NHS
The Tavistock and Portman
NHS Foundation Trust

Council of Governors Part Two

Agenda and papers of a meeting to be held in public

Thursday, 30th May 2024

For timings and venue, please refer to the agenda.

NHS
The Tavistock and Portman
NHS Foundation Trust

COUNCIL OF GOVERNORS – PART TWO
MEETING HELD IN PUBLIC
30 MAY 2024 at 3.10 – 5.50 p.m.
Lecture Theatre, 5th Floor
The Tavistock and Portman NHS Foundation Trust, as well as Online (via Zoom)

AGENDA

24/05	Agenda Item	Purpose	Lead	Format Verbal Enclosure	Time	Report Assurance rating
OPENING ITEMS						
001	Welcome and Apologies for Absence	Information	Chair	V	3.10 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Council of Governors' Declarations of Interest	Information	Chair	E		
004	Service Presentation – Fitzrovia Youth Action CAMHS	Discussion	Rachel James, Clinical Services Director	V	3.15 (15)	
005	Minutes of the Previous Meeting held on 28 March 2024	Approval	Chair	E	3.30 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	3.35 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	3.40 (10)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
008	Governor Feedback (including training, visits, etc)	Information	All Governors	V	3.50 (10)	
009	Updated Council of Governor Development Programme	Information	Director of Corporate Governance	E	4.00 (5)	
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
010	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	E	4.05 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Integrated Audit and Governance Committee (IAGC) Governor Observer feedback	Information	IAGC Governor Observer	V	4.10 (5)	
Comfort Break (5 minutes) 4.15pm – 4.20pm						

	PROVIDING OUTSTANDING PATIENT CARE					
011	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	4.20 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Quality and Safety Committee (QSC) Governor observer feedback	Discussion	QSC Governor Observer	V	4.25 (5)	
012	Integrated Quality and Performance Report (IQPR)	Discussion	Clinical Operations Director	E	4.30 (10)	Limited ☐ Partial ☐ Adequate ☐ N/A ☐
	DEVELOPING A CULTURE WHERE EVERYONE THRIVES with a focus on equality, diversity and inclusion					
013	People, Organisational Development, Equality, Inclusion and Diversity Committee (POD EDI) Assurance Report	Assurance	POD EDI Committee Chair	E	4.40 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	People, Organisational Development, Equality, Inclusion and Diversity Committee (POD EDI) Governor observer feedback	Discussion	POD EDI Governor Observer	V	4.45 (5)	
014	Staff Survey Results and Action Plan	Discussion	Deputy Chief People Officer	E	4.50 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
	ENHANCE OUR REPUTATION AND GROW AS A LEADING local, regional, national & international provider of training & education					
015	Education and Training Committee (ETC) Assurance Report	Assurance	E&T Committee Chair	E	5.00 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Education and Training Committee (ETC) Governor observer feedback	Discussion	ETC Governor Observer	V	5.05 (5)	
	IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY					
016	Performance, Finance and Resources Committee (PRFC) Assurance Report	Assurance	PFR Committee Chair	E	5.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
	Performance, Finance and Resources Committee (PRFC) Governor observer feedback	Discussion	PRFC Governor Observer	V	5.15 (5)	
017	Finance Updates • Finance Report – Month 12 • Financial Plan Update 2024-2025	Information	Chief Finance Officer	E E	5.20 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

CLOSING ITEMS						
018	Questions from the Public	Discussion	Chair	V	5.30 (5)	
019	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	5.35 (5)	
020	Issues to be escalated to the Board of Directors	Discussion	Chair	V	5.40 (5)	
021	Reflections and Feedback from the meeting	Discussion	Chair	V	5.45 (5)	
DATE AND TIME OF NEXT MEETING						
022	Thursday 17th October 2024 at 2.00pm – 5.00pm					

NAME	POSITION HELD (INCLUDING CONSTITUENCY)	FIRST APPOINTED	DESCRIPTION OF INTERESTS DECLARED	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
Julian Lousada	Rest of London	October 2021 (1st term)	NIL RETURN			
Michael Rustin	Rest of London	October 2021 (1st term)	NIL RETURN			
Michael Arhin-Acquaah	Rest of London	October 2021 (1st term)	Employed by Kids as a Playworker	Jun-21	Dec-21	Zero hour contract working with children with additional needs
			Research Assistant (employed/voluntary) at London South Bank University	Jun-23	present	No conflict as not involved in management decision making. - Working on project involving intervention courses for safeguarding staff working with transgender youth, particularly in the care sector. Developing signposting resources and research evidence to increase staff competence and confidence.
Michelle Morais	Rest of London	October 2021 (1st term)	NIL RETURN			
Stephen Frosh	Rest of London	December 2022 (1st term)	NIL RETURN			
Sebastian Kraemer	Rest of London	December 2022 (1st term)	NIL RETURN			
Natalia Barry	Camden	May 2022 (1st term)	Employed by North Middlesex Hospital as Associate Medical Director and ED Consultant	01/04/2020	present	No conflict declared – will withdraw from any decision making relating to the Tavistock & Portman NHS Foundation Trust
Ffyona Dawber	Camden	May 2022 (1st term)	NIL RETURN			
Jocelyn Cornwell	Camden	December 2022 (1st term)	Chair, board of trustees - Action Against Medical Accidents (3)	01/12/2021	present	no perceived conflict - Declared on application
Kenyah Nyameche	Rest of England & Wales	October 2021 (1st term)	NIL RETURN			
Sheena Bolland	Rest of England & Wales	October 2021 (1st term)	NIL RETURN			
Jessica Anglin d'Christian	Staff - Clinical, Academic, Senior	November 2021 (2nd term)	Employed by East London NHS Foundation Trust as a Specialist CAMHS Practitioner	05/12/2018	present	No conflict as there is no input in decision making within the Trust
			Employed by the Institute of Family Therapy as a course lecturer	01/09/2022	present	No conflict as only work on a contractual basis and have no input in any management of the company
Maisam Datoo	Staff - Admin & Technical	December 2022 (1st term)	NIL RETURN			

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NAME	POSITION HELD (INCLUDING CONSTITUENCY)	FIRST APPOINTED	DESCRIPTION OF INTERESTS DECLARED	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
Paru Jeram	Staff - Education & Training	December 2021 (1st term)	NIL RETURN			
Katharine Knight	Student	May 2022 (1st term)	Honorary Contract at Oxford Health NHS Trust	01/09/2022	present	Trainee psychotherapist voluntary placement.
David O'Mahony	Stakeholder - University of Essex	May 2021 (1st term)	NIL RETURN			
Peter Ptashko	Stakeholder - Local Authority	March 2022 (1st term)	NIL RETURN			
Kathy Elliott (Lead Governor)	Stakeholder - Voluntary Action Camden)	December 2020 (2nd term)	Trustee and Vice Chair of Voluntary Action Camden (3)	Sep-20	present	Stakeholder Governor representing Voluntary Action Camden
			Vice Chair Caversham Practice Patient Participation Group (3)	06/01/2014	present	no perceived conflict
			Chair Registration Panel; and Assessor UK Public Health Register (3)	06/01/2014	present	no perceived conflict
Robert Waterson	Stakeholder - University of East London)	December 2022 (1st term)	NIL RETURN			

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The Tavistock and Portman
NHS Foundation Trust

UNCONFIRMED MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN PUBLIC THURSDAY 28TH MARCH 2024, 3.10 – 5.30P.M. TRAINING ROOMS A & B, GARDEN WING, TAVISTOCK & PORTMAN NHS FOUNDATION TRUST AND VIRTUALLY VIA ZOOM

PRESENT:

John Lawlor	Trust Chair and Chair of the Council of Governors	JL
Kathy Elliott	Stakeholder and Lead Governor	KE
Sebastian Kraemer	Public Governor	SK
Ffyona Dawber	Public Governor	FD
Sheena Bolland	Public Governor	SB
Michael Rustin	Public Governor	MR
Michelle Morais	Public Governor	MM
Stephen Frosh	Public Governor	SF
Jocelyn Cornwell	Public Governor	JC
Natalia 'Talia' Barry	Public Governor	NTB
Julian Lousada	Public Governor	JLou
Paru Jeram	Staff Governor	PJ

IN ATTENDANCE:

Michael Holland	Chief Executive	MH
Adewale Kadiri	Director of Corporate Governance	AK
Gem Davies	Chief People Officer	GD
Peter O'Neill	Interim Chief Finance Officer	PON
David Levenson	Non-Executive Director	DL
Claire Johnston	Non-Executive Director	CJ
Clare Scott	Chief Nursing Officer (item 4.1)	CS
Emma Casey	Associate Director of Quality (item 4.1)	SF
Anne	Member of the Public	
Fiona Fernandes	Business Manager Corporate Governance (minutes)	FF

APOLOGIES:

David O'Mahony	Stakeholder Governor
Peter Ptashko	Stakeholder Governor
Robert Waterson	Stakeholder Governor
Kenyah Nyameche	Public Governor
Michael Arhin Acquaah	Public Governor
Maisam Datoo	Staff Governor
Jessica Anglin D'Christian	Staff Governor
Katharine Knight	Student Governor
Sal Jarvis	Non-Executive Director
Aruna Mehta	Non-Executive Director
Shalini Sequeira	Non-Executive Director
Janusz Jankowski	Non-Executive Director
Sabrina Phillips	Associate Non-Executive Director

MINUTE NO.		ACTION (INITIALS)
24/1.1	**WELCOME AND APOLOGIES FOR ABSENCE**	

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JL welcomed all to the meeting. It was noted that the date for this meeting was changed to align with the closed Board meeting, which was held on 27 March 2024, and due to the proximity of both meetings most of the Non-Executive Directors were unable to attend the CoG meeting.

Apologies for absence were received from Governors and Non-Executive Directors as noted above.

24/1.2	**CONFIRMATION OF QUORACY**

The Chairman **NOTED** and confirmed the meeting was quorate at the beginning of the meeting.

24/1.3	**DECLARATIONS OF INTEREST**

The Council **NOTED** there were no new declarations of interest.

24/1.4	**MINUTES OF THE PREVIOUS MEETING HELD ON 7th DECEMBER 2023**

DECISION: The Council of Governor's **APPROVED** the minutes of the previous meeting held on 7th December 2023 as an accurate record pending the amendment of KE's surname.

24/1.5	**ACTION LOG AND MATTERS ARISING**

Two open actions were approved for closure.

The action regarding the Freedom to Speak Up Guardian (FTSUG) was to remain open. AK noted that the recruitment of a second FTSUG was in progress.

As the Board Assurance Framework (BAF) was being reviewed, it was decided that this action was to remain open.

There were no other matters arising raised.

24/2.1	**GOVERNOR FEEDBACK**

KE provided the following verbal feedback:

- Overall, the Governor informal sessions had been incredibly helpful as were the meetings with the Non-Executive Directors (NEDS).
- Governor observers' attendance at the Committees had been well received as Governors were able to hear first-hand about the work of the Committees, acknowledging that the work of the Committee Chairs was challenging. Meeting with the Committee Chair prior to the Committee meeting had been very useful.
- Governors valued the service visits, and noted a new service visit programme would be beneficial. This should be expanded to include other services like Education, Finance, Corporate, etc.

- SB now sits on the Gloucester House Board. SB noted that she attended the GIC meetings and that it was a positive experience. The staff were very keen to show the good work that they do there.
- It had been difficult to get Governor's commitment to be involved in the recruitment process for the appointment of the Non-Executive Director.
- KE reminded Governors that attendance at the Joint Board of Directors and Council of Governors meeting on 11th April 2024 was mandatory.

NTB enquired about the actions being taken with regards the Staff Survey.

JL noted that the Board reviewed the Staff Survey at the Board Seminar and from the headlines, it scored the poorest on 'Recommended place to work'. There was improvement on staff engagement and other areas where progress was being made.

It had been clear at the all-staff meetings the tone and types of questions being asked had transformed more positively from anger, bitterness, abuse stemming not only from the Strategic Review, but it was also a combination of other external factors faced by the Trust.

JL noted that further discussions on Staff Survey was needed and should be an item for the Joint Board of Directors and Council of Governors meeting in April 2024.

ACTION: Staff Survey to be added to the agenda for the Joint Board of Directors and Council of Governors meeting in April 2024.

AK & FF

ACTION: A service visit programme to be produced for all services not only clinical. The programme should include other services like, Education, Corporate, Finance, Estates, etc.

AK

24/2.2	**CHIEF EXECUTIVE'S REPORT**

The CEO report was taken as read. MH provided the following key highlights:

- The Trust held the first series of Case for Change engagement sessions for staff, service users and stakeholders to discuss the potential risks and benefits of the impending merger. The sessions also provided the opportunity for all attendees to give their views on what we should look for in a potential merger partner and vice versa. The Case for Change sessions would continue running into March and there will also be sessions for specific staff groups.
- Around 30 Trust staff had attended a 3-day interactive training programme for the Patient Safety Incident Response Framework (PSIRF). The programme would bring together staff groups from across the Trust to think collectively about how to create a meaningful 'Just Culture' and, the next steps would be to collectively model and embed this compassionate engagement with involvement of those affected by patients' safety incidents which is key to PSIRF.
- An announced Special Educational Needs and/or Disabilities (SEND) inspection was carried out by Ofsted and CQC, coordinated by North Central London ICB across a range of services for school age children and young people in Haringey. With sampling site visits to the Trust on 31 January 2024. The outcome of the inspection would be communicated in due course.
- GIC recently held a quality improvement event and all those that attend were fully

engaged and positive. They embraced the sessions and fostered harmonious meaningful connections and successful exchange of knowledge and experience.

