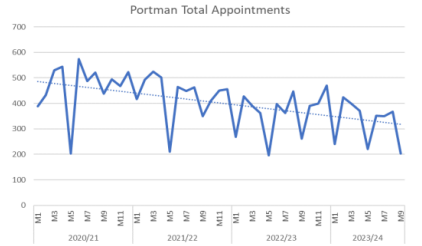
Complex Mental Health

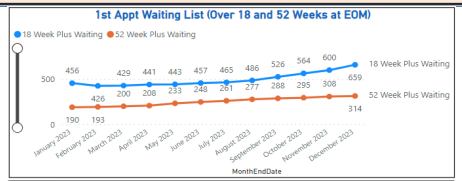
	Successes	Challenges
Safe	• Significant improvement of timely distribution of Care Plans in Child Complex Service in Q3	• Reduction in MAST compliance from 83% to 75% requires urgent attention in Q4 • Care of waiters on Autism waiting list requires dedicated resource and focus.
Effective	• Improvement in job planned activity compliance September to November, with October and November being over 100% • Early success of the Psychotherapy Team Assessment QI project – 17% reduction in patients waiting since Mid-Nov 2023	• Child Complex outcome measures requiring focused attention in Q4. • Waiting times increases with increases in referrals for ASC at 65% and 106% for Trauma compared to last year
Caring	• New Adult Complex Service waiting room opened which has supported a significant increase in collection of CORE and ESQ. Patient feedback has been positive with reception team commended by patients for their care and relational approach.	• ESQ completion rates low in a number of teams in Q3
Responsive	• Identification of key areas for service improvements following recent incidents and complaint responses e.g. how we communicate with patients about waiting times and what to expect from their visit, treatment, consultation etc	• FDAC reduction in cases, impacting on income and placement of team. Estates working closely with the team to work to a solution. • Space for staff - newly funded roles in Trauma and Autism Assessment require plan for available space
Well Led	• Reduction in complaints waiting investigation and summary correspondence	• Low clinical and line management supervision returns across many clinical teams • Staff morale is low, we are encouraging all staff to take part in the case for change sessions and to focus on business as usual.

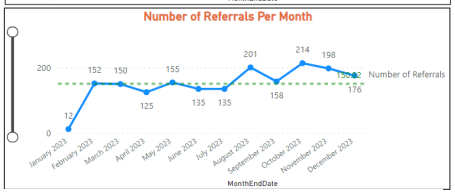
Activity Overview

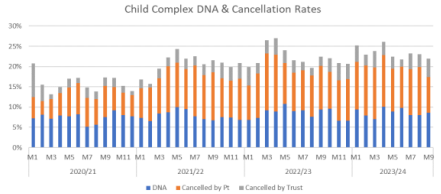


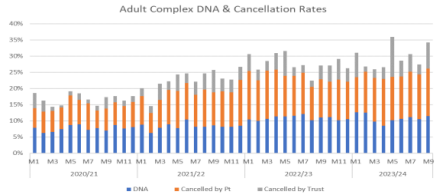












Analysis

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 PFRC.

Initial Job planning analysis for the service line:

Team	YTD Expected Appts	YTD Actual Appts	YTD	M1	M2	M3	M4	M5	M6	M7	M8	M9
FMH	2121	1943	83%	73%	84%	106%	75%	48%	78%	98%	99%	64%
FAKT	1003	689	84%	47%	74%	59%	77%	35%	118%	123%	153%	79%
AYAS	1489	1208	82%	61%	89%	92%	85%	44%	87%	119%	97%	26%
EDAS	1129	1034	88%	84%	61%	110%	93%	91%	87%	120%	84%	70%
Autism & LD	867	584	72%	38%	77%	89%	61%	54%	114%	110%	128%	85%
Child Complex Total	**6608**	**5458**	83%	62%	79%	93%	78%	52%	92%	112%	106%	62%
Trauma	1735	1495	78%	60%	84%	83%	88%	44%	76%	109%	97%	55%
Psychotherapy	2178	1450	75%	48%	82%	78%	90%	30%	72%	90%	105%	77%
Adult Complex Total	**3913**	**2945**	76%	54%	83%	80%	89%	38%	74%	99%	102%	67%
Portman	2523	2043	84%	57%	98%	87%	94%	57%	103%	102%	104%	57%
FCAMHS												
Returning Families												
Social Integration Total	**2523**	**2043**	84%	57%	98%	87%	94%	57%	103%	102%	104%	57%
Complex Mental Health Total	13043	10446	81%	59%	84%	88%	84%	49%	89%	107%	104%	63%
Cumulative Compliance	13043	10446	81%	59%	71%	77%	79%	73%	75%	80%	83%	81%

- 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, October & November were significantly better than previous months, particularly in Child Complex, which received intensive support and at The Portman
- December activity was just 63% compliant due to leave and sickness
- Adult Complex will receive targeted support in Jan and Feb to help understand the causes of their variance and support action plans being developed

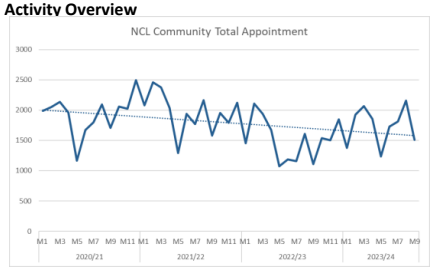
Next Steps

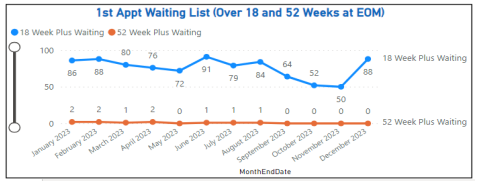
Concern	Cause	Countermeasure
Waiting Lists for ASC Assessment	Increased demand above expected growth levels	Programme of QI work developed (see A3s)
Waiting Lists for Trauma Treatment	Increased demand above expected growth levels	Programme of QI work developed (see A3s)
Reduced Activity Levels	To be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

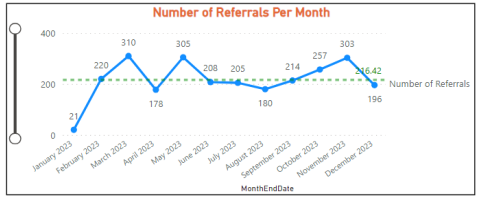
Community and Integrated

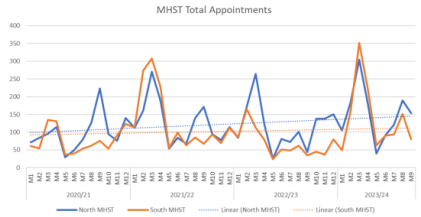
	Successes	Challenges
Safe	• Clinical notes compliance is very high in most teams. Those that have been below 90% compliant for 3 or more months are completing action plans.	• Gloucester House risks appear to have been removed from the Trust risk register. Lack of clarity of where we should log risks is meaning we are still not making progress here.
Effective	• Good levels of OM data collection at Time 1 in MHST and PCPCS • Waiting times remain low in NCL Community and MHST	• OM data collection is low in NCL community. • Low staffing in Surrey Mindworks T&P team has reduced activity.
Caring	• Advantage Mentoring scheme being established with Arsenal FC	• At least 10 staff in NCCT do not have consistent desk space. Staff in SCCT and South MHST are still sharing an undersized office and plans to address this need to be undertaken urgently.
Responsive	• NCL Community have offered 18% more appointments than last year YTD. MHST offered 62% more than last year and PCPCS 15% more.	• Job plan compliance fell to 55% in December with some teams falling under the 50% mark.
Well Led	• CQC action plan in place for all services in the service line with monthly monitoring of "must dos". Team are preparing data ready for an inspection focusing on areas of good practice.	• Team manager for SCCT leaves this month and no replacement has been recruited, Clinical Service Manager will cover taking her away from other duties

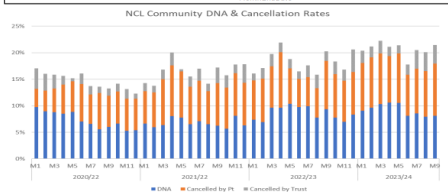
Activity Overview

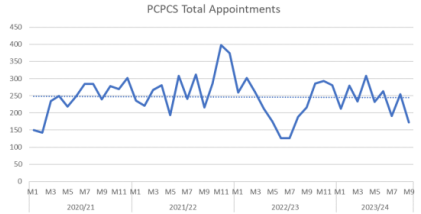


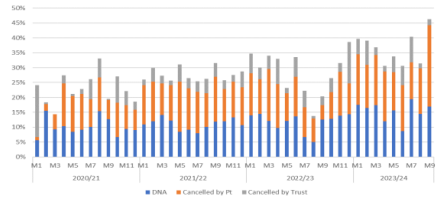












Analysis

Overall, Activity within the community and integrated service line has increased this year compared to 22/23 but remains lower than expected levels. 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 PFRC.

Initial Job planning analysis for the service line:

- Compliance in December was worryingly low in most teams, while there were many staff on leave, activity has not increased in previous months to balance this out. This is particularly concerning in North and South Camden CAMHS.
- In December we adjusted several staff job plans including increasing admin time for the more junior staff in CWP and MHST. This has resulted in more realistic job plans which we can see they are close to or have achieved.
- In April 2024 we will be moving to 52-week job plans which account for staff absence each month. We cannot do this sooner as ESR is required to make this work. The preparation will be undertaken now so we are ready to start in April.
- We have no job plans for Consultants currently and are working to develop those.

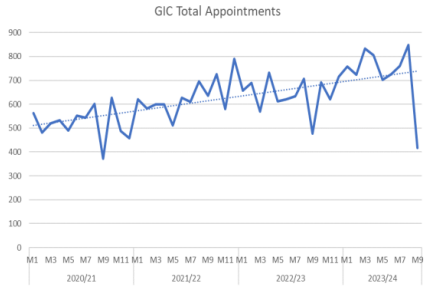
Next Steps

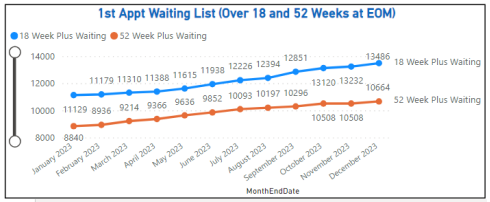
Concern	Cause	Countermeasure
PCPCS patient non-attendance	Patient engagement complexity	Pathway and modality of treatment review
Vacancy Rates	To be investigated	
Reduced Activity Levels	To be investigated	Review of Job plans
Inconsistency in record keeping	Different teams have developed SOPs in silos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

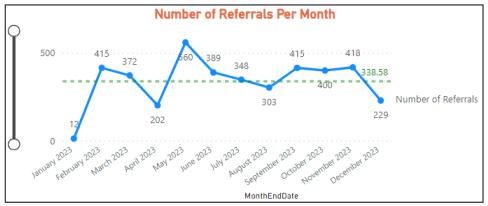
Adult Gender Identity Clinic

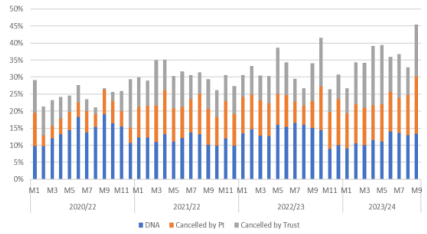
	Successes	Challenges
Safe	• The service has worked with Informatics and Quality assurance teams to allow the recording of activity to be added as clinical notes or a completed assessment form which will significantly improve compliance rate	• Vacancy rate of 19% . Rolling vacancies on Trac for Medical recruitment.
Effective	• Admin-Clinical Workshop feedback took place in November 2023 and lessons learnt shared with the service.	• Decreased number of 1st appointments due to clinical staff leaving.
Caring	• GIC Service Improvement week successfully took place in December 23 with positive feedback and engagement from staff. Six key areas of improvement were identified with an action plan to support delivery.	• GIC has one of the highest reported complaints in the Trust. Following the new complaints process we aim to respond to all complaints within the turnaround time and share learning in the Clinical Governance meetings as there are recurring themes around wait times.
Responsive	• DNA procedure has been finalised and once implemented we anticipate an improvement with our waiting list management.	• The GIC receives approximately 320 referrals a month and deliver approximately 60 first appointments per month, there is continued growth in the waiting list and capacity remains a concern.
Well Led	• The GIC have transferred over 500 cases as part of the NHSE/I Waiting List initiative the service will continue with the incremental transfer of non-complex cases to the identified pilot clinics.	• In discussion NHSE to ensure capturing of data endocrine advice (for patients/GPs) and other areas where working directly with professionals. GIC are working with informatics to ensure appropriate recording as part of the outcomes from the Kaizen week.