- GIDS – the Trust had been working collaboratively with the new providers to safely transfer the care of patients who were still under the Trust's care by the end of March. Support had been provided to GIDS staff during the closure of the service and, some staff had been redeployed into new roles within the Trust.
- The Trust was excited to be 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 both locally and nationally. The funding for the centre was from Research England's Expanding Excellence in England Fund.

The Council received the CEO report.

| 24/2.3 | **FINANCE REPORT** |

PON updated the Council on the position at Month 11 and reported that the Trust was £400k ahead of plan, and it was anticipated that it would achieve its year-end deficit plan of £2,517k.

The cash balance at the end of month 11 was £3,827k against the planned figure of £5,685k. The agreed capital expenditure for the year was £2.2million, and the Trust was on track to spend against this limit. The Trust was expected to meet the financial plan.

There was still a risk with the GIDS decommissioning costs of £4.1 million which the Trust was awaiting clarification from NHS England for support with the costs.

Responding to a question from SF, PON noted that the Trust was expected to deliver efficiency savings of £3 million to achieve the planned deficit of £2.5million.

The Council received the Finance report.

| 24/2.4 | **MEMBERSHIP AND ENGAGEMENT UPDATE** |

JM noted that in light of the impending merger, it would be more beneficial to establish a strategy to engage with the membership and Governors over the next 18 months ensuring this would be incorporated within the merger communications and engagement strategy and plan.

JL suggested to have similar engagement events for the membership as we have for staff. KE added that social media could also be used as a platform for engagement.

Responding to a question from KE, JM noted that she would provide information to the Governors regarding feedback from members on the merger information that was on the Trust website.

ACTION: To provide information to the Governors regarding feedback from members on the merger information on the Trust website.

JM

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ACTION: To arrange events for the membership – sessions for Young People and sessions for Adults.   **JM**

The Council received the Membership and Engagement update.

| 24/3.1 | **EDUCATION & TRAINING COMMITTEE (ETC) ASSURANCE REPORT** |

The report was taken as read.

Responding to a question from SF regarding international courses, MH noted that the Chief Medical Officer and staff of the Department of Education and Training were in China as part of a UK healthcare education mission to understand the current landscape in Chinese healthcare and international collaboration priorities in healthcare education, training, and research.

The Council received the ETC assurance report.

| 24/3.2 | **INTEGRATED AUDIT & GOVERNANCE COMMITTEE (IAGC) ASSURANCE REPORT** |

The report was taken as read. DL highlighted the key points:
- External audit, Internal audit and Local Counter Fraud all provided their draft plans for 2024/2025.
- The Committee received assurance on the progress of the Integrated Governance Action Plan.
- The Committee referred the findings from the Local Counter Fraud report to the People, Organisation Development, Equality, Diversity and Inclusion Committee (POD EDI) as majority of the actions were within the remit of the Chief People Officer.
- In relation to the external audit work, the Trust had new external auditors (Grant Thornton) and had fortnightly meetings with them. Progress was ongoing on the audit plan/process and work was in progress on scoping/risk areas.
- In relation with the Value For Money (VFM) report in the Annual Report and Accounts (ARA) and the auditor's opinion where areas of significant weaknesses were raised previously in three areas (Governance actions implementation for 2021-2022; payroll and audit completion). Huge progress had been made in these areas and we need to ensure that the Trust meets the reporting deadlines.
- Grant Thornton's approach was to look at the risk of significant weaknesses recurring in those areas.
- The Trust had been given assurance on the closure of GIDS; and the merger not having adverse implications.
- Grant Thornton were taking the right approach to materiality and are getting ready for the year end accounts. We were expecting to receive the audit plan at the next IAGC meeting in May.

KE noted for future appointments of the External Auditors, that the Governors are kept abreast and are involved in the process.

The Council received the IAGC assurance report.

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| 24/3.3 | **QUALITY & SAFETY COMMITTEE (QSC) ASSURANCE REPORT** |

The report was taken as read. CJ highlighted the key points:
- The Committee welcomed the two Governor observers KR and PJ.
- Following the work progressed by the Trust, the Quality and Safety element was now rated green under SOF3.
- PSIRF training was held over three days and was received well. There were good debates at service level. There is training and strengthened responsibilities in relation to patient safety and PSIRF for the Board which is currently being developed. 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.
- After Action Reviews were being trialled.
- The Committee reviewed the new version of the Trust's Complaints and PALS process alongside with the strengthened investigation report for formal complaints. The team are working with managers to reduce the backlog.
- The Gender services teams responded very well to the focussed quality reviews.
- The Trust's physical health review was led by the Associate Director of Nursing and the model will have continual physical assessments.
- Good progress had been made with the implementation of the Local Risk Management System (LRMS) replacement project.

KE noted that she had time to meet with the CJ prior to attending the meeting and was made to feel welcome. The meeting was chaired well and was very informative.

The Council received the QSC assurance report.

| 24/3.4 | **PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY COMMITTEE (POD EDI) ASSURANCE REPORT** |

The report was taken as read. GD highlighted the key points:
- Staff Survey had been discussed earlier on the agenda.
- AK provided a report on the outcome of the EDI review and the Committee were content with the recommendations. Regarding EDI training, AK and GD were asked to consider this and the outcomes to be taken back to the Committee and to the Board at a later date.
- The Committee requested a deep dive was undertaken across the organisation focussing on determining if patient data was significant and whether it required attention. The Associate Director of EDI would be working with the Chief Medical Officer as part of the Patient and Carer Race Equality Framework (PCREF) looking at staff/patient demographic.
- The Committee received an update on the Leadership and Management Development Programme noting the uptake had not been as expected and that none of the cohorts were full. The Committee asked the Executive Leadership Team (ELT) to ensure that all managers are freed up to attend the programme.
- A discussion was held around the approval of new/updated policies, and the Committee were informed that a full-time member of staff had been recruited to and, that they would be reviewing and revising the process of the Policy Approval

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Group (PAG) as a priority. Once done, this should ensure that the number of policies waiting to be signed off would be quickly turned around.

- The Committee received information outlining the potential impact of the merger and the closure of the decommissioned services. It would be the remit of the Remuneration Committee to sign off the redundancies. It was also noted that equality impact assessment (EQIA) would be undertaken in due course.
- The Committee also considered and approved the Terms of Reference for the POD Delivery Group that will hold human resources to account on the People Plan.

Responding to a question from SF, MH noted that the EQIA would come into the merger equalities section and is one of the criteria for the merger.

GD noted that as part of due diligence, we would look at staff in posts and get the records to help with the EQIA for staffing as well as service users.

FD noted that she was the Governor observer on the Committee and, it was useful hearing about the Staff Survey and the GIDS. The questioning was very well thought through. It was a positive meeting.

The Council received the POD EDI assurance report.

24/3.5	**PERFORMANCE, FINANCE & RESOURCES COMMITTEE (PFRC) HIGHLIGHT REPORT**

PON provided a verbal update and highlighted the key points:
- The Committee received a new abridged version of the Integrated Quality Performance Report (IQPR) that highlights the areas.
- The Committee went through the progress of the issues around team level budgets and discussed the future of that.
- Received reports on the Capital programme progress for the next financial year.
- Received reports through the IAGC about procurement and salaries.

The Council received the verbal highlight report from PFRC.

24/4.1	**DIRECTORS' FIT & PROPER TEST (FPPT) RESULTS 2023/2024**

JL noted that as a result of the Lucy Lethby case, NHS England (NHSE) published a new Fit and Proper Person Framework for Board Members in August 2023 alongside guidance for Chairs and staff on implementation.

The framework introduced a new requirement for an annual submission to the NHS England Regional Director. To ensure alignment with the new framework, the Board approved a new FPPT Policy for the Trust.

JL noted that following new national requirements for the Fit and Proper Person Test, all board members are required to do an annual self-attestation and, that he had overall responsibility for compliance for the CEO and the Non-Executive Directors, the CEO had responsibility for all of the Executive Directors and, the Senior Independent Director (SID) had responsibility for the Chair's compliance.

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Additionally, as part of the process, all Board members had been checked by the Corporate Governance team on their social media activity, employment tribunal records, bankruptcy and insolvency registers. All these checks came back without any concerns.

Following a review of all the evidence, JL confirmed that all NEDs on the Board were deemed to be Fit and Proper persons.

MH had reviewed the evidence and deemed that all Executives on the Board were Fit and Proper persons.

DL, as SID had reviewed JL's evidence and confirmed that he was a Fit and Proper person.

The Council received the FPPT report.

24/4.2	**TO RECEIVE A RECOMMENDATION FROM THE NOMINATION COMMITTEE FOR THE PROPOSED APPOINTMENT OF A NON-EXECUTIVE DIRECTOR**

AK reported that as Debbie Colson's term of office came to an end on 31st March 2024, Gatenby Sanderson had supported the Trust with the recruitment process for a new Non-Executive Director. The Trust received 94 applications from high calibre candidates which made the long listing process cumbersome 17 applicants were long listed from those, short-listed down to 5 applicants. The interviews took place on Tuesday 26th March with input from the stakeholder panels that consisted of Governors, service users, student, clinicians, and board members. Due to the impending merger, the criteria was focused on candidates with a commercial/finance background.

Governors were asked to approve the process and the appointment of Ken Batty. Although all 5 applicants were appointable, Ken had a demonstrable stronger commercial background, long NHS experience including as a Non-Executive Director, with local links and also Chairs two charities in Camden. He is experienced in education and research and has interest in innovative research at Regents College.

JL thanked the Governors that were part of the recruitment process. Positive references had been received for Ken from the Chair of East London and Lenovo.

At the time this item was discussed, the meeting was inquorate and therefore it was not feasible to approve the appointment. AK noted that he would send out a short paper to the Governors for their approval.

ACTION: AK to send out a paper to the Governors for the approval of the appointment of Ken Batty as a new Non-Executive Director.   **AK**

24/4.3	**REVIEW OF DELIVERY OF TRUSTS QUALITY PRIORITIES 2022/23 AND UPDATE ON SELECTION PROCESS FOR QUALITY PRIORITIES 2023/24**

EC presented the slides for the Quality Priorities for 2024/25. She highlighted that in the past having a large number of priorities made it difficult to monitor. It was

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therefore decided that when developing the priorities for 2024/25, they would be linked to the Strategic Ambitions of the Trust. A stakeholder event was held where those invited included the CQC, Local Authority and external stakeholders. Several areas were identified and once finalised it would be sent to the KE as the Lead Governor.

EC provided the following highlights:
- New vision, mission and values were agreed for the whole Trust.
- Strengthened accountability through the IQPR and review the sub-committee structure.
- Beginning a merger process, engaging with patients, students, staff and the community, and formally inviting expressions of interest from potential partner organisations.
- Working with NHSE and new providers on safe transfer of care for GIDS patients.
- As part of strengthening our patient safety culture, 85% of staff would be trained on patient safety through PSIRF.
- Staff would be trained in new investigative techniques, increasing patient involvement in investigations and strengthening the investigation templates.
- Looking at psychological safety across all areas mirroring the mission, vision and values.
- Clinical effectiveness – looking at clinical harm reviews, review of outcome measures, implementation of the PCREF.
- Patient experience – looking at strengthening and developing the way we collect and act on patient feedback and having feedback loops to the patients, clinicians and public.

Next steps would be that the draft Quality Priorities would be presented to the Quality and Safety Committee for approval, and to KE as the Lead Chair for comments. The final sign off would be on 30 June 2024.

The Governors received the Quality Priorities report.

| 24/5.1 | **QUESTIONS FROM THE PUBLIC** |

A member of the public (Anne) was present online and posed the following questions through the chat function. The chat has been reproduced verbatim for accuracy.

Comments from Anne
This concerns the excessive waiting times for treatment at the Tavistock. In the Board of Directors meeting papers on the Tavistock website the waiting time data collated is for '1st appointment waiting times.' '1st appointments' are usually assessment appointments, the '1st appointment' data reflects excessive waiting times in most departments. Following assessment appointments service users are then placed on a further long waiting list for their actual treatment. There does not appear to be data for the additional long waiting times for the actual start of treatment. How can the Tavistock realistically improve service users' waiting times for actual treatment when the data collated does not appear to reflect the waiting times for actual treatment? Are the Governors aware of this? Also, do the Governors know if that data has been collated and if so do they know where it can be viewed?

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The 1st appointments after referral are the assessment appointments - this is not the actual treatment. There is a further long wait after assessment that is not documented in the data collated. This applies to more than two departments - this applies to Cahms and Adult Complex needs departments etc etc. Please can the Governors put the above point to the board!
Where is that data please - it isn't in the Board of Directors papers - they only have data to 1st appointment ie the assessment appointments
Why isn't that data visible in the Board of Directors paperwork?

The Tavistock's primary function is as a service user provider - it is currently failing service users due to waiting times. It is very important to address this.
Thank you.

Anne raised the points with CS and EC through the chat function as they were also both in attendance virtually.

In response, JL noted that the data was available in the IQPR (Performance Report). JL requested that Anne provides her contact details so that a formal response would be sent to her by the Trust. Alternatively, JL mentioned he would be happy to meet with Anne to discuss her concerns.

Anne did not provide any contact details.

FD thanked Anne for raising the concerns.

24/5.2	**ANY OTHER BUSINESS**

There was no other business raised.

24/5.3	**ISSUES TO BE ESCALATED TO THE BOARD OF DIRECTORS**

Agenda for the Joint Board of Directors and Council of Governor to include Staff Survey.

24/5.4	**REFLECTIONS AND FEEDBACK FROM THE MEETING**

The Council noted the following:
- The technology worked well in the Training Rooms and those online had no difficulty hearing those who were present in the room.
- The meeting although long, did not feel repetitive.

The Chair closed the meeting at 5.35pm.

Date of Next Meeting in Public: Thursday, 30 May 2024 at the Tavistock and Portman NHS Foundation Trust.

Signature   _____   Date _____

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Council of Governors 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

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)
8.6.23	2.7	Council of Governors Development Programme 2023/24	Training - Governors Development Programme to be developed.	14.9.23	Adewale Kadiri, Director of Corporate Governance	To Close	Governors are booked onto relevant events run by NHS Providers. **This was discussed at the December 2023 meeting.** On the agenda for the May 2024 meeting.
14.09.23		Freedom to Speak Up Guardian Report	As there was no mention in the BAF and the risk register of psychological safety, it was agreed that there should be a review of the risks considered in the inclusion of BAF and risk register.	May-24	Sarah Stenlake, Freedom to Speak Up Guardian & Adewale Kadiri, Director of Corporate Governance	To Close	The 2024/25 BAF risks have been reviewed in conjunction with the Board Committees and Executive Leads, and presented at the May Board. This issue has been reflected in the People related risks.
28.03.24	6	Governor Feedback	Staff Survey to be added on the Joint Board of Directors and Council of Governors meeting in April 2024.	April	Fiona Fernandes, Business Manager Corporate Governance	To Close	This was discussed at the Joint Meeting of the Board of Directors and Council of Governors on 11th April 2024
28.03.24	6	Governor Feedback	A service visit programme to be done for all service not only clinical. The programme should include other services like, Education, Corporate, Finance, Estates, etc	May-24	Adewale Kadiri, Director of Corporate Governance	Open	In progress - the service visit programme for 2024/25 is currently being developed and will be circulated to the CoG by email in due course.
28.03.24	9	Membership & Engagement Update	To provide information to the Governors regarding feedback from members on the merger information from the website.	May-24	Jane Meggitt, Interim Director of Communications	To Close	Although feedback was received from the public during the Phase 1 engagement sessions, we were unable to distinguish between feedback received from FT members and the public. Other engagement activities are planned (see below).
28.03.24	9	Membership & Engagement Update	To arrange events for the membership – sessions for Young People and sessions for Adults.	Jun-24	Jane Meggitt, Interim Director of Communications	Open	In progress. Two events had been scheduled for 29th May and 11th June but these have been postponed given the announcement of a General Election on 4 July and the pre-election period guidance.
28.03.24	16	To receive a recommendation from the Nominations Committee for the proposed appointment of the new Non-Executive Director	To send out a paper to the Governors for the approval of the appointment of Ken Batty as the new Non-Executive Director.	Mar-24	Adewale Kadiri, Director of Corporate Governance & Fiona Fernandes, Business Manager Corporate Governance	To Close	This was emailed to the Governors on 5th April 2024

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)**
28.03.24	17	Review of delivery of Trusts Quality Priorities 2022/23 and Update on selection process for Quality Priorities 2023/24	Send the Quality Priorities for 2024/2025 slides to the Governors.	Mar-24	Fiona Fernandes, Business Manager Corporate Governance	To Close	This was emailed to the Governors on 8th April and 13th May 2024

MEETING OF THE COUNCIL OF GOVERNORS PART II – PUBLIC – Thursday, 30 May 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:	None			
Executive Summary:				
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐			
Situation:	This report provides a focused update on the Trust's response to specific elements of its service delivery and subsequent future, and the evolving health and care landscape.			
Background:	The Chief Executive's report aims to highlight developments that are of strategic relevance to the Trust and which the Council of Governors should be sighted on.			
Assessment:	This report covers the period since the meeting on 5 March 2024.			
Key recommendation(s):	The Council of Governors is asked to receive this report, discuss its contents, and note the progress update against leadership responsibilities within the CEO's portfolio.			
Implications:				
Strategic Ambitions:				

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

Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒		CRR ☐		ORR ☐
	All BAF risks				
Legal and Regulatory Implications:	Yes ☐			No ☒	
	There are no legal and/ or regulatory implications associated with this report				
Resource Implications:	Yes ☐			No ☒	
	There are no resource implications associated with this report.				
	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:	None			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☐ Partial Assurance: There are gaps in assurance	☒ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Chief Executive's Report - 30 May 2024

Providing outstanding patient care

1. Patient Safety Incident Response Framework (PSIRF)

The Trust held a PSIRF week starting with the formal launch on 22 April 2024. The week focused on the principles of PSIRF starting with 'compassionate engagement and involvement for patients, families and staff'. It was a major success with a focus on reinforcing some of the work that staff have been trialling, such as After-Action Reviews and 72-hour reports. There was also a spotlight on the role of the Patient Safety Partners who have already made valuable contributions in their attendance at meetings of the Quality and Safety Committee and various sub-groups.

2. Patient and Carer Race Equality Framework

The PCREF implementation plan has been formally approved by the Quality and Safety Committee, and the implementation group will be holding their first meeting in the next few weeks. Once this has taken place, an engagement plan will be launched to ensure this work is integrated into front line clinical governance. This will be an important tool in helping the Trust ensure that its services are fully accessible to all sections of the communities it serves.

3. Gender Identity Development Service (GIDS) update

The children and young people's Gender Identity Development Service (GIDS) formally closed on 31 March 2024, following NHS England's decision to decommission it.

Enhancing our reputation as a provider of training and education

4. International conference for infant observation

The 9th international conference for infant observation was held in person once again at the Tavistock Centre on 5-6 April 2024. It was attended by speakers and participants from around the world and focused on how social forces and structures (including social class, gender, race, sexuality, neurodiversity and disability) influence the infant's emotional experience and developing social identity. The conference was chaired by Dr Matthew Chuard, MA Course Lead and child psychotherapist here at the Trust.

5. Delegation to China

During March, Chris Abbott, Chief Medical Officer, and Paul Dugmore, Associate Dean travelled to China as part of a UK healthcare education mission to cities such as Shanghai, Guangzhou and Shenzhen. The primary objective of this trip was to understand the current landscape in Chinese healthcare and international collaboration priorities in healthcare education, training and research. We were the only NHS trust invited to join, recognising our unique combination of service and educational provision, and commitment to mental health research.

One early outcome from the visit was an agreement for the Trust to launch a blended long course, to take place both virtually and face to face – with Trust staff flying out to China to

teach. This could mark a significant step forward in our strategic ambition to grow our training provision internationally.

Developing a culture where everyone thrives

6. Stephen Lawrence Day

22 April 2024 marked the day 31 years ago when Stephen Lawrence, an 18-year-old student from South-East London was tragically stabbed to death in an unprovoked racist attack. His killers did not know him, and he did not know them. After the initial police investigation, five suspects were arrested but not convicted. A subsequent public inquiry into the handling of the investigation led to the publication of the Macpherson Report which has been described as one of the most important moments in the modern history of criminal justice in Britain, and it led to profound cultural changes in attitudes to racism, the law and policing.

Here at the Trust, we marked the day by sharing a number of articles, stories and discussions on race, confronting biases, challenging discrimination and working towards a more inclusive society. We expressed our collective determination to continue to educate ourselves, advocate for change and actively challenge systemic injustices wherever they may exist.

7. NHS national industrial action

The Government reached an agreement to put a revised pay reform offer for consultants to members of the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA), with the offer being voted on until 3 April 2024. The offer included reforms to the consultant pay scales which would be backdated to 1 March 2024. This revised offer has now been accepted.

The deal builds on a headline pay uplift of 6% for 2023/24 which was settled through the pay review body process. Headline pay for 2024/25 will be determined through the DDRB process as usual, with government expected to announce details before the end of July 2024.

A separate discussion regarding the need and/or appetite for separate agenda for change spine points for nurses is ongoing. There were consistent messages from across the country and an overwhelming consensus that employers in the NHS do not support anything that would threaten the integrity of the original Agenda for Change (AfC) agreement, as this created the unified pay and banding system we have in place.

The call for evidence online portal closed on 4 April. We understand that DHSC will consider all submissions received before deciding on any next steps. NHS Confederation will await their response and keep trusts informed.

8. Agency usage

A new directive has been received, requiring all trusts to cease off framework agency usage by the end of July 2024. Our people and finance teams are therefore working closely to identify current usage with the aim of ceasing assignments, moving the affected staff to framework agencies, bank or fixed term contracts, and/or permanent employment.

9. Staff engagement

On 23 April, the People Team and Communications Team launched an engagement programme that ties into the Trust's Staff Survey action plans, focussing on improving staff

experience. Across a number of activities, the Trust seeks to hear from staff to get a broader understanding, and what specific interventions we can make to improve working life at the Trust.

Staff engagement around the merger continues, with updates at all-staff meetings and forums, and weekly all-staff drop-in sessions taking place, where colleagues can ask members of executive team questions and share ideas.

Improving value, productivity, financial and environmental sustainability

10. Merger update

The merger process is continuing with executive level engagement taking place between the Trust and its proposed partners. We remain on track to announce our preferred merger partner following our Private Board's decision in June. Noting the pre-election period restrictions during this time.

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

The latest financial plan for 2024/25 was submitted to the ICB for inclusion in the consolidated ICS summary for NHSE, on 29 April. This continues to show a planned deficit of £2.4m and was developed in line with the ICS planning process. The Trust is still therefore planning to achieve a balanced financial plan in 2025/26.

The closure of GIDS at the end of 2023/24 with the associated loss of income is the primary driver for a two-year timescale to get back to a balanced plan position.

The reported financial position as at 31 March 2024 (reporting month 12) was a deficit of £2,373k in the period, against a planned deficit of £2,517k i.e., positive variance of £144k. This reported position now reflects the agreed income and expenditure associated with the decommissioning of GIDS. The previously highlighted risk is now fully mitigated by agreed NHSE income.

The development of monthly budget reporting process continues, with both budget and actual expenditure information shared with all clinical services from month 9 onwards. The reconciliation between the budgets and the Electronic Staff Record (ESR) continues, with input from the service leads, is a key part of the work. This is a key component in enabling financial accountability at service line/team level and providing a further level of detail to the summary reports provided in the Integrated Quality Performance Reports.

Regional and National Context

12. London CEO Meeting

I attended the London CEOs meeting on 17 April. One of the key presentations was from Professor Oliver Shanley, OBE, who chaired the independent review of Greater Manchester Mental Health NHS Foundation Trust which presented its final report in January 2024. He highlighted the key findings from the review, most of which are depressingly familiar – that patients at the Edenfield unit did not feel listened to or believed, that the board was disconnected from the reality of patient and staff experience, that there was a culture of suppressing bad news and intimidation, and that the unit was extremely understaffed. There was also some criticism for the CQC which had failed to identify the closed culture that existed in the trust, placing too much reliance on their 'Good' rating. The review made 11 recommendations covering a range of areas including patients, families and carers' voice, clinical leadership, organisational culture and governance.

The meeting also highlighted the productivity challenge in London, demonstrating through the data presented the extent to which activity levels within each of the 5 ICBs had deteriorated between 2019/20 and 2024/25 in spite of consistent inflation adjusted expenditure growth during the period. Measures to be taken to address this include the imposition of robust workforce controls, standardisation of clinical operational processes and an understanding of the opportunities to improve non-pay productivity.

13. 2024/25 CRN North Thames funding

I received a letter on 15 April from the National Institute for Health and Care Research informing me that the current Clinical Research Network will cease to exist in September 2024 to be replaced by the Research Delivery Network. The new organisation will have new processes, structures and governance, and the letter confirmed the funding that has been allocated to the Trust for 2024/25 and the conditions for accessing this. We look forward to working with the new organisation.

14. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) 2023 Annual Report

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) published its annual report 2023 which sets out findings relating to people aged 10 and above who died by suicide between 2010 and 2020 across all UK countries. Key findings include:

- There was a 6% decrease in the suicide rate in the general population in 2020.
- 27% of all people who died by suicide in 2010 – 2020 had recent contact with mental health services. 7 Overall page 29 of 124.
- The majority of patients who died had a history of self-harm (64%) and there were high proportions of those with problem alcohol (48%) and drug (37%) use, and comorbidity, i.e., more than one mental health diagnosis (53%). Nearly half (48%) of all patients lived alone. In 5% of cases, the patients were recent migrants. Clinicians should focus on these factors to reduce suicide rates.
- 23% of all patient suicides had missed their last contact with services. These patients had higher rates of exposure to conventional risk factors for suicide including unemployment, living alone, previous self-harm and problematic alcohol and/or drug use. Services had only made contact with patient's families in 25% of cases where patients missed their final appointment. Services should actively re-establish care in these scenarios, involving family members where possible.
- Among mental health inpatients who died by suicide in 2020, 50% were on agreed leave and 11% of all suicides were patients who had been discharged from mental health inpatient services in the 3 months before their death. The highest number of deaths occurred on day 3 post-discharge. Services should remove low-lying ligature points and ensure planning for pre-discharge leave and discharge from hospital addresses adverse circumstances patients may face in the community.
- 27% of all patient suicides occurred among people who had experienced economic adversity in the three months before their death including serious financial difficulties or job, benefits or housing loss. Clinicians should be aware of these risks and be able to signpost patients to appropriate support.