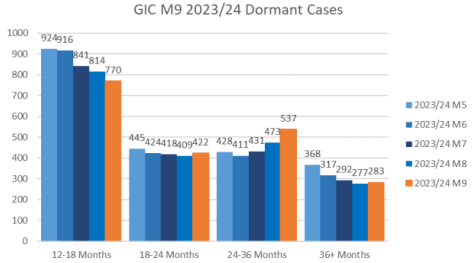
Activity Overview











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 appointments 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 QI 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
Consultant	5.2	1.0
Specialty Doctor	3.8	3.4
Endocrinology	5.6	0
Counselling/Clinical psychology	5.6	2.6
SLT	3.6	3
CNS	0	3
Total	23.8 WTE	13 WTE vacancy

- Sickness Levels within the team have remained high at 9.12% for December, however this is a reduction of 3% from the previous month.
- Risk highlighted with NHSE regarding the transfer protocol to the new clinics has been resolved and the new process is being enacted.
- The DNA rate is increasing and remains above the NHS DNA rate target. The service have taken initiatives to help decrease DNA such as: Three automated text messages sent ahead of appointments / DNA procedure finalised / Monitoring consecutive DNA through the Patient Tracking List (PTL) meetings

Next Steps

Concern	Cause	Countermeasure
Waiting List	See priority area A3	
Vacancy Rates	National Clinical Issue	Rolling adverts and increased promotion of vacancies
Inconsistency in record keeping	Different teams have developed SOPs in silos	Review and align SOPs across all service Lines

Gender Identity Development Service

	Successes	Challenges
Safe	• Clinicians prioritising preparing transfer templates for Phase one providers. Teething problems with new form. • Meetings undertaken with the new service leads to discuss transfer templates and how risk queries will be managed. • Commercial Director worked with GIDS project managers to rework patient trackers and support team with using the new combined Tracker to ensure full oversight for the Trust and NHSE.	• Managing distress in patient group and informing some service users that they will not complete the pathway to Endocrine in the service. Wraparound provision service still to be confirmed. • HR consultation outcome is resulting in loss of staff and potential caseload transfers to new clinicians. • Output of GIDS PTL meetings compromised in terms of activity management as specific requirements for Phase One transfer are prioritised.
Effective	• Project Team in place to join-up Demobilisation workstreams, to manage actions and tasks and ensure continuity. • Transfer template developed and loaded as a template on Carenotes and written guidance developed and shared with staff.	• Staff completing transfer documentation for patients to the new services and seeing some patients for the last time over the coming months. • BAU affected due to changing demands and notice of redundancy/redeployment.
Caring	• Continued support for YP whilst they await transfer of care to the new services. • Official discharge notification letter sent to all patients on 17+ waiting list who were transferred to adult GICs.	• Impact on YP surrounding the ambiguity of proposed wraparound service for those undergoing/due to undergo Endocrine treatment. • Delays in adult services picking up YP 17+ on the Endocrine pathway. UCLH meeting to discharge stable over 18's who can be managed by their GP. • Staff feeling increasingly demoralised, frustrated and upset from changes and delays in the transfer process.
Responsive	• Drop-in sessions for staff at risk following outcome of HR consultation. Staff adapting to constant changes to the stages of transfer and simultaneously maintaining patient care.	• Demobilisation of service and staff notice of redundancy has increased staffing risks and attrition and has by default added extra workload pressure on existing staff. • Reviewing outcome of clinical audits carried out on patient transfers to identify any areas of clinical risk. • Developed letters to patients regarding transfer and agreement for this.
Well Led	• Team managers demonstrating effective leadership by supporting clinical staff with their 'at risk' status. • Managers overseeing the demand clinical staff have, to deliver completed cases for transfer within fluctuating parameters.	• Clinical staff dealing with their 'at risk' status as well as being responsible for the quality and safety of patient care and patient experience during the transfer process. • Pacing work and providing written guidance. • Focussing on clear and timely communications to staff as new information emerges.

High Level Open Caseload Data

Patient Type	Total
Number of Patients currently open to the service.	**782** (open caseload as of 16th January 2024)
Number of Patients to be transferred to Early adopters, i.e., patients on open caseload under 17 years old on 1st April 2024 & not on an Endocrinology pathway.	**253** (number of 17 years old and under on 1st April 2024)
Number of Patients Open to Endocrinology.	**382**
Number of Patients to be transferred to Endocrine Wrap-around service, i.e., 17 years and under 31st March 2024.	**107**
Number of Patients requiring face-to-face handover due to complexity and/or risk.	**58**
Number of Patients offered the possibility of rapid re-referral 17 years and under 31st March 2024.	**55**

Data taken from Clinical patient trackers 16 January 2024

Risks Highlighted by the Service

- Risk of increased distress for young people expecting possibility of access to an endocrine referral in GIDS, who are no longer able to do so
- Risk that some young people, with or without the support of their families, will access hormone treatment outside the NHS
- Risk of increased distress for young people learning they will restart assessment in the new services
- Delay in having information about the model of care/pathways in the new services will not leave sufficient time to gain consent to transfer for the relevant GIDS open caseload
- Risk that young people (17+) referred to adult services and still in GIDS endocrine will not have been picked up by GICS by April 2024
- Risk that some 17+ young people will not have an active referral to a GIC in place as either the GIC does not accept referrals before 18 years, the GIC will not accept referrals for YP on a titrating GAH regimen and/or the GIC has closed their waiting list
- Risk of reduction in clinical & admin staff through leaving the service, redeployment or sickness, meaning open caseload cannot be safely maintained, in progress referrals to endocrine cannot be completed & consent for transfer & transfer paperwork to the new services for all eligible young people cannot be completed by April 2024
- Risk of increased distress & access to unregulated treatment in young people on the waiting list held by AGEM as information from Cass, the new services & blocker consultation is shared

Key Updates from Service Line IQPR held January 2024

GIDS to be decommissioned 31st March 2024 and the service is in the throes of the demobilisation process. Staff are undertaking extraordinary tasks outside of their BAU responsibilities and roles.

Several iterations of patient transfer management trackers have been in place to deliver a safe and effective transfer. Versions of these trackers also serve as mechanism to respond to weekly NHSE data requests.

Phase One of transfer takes place January 2024. Completion of specific eligible caseload prioritised in terms of age, complexity and risk. Phase Two to commence February 2024 to include cases on Endocrinology pathway assigned to wraparound service.

100% of 17+ waiting list transfers to adult GICs completed, and official discharge notification letter sent to all patients.

Well-being is of paramount concern for staff at risk. Departures are taking place via redeployment and resignations.

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.

NHS
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Are we Caring?

Delivering our vision – How are we doing?

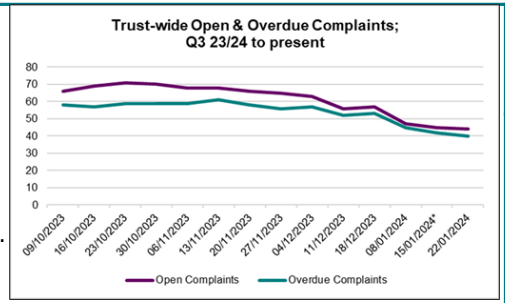
Caring- service involves and treats people with compassion, kindness, dignity and respect

The Tavistock and Portman NHS Foundation Trust

The Trust has recorded 3 Formal Complaints in December, 0% responded on time

Performance for closing formal complaints within the set timeframe continues to be below target. The reason for the accrual of the backlog was due to historical under-resourcing of the Complaints function, however more recently capacity of services to undertake complaint investigations, plus some increasing complexity of complaints, has meant that progress to address the number of overdue complaints was slower than anticipated. However there has been a notable reduction since November 2023 - overdue complaints have reduced from 68 at the beginning of November 2023 to 41 at the end of January 2024.

An improvement plan for the Complaints & PALS function remains in place.



Formal complaints responded to on time 0%

The Trust has recorded 1 Informal Complaint

The Trust's new complaint process was approved by the Quality & Safety Committee in January 2024, following engagement with complaint leads and managers across service lines. The new process emphasises early and local resolution as much as possible in line with recommendations from the Parliamentary and Health Service Ombudsman. The new process will be publicised with supporting documentation and training for staff on informal resolution. With this change, we expect informal complaints to increase and formal complaints to decrease as we manage these complaints more effectively.

This approach has been evident in the number of complaints received in Quarter 3 23/24 that have ultimately been resolved informally and/or through the Patient Advice & Liaison (PALS) team.

Informal complaints 1

The Trust has recorded 83% of ESQ Positive Responses

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.

There is an A3 project in place focused on user experience that has specified actions to address areas of concern related to collecting, reporting and improving experience data across all Trust services (slide 4).

Positive responses 84%

The Tavistock and Portman
NHS Foundation Trust

Are we responsive?

Delivering our vision – How are we doing?

Responsive – services meet people's needs

The Tavistock and Portman NHS Foundation Trust

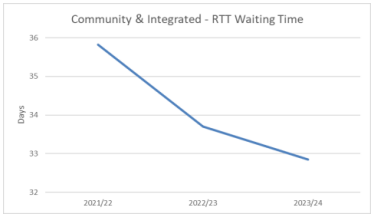
The Trust has declared RTT 14,238 18-week breaches across our services

The trust has identified key teams where waiting times for patients are above optimal levels (GIC, ASC, Trauma, PCPCS). Waiting List management is a key priority area for us, focussing on the teams requiring the most support. Unprecedented increases in referrals in these area have led to further waiting list increases. Please see slide 3 for further detail on the work to date.

RTT breaches
14,238

The Trust has declared an average wait of 21 days to first appointment in our Community and Integrated Service Line (excludes PCPCS as highlighted as an area of concern)

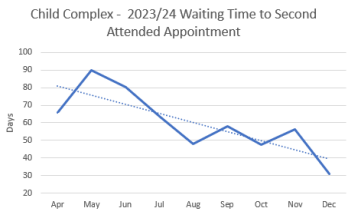
Our Community and Integrated service line reviewed their intake processes in 2023 following a rise in waiting times. They instigated a review using QI methodologies and we have seen a steady improvement across the service line. Their RTT average for December is 29 days.



Average Wait - Patients seen
21 days

The Trust has declared an average wait of 65 days to first appointment in our Complex Mental Health Service Line (excludes ASC and Trauma as highlighted as an area of concern)

This service line currently has a waiting time target of 11 weeks for adult services, 4 weeks for children's services and 18 weeks for our specialist Portman service. Child complex service average wait time in M9 to first appointment was 20.5 days and RTT was 30.9 days. The adult psychotherapy waiting times peaked in April 2023 at 42 weeks for a first appointment, this has been improving over the year and in December the waiting time for first appointment average was 28.6 weeks.