MEETING OF THE COUNCIL OF GOVERNORS PART II – PUBLIC – Thursday, 30 May 2024

Report Title: Council of Governors' Development Programme			Agenda No.: 9	
Report Author and Job Title:	Adewale Kadiri Director of Corporate Governance	**Lead Executive Director:**	Adewale Kadiri Director of Corporate Governance	
Appendices:	None			
Executive Summary:				
Action Required:	Approval ☒ Discussion ☒ Information ☐ Assurance ☐			
Background:	The Council of Governors is a key group within the formal governance structures of an NHS Foundation Trust. It is therefore essential that the Council is provided with all the tools and support that they need to perform their role effectively. In particular, the Council should have in place a clear and effective development programme to ensure that members have the skills and knowledge that they need, and that they are able to keep abreast of any changes in legislation, guidance or practice. The Director of Corporate Governance presented a paper at the Council of Governors' meeting in December 2023 setting out proposals for a holistic development programme combining existing training and development opportunities through and other external providers, with bespoke sessions mainly delivered internally. It is however acknowledged that due to a combination of work pressures and an inability to find the time within governors' schedules, these proposals have not yet been delivered. The main purpose of this updated paper is to assure Governors of the Trust's commitment to support you to be able to effectively fulfill all aspects of your statutory remit.			
Assessment:	There have historically been gaps in the level of support provided to the Council of Governors at this Trust, leading to variations in the knowledge and understanding of the Governor role across the Council. This paper seeks reopen the conversation with Governors as to how those gaps can most effectively be filled.			
Key recommendation(s):	The Council of Governors is asked to: **DISCUSS** the proposals, and in particular, assist us in knowing how we can best use your time in the organization to provide the support that you need.			
Implications:				
Strategic Ambitions:				

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

9. Council of Governor Development Programme update

Relevant **CQC Quality Statements** (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☐		CRR ☐		ORR ☐
	No related BAF risk.				
Legal and Regulatory Implications:	Yes ☒			No ☐	
	The CQC's Well Led domain requires that organisations have clear and effective governance and accountability requirements.				
Resource Implications:	Yes ☒			No ☐	
	The Trust may need to engage the services of external trainers to provide some of the content set out in this programme.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒			No ☐	
	Members of the Trust's Council of Governors come from a range of backgrounds, and some have protected characteristics. It is essential that this programme takes account of any additional needs that they may have, to ensure that all Governors understand their role and are able to fully contribute.				
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	

Council of Governors' Development Programme Update

1.   Purpose of the report

1.1.   The purpose of this report is to revisit the issue of how best to meet training and development needs within the Council of Governors.

2.   Background

2.1.   Initial proposals were presented to the Council of Governors last December, but these have not been implemented due to a combination of work pressures and an inability to find the time to fit them in.

2.2.   There is an urgency to resolve this issue - as the Trust approaches a key decision making point in the merger process, the Council has a specific statutory role in this process. It is important therefore to ensure that all governors are fully equipped and supported to perform their functions.

2.3.   It is acknowledged that in the past, the approach to training and development for the Council has not been consistent. This updated paper therefore seeks to set the foundations for the establishment of a formal yet realistic programme, combining externally provided set-piece training sessions, with in-house bespoke sessions, and written briefings and presentations about various aspects of the work of the Trust.

3.   Governors' Induction and initial training offer

3.1.   It remains our commitment that going forward, any new governors joining the Council will undergo a formal induction programme to welcome them to the Trust and introduce them properly to the role. This will, as much as practicable, be linked to the Trust's corporate induction, and indeed, new governors will be asked to participate in relevant aspects of that process. In addition, there will be sessions on how the NHS works, an introduction to Foundation Trusts, the roles and powers of the Council of Governors, and the relationship between governors and Foundation Trust Members.

3.2.   We know that many existing Governors have never had an induction, but it may no longer be necessary or appropriate at this stage to take people through such a process. However, conversations with a number of governors indicate that they would benefit from some form of "refresher" training. This is both in relation to "generic" issues, including the role of the Council itself, deeper dives into various aspects of the Trust's work, and other topical NHS-wide issues, such as developments in system-based working and new approaches to patient and service user involvement.

3.3.   Governors' feedback on what they would find most useful in this area would be appreciated.

4.   Ongoing training and development

4.1.   In terms of opportunities for ongoing training and development, it is proposed that there is a combination of Trust-specific sessions relating to the work of individual teams and services, and other programmes on the role of the Governor, to be delivered internally, across the ICB or externally. On the latter point, we know, for

example, that governance leads across the NCL system are beginning to think about how to build on and share best practice around engagement – it would be very helpful if in due course governors could become involved in joint work of this nature.

4.2. Working with the Quality Team and others, we are now committed to having service user and/or student presentations at CoG meetings. Although a programme of presentations has been created, if there are any particular teams or departments whose work the Council would like highlighted, it would be useful if this could be shared.

4.3. Opportunities are also being created for governors to join NEDs and EDs on service visits, and again governors are encouraged to enquire and take advantage of these.

4.4. Important subjects for ongoing development would of course include the role of the Council within the merger process and what Governors could expect as participants in any future CQC Well Led inspection. In addition to these two specific items, it would be important for Governors to be refreshed from time to time on more routine items, such as holding NEDs to account, engaging with Members and appraisals, including through the Governwell programme as discussed earlier. There is also the possibility, if required, of inviting Governwell, or any other similar body to provide bespoke training in response to a specifically identified need.

5. Suggested programme and time commitment

5.1. As stated above, one of the stumbling blocks that we encountered previously in seeking to take this work forward is finding the time to fit it all in. Appreciating that all our Governors are volunteers and can only devote so much time to Trust business, it is important that the right balance is struck between providing the training and development that Governors need and not demanding too much additional time.

5.2. We would very much like to hear from governors themselves as to what would work best for them. For example, would Governors wish to devote any time from existing engagements purely to development activities, or would you be amenable to identifying additional time for these activities – particularly in non-CoG months? Alternatively, would you prefer that material that you could look at in your leisure is shared rather than relying on people attending sessions?

5.3. In the meantime, set out below is what the first few months of a new development programme could look like:

Month	Item
May 2024	Service presentation – Fitzrovia Youth Action CAMHS
July	Introduction to the Significant Transaction regime
September	CQC Well Led briefing
October	Service presentation (TBA)
November	Member and Public Engagement
December	Service presentation (TBA)

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – Thursday, 30 May 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Integrated Audit and Governance Committee	21st May 2024	David Levenson, Non-Executive Director	Peter O'Neill, Interim CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 10**		

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. **Internal Audit Update:** • The Committee received 3 reports with partial assurance, Waiting List Management, Safeguarding, and Key Financial Controls. • It was agreed that a follow up review was required for the accounts payable control risk. With other identified actions highlighted in the reports being agreed as adequate to mitigate key risks.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. **External Audit Update** • Grant Thornton presented their Sector report, Audit plan update, and Audit Progress report. • The Progress report indicated that the audit is currently on track to achieve the national submission deadline of 28th June.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
3. **Estates Valuation** • Report received from professional valuers Gerald Eve LLP describing the methodology for updating the Trust land and buildings for inclusion in the annual accounts. No issues were reported.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. **Other** - A draft of the Annual Report (including the Annual Governance Statement) was received, showing the proposed structure and information to be included. - The Integrated Governance Action Plan closure report was received. - The Risk Management Policy update was received and approved.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
Summary of Decisions made by the Committee:	
• The Committee was not required to make any decision except as indicated above.	
Risks Identified by the Committee during the meeting:	
Limited External Audit timetable, Safeguarding and Accounts Payable process risks were identified.	

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

Update on the review of the identified Accounts Payable process risk.

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

Item	Purpose	Date
None	Action	

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – Thursday, 30 May 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Quality & Safety Committee	7 March 2024 18 April 2024	Claire Johnston, Committee Chair, Non-Executive Director	Emma Casey, Associate Director of Quality	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 11**		

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

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

Key headline	**Assurance rating**
1. 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. It was noted that a launch week will be held in April 2024, which will be a series of bitesize sessions based around the four pillars of the PSIRF, with the intent of increasing awareness of the ethos and processes of PSIRF across all Trust staff. This will be supported by the ongoing communications campaign. It was also noted that an A3 quality improvement diagram has been drafted to articulate and formally document progress against the framework to date and clearly establish the success criteria that will be met to get to compliance. The document will undergo further refinement before being agreed.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Local Risk Management System (LRMS) replacement The Committee received updates 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. There was also an additional risk noted in relation to the changes within the project management team that are leading the implementation of the project. There is now a plan in place to address however the challenges on capacity do remain an area of risk.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. Quality Framework Improvement Plan The Committee received an update in relation to progress against the Quality Framework improvement plan, which was developed in 2022 following a review of the Trust's quality governance, function, systems and processes. This	Limited ☐ Partial ☐ Adequate ☒

improvement plan was also intended to provide the assurance of actions to the System Oversight Framework (SOF) with assurance to move quality governance out of level 3. The framework has been an evolving document and actions have been added as identified. A significant number of the actions have also been evidenced as completed since the time the plan was developed in 2022. The Committee meeting of 18th April received the updated exist criteria issued to the Trust from NCL ICB. The update noted the significant progress in respect of the criteria associated to Quality, linked to the Quality Framework Improvement Plan, and the overall domain has been subsequently rated as green.	N/A ☐
4. Quality & Safety Report A new Quality Report was designed in May 2022 to provide assurance on the quality and safety of services at the Tavistock and Portman NHS Foundation Trust. It was an evolving document since that time, alongside the review of the way in which the Trust holds itself to account through structures such as the Integrated Quality & Performance Report (IQPR) process. Following the implementation of the IQPR process, it was agreed that the Quality Report in its previous format would be stood down and incorporated into the IQPR. The Committee reviewed and discussed the new format of the Quality & Safety report, which expands on the detail in the IQPR, and includes detail against the new set of quality and safety metrics following approval by the Committee in November 2023; including clinical incidents, complaints & enquiries, compliments and feedback. This report will be informed by the data within the Trust wide Integrated Quality & Performance Report (IPQR), narrative from clinical teams, subject matter experts and clinical governance processes. Where appropriate and possible, it will capture themes across the individual data sets and further triangulate across all quality and safety metrics. The report is a developing process and will be expanded in future months to include further data sources and potential for triangulation of feedback and learning.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Safeguarding – Internal Audit & Action Plan As part of the Trust's 2023/24 Internal Audit Plan, a review into the safeguarding arrangements was undertaken to provide assurance on whether suitable systems were in place to ensure that vulnerable children and adults were safe from harm. The Committee noted that two high priority management actions were raised during the review, as well as three medium priority and one low priority management actions. An action plan has been developed to address these identified areas and will be monitored by the Committee.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐

Summary of Decisions made by the Committee:

7 March 2024
- The Committee APPROVED the Clinical Incident & Safety Group Terms of Reference
- The Committee APPROVED the Clinical Audit & Effectiveness Terms of Reference
- The Committee APPROVED the Research & Development Group Terms of Reference

18 April 2024
- The Committee APPROVED the Mortality Group Terms of Reference

- The Committee APPROVED the PCREF (patient and carer race equality framework) Steering Group Terms of Reference and the PCREF implementation plan
- The Committee APPROVED the refreshed Duty of Candour policy
- The Committee ENDORSED the Trust's Quality Priorities for 24/25

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 COUNCIL OF GOVERNORS PART II – PUBLIC – Thursday, 30 May 2024			
Report Title: Integrated Quality and Performance Report (IQPR)			**Agenda No.:** 12a
Report Author and Job Title:	Amy LeGood, Acting Director of Commercial; and Hector Bayayi, Clinical Operations Director	**Lead Executive Director:**	Sally Hodges, Chief Clinical Operations Officer; and Peter O'Neill, Interim Chief Finance Officer
Appendices:	Appendix 1: Integrated Quality and Performance Report (slide deck)		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This report covers the IQPR for month 11 data.		
Background:	The IQPR data has been been discussed and reviewed within the local teams, clinical service line IQPRs and the Performance, Finance and Resources Committee (PFRC) on 18 April 2024. Wait time data has not improved as the mechanisms with which improvement can be realised have not been fully implemented. Namely, embedding the PTL process and reporting function on CareNotes, aligning clinical pathways to best practice and commissioned functions and optimising job plans. However, all service lines have made significant progress in recruiting to existing vacancies, with some services near the. The implementation of a hard cut off has had an impact on data quality (e.g., a greater number of unoutcomed appointments), and we still have inconsistencies regarding when the data is drawn, making the data not easy to compare. The implementation of job planning although marginally successful, requires greater visibility of prospective appointments booked to improve visibility, as a measure of target vs planned activity and to improve clinical and operational oversight of RTT. The ongoing work on automation of the IQPRs will be beneficial, as will pulling together the three BI dashboards (HR, Contracts and Quality) in use currently.		
Assessment:	A3's are now discussed weekly at the Executive Leadership Team (ELT) and in the weekly Quality Improvement (QI) huddles driving a clear focus on improvement in relation to the strategic ambitions. In addition, each priority service line will have within the next six weeks a clear delivery plan aligned to the A3's and Trust strategic priorities. The PFRC reviewed this report and whilst they consider it a work in progress with month-on-month improvements, the Committee noted that it provided limited assurance.		
Key recommendation(s):	The Council of Governors is asked to review and **DISCUSS** the contents of this report.		
Implications:			
Strategic Ambitions:			
☒ Providing outstanding patient care	☒ To enhance our reputation and grow as a leading local, regional,	☒ Developing partnerships to improve population health and building	☒ Developing a culture where everyone thrives with a focus on	☒ Improving value, productivity, financial and

	national & international provider of training & education	on our reputation for innovation and research in this area	equality, diversity and inclusion	environmental sustainability
Relevant CQC Quality Statements (we statements) Domain: (tick)	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Link to the Risk Register: (tick)	BAF ☒		CRR ☐		ORR ☐
	All BAF risks in relation to Performance, Quality and Resources.				
Legal and Regulatory Implications:	Yes ☒		No ☐	
	There are regulatory implications (wait times) associated with this report.			
Resource Implications:	Yes ☐		No ☒	
	There are no additional resource implications associated with this report.			
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	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:	Local IQPR's - 26th March 2024 Performance, Resources and Finance Committee - 18th April 2024			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

Board Integrated Quality and Performance Report

May 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

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
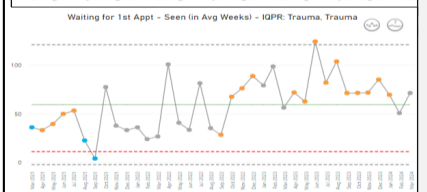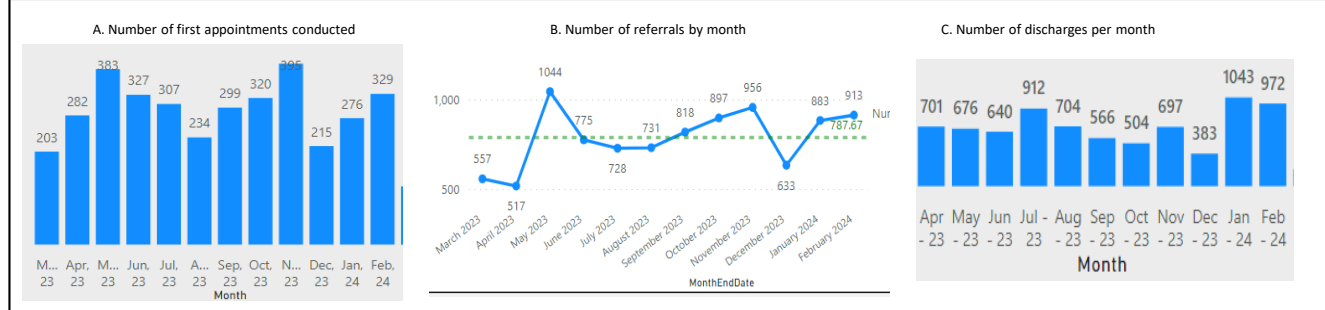
Historical Performance
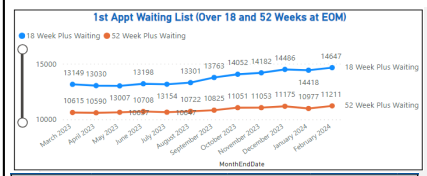
This chart indicates the number of patients that have been waiting in excess of 18 weeks (blue) and 52 weeks (orange)
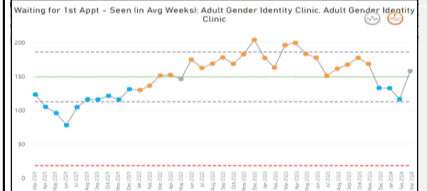
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern
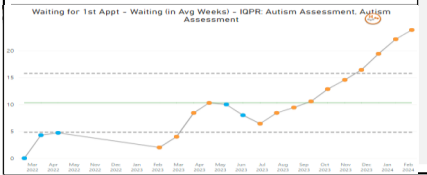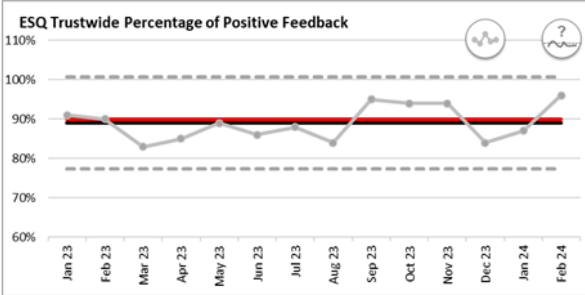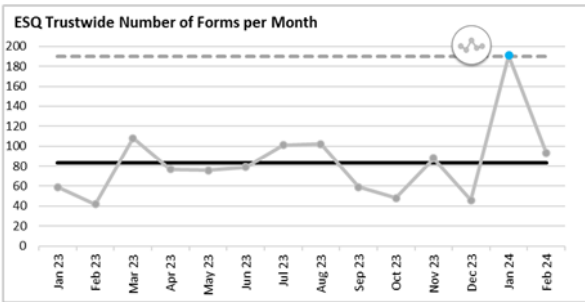
Monthly Stratified Data

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
There are patients that are dormant for more than 12 months that need review and/or discharge	Focus has been on active cases. PLT not in place to pick up dormant cases previously	Review and discharge dormant cases from PTL	Variable, in Gender expectation is that resource will be freed up for active case load management	Hector and GM/s
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

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Metric	User experience	SRO	Clare Scott	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

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

Vision & Goals

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

G1: Number of ESQ form rates to be monitored against benchmarks set in March 2024 every 3 months for the next 12mnths action plans put in place per service line to support progress

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

Historical Performance

- SPC charts now available for all service lines: C&I, CMH and GIC
- Data as run on 21st March 2024. The number of forms completed includes Trust Internal ESQ and GIC PEQ forms

ESQ Trustwide Percentage of Positive Feedback

ESQ Trustwide Number of Forms per Month

Progress on Improvements

Concern	Countermeasure in progress	Agreed priorities/actions	Owner
Ensure newly set benchmarks for service lines for ESQ responses are monitored and services supported to develop action plans to meet targets	• Benchmark baseline rates of 200% now established for each service line and will be monitored every 3 months via the monthly A3 meetings. • Highlight service lines (and teams within this) who are doing well and share learnings with other clinical areas who are struggling to increase their response levels.	Ensure benchmarking data is incorporated in IQPR quality slides. Use QI tools to explore successes and challenges to understand why numbers are increasing/decreasing	Antonia & Marcy
There is a wide range of ESQ's being used and varying ways to collect feedback	• Review what versions of ESQ are being used • Ensure SU preferences for development of a standardised ESQ are incorporated • Ensure contractual reporting requirements are fulfilled (MHSDS)	Collate all ESQ version being used Trust wide Establish Task & Finish group to agree a standardised Trust ESQ	Marcy/GM

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Metric	Student Intake	SRO	Elisa Reyes-Simpson	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

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

Historical Performance

Year	Applied	Offers Made	Offers Accepted	Enrolled
2021-22	855	767	584	614
2022-23	998	727	546	528
2023-24	1080	764	561	551

Student Admissions 2021-24

(Bar chart showing Applied, Offers Made, Offers Accepted, Enrolled for 2021-22, 2022-23, 2023-24)
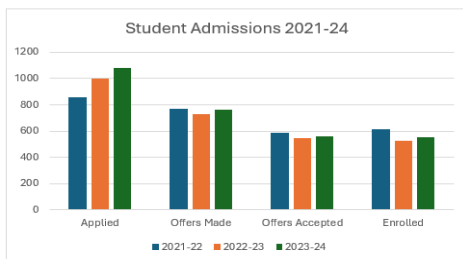
The fee status differential has altered considerably between 2019 – 2023 (noting the effect of the pandemic on student recruitment in those years).

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.

Notes on tables:

•Perinatal has been excluded from all years to streamline data.
•This does not include enrolments done outside of the Trust (e.g. M23).
•Withdrawn and swapped applicants have been excluded.
•Deferrals are included in the enrolment stats, which explains the high-seeming conversion rate from offers accepted.
•ECP has been included in the 2023-24 figures.

Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
Inability to provide modular/flexible delivery (long course)	Current implementation of SITS does not allow for flexible student management	Comprehensive external discovery/review of SITS approved and due to commence in late-Feb/early-Mar.	Resigned SITS system (and corresponding processes) to allow for flexible student management (i.e., modular delivery).	ERS (RSD)
Lack of agility in relation to long course development	Restriction on validation from university partner, professional accrediting bodies	Ongoing discussions with existing partner/professional accrediting bodies, as well as scoping new additional partnership(s). *(Note: we are hampered by unwieldy nature of university validation processes).*	More agile approach to course development to enable responsiveness to market demand	ERS (PD)
Systems not suitable for short course management	Inadequate design and implementation of SITS; lack of Moodle-SITS integration; no dedicated booking system; no CRM and inability to communicate with customers; lack of dedicated space and systems for video recording.	Comprehensive external discovery/review of SITS approved and due to commence in late-Feb/early-Mar. Proposal being prepared for Moodle-SITS integration.	Flexibility of provision and increased number of students including those accessing LLE and competing with wider sector	ERS (PD)
Lack of capacity and skills-mix in workforce	Reliance on visiting lecturers and absence of substantive staff.	A review of course viability, market demand, and staffing need to determine recruitment of substantive staff (faculty and operations) to develop and deliver new courses. Recruitment of new staff and redeployment of existing staff as required.	An agile, diverse, and skilled workforce able to meet evolving market demand and meet our growth target.	ERS (RSD)
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, 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
Lack of staffing resource across Professional Services teams	No investment in staffing in recent years – to match student growth	Approved FIRM proposal to be discussed at ELT, 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)
Lack of capacity for horizon-scanning in workforce planning	No dedicated resource for this activity	Recruitment of Associate Director of Business Development. Redeployment of NWSDU staff to DET Operations team to apply market intelligence of NHS workforce	Develop programmes in line with the NHS Long-term Workforce Plan	ERS

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Metric	Sustainable Partnerships	SRO	Elisa Reyes-Simpson	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement	We do not have a sustainable and diverse portfolio of incoming generating partnerships to help achieve significant contribution to the DET income. Such partnerships will provide access to global markets, enabling wider reach of our influence and 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: Produce prospectus for international markets
G2: Produce an international strategy including detailed market intelligence and identification of key markets; a decision making matrix to assess viability, relevance and value of prospective partners
G3: Identify X number of national and international partners (segregated into tiers by revenue value) per annum until 2030
G4: Generate income of £200k X in 2024-5FY and minimum of £1m p.a.by 2030

Historical Performance

Income and Contribution					
Contribution after direct costs only (e.g., teaching, travel expenses etc.). DSCP staff costs not included					
Year	Sum of INCOME	Sum of TOTAL DIRECT COST	Sum of CONTRIBUTION	Sum of OVERHEADS	%
2018-19	£148,547	£76,566	£71,981	£22,282	48%
2019-20	£94,930	£44,529	£50,381	£14,237	53%
2020-21	£88,065	£1,648	£86,417	£13,210	98%
2021-22	£116,596	£10,783	£105,811	£17,489	91%
2022-23	£76,186	£12,552	£63,634	£11,428	84%
Grand Total	£559,354	£151,887	£437,666	£78,046	
Type of activity					
Group training in Dubai	1				
Group training in Geneva	1				
Group training in Poland	1				
Group visit to Tavistock	15				
Individual visitor	2				
Online video content	42				
Online, live, in person	10				
Grand Total	72				

Progress on Improvements

Concern	Cause	Countermeasure in progress	Expected impact	Owner
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 |
| Lack of data to identify key applicant audience on a regional and national level | | | | |
| Lack of breadth in student recruitment markets | Student recruitment has historically not followed a market intelligence/data-led approach | Vietnam: discussions ongoing following trade mission in 2023 to offer CAMHS consultancy

Brazil – exploration of potential partnership with Oswaldo Cruz German Hospital (Sao Paolo) | Increased potential for impactful revenue generating international partnerships for the medium/long-term | ERS (PD) |
| 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 |
| No degree awarding powers, which limits the type/scope of TNE partnerships globally | Staffing resource, systems and processes not viable when last scoped | Explore additional University Partnerships
Explore required resource for Degree Awarding Powers | Without Degree Awarding Powers (DAPs) – we are limited to international digital provision (through franchising/licensing). In the absence of DAPs, alternative University Partners *may* provide additional scope for partnerships | ERS |

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12b IQPR report for May CoG - v2 - final

Metric	Having a Voice		SRO	Chris Abbott	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

As a Trust, we lack sufficient regional influence and representation in population health discussions. 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

Historical Performance

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

Progress on Improvements

Concern	Cause	Countermeasure in progress
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

Metric	Prevention & Partnerships	SRO	Chris Abbott	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

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

Historical Performance

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

- i-THRIVE Programme
- NCL Waiting Room website
- Intake Team / Integrated Front Door
- Eating Disorder Prevention / E. Difficulty Service
- Mental Health Support Teams (MHSTs)
- Trauma Informed CAMHS (e.g. FAKT)
- Adolescent & Young Adult Service (AYAS)
- Whole Family Team with Perinatal
- Under 5's work in South Camden (?)
- First Step + First Step Plus
- Gloucester House School + Outreach
- Creative Arts Therapy Service (CATS)

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.

- 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)

Root Cause/ Gap Analysis

Lack of clarity how we fit into the local prevention landscape → Mapping + Engagement → Strategic oversight of internal and external prevention services

Lacking formal relationships with local VCSE groups → Mapping + Engagement → NCL Waiting Room presence + sustained relationships and engagement of VCSE

No strategic focus on ' → Director Level Coordination → T&P Prevention Efforts aligned with Camden Strategy + Royal College Evidence Based Interventions

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

Progress on Improvements

Concern	Cause	Countermeasure in progress
Current Trust Prevention Initiatives are fragmented with no clear strategy and aim.	Trust does not have a prevention strategy in place and individual teams do not work together as no uniform leadership in area	Trust prevention strategy to be formulated and to consider operational and clinical leadership structures
No target population	Multiple areas of concern identified without agreement on where to focus work	Meeting with Camden to agree target of prevention work
No formal relationship with VCSE groups within the local area	The Trust has not reached out to work with these groups in the past so a relationship has not been formed	Start to identify VCSE groups and engage with groups that we want to create a formal relationship with

12b IQPR report for May CoG - v2 - final

Metric	Bullying and Harassment		SRO	Gem Davies	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement	WRES and WDES reflect that staff from minoritised ethnic backgrounds and staff with Disabilities and LTC experience more bullying, harassment and abuse compared to their counterparts. However, this is not reflected via other formal routes. This impacts culture, staff morale and the sense of inclusion.