Average Wait - Patients seen
65 days

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NHS Foundation Trust

Are we well-led?

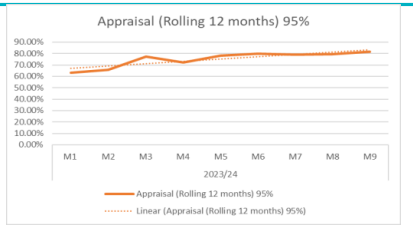
Delivering our vision – How are we doing?

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

The Tavistock and Portman NHS Foundation Trust

The Trust declared 81.47 % of Appraisal Completion

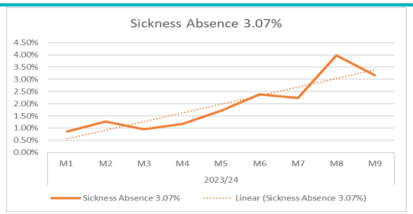
Although we are not yet at the target of 95% for Appraisal completion, there has been a steady increase in compliance due to the measures that have been put in place over the last 9 months to support managers and staff.



% Appraisal completion
81.47

The Trust declared 3.17 % of Staff Sickness in December 2024

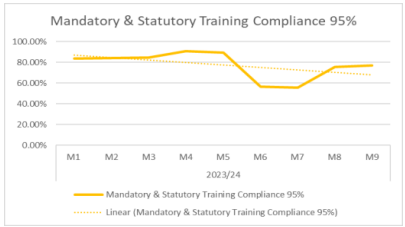
Staff sickness rates across the trust are increasing as they are better recorded and more accurately reflect the absence, however out sickness rates remain lower than other London providers. We continue to train managers on ESR supervisor self service and have also put support mechanisms in place for services where teams have high sickness levels.



% Staff sickness
3.17

The Trust declared 76.93 % of MAST Completion

Although we are not yet at the target of 95% for MAST completion, the impact of the implemented projects to support managers is having a positive impact on completion rates. The people team will continue to work with staff across the organisation to further increase these rates.



MAST training (%)
76.93

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Do we use resources effectively?

Delivering our vision – How are we doing?

Effective use of resources

The Tavistock and Portman NHS Foundation Trust

The Trust declared £2,781k YTD planned position for month 9 Income and Expenditure: The Trusts planned deficit of £2.5m requires the delivery of a £3m efficiency to achieve this. This is to be delivered by £2m of non-recurrent income and identified non-pay schemes of £1m. The Trust will in addition establish a process for planning and delivering recurrent efficiency opportunities to run alongside the current non-recurrent program to support the financial performance in future periods as part of the development of medium-term financial plans designed to get the Trust back further towards a balanced financial position. 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, there is a risk that we may be required to recognize the cost in this financial year by way of a provision. Given the level of uncertainty about the level of cost that the Trust will ultimately incur the current year-end projection does not include any estimates for these costs. 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 careful management to ensure the Trust spends to plan. 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.	**23/24 YTD planned position £2,781k deficit**
The Trust declared £2,698k deficit YTD actual position for month 9 Income & Expenditure: The Trust incurred a net deficit of £2,698k in the period, against a planned deficit of £2,781k i.e., a positive variance of £83k. Capital Expenditure: To date capital spend totals £1,266k, versus the plan total of £1,810k. Anticipated expenditure at the year-end still expected to be on plan at £2,196k. Cash: The cash balance at the end of the period is £4.6m against the planned M09 figure of £4.9m. The negative variance reflects the impact of the deficit and a continued lower income receivables figure from NHS sources	**23/24 YTD actual position £2,698k deficit**

The Tavistock and Portman NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	4 January 2024	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:			**Agenda Item: 9**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. Patient Safety Incident Response Framework (PSIRF) The Committee received an update on the work of the PSIRF Transition Group, and the work undertaken to support the Trust's transition to implementing the new framework. The new national framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It was noted that; • 30 members of staff will undertake three days of formal PSIRF training in January 2024, delivered by an external training provider. Plans are also underway to introduce the level 1 Essentials of Patient Safety training for all staff via ESR. There is training and strengthened responsibilities relative to patient safety and PSIRF for the Board which is currently being developed. • Three Patient Safety Partners were recruited in December 2023 following successful applications and interviews. Work planning for the new roles is underway including training and orientation with the Trust. • A series of engagement workshops with staff to introduce the principles of PSIRF and the difference this means in practice took place during November and December 2023. These were very successful in terms of beginning the conversations around PSIRF and what it means for our staff and processes. The Chair noted the speed at which the teams had progressed the PSIRF and commended the inclusivity of this work.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

2. Physical Health review The Committee received an update on the review of the Trust's physical health service, alongside proposals on future steps. Scoping work has taken place over the past year to gather feedback and evidence on what patients and staff need from a physical health provision benchmarked against national evidence and drivers. The findings of the scoping work indicated that the Trust's future provision may be different to that which was previously provided, but in line with a holistic approach to health and wellbeing. It was noted there are initially two phases of work in the next steps phase; firstly, a trainee health psychologist will undertake phase one of the work of developing the Physical Health Form along with its contents in the next six months. Phase two of the next steps will focus on refreshing the resource pack, which will be maintained as part of the NCL Waiting Room project. The Committee noted the significance and innovation of this piece of work.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. Local Risk Management System (LRMS) replacement The Committee received an update in relation to the new Local Risk Management System (LRMS). It was noted that good progress had been made in the project and implementation plan, however the project is in amber status due to the ambitious timescales and breadth of work that is needed. The Communications & Engagement plan, plus training requirements, is currently under development.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
4. Complaints The Committee reviewed a new version of the Trust's Complaints & PALS process, alongside a strengthened investigation report for formal complaints. This followed an extensive engagement exercise with clinical services and lead members of staff for complaints. The main points noted included: • The removal of 25 day working process timeline for response and replaced with 40 working days. • The Complaints & PALS team are developing a SOP and documents to support the local resolution process. • There is a current backlog of 48 open complaints, which was a significant reduction in number from previous months. • Training around the new complaints process will commence in January 2024. • Strengthened accountability of all managers to be responsible for timely complaints management and the culture of feedback within their teams. The Committee approved the new investigation report template and process for complaints.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

- The Committee APPROVED the PSIRF Transition Group Terms of Reference
- The Committee APPROVED the CQC Improvement Group Terms of Reference

Risks Identified by the Committee during the meeting:

There were no new risks identified by the Committee during this meeting.
Items to come back to the Committee outside its routine business cycle:
None.
Items referred to the BoD or another Committee for approval, decision or action:

Item	Purpose	Date
N/A		

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – 21st February 2024			
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 ☐ Discussion ☐ Information ☒ Assurance ☐		
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 Q3 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:			
☒ Improve delivery of high-quality clinical services which make a significant difference to the lives of the people & communities we serve.	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all thrive and feel proud in a culture of inclusivity, compassion & collaboration.	☐ Develop & deliver a strategy & financial plan that supports medium & long-term organisational sustainability & aligns with the ICS.	☐ Be an effective, integrated partner within the ICS & nationally, supporting improvements in population health & care & reducing health inequalities.	☐ Ensure we are well-led & effectively governed.
Relevant CQC Domain:	Safe ☒	Effective ☐	Caring ☐	Responsive ☐	Well-led ☐
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 5 – workforce development, retention and recruitment				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no legal and/ or regulatory implications associated with this report.				
Resource Implications:	Yes ☒	No ☐			
	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 ☒		No ☐	
	Junior doctors with caring responsibilities, e.g. parents of young children could have their work/life balance affected if they are required to take on higher than expected extra hours.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Guardian of Safe Working Hours Q3 report 2023/24

Executive Summary

The report details concerns raised by trainees regarding fine payments, DRS login issues resulting in reporting breeches on later dates. There has been a new staff appointment to oversee the fine payments. Diary monitoring exercise discussed with HR in October junior doctor's forum.

Recommendation to the Board

Members of Board are asked to note this paper.

1. Introduction

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

2. Exception reports

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
October	7	0	7	0
November	2	0	2	0
December	4	0	4	0

2.2 Work schedule reviews

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

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies.

2.4 Locum

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

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

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

	Extra hours worked Normal Enhanced		Total fine	Amount paid to trainees	Fine Remaining
	hrs	hrs	£	£	£
October	0	23hrs 30 min	3551.79	1331.98	2219.81
November	1hr	6hrs	1017.16	475.92	635.7
December	0	16 hrs	2418.24	906.88	1511.36
Total	1hr	45hrs30in	6987.19	2714.78	4366.87

Junior Doctors Forum (JDF)

New Trainee representatives in post. JDF meeting on 15th January 2024.

3. Local Negotiating Committee (LNC)

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

Conclusions and Recommendations

3.1. Members of the Board are asked to note the report.
3.2. We continue to monitor the impact of the junior and senior clinicians strikes on the exception reports.

MEETING OF THE BOARD OF DIRECTORS – 21th February 2024			
Report Title: Mortality and Learning from Deaths			**Agenda No.: 11**
Report Author and Job Title:	Dr C McKenna Deputy CMO	**Lead Executive Director:**	Dr Chris Abbott, CMO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☒ Assurance ☐		
Situation:	The Trust is committed to reporting, reviewing, and where appropriate investigating deaths. The processes and mechanisms for ensuring this occurs are undergoing significant change across the NHS through the introduction of the Patient Safety Incident Response Framework (PSIRF, NHS England » Patient Safety Incident Response Framework and also see Trust intranet) . The emphasis in this new framework is on learning and improving patient safety. There are additional internal changes supporting mortality reporting and learning from deaths which are discussed below.		
Background:	The Trust has an established though recently re-constituted monthly Clinical Incident and Safety Group chaired by the Associate Director of Quality. A Mortality and Learning from Deaths subgroup chaired by the Deputy CMO will report alongside the Clinical Incident and Safety Group. All deaths will be reviewed, and decisions taken about how to proceed within the new framework (PSIRF). This subgroup will proactively monitor and review deaths, review reports e.g. After Action Review, SJRs and consider the findings of mortality audits. A 3-day intensive PSIRF training for a group of senior clinical and administrative staff took place recently. The development of PSIRF in the Trust is in keeping with several other NHS Organisations (information recently shared at the Quality and Safety Committee). The Mortality and Learning from Deaths subgroup will seek to provide assurance to the Trust Board that through PSIRF all deaths are reported and responded to appropriately to ensure learning is shared, improvements are implemented, monitored, and maintained and that the organisation evidences how it enacts a just culture. Specific mortality audits have previously been presented to the Quality and Safety Committee (Nov 2023) and to the Trust Board (April 2023). The findings have been escalated to NHS England where appropriate, particularly in relation to long waiting lists for specialist services. An audit of deaths occurring within 6 months of case closure in Adult GIC is currently being undertaken. The next significant Trust wide mortality audit to be completed will be an audit of patient deaths (open cases and waiting list) 1 April 2023-31 March 2024. The key questions are– what are the number of unexpected		

	deaths and how many are classified as unexpected unnatural deaths? How can patient safety and patient care be improved, including for those on waiting lists? The Trust Risk Management and Compliance System is being replaced by Radar (www.radarhealthcare.com).The implementation project is underway but will take several months. There has been an initial scoping of the mortality module by key people in the Trust who will be using this module. H.M Coroners in England and Wales have a duty to write a Regulation 28 report when they identify causes for concern that, if addressed, could prevent future deaths. The Trust received two Regulation 28 rulings (Prevention of Future Deaths) during 2023 (April and December) and in both cases this related to death of patients on Adult GIC waiting list. See links - Prevention of future deaths report - 2023-0503 (judiciary.uk) Prevention of future deaths report - Courts and Tribunals Judiciary In relation to the GIC, the Trust is working with NHS England and other providers to develop innovative ways of reducing the waiting list and providing support to patients while on the waiting list; this includes the development of new roles including nurse led triage and peer support workers. A timetable of learning lessons events for the calendar year is in draft and includes presentations on the National Child Mortality Database NCMD | The National Child Mortality Database, Annual Report from The National Confidential Inquiry into Suicide and Safety in Mental Health NCISH | The University of Manchester and Suicide Prevention. The Trust has established a working group to consider how best to support Trust staff following the death of a patient by suicide.
Assessment:	New processes are being established to ensure that the Trust continues to support mortality reporting, learning from deaths and safety incidences. The planned mortality audit (April 2023-March 2024) will be reported in Q1 2024/25 and there will be an associated learning event.
Key recommendation(s):	The Board of Directors is asked to note the work that is currently being undertaken to ensure that new structures, processes, and mechanisms will be in place to support reporting and learning from deaths.