Historical Performance

Percentage of staff experiencing harassment, bullying or abuse from staff (2019-2023)

	19/20	20/21	21/22	22/23	23/24
White (T&P)	20.5%	21.3%	19.9%	21.3%	20.7%
Other Ethnic Groups (T&P)	27.5%	23.4%	30.8%	30.1%	28.5%
Other Ethnic Groups (National Av)	24.9%	25.0%	22.9%	22.8%	21.0%

The WRES shows that harassment, bullying and abuse of staff from minoritised ethnic groups colleagues is decreasing. However, we are 7.5% worse than an average NHS Trust and have regressed from our position in 2019.

Percentage of staff experiencing harassment, bullying or abuse from staff (2019-2023)

	19/20	20/21	21/22	22/23	23/24
LTC or Illness (T&P)	21.0%	24.7%	24.2%	23.0%	21.1%
No LTC or Illness	11.4%	11.2%	12.6%	13.4%	11.0%
LTC or Illness (Nat. Average)	22.9%	21.3%	20.2%	18.9%	18.9%

The WDES shows the proportion of staff with Disabilities and LTC compared to Non-disabled staff experiencing harassment, bullying or abuse from staff over the last 5 years. While we have made gradual improvement over the last three years our current position is not better than we were 5 years ago (2019) . Our position is 2.2% below average NHS Trust.

Grievance/Bullying and Harassment Cases - 2023-2024
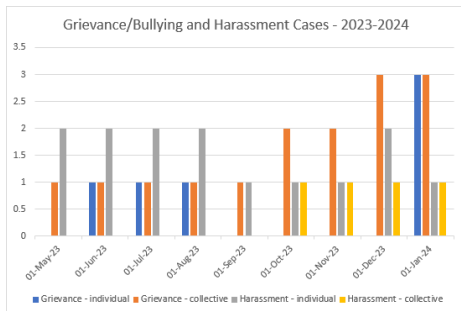
- Historically, we included interpersonal issues as "grievances", but have now moved to record these as "harassment" on ESR, so reporting will be more accurate going forwards. "Grievances" now relates to systems issues, such as pay, recruitment, etc and "harassment" relates to interpersonal issues.
- We currently have 9 people who have raised formal grievance cases (5 x white, 1 x mixed background, 1 x any other background, 1 x Asian – Indian, 1 x Black – African).
- We currently have 4 people who have raised formal harassment cases (1 x white, 1 x Black African, 1 x Black – Caribbean, 1 x mixed background). There are 2 individuals against whom harassment allegations have been made (1 x white, 1 x any other background).
- Currently most grievances/harassment cases relate to poor management practices (e.g. small issues not being tackled, which then blow up into formal issues)

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

Root Cause/ Gap Analysis

The 2023-24 WRES and WDES data highlights the following points:
WRES: (i) There has been a 1.6% reduction in the number of staff from minoritised ethnic groups experiencing BHA from colleagues. However, this is still above national average. (ii) Staff from a minortised ethnic background are x2 more likely to be discriminated by their manager/team leader than their peers.
WDES: Staff with LTC are citing a (i) significant reduction (nearly 15%) in BHA by managers. However, this is still 8.5% worse than national average, (ii) reduction of 1.9% in BHA from colleagues but they are still about 2x worse off than their counterparts without LTCs.

Progress on Improvements- Improvement Action Plan (WRES)

WRES & WDES Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Lead & Exec Owner	Timescale
Establish an Inclusive Recruitment Culture	• Debias Recruitment Process and have a more representative workforce	• All interviews have a trained manager and EDI Rep	Embed in Recruitment and Selection Policy	Associate Director of HR / EDI & CPO	Ongoing
Reduce number of staff experiencing Bullying, Harassment and Abuse	• Design posters to raise awareness about BHA	• Launch a poster campaign • Facilitate trust wide visibility	Deep dive workstream into BHA	Associate Director of EDI / HR & CPO	Deep Dive to be determined by EDI Progr. Board
Strengthen key EDI governance structures and staff networks	• Increase awareness of EDI governance • Develop relationship between Executive Sponsors and staff networks • Cascade EDI responsibility and accountability at all levels and facilitate local ownership	• Relaunch Staff Networks • Review Executive Sponsor role and responsibilities • Embed staff network maturity framework	Implement recommendations of EDI Review Set up functional staff network committees	Associate Director of EDI CPO	May 2024
Reciprocal Mentoring	• Implement Reciprocal Mentoring Programme	• Plan, select and pair mentors and mentees for pilot • Review pilot	Roll out pilot to whole organisation	Associate Director of EDI CPO	June 2024
Remove reporting barriers by completing root to branch review	• Create simplified version of grievance and disciplinary procedure • Embed Just Culture Approach • Develop and implement a Resolution Policy underpinned by Just Culture	• Facilitate collaborative approach between HR, EDI, FTSUG, staff side, DET, PPI • Policy development	Simplified version of grievance and disciplinary procedure Launch Resolution Policy underpinned by Just Culture	Associate Director of EDI / HR CPO	July 2024
Disseminate EDI data trust wide and facilitate local ownership	• Facilitate Service/Team level ownership of EDI data	• Launch A3 approach to EDI	Visit different Services / Teams and support with A3s	Associate Directors of HR & EDI	May 2024
Improve career progression opportunities for staff with Disabilities and LTC and for staff from minoritised ethnic backgrounds	• Develop fairer and transparent internal promotion process • Improve staff perception on equal opportunities for career progression and promotion	• Establish an Internal Promotion Panel	Develop Internal Promotion Panel Terms of Reference Agree membership of Promotion Panel	CPO Associate Directors of HR & EDI	August 2024
Improve representation in Agenda for Pay Bands 8a and above in the non-clinical cohort and Pay Bands 5 and above in clinical cohort	• Develop a career progression and talent management plan to improve the diversity of representation in workforce	• Implement career progression and talent management plan	Reviewing CPD process and Training Needs Analysis. Embed career conversations in appraisals	CPO Head of People (OD, Culture and Engagement)	September 2024

Metric	EDI score	SRO	Gem Davies	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

Problem Statement

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

Vision & Goals

Vision: To consistently match or exceed the national average score

G1: Improvement in indicative factors on pulse survey by 0.4 every 3 months

G2: Improve EDI from 7.36 to national average 8.3 by March 2025

Historical Performance

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

Description
Workforce Indicators Focus (Organisational Processes – Available 31st March)
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (data from a two-year rolling average).
4. Relative likelihood of staff accessing non-mandatory training and CPD
National NHS Staff Survey Indicators (Organisational Culture)
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. Percentage believing that Trust provides equal opportunities for career progression or promotion
8. Percentage of staff who have personally experienced discrimination at work from Manager/Team Leader or other Colleagues
Board Representation Indicator (Available 31st March)
9. Percentage difference between the organization's Board voting membership and its overall workforce

Score overview:

Our diversity and inclusion score **increased by 0.11** from 21 to 22 (during a lower response rate period) and **increased a further .04 in 23 in a higher response rate period**. This is in the context of the best and average results in our benchmark group declining by 0.01 in 2022 to 2023.

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 is expected to improve over time as well – annual data will be downloaded from ESR on 31.03.24.

Root Cause/ Gap Analysis

We will be refreshing our WRES and WDES workforce composition actions for 2023 in line with the stipulated national data collection period (31st March 2023). This will assist in the review of the root cause / gap analysis.

However, early indications suggest that there is an increase in staff with LTC and staff in "other ethnic groups" indicating that we provide opportunities for progression. Also, there is a fantastic 14% increase in staff with LTC citing that reasonable adjustments have been carried out. In addition, there is a noticeable reduction in the number of staff from the same groups experiencing discrimination from managers and Bullying, Harassment and Abuse from colleagues.

WRES & WDES Improvement Action Plan

Action	EDI Strategy Objectives	Progress	Next Steps	Lead & Exec Owner	Timescale
Establish an Inclusive Recruitment Culture	• Debias Recruitment Process and have a more representative workforce	• All interviews have a trained manager and EDI Rep	Embed in Recruitment and Selection Policy	Associate Director of HR / EDI & CPO	Ongoing
Reduce number of staff experiencing Bullying, Harassment and Abuse	• Design posters to raise awareness about BHA	• Launch a poster campaign • Facilitate trust wide visibility	Deep dive workstream into BHA	Associate Director of EDI / HR & CPO	Deep Dive to be determined by EDI Progr. Board
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Reciprocal Mentoring	• Implement Reciprocal Mentoring Programme	• Plan, select and pair mentors and mentees for pilot • Review pilot	Roll out pilot to whole organisation	Associate Director of EDI CPO	June 2024
Remove reporting barriers by completing root to branch review	• Create simplified version of grievance and disciplinary procedure • Embed Just Culture Approach • Develop and implement a Resolution Policy underpinned by Just Culture	• Facilitate collaborative approach between HR, EDI, FTSUG, staff side, DET, PPI • Policy development	Simplified version of grievance and disciplinary procedure Launch Resolution Policy underpinned by Just Culture	Associate Director of EDI / HR CPO	July 2024
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Improve career progression opportunities for staff with Disabilities and LTC and for staff from minoritised ethnic backgrounds	• Develop fairer and transparent internal promotion process • Improve staff perception on equal opportunities for career progression and promotion	• Establish an Internal Promotion Panel	Develop Internal Promotion Panel Terms of Reference Agree membership of Promotion Panel	CPO Associate Directors of HR & EDI	August 2024
Improve representation in Agenda for Pay Bands 8a and above in the non-clinical cohort and Pay Bands 5 and above in clinical cohort	• Develop a career progression and talent management plan to improve the diversity of representation in workforce	• Implement career progression and talent management plan	Reviewing CPD process and Training Needs Analysis. Embed career conversations in appraisals	CPO Head of People (OD, Culture and Engagement)	September 2024

Integrated Quality and Performance Report

Month 11

Metric	Team Level Budgets	SRO	Peter O'Neill	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

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.

Historical Performance

Current Situation - initial
- 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.

Update and Next Steps 14th March
- **Consistent set of budget reports produced for C&I, CMH & Corporate, from M10**
- **DET and Gender reports produced as previous months**
- **Assessment of scale of budget queries being produced**
- **M11 & M12 – budget queries continue to be updated**
- **Budgets at M12 to form basis of base budgets 24/25**
  - **Consistency check/update to reflect 24/25 trust level plan**
  - **Significant budget variances to be investigated, with individual budgets updated if required.**
- **Budget report summaries to be included in IQPR reporting from M11**
- **CIP plans and delivery to be incorporated into the financial reporting for 24/25**

Vision & Goals

1. 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. Updated base budget reports to be available and distributed to budget holders. To be consistent with the financial plan 24/25, April 24.

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.

Progress on Improvements

Concern	Cause	Countermeasure in progress
Risk of not maintaining papers for future budgets	Not BAU for Finance and HR to maintain budget working papers	- Put process in place - Put assurance process in place
Reporting Process not adequate to generate team level accountability	No budget reporting done routinely	Budget reporting being developed with adequate monthly budget management

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Metric	MTFP		SRO	Peter O'Neill	Target		Measure		Outstanding Pt Care	Education & Training	Partnerships for Research & Innovation	People Culture	Sustainability

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

Historical Performance

- 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.

Progress on Improvements

Concern	Cause	Countermeasure in progress
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

Business Rules

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

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

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Watch Metrics Score Card

CQC Measure	Metric	Target	Variation	Assurance	Mean	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
	Patient safety incidents (actual or potential harm)	N/A				12	18	12	10	9	8
	Open SI / PSI investigations	TBC				3	3	3	3	3	3
	Violence & aggression incidents	0				8	9	11	6	6	4
	Restraint incidents	0				1	1	0	0	0	
	Lower-level physical intervention	TBC				18	30	15	8	5	
	52-week+ dormant cases					2473	2380	2350	2366	2266	2185
	No of referrals (including rejections)	919				828	913	967	640	900	947
	No. of attendances	7046				5865	6088	7459	4859	6687	6856
	No. of discharges	919				566	507	698	385	1046	971
	% of Trust led cancellations	<5%				4.08	5.52	3.82	6.42	4.69	4.41
	% of DNA	<10%				10.11	10.19	9.60	10.07	10.05	9.85
	Number of formal Complaints received	<10				7	5	7	3	5	5
	Formal complaints responded to within agreed timeline (%)	90%				42%	0%	0%	0%		

Watch Metrics Score Card

CQC Measure	Metric	Target	Variation	Assurance	Mean	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
	Number of informal (local resolution) complaints	TBC				0	4	1	1	0	0
	ESQ positive responses (%)	90%				95%	94%	94%	84%	87%	96%
	18-week RTT breaches excluding ASC/GIC/Trauma/PCPCS	0				183	168	143	129	135	134
	18-week RTT breaches ASC	0				31	41	52	69	79	93
	18-week RTT breaches GIC	0				12837	13106	13219	13473	13343	13501
	18-week RTT breaches Trauma	0				432	455	485	522	563	612
	18-week RTT breaches PCPCS	0				61	48	46	74	82	93
	Mand and stat training	>95%				56.33%	55.72%	75.78%	76.93%	77.97%	75.68
	Appraisal completion	>95%				79.70%	78.86%	79.57%	81.47%	80.65%	80.36%
	Staff sickness	<3.07%				2.39%	2.23%	3.98%	3.17%	1.45%	1.61%
	Staff turnover	<2.20%				1.88%	0.57%	1.07%	1.47%	2.46%	0.75%
	Vacancy rate (On Hold)	<15%				15.41%	12.35%	12.46%	12.90%	12.6%	13.06%
	YTD savings										
	CIP										

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Are we safe?