Implications:				
Strategic Objectives:				
☒ Improve delivery of high-quality clinical services which make a significant	☐ Be a great & safe place to work, train & learn for everyone. A place where we can all	☐ Develop & deliver a strategy & financial plan that supports medium & long-term	☐ Be an effective, integrated partner within the ICS & nationally, supporting	☐ Ensure we are well-led & effectively governed.

difference to the lives of the people & communities we serve.	thrive and feel proud in a culture of inclusivity, compassion & collaboration.	organisational sustainability & aligns with the ICS.	improvements in population health & care & reducing health inequalities.	

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title:				
Legal and Regulatory Implications:	Yes ☐	No x☐			
	However, there may be legal and regulatory implications related to deaths (PFD, Regulation 28)				
Resource Implications:	Yes ☒	No ☐			
	There are resources implications arising from this report in terms of continuing to support 1. audits, 2 supporting inquests, 3 legal advice via NHS R				
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☒	No ☐			
	Very long waiting lists preclude easy access to the service.				
Freedom of Information (FOI) status:	x☐ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.			
Assurance:					
Assurance Route - Previously Considered by:					
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS (PART 2) – 21ST FEBUARY 2024			
Report Title: Patient and Carer Race Equality Framework (PCREF)			**Agenda No.:12**
Report Author and Job Title:	Dr Christopher Abbott CMO	**Lead Executive Director:**	Dr Christopher Abbott CMO
Appendices:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	• There has never been a national, systematic way of identifying and changing race inequality within NHS services • National and local data shows us that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services		
Background:	• PCREF was a recommendation following the national Mental Health Act Review in 2018 • The aim is to move to equity in access, experience and outcomes for Culturally and Ethnically diverse communities • PCREF will be contractually required for all Mental Health Trusts from April 2024		
Assessment:	Dr Abbott (CMO) to be named exec lead for PCREF and to work with EDI team to set clear plan for the first year focused on engagement and data.		
Key recommendation(s):	This paper is for information so that the board is aware of what PCREF is and how it will work within the Trust		

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

Relevant CQC Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title: BAF 1 – delays to treatment, long wait times/demand; BAF 2 – maturity of data quality to support transformation; BAF 4 – quality assurance.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	PCREF is a legal requirement for all NHS Trusts from April 2024				

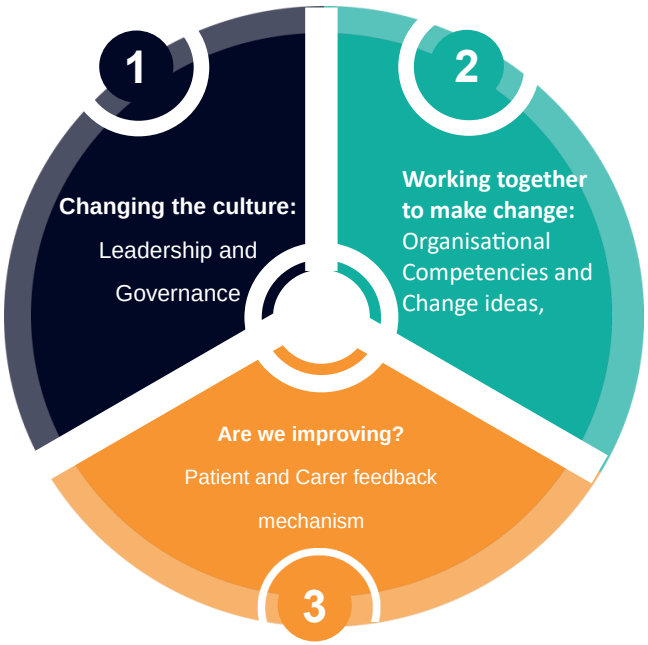
Resource Implications:	Yes ☒		No ☐	
	EDI Team will be leading on PCREF but more resources may be needed to ensure we meet our goals within the first year.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	EDI is the foundation of PCREF and will influence all we do within the Trust moving forward.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	PCREF plan to go to March Quality Committee and then Board for agreement in April.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☒ Not applicable: No assurance is required

Introduction

- There has never been a national, systematic way of identifying and changing race inequality within NHS services
- National and local data shows us that Black African, Black Caribbean and Mixed Black people are more likely to have poorer access, experience and outcomes when they use mental health services
- PCREF was a recommendation following the national Mental Health Act Review in 2018
- The aim is to move to equity in access, experience and outcomes for Culturally and Ethnically diverse communities
- PCREF will be contractually required for all Mental Health Trusts from April 2024

What is PCREF?

- There are three core parts to the work;



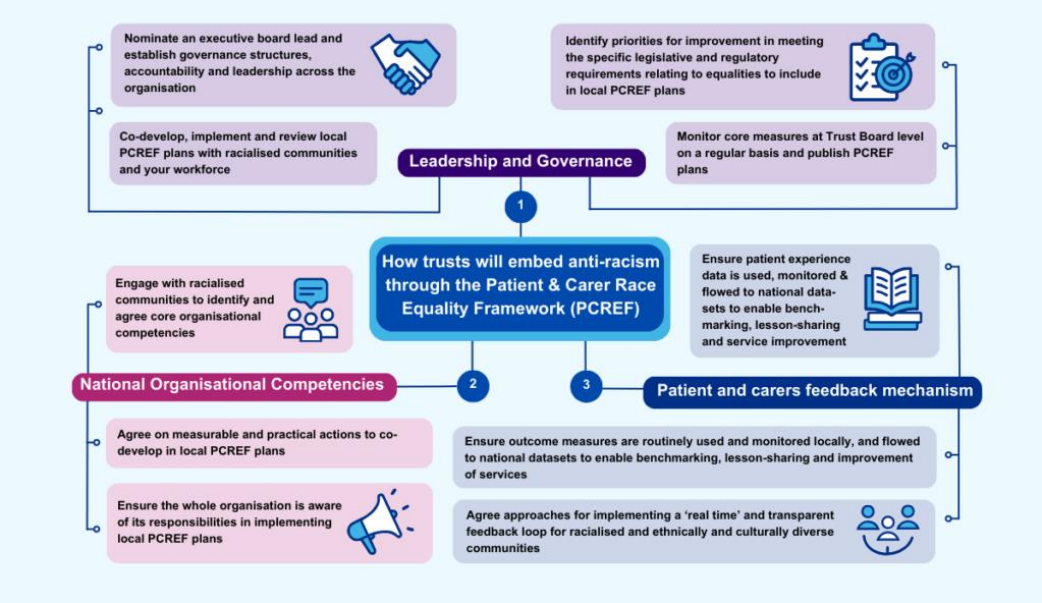
1. **Changing the culture around service delivery**
2. **Identifying the root causes of why there is inequity and what we can do together to change them**
3. **Checking if we are improving access, experience and outcomes – and if we aren't, do something different**

- The PCREF aims to be an accountability framework, enabling organisations to understand and take steps to improve experience and outcomes for individuals of diverse ethnic background
- It aims to identify areas of improvement by developing core organisational competencies. Ten national organisational competencies have been

identified, of which, six where highlighted as the most important competencies from the community:

1. **Cultural Awareness**
   Recognising and understanding the diverse cultural backgrounds of the communities our Trust serves, and being sensitive to those when providing care
2. **Staff Knowledge and Awareness**
   Recognising and understanding the racialised experiences of the communities our Trust serves and overcoming biases and prejudices by acting upon them
3. **Partnership Working**
   Services working more closely with ethnically and culturally diverse communities, leaders and organisations beyond the NHS
4. **Co-production**
   Ensuring ethnically and culturally diverse patients and carers are treated as equal partners in decision making with their care and treatment plans
5. **Workforce**
   A culturally competent and diverse workforce that has a positive impact on patient and carers from racialised diverse communities
6. **Co-learning**
   A two-way process that strengthens collaborative knowledge sharing beyond co-production principles

Implementation



What do we as a Trust need to do?

Part 1 – Leadership and governance

A commitment to a strong leadership and a governance structure is required for Trusts and mental health providers to deliver PCREF Part 1. To assist Trusts and mental health providers, NHS England has identified 12 key legislative and regulatory requirements, which apply to Trusts and mental health providers, and which impact upon racialised and ethnically and culturally diverse communities.

To enable delivery against these requirements and the implementation of the PCREF, each Trust and mental health providers will be expected to embed the PCREF in their governance structures. Based on PCREF pilot trusts learnings and recommendations, each Trust and mental health providers should have in place a nominated executive lead at Trust and mental health providers board level who is accountable for the delivery and oversight of the PCREF to evidence how Trusts and mental health providers are:

- elevating the voices of community representatives within Trusts' / mental health providers governance structures
- establishing partnerships with Local Authorities and voluntary sector organisations to engage on local priorities.
- implementing culturally appropriate care
- committing to become an anti-racism organisation

Legislation
The following legislation includes duties for Trusts and mental health providers which impact on racialised and ethnically and culturally diverse communities:

- NHS Act 2006
- Carers Leave Act 2023
- The Mental Health Units (Use of Force) Act 2018
- Children Act 2004
- Human Rights Act 2007
- Mental Health Act 1983
- Health and Care Act 2022
- Health and Social Care Act 2008
- Equality Act 2010
- Mental Capacity Act 2005
- Children and Families Act 2014
- Care Act 2014
-

Trusts and mental health providers are to actively demonstrate how they are reducing inequalities for racialised and ethnically and culturally diverse communities.

Leadership and governance summary

- Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation.
- Co-develop, implement and review local PCREF plans with racialised communities and your workforce.
- Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans.
- Monitor core measures at Trust Board level on a regular basis and publish PCREF plans.

Part 2 – National organisational competencies

PCREF Part 2 outlines critical competencies for Trusts and mental health providers, and mental health service provisions, these help to focus service transformation to better meet the needs of racialised and ethnically and culturally diverse communities.

The six most consistent areas of focus identified as national organisational competencies to improve the experience of racialised and ethnically and culturally diverse communities were:

1. Cultural awareness
2. Staff knowledge and awareness
3. Partnership working
4. Co-production
5. Workforce
6. Co-learning

Pilot trust and early adopter sites have been working with their local community networks, and their ethnic led voluntary sector organisations, to identify opportunities to strengthen, and purposefully deliver, these six organisational competencies to improve access, experience and outcomes for racialised communities.

National organisational competencies summary

- Engage with racialised communities to identify and agree core organisational competencies.
- Agree on measurable and practical actions to co- develop in local PCREF plans.
- Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.

Part 3: Patient and carers feedback mechanism

PCREF Part 3 supports Trusts and mental health providers to improve the routine use and collection of patient experience and outcomes data both nationally and locally and put in place an approach which allows learning from experience. This, combined with the routine monitoring of the core metrics from Part 1, should provide a well-rounded view of how patients and carers are faring, how they feel about the service, and whether the actions the Trust and mental health providers are currently undertaking are demonstrating an impact in addressing racism and discrimination.

PCREF Part 3 focuses on:

1. Agreeing the most suitable and impactful tool to measure the experience of ethnically and culturally diverse patients and carers at a local level. Further, evidencing how these experiences vary, and how feedback is being taken on board in a transparent way.
2. Routinely flow access and outcomes measures, in line with national requirements to national mental health datasets (i.e. Talking Therapies recovery) to better understand the impact of mental health services of racialised ethically and culturally diverse communities accessing/receiving care from Trusts and mental health providers.
3. Agreeing/co-producing with racialised and ethnically and culturally diverse experts by experience which of these access, experience and outcomes measures to monitor routinely at a Trust and mental health provider board level. This should be alongside the existing nationally recommended outcome and experience tools, as well as the metrics already specified in Part 1.

Nationally, mental health trusts and mental health providers are required to submit outcome measures to national datasets for IAPT, Adult Community, Children and Young Peoples and Perinatal mental health services. The use of outcomes and experience measures will support Trusts and mental health providers to get a better understanding of:

- Needs of the service user and areas of progress in relation to the service and staff, their care and wellbeing, and their symptoms/functioning leading to more personalised care.
- Identifying gaps in the service, demonstrating a service's accountability to improve delivery of care for racialised and ethnically and culturally diverse communities.
- Where Trusts and mental health providers are benchmarked to enable learning from each other to embed cultural changes for improving patient experience and outcomes.
- The impact of mental health activity in a local system.

Patient and carer feedback mechanism summary

- Ensure patient experience data is used, monitored and flowed to national data-sets to enable bench- marking, lesson-sharing and service improvement.
- Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.
- Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	January 2023	Shalini Sequeira, NED	Gem Davies, Chief People Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 13**		
Assurance ratings used in the report are set out below:					
Assurance rating:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	
The key discussion items including assurances received are highlighted to the Board below:					

Key headline	**Assurance rating**
1. EDI considerations • The committee received a paper from TM on the work on EDI considerations across the organisation, including a review of patient demographics. The chair made a request that a deep dive is undertaken at the next EDI Programme Board, focussing on ascertaining if the patient data is significant and whether it requires attention and if so, what the next actions should be. • The committee received AK's EDI review report and was comfortable with the recommendations provided. In relation to potential EDI training, the committee asked AK and GD to consider and bring to POD EDI the outcomes we hope to achieve through the training before sourcing a relevant provider.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. Leadership & Management Development Programme • The committee received a paper from SM, updating on the take up and cost of the programme to date. It was noted that there was a disappointing level of cancellations on the day of training, and disappointing uptake of the programme as none of the cohorts were full or nearly full. and that whilst some participants were clear that the programme was mandatory, others had not understood this. Exec presence on the first day of two cohorts had not been there however this has been addressed for future cohorts. The committee asked the EMT to ensure that all managers in their teams were freed up to go on the programme and enrolled themselves. The committee noted the excellent feedback for the programme from participants.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Policy Review • The committee discussed the progress on producing and approving new/ updated policies to date and was informed that progress had stalled due to the rather confusing approval route. AK noted that FT's post had now been recruited to and that a review and revision	Limited ☒ Partial ☐ Adequate ☐ N/A ☐

of the Policy Approval Group would be a priority for the incoming postholder. This should ensure that a number of policies awaiting final sign off can quickly be signed off.	
4. Merger and service decommissioning impact • The committee received a paper from GD, outlining potential impacts of both the merger preparations and implementation, and the closure of decommissioned services. It was noted that EDI considerations will be paramount in indicating the likely success of a merger and an equality impact assessment will be undertaken in due course. It was also noted that one of the impacts is a huge amount of extra work, on top of BAU, for the People team.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

The Committee approved the Terms of Reference for the POD Delivery Group.

Risks Identified by the Committee during the meeting:

There was no new risk identified by the Committee during this meeting, however a paper was circulated after the meeting on BAF risks and the committee members were asked to read it and return comments to AK.

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

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

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

Item	Purpose	Date
None		

The Tavistock and Portman
NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS

Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	Thursday 18th January 2024	Sal Jarvis, Non-Executive Director	Elisa Reyes-Simpson Interim CETO/Dean of Postgraduate Studies	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item:** 14		

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Finance & Business: CETO Budget 23/24: • The Committee received an update on the financial position of the Education and Training budget to the current full year forecast, including income by cost centre. • The forecast will continue to be updated; this version is likely to be used for the first draft of the 24/25 budget to be submitted to NCL in January 2024. • Work to refine the accuracy of the forecast will continue to ensure that the 24/25 Budget is based on the most realistic current data i.e., that non-recurrent income and expenditure is removed, and staff are recorded in the correct cost centres, as well as budgeting for vacancies into 24/25. • Fees have been set for AY24/25 and the expected impact of these for tuition fee. • income against student number assumptions will be reported in the next ETC report. • We are awaiting confirmation of additional resource to take forward the Visiting Lecturer review in a project managed manner. • The National Workforce Skills Development Unit will not continue after 31 March 2024. • The Annual Financial Return 2023 to the OFS has been submitted.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. CETO/Dean's report: • There has been much focus on implementing enhancements that have been identified through a range of feedback opportunities from students, staff, and other stakeholders. • Work is ongoing to strengthen our fundraising and bursaries offering and we are taking on board applicant feedback in relation to what we might develop. • We have continued our staff engagement events, which have been well attended with staff making good use of this space to share their thoughts and concerns.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

• There continue to be gaps in staffing. We are actively recruiting to the permanent CETO role and vacant Head of Academic Registry role. Interim arrangements are in place to mitigate any impact on staff and student experience. • We have reviewed our staffing and infrastructure in terms of our readiness and ability to embrace our strategic ambitions for growth, with a proposal being developed for FIRM. • Planning is underway in relation to enhancements in respect of this year's recruitment cycle. • Focused work is underway to deliver DET's objectives to achieve our 3-year improvement plan and Trust strategic objectives. Positive progress has been made in relation to the A3 QI work on growing student intake and developing sustainable partnerships.	
3. Workforce Innovation Unit (WIU) regular activity and performance report • The National Workforce Skills Development Unit is progressing on its 23/24 project portfolio for NHS England Workforce Training and Education directorate (NHSE WT&E). Several Unit and project related risks continue to remain high as a result of NWSDU contract termination in March 2024. Staff received formal redundancy consultation on 9 January 2024. • A new three-year business plan with a range of future options in light of the loss of the NWSDU contract was developed and submitted for review at the December ELT meeting. Following this a further option appraisal with be undertaken led by the Director of Strategy and Business Development. • The National Workforce Skills Development Unit is on target in year with eight open projects in 23/24 but faces two existential challenges, one in the recall of unallocated funding for 23/24 and the other in being decommissioned at the end of 23/24. • The TC / i-THRIVE part of the WIU appears to be on track to achieve a £235k (£20% of revenue) contribution to the Trust in 23/24. This contrasts with the £100,000 (12%) loss that these combined units have generated in the past. (i- Thrive has consistently contributed 25% to overhead over the last three years, hence the losses have been and continue to be driven by TC).	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. DET Development Update: • We are currently exploring international opportunities including to develop an overseas placement offer which would build on our existing visitors programme. • We are preparing a submission for the Department of Business & Trade's (DBT) UK Healthcare Education mission to China, taking place in March 2024. • The Trust's international development lead (0.2 WTE) has recently resigned. This provides an opportunity for us to think about how to resource this important, strategic area of work. • We are shortly to go out to recruitment of the Commercial Development Lead for DET and are also exploring the possibility of redeployment of Project Managers from NWSDU to support the work of the Digital and Short Course Portfolio.	Limited ☐ Partial ☐ Adequate ☒ N/A ☒
5. Annual Student Complaint Report: • We continue to manage complaints in line with our procedures, with the number of complaints received on par with previous years.	Limited ☐ Partial ☐

• There are some areas which require further work, particularly around ensuring both professional services staff and faculty are aware of their roles and responsibilities. This is particularly acute given changes in staffing post-strategic review. Several areas of concern in academic year 2022-23 related to these staff changes as well as vacancies in key roles. • There is a need to pick up the work in relation to standard operating procedures to remove the risk of being over-reliant on emails. • The proposal to the Financial Investment Review Meeting (FIRM) details a structure to address identified gaps in staffing. This includes a dedicated student credit controller. The SITS review will be looking to make sure our system and MyTap are fit for purpose. The cumulative effect of this alongside a general enquiry management/ticketing system, should be a reduction in gaps/single points of failure, shared processes, and a reduction in complaints.	Adequate ☒ N/A ☐
6. Student Cases Report 2022/2023: • The number of student cases (appeals, academic misconduct, student conduct concerns, professional suitability) continue to be low in relation to the number of students enrolled at the Trust, for most types of student case. • An exception is Extenuating Circumstances, where high numbers of cases continue to be seen, although these have reduced.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. Psychoanalytic Clinical Portfolio Report for ETC 2023: • There is a programme underway to consolidate the D58/D58L/BD58 with the D59I and D59F to create a modular master's training (M58/BM58/LM58) over four years that leads to registration with the British Psychoanalytic Council (BPC). The portfolio is also in the process of launching a post-graduate specialist training (Complex Trauma: The Tavistock Model – D19) over two years, based on the clinical model of the Tavistock's Trauma Service. • One of the key developments is that discussions are underway to develop international versions of the programme, specifically to a Chinese market. Initial investigations are also underway to potentially extend the M58 programme to incorporate a Doctoral award. • In terms of staffing, there is a full compliment. Recruitment is underway for an associate lecturer on M34, and the assessment lead role on M80 has been augmented. A joint research post, across M80 and M4 (in the Interprofessional Portfolio) has also been agreed and is going to advert. This will increase the profile and quality of research teaching across these doctoral programmes and ensure better governance of research degrees.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
8. Proposal For Tavistock Awards: • We are proposing to create a Tavistock Awards series to run alongside the current University of Essex honorary doctorate process and conferment. • By creating a Trust wide Tavistock Award Series, we would be able to widen the pool of potential recipients to others the Trust wishes to recognise, whilst maintaining staff and student experience of the event.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
9. Strategic and Operation Risks relating to Education and Training:	Limited ☐ Partial ☐

• It was noted that Education & Training is not a specific risk on the BAF. It was suggested that the A3 documents could be used as a starting point for thinking and developing the risk.	Adequate ☒ N/A ☐
10. Integrated Governance Action Plan (IGAP) Milestones for Sign-off • All of the milestones/ actions on the Integrated Governance Action Plan (IGAP) within the remit of the Committee have been completed.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

- The Committee **APPROVED** the recommendations to develop a Tavistock Award Series
- The Committee **AGREED** to hold a dedicated BAF seminar to determine the risks that could prevent the Trust from achieving its strategic ambition around education and training.
- The Committee **APPROVED** the 7 completed actions as final sign-off of implementation of the actions from the IGAP by the Committee.