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The Trust reported 8 Patient Safety Incidents in February 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). A new 72 hour investigation template has been approved and is in use. An incident was reported in February regarding the automatic population of the Care Plans and Review Care Plans letters in some mental health services. Due to an IT issue there was the possibility that some information had not been shared correctly. The issue is now fixed and a clinical review of all letters affected is in the final stages. *Patient Safety classification of actual or potential harm.*	**Pt safety incidents** **8**
The Trust reported 4 Violence & Aggression incidents in February The majority of 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. A thematic review of these incidents is currently being planned. The Clinical Incident & Safety Group (CISG) reviewed an after action review following an incident of violence in a clinical setting. An update from the resultant actions of this will be reviewed by the Group at its next meeting to ensure that learning is progressing. 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** **4**
The Trust reported 0 physical restraint Incidents in February Restraint incidents are reported for our specialist school, Gloucester House (Community & Integrated service). Although 0 physical restraints have been recorded for this period, lower level holds are recorded separately. The quality team is working with Gloucester House team to review the way in which these incidents are recorded, reported and reviewed is being strengthened.	**Restraint incidents** **0**

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Are we effective?

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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:

23-24 Plan vs Q3 Actual

Long courses:

23/24 Total Plan vs Total Actual
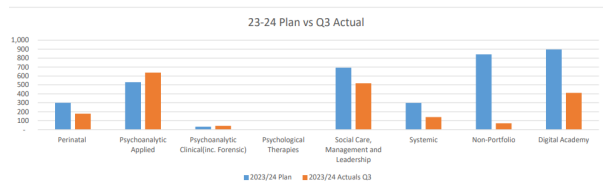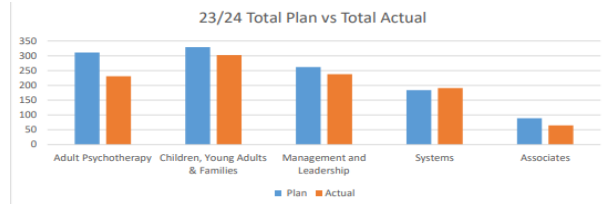
Although our enrolment numbers for long courses are lower than the target figures for the year, we have recorded slightly higher numbers of enrolments for 23/24 compared to the prior year. We have also seen a dramatic increase in the number of incomplete applications - marketing and admissions teams 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

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.

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Complex Mental Health Overview

	Successes		Challenges
Safe	• The FDAC new building is a safer & more bespoke for patients and staff. ERF funding supporting staff morale, shorter waits and continuity service in trauma & autism services .	•	Further staff consultation likely to engender trauma response from staff group.
Effective	• Staff recruitment to autism is helping productivity and to pilot new assessment model. Collaboraton with LBC Good Employment workstream for adults with MH difficulties. Psychotherapy QI on OM process and activity.	•	Additional pressures on productivity and managers may lead to burnout , sickness, conflict
Caring	• Our services are founded on dignity, respect and kindness, recent increases in ESQ return rates and AYAS review of patient feedback in Team Governance Meeting indicate positive patient experience of compassionate clinical care.	•	Monroe bulding needs soundproofing and security measures re safety & quality of care
Responsive	• EDI - Ethnicity intake audit and evaluation of Portman demographic with planned next phase of telephone follow up with patients that do DNA or drop out to increase global majority take up.	•	Space for new staff in Trauma and Autism Assessment remains a concern, with staff due to start in April with no rooms identified.
Well Led	• Involving managers and leads in IQPR process and encouraging all supporting services to help triangulate our data sest by inputting their own area (e.g. complaints, finance, HR)	•	Some team managers continue to need help taking up role and effectively line managing. Clarity around medical line management plans would be helpful.

Activity Overview
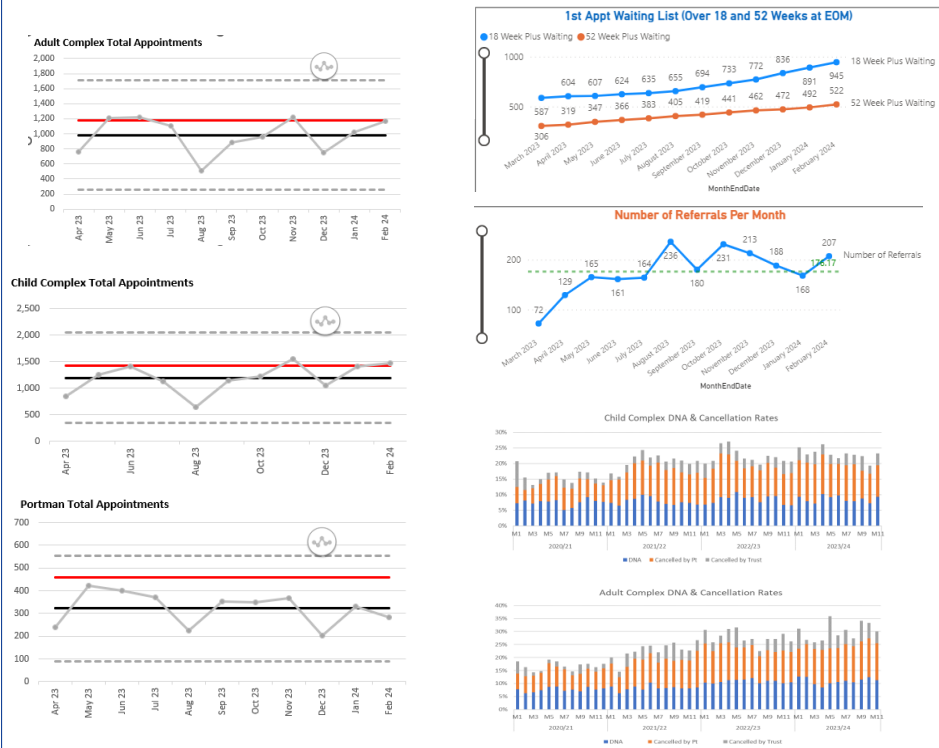
Analysis

Overall, performance against job plans has considerable improved, with the past 5 months averaging 91% compared to 76% in months 1-6. However, performance still varies by team and we remain significantly behind contracted activity targets. AYAS and Trauma will receive targeted support to work on their job plan performance.

Waiting times across CMH remain low for the majority of teams and are reducing in Adult Psychotherapy following a QI initiative to improve assessment capacity and booking processes. However, waits for Trauma and Autism assessments continue to grow as a result of referrals increasing by ~100% & 80% respectively. A3 improvement plans are in place to address these waits, with the detail being provided in slides 7-10. The posts funded via ERF are in the process of being recruited, with 3 of the Trauma Team expected to join in April. Room capacity remains a concern for this staff group. The exec team are asked to help identify and allocated 5 rooms to move staff off of the 4th floor to enable this new workforce to have the space required to see their patients.
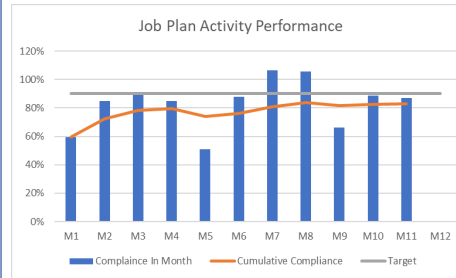
Next Steps

Concern	Cause	Countermeasure
Job Plan / Activity Performance	Patient engagement complexity	Pathway and modality of treatment review
Demand vs Capacity & Pathways in Trauma & Autism Assessment	Varied – see A3 slides 7-10	See A3 slides 7-10

Adult Gender Identity Clinic
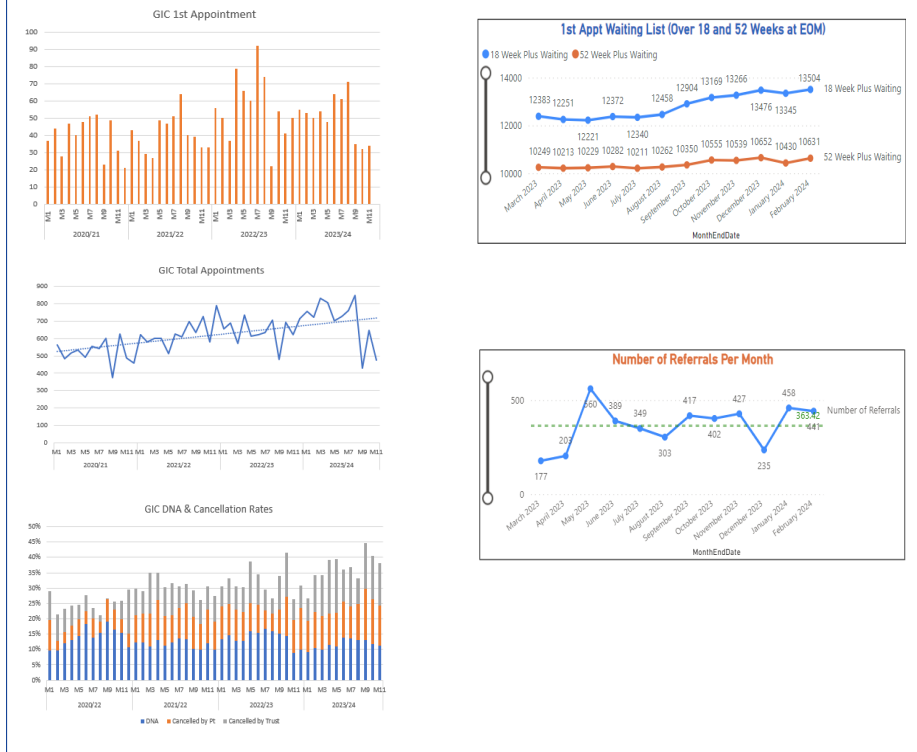
	Successes		Challenges
Safe	• The service has initiated a letter sign off process where a clinician is away long term to enable patients to receive clinic letters on time	•	Allocating responsibility and managing risk on the waiting list of 16000 patients
Effective	• GP sessions led by the service where advice is shared on treatment and prescribing trans patients are in demand	•	Continued I.T issues have resulted in disrupted clinical service.
Caring	• Areas of good practice in the service where clinicians are supporting primary care with patient diagnosis	•	Endocrine service are inundated with clinical queries which are time sensitive, the team have been working over their hours.
Responsive	• Consecutive DNAs are being validated and reviewed with clinical director and has reduced from over 100 to under 30 patients	•	The number of staff able to complete Initial assessments has decreased impacting wait times . The appointments are booking 1IAs for patients referred between Nov-Dec 2018 offering a total of 34 first appointments.
Well Led	• The GIC QI project feedback has been used to support other services	•	Delays organising Task and finish Group for developing triaging process for Core Pathways

Activity Overview

GIC 1st Appointment

GIC Total Appointments

GIC DNA & Cancellation Rates

1st Appt Waiting List (Over 18 and 52 Weeks at EOM)

Number of Referrals Per Month

Analysis

Overall, Activity within the GIC service line has increased this year compared to 22/23 but has been lower than target the past few months. There has been a decrease in number of IA1 appointments which has also impacted our waiting times. The service has had challenges recruiting into vacancies which has also impacted activity levels.

Actions plans are being developed at team level to support Quality Improvement initiatives to increase activity by ensuring clearly mapped pathways, job planning analysis and complete data capture.
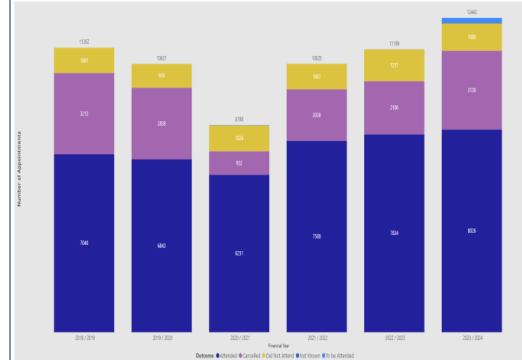
- • As part of the Quality improvement project the service is prioritising how to capture noncommissioned activity and the induction and training process into the service
- • 18-week RTT target for Gender is a challenge as we have patients waiting 5-6 years for fist appointment
- • We have no job plans for Medics currently and are working to develop those.
- • Wait between 1st and second appointments are steadily reducing.