Risks Identified by the Committee during the meeting:

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

- There is a risk that Visiting Lecturers could try and take legal challenge to the current contract in force without a review.
- Growing a sustainable source of bursaries applicable to a broader pool of students remains a significant challenge.
- There is a risk to student experience if we do not recruit to the Head of Academic Registry role in a timely manner.
- There is a risk we will not be able to meet our strategic ambitions for growth if we do not address gaps in our staffing and infrastructure.
- If commissions fall short of last years' the Digital and Short Course Portfolio will fail to meet its 10% increase in contribution.
- There is a risk that if we do not respond to student complaints and make enhancements/improvements to our education and training delivery in accordance with complaint outcomes, then this could lead to an increase in or repeat of student complaints, impacting on progression and recruitment, resulting in reputational damage and potential financial impact.
- There is a risk that if we are not seen to be responding to student complaints, then students will not raise their concerns until it is too late and/or use other avenues to raise their concerns.
- 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.

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

The Committee did not request any items to be tabled outside its routine business cycle.

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

Item	Purpose	Date

MEETING OF THE BOARD OF DIRECTORS PART 2 - PUBLIC – Wednesday, 21 February 2024			
Report Title: Finance Report - As of 31st December 23 (Reporting Month 09)			**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:			
Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 09 (cumulative position to 31st December 23) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £2,698k in the period, against a planned deficit of £2,781k i.e., a positive variance of £83k. **Capital Expenditure** To date capital spend totals £1,266k, versus the plan total of £1,810k. Anticipated expenditure at the year-end still expected to be on plan at £2,196k. **Cash** The cash balance at the end of the period is £4.6m against the planned M09 figure of £4.9m. The negative variance reflects the impact of the deficit and a continued lower income receivables figure from NHS sources.		
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:	**Income and Expenditure** The Trust's planned deficit of £2.5m requires the delivery of a £3m efficiency to achieve this. This is to be delivered by £2m of non-recurrent income and identified non-pay schemes of £1m. The Trust will in addition establish a process for planning and delivering recurrent efficiency opportunities to run alongside the current non-recurrent program to support the financial performance in future periods as part of the development of medium-term financial plans designed to get the Trust back further towards a balanced financial position. 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, there is a risk that we may be required to recognize the cost in this financial year by way of a provision. Given the level of uncertainty about the level of cost that the Trust will ultimately incur the current year-end projection does not include any estimates for these costs. **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 careful management to ensure the Trust spends to plan.		

	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.
Key recommendation(s):	The Committee is asked to **NOTE** the position outlined in the report.

Implications:

Strategic Objectives:

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

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

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

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

Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

The Tavistock and Portman
NHS Foundation Trust

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD)					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit and Governance Committee	6th February 2024	David Levenson, Non-Executive Director	Peter O'Neill, Interim Chief Financial Officer	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 17**		

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

The key discussion items including assurances received are highlighted to the Board below:	
Key headline	**Assurance rating**
1. External Audit Planning: • The Committee welcomed Grant Thornton to their first IAGC meeting. • Parris Williams (GT) outlined the proposed approach to the 2023/24 audit and described the planning work done to date with the internal team. No major concerns or risks were highlighted by Parris, with a bespoke detailed audit plan to be finalized, as the pre audit work continues. • The Committee discussed the potential risk that the limited internal resource could pose. It was recognized that the key to mitigating this risk is the early identification of the likely peaks in work, in particular sampling of transactions, and a more robust management of the audit as it progresses. • GT are planning to complete all of the detailed audit work by mid-June to allow sign off by the deadline of 28th June.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Internal Audit: • The Committee received the draft internal annual plan for 2024/25, that had previously been agreed by ELT. The plan was agreed as presented with changes needed. • The Committee received an update on the 2023/24 Internal Audit work, including the HFMA action plan. There are a reducing number of outstanding action points, with the majority relating to ongoing budget cleansing work and the development of the 24/25 efficiency program.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. Local Counter Fraud Plan: • The Committee received the draft annual local counter fraud plan for 2024/25, that had previously been agreed by ELT. The plan was agreed as presented with changes needed.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. IGAP Assurance:	Limited ☐ Partial ☐

• The Committee received an update on the IGAP plan to complete the recommendations from the Well-led review, with no significant risks to be referred to the Board of Directors.	Adequate ☒ N/A ☐
5. Pre-Employment Checks: • The Committee referred the findings in the local counter fraud report to the POD/EDI subcommittee, as the majority of the actions sit with the Chief People Officer.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

Risks Identified by the Committee during the meeting:

The Committee identified the following risk for escalation to the Board

BAF 8: Delivering Financial Sustainability Targets.
A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act.

BAF 10: Suitable Income Streams
The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust establishing sustainable new income streams and adapt the current Trust service configuration.

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

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

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

Item	Purpose	Date

The Tavistock and Portman NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – 21th February 2024			
Report Title: Annual EPRR Core Standards Assurance for NHSE		**Agenda No.: 18**	
Report Author and Job Title:	Lisa Tucker - EPRR Lead/Health and Safety Lead Clare Scott – Chief Nursing Officer	**Lead Executive Directors:**	Clare Scott – Chief Nursing Officer as AEO
Appendices:	EPRR Assurance Report		
Executive Summary:			
Action Required:	**Approval** ☒ **Discussion** ☐ **Information** ☐ **Assurance** ☒		
Situation:	This report sets out the assurance rating assigned to the Trust by NHSE for compliance against the Emergency Preparedness, Resilience and Response (EPRR) Core Standards. This report outlines the outcomes of NHSE review process. The Trust received the assurance report on the 4th of December 2023 with a rating of partial compliance. Six areas were rated as amber, and one area was rated as red. Red - 49. Data protection and security toolkit Ambers – 24. Responder Training 55. Governance (around HazMat) 57. Specialist advice for HazMat/CBRN exposure 58. HazMat/CBRN planning arrangements 63. HazMat/CBRN training resource 64. Staff training – recognition and decontamination		
Background:	All healthcare provider organisations are asked to provide a self-assessed assurance return against EPRR core standards. The self-assessment and associated documents are then assessed by peers, other NHS Trusts, followed by an assurance meeting with NHS England. Our Core Standards EPRR Assurance self-assessment document and relevant Policies were submitted to NHSE EPRR in September 2023. These were reviewed with NHSE EPRR leads at our Assurance review meeting on 9th November 2023. The meeting was attended by Chief Nursing Officer at Tavistock & Portman, as AEO; EPRR Lead for Tavistock & Portman; NCL ICB EPPR representative and NHSE EPRR Lead and colleagues. In accordance with the requirements laid out in the EPRR 2023/2024 Assurance Process Letter (July 2023), the overall level of compliance is based on the total percentage of amber and red ratings.		
Assessment:	For 2023/24 the Trust has moved from non-compliant in 2022/23 to partially compliant. The review team recognised the hard work that Tavistock and Portman had put into EPRR and Business Continuity arrangements especially in light of the changes in staffing in the last 12 months. During the meeting, the review panel discussed and agreed the following. **Areas for development**		

- Updating Business Continuity Plan
- Updating EPRR Policy and Major Incident Plan with the suggested recommendations for Action Cards.
- Highlighting clearer governance of the Trust documentation within the EPRR and Business Continuity Policy.

Note – all areas were completed prior to publication of report.

Agreed actions.

- The Trust to review sections on governance, including EPRR work plan and relevant committee; finance arrangements, policy, and plan review cycle, identify minimum service levels, lessons learned and debriefing.

- To arrange new IG toolkit training with the IG team and HR. The Data Security and Protection Toolkit is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards. Version 6 was introduced in 2023/24, replacing 2018 toolkit.

- To add into the EPRR policy the AEO being accountable for HAZMAT/CBRN, and that planning is in place and governance arrangements, training and equipment relating to CBRN.

- To update the CBRN/HAZMAT planning arrangement with the new IOR guidance – 'Recognise, Assess and React (RAR)'.

- Trust to develop an action plan surrounding the outcomes of the assurance review and meeting based on the results presented within this report.

Note – The above areas are incorporated into action plan.

Next steps, action plans and governance
The organisation is required to submit the following to england.london-assurance@nhs.net within two weeks of the assurance meeting and no later than 14 December 2023. Board Review and Agreement to submitted to NHSE Feb 2024

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

NHSE acknowledged that due the delay in the Trust receiving the report the action plan could be submitted once approved at Board level, through ELT and Audit Committee of related Polices and Plans.

The declaration from the AEO has been submitted and accepted.

The Action plan will be reported to and monitored by the Executive Leadership Team Quarterly.

A new Resilience Working Group will be established in quarter 1 of 2024/25; the group will be responsible for implementing and monitoring progress of the Action

	Plan, as well as the review and update of local business continuity plans (BCPs). The group will also provide a debrief and analysis of any After Action Reviews.
Key recommendation(s):	The Board is asked to: - Note the EPRR Assurances Report from EPRR NHS England - Confirm the Level of Compliance - Approve the action plan that has been put in place to address the issues raised.

Implications:

Strategic Objectives:

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

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

Link to the Risk Register:	**BAF ☐**	**CRR ☐**	**ORR ☐**
	None		

Legal and Regulatory Implications:	Yes ☒	No ☐
	Civil Contingencies Act (2004) requires NHS organisations and providers of NHS funded services, to show that they can deal with and respond to a wide range of incidents and emergencies that could affect health or patient care. New arrangements for local health EPRR form some of the changes the Health and Care Act 2022 is making to the health system in England.	
Resource Implications:	Yes ☒	No ☒
	There will be a small amount of funding required for procurement of training for staff and procurement of equipment for control centre. Further business case to financial investment review group (FIRM) is included in the action plan.	
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐
	The Trust's ability to respond to and effectively deal with incidents while maintaining services is essential in ensuring equitable access to the diverse population of people who use our services.	
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.	☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.

Assurance:

Assurance Route - Previously Considered by:	NHS England - 9th November 2023 – assurance meeting. Audit and Risk Committee – 23rd November 2023 – approval of relevant policies Executive Leadership Team – 18th December 2023 – report for review and approval.			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Action Plan – Identification of Key Priorities

Action	Plan	Lead	Deadline
Data Protection and Security Toolkit Compliance (49)	IG toolkit training and compliance to be arranged with the IG team and HR.	IG and HR	March 2024 / June 2024
Training and Exercising (24 – Responder Training)	Ensure Responder Mandatory training cycle. • Full PoHC or in house training every three years, Annual refresher training/exercise. • Strategic Response, Director on Call training and assurance. • Tactical (operational) response, training for operational staff who would take on role of tactical in hours; to include relevant Support teams in training and exercises. • Establish a Resilience Working Group with operational membership for governance of EPRR planning. • Training and Evaluation records. • Contingency Funds for EPRR	Lisa Tucker as EPLO, Clare Scott as AEO, and External Contractor for training.	March 2024

Incident Command and Control Room	• Establish ICC equipment and regular testing. • Contingency Funds for equipment.	Lisa Tucker	March 2024
CBRNe and HazMat Training and Governance (55 – Governance around HazMat 57 – specialist advice on HazMat/CBRN exposure 63 – HazMat training 64 – Staff training-recognition and decontamination 66 - exercising)	• The organisation must have an adequate training resource to deliver Hazmat/CBRNe training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments and Governance. • Equipment available in the event of a HazMat exposure incident. • AEO to be cited for responsibility in the EPPR Policy.	Lisa Tucker	March 2024

EPRR Assurance Report 2023/24

Tavistock and Portman NHS Foundation Trust

9th November 2023

EPRR Assurance Process

Annually, all NHS funded organisations are asked to provide a self-assessed assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The NHS England - London EPRR, in partnership with the lead ICB, conducts individual reviews with each organisation to discuss and agree their level of compliance. This report details the outcomes of the review process.

Main assurance

In accordance with the requirements laid out in the EPRR 2023-24 Assurance Process Letter (26 May 2023), the overall level of compliance is based on the total percentage of amber and red ratings against green compliant ratings (note: not all standards are applicable to all organisations).

Deep dive

Each year a subject is selected nationally as deep dive to further explore an EPRR related topic. The deep dive for 2023/24 is training and exercising. The results of the deep dive do not impact the overall compliance rating for the organisation.

A full break down of the return and the discussion is shown in Appendix 1.

Review outcomes

Assurance review attendees		
Organisation EPLO and Deputy	Lisa Tucker	Tavistock and Portman NHS Foundation Trust
Organisation AEO	Clare Scott	Tavistock and Portman NHS Foundation Trust

Chair	Liz Rogers Andrea Jesikova	NHS England - London
Engagement Lead ICB Lead(s)	Nathan Welch Robyn Cassidy	North Central London ICB

Main Assurance		
Red ratings	**Amber ratings**	**Green ratings**
1	7	51
Total number of red / amber ratings	8	
Agreed overall level of compliance	PARTIALLY COMPLIANT	

Deep Dive		
Red ratings	**Amber ratings**	**Green ratings**
0	0	10
Total number of red / amber ratings	0	

Summary

The review team recognised the hard work that the organisation had put into their EPRR and Business Continuity arrangements especially in light of the challenges of the last 12 months.

During the meeting the review panel discussed and agreed the following.

Areas for development

- Updating EPRR Policy and Major Incicent Plan with the suggested recommendations
- Updating Bussiness Continuity Plan
- Highlighting clearer governance of the Trust documentation within the EPRR and Business Continuity Policy.

Agreed actions

- The Trust to review sections on governance, including EPRR work plan and relevant committees; finance arrangements, policy and plan review cycle, identify minimum service levels, lessons, and debriefing.

- To arrange new IG toolkit training with the IG team and HR.
- To add in their EPRR policy AEO being accountable for HAZMAT/CBRN and that planning is in place and governance arrangements, training and equipment relating to CBRN.
- To update their CBRN/HAZMAT planning arrangement with the new IOR guidance - Recognised, Assess and React (RAR)
- Trust to develop an action plan surrounding the outcomes of the assurance review and meeting based on the results presented within this report

Next steps, action plans and governance

The organisation is required to submit the following to england.london-assurance@nhs.net within two weeks of the assurance meeting and no later than 14 December 2023.

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

Finally, on behalf of the NHS England – London thank you to all colleagues involved in this assurance process.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
Domain 1 - Governance					
1	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.			Organisational evidence: Chief Nursing Officer, EPRR Policy Page 8; BC Policy The EPLO reflected on last year. It was a challenging year; the trust were under strategic review with several interim managers. Theres is now an established executive team, fully engaged with emergency planning. There is director on-call rota and directors on-call are committed to undertake Principles of Health Training. The new AEO joined at the end of July. The ICB reflected progress over the last 12 months despite the challenges experienced, and recognising the trust differed from other organisations. Overall, there was good communication between the two organisations, and support would continue to be offered. The ICB stated that the Trust was in a better place than last year. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.			The EPRR Policy was approved on 4th January 2023 with a review date of January 2025. The EPRR Policy has been reviewed and due for ratification at the Trust Audit and Risk Committee in November. Recommendations from last year were considered in the latest version of the document. The panel made the following recommendations: • Governance recommendation to update version control when making amendments as cannot be the same version number as last year. • Explain what ICS and ICB stands for as it could be useful for new members of staff. Recommendation to add it to Page 5; 3.0 Definition and explanation of any terms used. • Page 12; 6.4 Incident Control Room – it shows as the ICR will meet the requirements of the NHS Commissioning Board Command and Control. Recommendation to update it with EPRR Framework 2022 • ICC to be tested quarterly as per EPRR Framework 2022. • Camden risk register showed in document, however recommendation to add London Risk Register and Trust's Risk Register, Haringey and LHRP Risk register. • Add staff welfare – ensuring that staff welfare, including wellbeing arrangement are put in place. Just one paragraph will suffice.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					• Debriefing is mentioned under Training and Exercising. Recommendation to have a separate section about debriefing describing the various debrief types, and implementation of learning and report writing. • Add EPRR resource funding – how to access finances to use on resources, training and incident response expenditure • Add training needs analysis • Check formatting. Given the current document is still in date but the content of the revised document show improvement, the Panel agreed for this to be fully compliant with caveat that the document gets ratified by the committee on 23rd November. The Trust's AEO sent confirmation by email that the EPRR Policy was approved by their Trust Audit and Risk Committee on 23rd November 2023. The Trust provide sufficient evidence to assure the panel of the self-assessed compliance rating.
3	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
6	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
Domain 2- Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
Domain 3 - Duty to maintain Plans					
9	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
10	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.			The Trust's Major Incident Plan (MIP) expired in September 2023. A draft plan was submitted which was awaiting to be ratified by Trust Audit and Risk Committee on 23rd November 2023. The Panel provided further recommendations to improve the plan: • Update version control when making amendments as cannot be the same version number as last year • Formatting issues - in Content – the page numbers start from 3 after 21 • 5.5 loggists and situations reports – legal documents – suggest amending title as could be a bit misleading • Update the Plan for escalations to reflect that initial escalations now go via the ICB and not NHS England – London • New telephone number for PageOne is 0333 200 5022 • Update Debriefing and Incident Investigation as cold debrief is missing. Recommendation to split these out and provide more details e.g. timeframe for the cold debrief and the timescale for issuing reports. • Page 19 – References – ISO 22301 but we think it should be EPRR Framework 2022. Different link to be added to the ISO. • Action cards – ICB to be first point of contact

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					• To update loggist action card as there are some items for administrators. Would recommend to separate them into two. Recommendation to consider having changeover of loggist more frequently due to wellbeing. • Ensure that SBAR information and processes are clearly documented • Add page numbers It was agreed by the Panel that if the Trust confirms that the new plan was approved by their committee it would review this core standard. The Trust's AEO sent confirmation by email that the MIP was approved by their Trust Audit and Risk Committee on 23rd November 2023. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
11	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
12	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
13	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
14	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment			The Panel noted that Trust expansion wording on countermeasure arrangements in the MIP. The Panel advised that countermeasures and mass casualties are not the same. Recommendation to take mass casualties reference out from there as the Trust will not receive mass casualties. However, the Trust will provide mutual aid to other organisations that will be responding to Mass casualty event, e.g., identify clinicians, support with space – safe secured casualty clearing. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
15	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.			The Panel advised that countermeasures and mass casualties are not the same. Recommendation to take mass casualties reference out from there as the Trust will not receive mass casualties. However, the Trust will provide mutual aid to other organisations that will be responding to Mass casualty event, e.g., identify clinicians, support with space – safe secured casualty clearing. ICB will provide support to add some words on the Mass Casualty. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
16	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint for this year. Last year's comments were that the local evacuation procedure is in place, however the panel recommended to add shelter information into the plan. The Trust advised that the procedure is awaiting approval. Once approved it will be tested. It was agreed by the Panel that if the Trust confirms that the new procedure was approved by their committee it would review this core standard. The Trust's AEO sent confirmation by email that the new procedure was approved by their Trust Audit and Risk Committee on 23rd November 2023. The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
17	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
18	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
19	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

<table>
<tr><th>Ref</th><th>Standard</th><th>Detail</th><th>Self-assessed RAG</th><th>Agreed 2023 RAG rating</th><th>RAG rating rationale & meeting comments</th></tr>
<tr><td colspan="6">Domain 4 - Command and control</td></tr>
<tr><td>20</td><td>On-call mechanism</td><td>The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.</td><td></td><td></td><td>The Panel advised that the Trust had achieved the best practice (10 minutes) for five out of seven. The Panel is pleased to hear that the Trust has director on call systems in place.
<table><tr><th>Jan-23</th><th>Feb-23</th><th>Mar-23</th><th>Apr-23</th><th>May-23</th><th>Jun-23</th><th>Jul-23</th><th>Aug-23</th><th>Sep-23</th></tr><tr><td>00:00</td><td>00:09</td><td>00:08</td><td>No comm-ex</td><td>02:37</td><td>00:05</td><td>No comm-ex</td><td>No response</td><td>00:04</td></tr></table>
The Trust now has director on call procedures in place, including accessible on-call resources, handover procedures and have a folder where all director on call have access to handover procedures and expectation for any pager messages to be responded within 20 minutes. All director on call, except two have attended Principles of Health Command Training. The remaining two are booked in December’s training.

Challenges were highlighted that the Trust does not experience the same incidents as other organisations, so they are aware that the POHC training is very important. They are arranging training for directors and the AEO is liaising with directors from her previous organisations to support training. The Trust recently had a fire incident, and worked closely with Whittington partners who owned the site. BCPs were enacted and helped with the response. EPLO is coordinating AAR to identify learning.

The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.</td></tr>
<tr><td>21</td><td>Trained on-call staff</td><td>Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions</td><td></td><td></td><td>Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint. Last year’s recommendation was to ensure that all directors on call have completed the Principles of Health Command as part of their EPRR Training.

All, except two, directors on call have attended Principles of Health Command Training. The remaining two are booked in December’s training.

The Trust also advised that they have buddy system via WhatsApp and AEO is happy to provide support to the directors on call.

The Panel agreed for this core standard to be fully complaint as majority of director on call are trained.</td></tr>
</table>

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
Domain 5 – Training and exercising					
22	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
23	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
24	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint. Last year the Panel advised that this need to be in line with National occupational standards. The Trust advised that strategic commanders have undertaken POHC training. They also advised that they are looking at the tactical roles to ensure they have training in line with Minimum Occupational Standards. The Panel is happy that they have systems in place for tactical roles to be trained and they understand that last year was a challenging year and the focus was directed elsewhere. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
25	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint. The Trust confirmed they have processes in place and staff are aware of their role in an incident and know where to find relevant plans to their area of work. They are planning on doing a tabletop exercise with scenario that will involve hostage. The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
Domain 6 - Response					

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
26	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
27	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
28	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
29	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained loggist(s) to ensure support to the decision maker			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. Last year's comments were to increase the number of trained loggists. The Trust advised that they have a further three trained loggists and the training is going to be extended to all Exec PAs. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
30	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
31	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	N/A	N/A	N/A
32	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	N/A	N/A	N/A
Domain 7 - Warning and informing					
33	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
34	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.			There is a comms action card is in place for 24/7 cover. The Trust advised that there will not be a Comms director on-call 24/7 as it is not required, however they have drafted statements and the Comms director is accessible 24/7 and will either respond or identify a member of the team to respond when required. The Chair recommended for Trust to engage with ICB to discuss any additional comms support. The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
35	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.			At the meeting the Trust confirmed that they have arrangements in place to communicate with patients, staff, partner organisations, stakeholders and public, however NCL ICB's 24/7 on-call sign to be added to the plan. It was agreed by the Panel that if the Trust confirms that the on-call pack has been added with NCL ICB's on-call sign, the Panel would review this core standard. The Trust confirmed by email that the NCL ICB's on-call sing has been added to the plan. The Trust provided sufficient evidence to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
36	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
Domain 8 - Cooperation					
37	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
38	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
39	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
40	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	N/A	N/A	N/A
41	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	N/A	N/A	N/A

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
42	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	N/A	N/A	N/A
43	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
Domain 9 - Business Continuity					
44	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. Last year's comments were for the Trust to separate BC Policy from BC Plan. The Trust provided BC Policy in draft format and advised it is a new Policy that is awaiting sign off from The Audit and Risk Committee. The Panel provided the following recommendations to improve the policy: • Page 4 – referring to BS22301, however it should be ISO22301. Recommendation to update it. • To add PDCA (Plan, Do, Check, Act) cycle for ISO22301 to support the development of a business continuity programme. You can use the ISO22301 diagram. • Page 10; 7 Training and Testing – add Exercising in the title as there is reference to it in in the text. • Page 10; 8 Reporting Requirements – escalations to reflect that initial escalations now go via the ICB not NHS England – London • Recommendation to add governance section, e.g. Risk assessment, Document control and archiving, Document storage and records management, monitoring/auditing arrangements. The Panel recommended the Trust to contact Moorfields as they have a good BC Policy. It was agreed by the Panel that if the Trust confirms that the BC Policy has been signed off by their committee, the Panel would review this core standard. The Trust confirmed by email that the BC Policy has been signed off by their Audit and Risk Committee.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					The Trust provided sufficient evidence to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
45	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. The Trust provided in in their submission that 'BCMS' and KPIs are measured for assurance for the Quality Committee and Audit Committees, example including BAU through recent care notes outage - BC and recovery. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
46	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. Last year's comments were to add critical services to BIAs All community service lines have standardised BIA within their BCP, and they review it annually. The ICB shared their BIA templates with the Trust, and they are similar to their local BCPs and they do it annually. The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
47	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. Last year's comments were for the Trust to have a key performance indicator process for the critical services. The Panel can see that the date approval for this BCP is in 2022 and up for review in 2023.They have made no changes to the Plan. The Panel advised that the Plan needs to go through ratification and needs to be approved by their committee. The Panel provided the following recommendations: • To update the escalations to reflect that initial escalations now go via the ICB not NHS England – London. • Add IT security information to the plan. The Trust advised that they are chasing their IT department for failure and recovery plan. They require BCPs from all their IT packages and software system. They are in progress of doing it. • Page 10 – to correct formatting. The Panel agreed for this to be partially compliant, however if the Trust confirms that the plan was approved by their committee it would review this core standard.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					The Trust's AEO sent confirmation by email that the BC Plan was approved by their Audit and Risk Committee on 23rd November 2023. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
48	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
49	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.			Data Protection and Security Toolkit shows as '22/23 Standards Not Met' Organisation Details (dsptoolkit.nhs.uk) The Trust advised that new IG toolkit training was being arranged with the IG team and HR. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
50	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.			The Trust advised that there is an annual submission to the Board. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
51	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
52	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
53	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
54	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	N/A	N/A	N/A
Domain 10 - CBRN					
55	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint. The Panel advised that this core standard is for documented responsibility for planning phase of CBRN hazmat incident. The Panel advised that the Trust needs to add in their EPRR policy, that AEO is accountable for HAZMAT/CBRN and that the planning is in place including governance arrangements, training and equipment relating to CBRN. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
56	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. The Trust advised that they have CBRN action card in place and all sites are access controlled and outpatient only. The Panel advised for next step is to evaluate this is and to keep it as fully compliant is to have it included to their risk register that they risk assessed this. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
57	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents			The Trust provided in their organisation evidence that outpatient facilities would be defer to LAS and LFB. The Trust advised that their biggest contingency are students. The Panel advised to check with other trusts what they have in their documentation. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
58	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard and this year they also marked themselves as partially complaint. The Panel advised that IOR is now superseded to Recognised, Assess and React (RAR) https://www.npsa.gov.uk/security-campaigns/recognise-assess-react-rar-chemical-biological-and-radiological-cbr-incidents. The Panel recommended to update this with the correct guidance.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
					The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
59	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	N/A	N/A	N/A
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
61	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
62	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	N/A	N/A	N/A
63	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments			The Trust advised that an in-house training is to be organised and implemented. They are working with GOSH and Moorfields on training material. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
64	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented			Last year the Trust was at the agreed RAG rating of partially compliant for this core standard. Last year's comments are that the Trust has decontamination training in place; however, a programme of delivery was outstanding at the time of the assurance meeting The Trust advised they are updating training material. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
65	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
66	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme			The Trust advised that action cards, training records for front of house staff is to be updated. The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
Deep Dive – EPRR Training					
1	**EPRR TNA**	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
2	**Minimum Occupational Standards**	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.			The Trust provided sufficient evidence at the assurance meeting to assure the panel that the self-assessed compliance rating be amended from partially compliant to fully compliant.
3	**EPRR Staff Training**	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
4	**Senior Leadership Training**	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
5	**Access to training materials**	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
6	**Training data**	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
7	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
8	**JESIP doctrine**	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.
9	**Continuous Improvement Process**	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

Ref	Standard	Detail	Self-assessed RAG	Agreed 2023 RAG rating	RAG rating rationale & meeting comments
10	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.			The Trust provided sufficient evidence to assure the panel of the self-assessed compliance rating.

NHS
The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS PART II - PUBLIC – Wednesday, 21 February 2024			
Report Title: Public Board of Directors Forward Planner 2023/24			**Agenda No.:** 19
Report Author and Job Title:	Amanda Hawke, Corporate Governance Manager	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Board of Directors (Public) Forward Planner 2023/24		

Executive Summary:	
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐
Situation:	This report provides the Board with the Public Board of Directors Forward Planner for 2023/24 (attached as Appendix 1) for information.
Background:	It is good corporate governance practice for the Board to agree a forward plan of its activities and be apprised of any changes to the planner during the year. The Public Board Forward Planner for 2023/24 was approved at the June 2023 meeting and is being presented to each meeting of the Public Board for information (highlighting any changes).
Assessment:	The Governance Manager administers the Board Forward Planner and there have been no updates to the planner since the last Public meeting of the Board.
Key recommendation(s):	The Board is asked to **NOTE** the Public Board of Directors Forward Planner for 2023/24.

Implications:

Strategic Objectives:

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

Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, the BAF is a standing item on the Board Forward Planner.				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Board Forward Planner includes Statutory items for oversight by the Board.				

Resource Implications:	Yes ☐		No ☒	
	There are no additional resource implications associated with this report.			
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐		No ☒	
	There are no EDI implications associated with this report.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from Publication under the FOI Act which allows for the application of various exemptions to information where the Public authority has applied a valid Public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

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Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**Apr ▼**	**Jun▼**	**Jul▼**	**Oct ▼**	**Dec ▼**	**Feb▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Agenda Section ▼**	**Frequency ▼**	**Purpose** Matches the purpose on the request sent to the report owner and author following agenda setting.	**Author(s)**
Date of Meeting			**19 Apr**	**14 Jun**	**27 Jul**	**11 Oct**	**13 Dec**	**21 Feb**						
Paper Deadline			**29 Mar**	**xxx**	**xxx**	**xxx**	**xxx**	**xxx**						
Standard monthly meeting requirements														
Opening / Standing Items (every meeting)														
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/ C	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly		
Closing Matters (every meeting)														
Annual Board Forward Planner (For approval in Apr 23 and Feb 24)	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly		
Bi-monthly (6)														
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly		
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	D	P	P	P			Corporate Reporting	Bi-monthly		
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			High Quality Clinical Services	Bi-monthly		
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Develop & Deliver a Strategy & Financial Plan	Bi-monthly		
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Bi-monthly		
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly		
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly		
Integrated Governance Action Plan Report	Assurance	CEO		P	D	P	P	P	Audit Committee		Well-led & Effectively Governed	Bi-monthly	Review progress of governance recommendations and seek assurance of embedding required improvements. Board to receive updates bi-monthly from the Audit Committee	Dorothy Otite, Governance Consultant
Quarterly (3 - 4)														
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDOCG	P			P	P	P			Well-led & Effectively Governed	Quarterly		Frazer Tams, Interim Risk & Assurance
Audit Committee Chair's Assurance Report	Assurance	NED		P			P	P			Well-led & Effectively Governed	Quarterly		
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Great & Safe Place to Work, Train & learn	Quarterly		
Guardian of Safer Working Report	Information	ICMO			P		P	P			High Quality Clinical Services	Quarterly		
Six-monthly (2)														
Mortality / Learning from Deaths	Assurance	ICMO			P			P			High Quality Clinical Services	6 monthly		
Annual (1)														
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (Audit; POD EDI; ETC; PFR; Quality; EA&R)	Discussion	Chair		P							Well-led & Effectively Governed	Annual		
Review of Committee Terms of Reference	Approval	Chair				P					Well-led & Effectively Governed	Annual		
Medical Revalidation	Discussion	ICMO				P					Great & Safe Place to Work, Train & learn	Annual		
Freedom to Speak Up Guardian Annual report	Discussion	CPO			P	R			POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Prepardness, Resilence and Response (EPRR)	Discussion	ICNO					P		Audit Committee		Well-led & Effectively Governed	Annual		
Quality Priorities 2023-2024	Discussion	ICNO	P						Quality Committee		High Quality Clinical Services	Annual		
Staff Survey Results and Action Plan	Discussion	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Workforce Disability Equality Standard (WDES)	Approval	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		

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Date of Meeting			**19 Apr**	**14 Jun**	**27 Jul**	**11 Oct**	**13 Dec**	**21 Feb**						
Workforce Race Equality Standard (WRES)	Approval	CPO					P		POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Gender and Race Pay Gap	Approval	CPO		D	P				POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Equality, Diversity and Inclusion Annual Report 2022/23 (including Department of Education & Training)	Approval	CPO		D	P				POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Research and Development Annual Report	Discussion	ICMO	D	P							High Quality Clinical Services	Annual		Director of Research and Development
Annual Infection Prevention and Control Plan and Statement	Discussion	ICNO		D	D	P			Quality Committee		High Quality Clinical Services	Annual		
Annual Objectives and Strategic Priorities (Final)	Approval	CEO				P					Corporate Reporting	Annual		
Compliance Against Provider Licence	Approval	IDOCG		P					Audit Committee		Well-led & Effectively Governed	Annual		
Budget 2023/24	Approval	CFO		P							Develop & Deliver a Strategy & Financial Plan	Annual		
UCL Alliance Business plan	Approval	CFO		P							Effective, Integrated Partner within the ICS & Nationally	Annual		
Non-Executive Director Commitments 2024/25 (including Champions and Committee Membership)	Approval	Chair						P			Well-led & Effectively Governed	Annual		
Board and Board Committee Meeting Dates 2024/25	Approval	IDOCG					P				Well-led & Effectively Governed	Annual		
Honorary Doctorate Nominations	Approval	ICETO					P		Education & Training Committee		Great & Safe Place to Work, Train & learn	Annual		
National Annual Patient Survey report (when available)	Discussion	ICNO							Quality Committee		High Quality Clinical Services	Annual		
Board Skills Review	Discussion	Chair							RemCo		Well-led & Effectively Governed	Annual		
Fit & Proper Persons Test	Discussion	Chair		D	P				RemCo		Well-led & Effectively Governed	Annual		
Board Development Programme	Discussion	Chair			P				RemCo		Well-led & Effectively Governed	Annual		
Financial Recovery Plan	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Annual		
Strategy / Policy Approval/Ratification (usually every 3 years)														
Year 1 (2023/24)														
Modern Slavery Statement	Approval	ICNO									Well-led & Effectively Governed	Annual		
Scheme of Delegation	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual		
Standing Financial Instructions	Approval	CFO					P		Audit Committee		Well-led & Effectively Governed	Annual		
People Strategy and Plan	Approval	CPO							POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Staff Engagement Strategy (Internal Communications Strategy)	Approval	CPO	P						POD EDI		Great & Safe Place to Work, Train & learn	Annual		
Year 2 (2024/25)														
Estates Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly		
Green Plan/ Sustainability Strategy	Approval	CFO							Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	3 yearly		
External Board Review (once every three years) Report	Discussion	Chair							RemCo		Well-led & Effectively Governed	3 yearly		
Year 3 (2025/26)														
Ad hoc/ As Appropriate														