Next Steps

Concern	Cause	Countermeasure
Staff not meeting job plans	Job plans not fully developed	To be approved so that service can assess demand vs capacity and report on job plan analysis
High Vacancy Rates	Candidates not meeting JD and person Spec	To revise the current job descriptions to better accommodate for junior staff during the recruitment process. Include flexibility in the JD to attract a diverse pool of candidates.
Increase number of 1st appointments	Reduced qualified signers	Train new staff and recruit to all vacant posts/ senior staff support
High number of referrals to service	no clear intake pathway process	Clinical Triaging at point of referral to minimise unsuitable referrals being accepted and patient portal implementation

Community and Integrated

	Successes		Challenges
Safe	• Camden teams undertaking focused work on attaching notes. Overall improvement in notes completion 90% • B7 recruited to Advantage Arsenal FC project	•	Gloucester House's risks are currently being held on a separate register, overseen by the steering committee. Going forward, we need to ensure that these risks are also present in the central risk register.
Effective	• Good levels of OM data collection at Time 1 in MHST and PCPCS • Waiting times remain low in NCL Community and MHST	•	PCPCS scrutiny at overall performance of service. Meetings are underway to try to resolve. • Psychiatry provision to First Step remains unclear
Caring	• Camden CAMHS new proposal for care leavers and unaccompanied asylum seekers.	•	Staff space across several teams is a clinical risk
Responsive	• NCL Community have offered 18% more appointments than last year YTD. MHST offered 62% more than last year and PCPCS 15% more. North Camden weekly huddles to focus on priority cases started.	•	Job plan compliance data unavailable • Recruitment to vacant posts remains an issue. Outsourced HR confusion re; GH contracts/payscales and which LW to apply to vacancies generally.
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. £350K new money for LAC to 5 children centres clinical time and to WF-perinatal	•	NHSE directive for local CAMHS to prioritise GIDS CYP on waiting list and complete assessments by June will impact on service delivery and capacity.
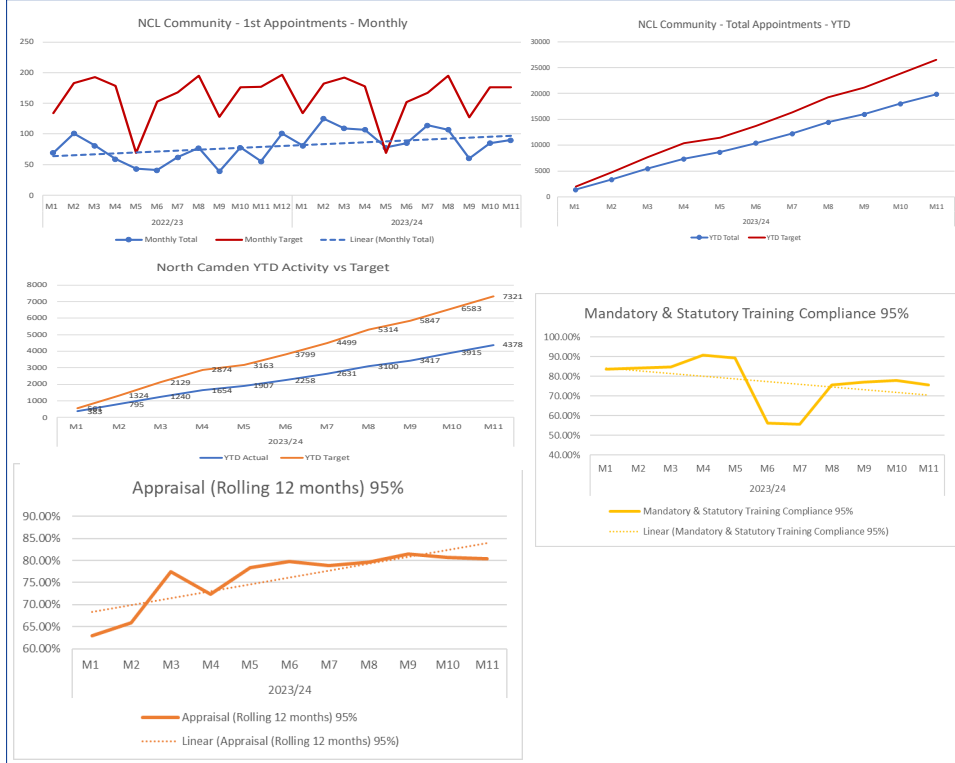
Analysis

Overall, activity within the community and integrated service line has increased this year compared to 22/23 but remains lower than expected levels. Activity within individual teams is variable but is below targets in all teams, North Camden cited here as an example only. This situation is not helped by a high vacancy rate for community and integrated services = 13.6%., however turnover is low at 0.75%

The high rates of DNAs and cancellations in several teams impacts total appointments, this could be reviewed for improvement using A3 / PDSA cycles using buffering for example.

MAST compliance appears to be remaining steady for the past 3 months and is currently 75.68% in the Trust overall and 82.63% in the Community and Integrated division.

Appraisals are actively being undertaken by staff with the current rate at 80.36% in the Trust and 80.28% in C&I. This is below target.

Team slides are included later in the deck however it is important to note in this summary slide that PCPCS is currently under increased scrutiny by NEL commissioners. This is being taken forward by a group of clinical and operational lead staff .

It is noted that there seems to be an absence of timed regular reports from team leads to the GM to explore the detailed data at team level and challenges being faced. There is a plan to start regular reporting with ops managers from April. This might be well supported by a cascaded agenda for wider team business meetings through service lines.

Next Steps

Concern	Cause	Countermeasure
patient non-attendance	Patient engagement complexity, changes to models	Pathway and patient engagement reviews via A3 (e.g. PCPCS)
Vacancy Rates	Multiple possible causes	Requires a joint dept action plan across Trust.
Reduced Activity Levels	Multiple possible causes	Needs a team level deep dive and an overview
Inconsistency in record keeping	To be explored in teams	Training delivered and SOPs aligned

Are we Caring?

23

Delivering our vision – How are we doing?
Caring- service involves and treats people with compassion, kindness, dignity and respect

NHS
The Tavistock and Portman
NHS Foundation Trust

The Trust recorded 5 Formal Complaints in February
 Performance for closing formal complaints within the set timeframe continues to be below target, however work to reduce the number of overdue and open complaints continues in a positive downwards trend. Overdue complaints has reduced to 21 as of the middle of March 2024. 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 is slower than anticipated although continues to be prioritised.

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

Trust-wide Open & Overdue Complaints; Q3 23/24 to present

Legend: Open Complaints — Overdue Complaints
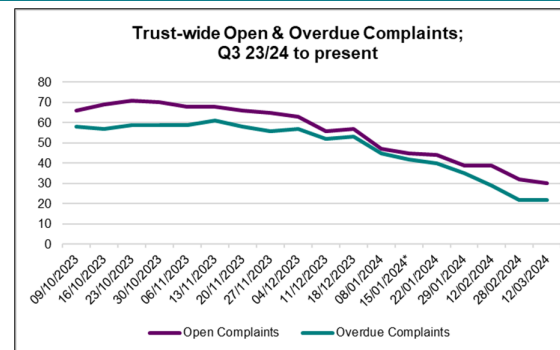
Formal complaints responded to on time
0%

The Trust has recorded 0 Informal Complaints in February
 The Trust's new complaint process emphasises early and local resolution as much as possible in line with recommendations from the Parliamentary and Health Service Ombudsman. The new process is being 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. It is important to note that this data will change month on month as some complaints originally recorded as formal will ultimately be resolved informally. This approach has been evident in the number of complaint contacts received since January 2024 that have ultimately been resolved informally and/or through the Patient Advice & Liaison (PALS) team.

Informal complaints
0

The Trust has recorded 95% 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%, although this does vary month on month. 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).
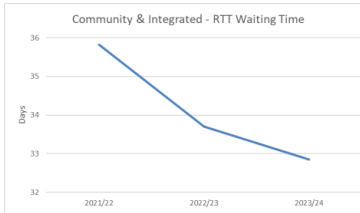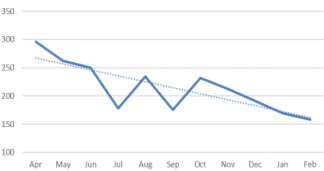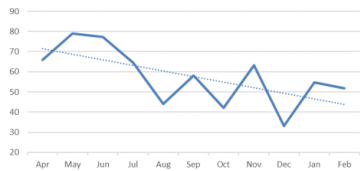
Positive responses
96%

Are we responsive?

25

NHS
The Tavistock and Portman
NHS Foundation Trust

The Trust has declared RTT 14,850 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
14,850

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 February is 26 days.

Community & Integrated - RTT Waiting Time

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 M11 to first appointment was 32 days and RTT was 52 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 February the waiting time for first appointment average was 22.7 weeks.

Psychotherapy 2023/24 Waiting Times to First Attended Appointment - Days

Child Complex 2023/24 Waiting Time to Second Attended Appointment - Days

Average Wait - Patients seen
65 days

12b IQPR report for May CoG - v2 - final

26

Are we well-led?

27

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 Trust declared 80.36 % of Appraisal Completion

Although appraisal rates are steadily improving, and a considerable increase in compliance has been achieved over the year, further improvement is still required. The upcoming merger processes make career conversations and development opportunities even more important, and managers are reminded to prioritise this crucial support mechanism for this purpose.

Appraisal (Rolling 12 months) 95%

— Appraisal (Rolling 12 months) 95%
······ Linear (Appraisal (Rolling 12 months) 95%)

% Appraisal completion

80.36

The Trust declared 3.17 % of Staff Sickness in February 2024

The increase in sickness reporting following the introduction of the new Supporting Health and Wellbeing Policy (and associated training) is positive. For the coming months we expect to see a further increase in reporting, in light of the new ESR self-service roll out which will enable managers to accurately record sickness absence (with reasons for absence) directly into ESR for those people they manage. We will subsequently be undertaking a deep dive for POD EDI Committee on absence reasons, durations, and themes. All reasons for absence must therefore be recorded.

Sickness Absence 3.07%

— Sickness Absence 3.07%   ······ Linear (Sickness Absence 3.07%)

% Staff sickness

3.17

The Trust declared 76.93 % of MAST Completion

Following a significant dip in MAST compliance with the implementation of the OMMT and associated technical issue in ESR, we are slowly seeing an improvement now the ESR workaround has been applied. The ELT will be reviewing the required MAST list shortly; in addition, the tier one part 2 and tier 2 compliance details will be added depending on professional staff group. Managers are requested to ensure that everyone in their team has protected time to complete their MAST.

Mandatory & Statutory Training Compliance 95%

— Mandatory & Statutory Training Compliance 95%
······ Linear (Mandatory & Statutory Training Compliance 95%)

MAST training (%)

75.68

28

Do we use resources effectively?

29

The Trust declared £2,781k YTD planned position for month 11

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 into the reported position for 23/24, with some of the cashflows being in the first few months of 24/25.. The assumption being that all decommissioning costs would be funded and hence not impact on the planned year end position.

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 11

Income & Expenditure: The Trust incurred a net deficit of £2,933k in the period, against a planned deficit of £3,333k i.e., a positive variance of £400k.

Capital Expenditure: To date capital spend totals £1,635k, versus the plan total of £1,991k. 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 £3.8m against the planned M11 figure of £5.6m. The negative variance reflects the continued lower income receivables figure from NHS sources.

£

23/24 YTD actual position £2,698k deficit

30

12b IQPR report for May CoG - v2 - final

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – 30 May 2024					

Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
People, Organisational Development, Equality, Diversity and Inclusion Committee	14 March 2024	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 the LGBTQI+ network highlighting events that various chairs over the last couple of years have held and bringing up the important topic of cultural incompetence in terms of seeking to understand the lived experience of others. • EDI Governance Review – AK returned with an overview of the EDI Governance Review Report; the review has been updated to solidify recommendations and add dates and owners to each of the actions. AK proposed that we use the EDI Programme Board as first port of call for holding owners of actions to account going forward. In addition, the EDI Programme Board will specifically receive updates on the staff survey action plan.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
2. **ER and Workforce updates** • There has been an increase in reporting of sickness absence in the Trust since we have started to train managers on ESR; and we are also starting to see managers using the system properly by recording the reason for the absence. This will change the way we are able to receive and review reports, including highlighting various hotspots across the trust and their impact on other areas of employee relations. • We have seen little movement with regards to appraisals across the board; compliance rates are included within the IQPR watch metrics and can therefore be escalated via this route. The people team are also supporting senior managers to make improvements in compliance particularly as this may affect individual's pay progression. • The Trust is doing considerably well with the right to work compliance.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. **Reflections**	Limited ☐

	Partial ☐
• We are adjusting to a new culture and how we need to not blame but learn from experience.	Adequate ☐
• We held a robust conversation on staff survey results; a difficult balance as we have some disappointing responses, but we also have some green shoots.	N/A ☒
• We dealt with some very difficult issues at this meeting, very productively and positively but equally it shows just how hard working our colleagues in the People Team are, and how much this has changed this last year.	
• FD observed the meeting and thanked SS for letting her do so, stating that she noticed the calmness and the respect that individuals showed each other, and did not think there was any discussion point where there wasn't a thought through response.	

Summary of Decisions made by the Committee:

The Committee approved the Annual Schedule of Business for 2024/25.

Risks Identified by the Committee during the meeting:

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

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

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

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

Item	Purpose	Date
None		

MEETING OF THE COUNCIL OF GOVERNORS PART II – PUBLIC – Thursday, 30 May 2024			
Report Title: Staff Survey Results and Action Plan			**Agenda No.:** 14
Report Author and Job Title:	Gem Davies, Chief People Officer (CPO)	**Lead Executive Director:**	Gem Davies, CPO
Appendices:	None		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☒		
Situation:	The national survey was conducted online and 53% of the Trust's staff responded, this is a significant increase on last year and we have a higher response rate than our benchmarked average (52%). Nationally, the staff survey results have been declining over the past few years however, the most recent results for our Trust highlight the low morale and difficulties our staff have felt during a long period of uncertainty driven by the COVID pandemic, the specific context of the Trust in relation to our Gender Services, ongoing industrial action, and the bedding in of a new organisational structure (Strategic Review). The Trusts results for 2023 showed that the experience of our people at The Tavistock and Portman is below that experienced by staff in the Trusts we were compared against. However, in 2022 we were the lowest score across all nine themes, whereas for 2023 we are the lowest in seven of the nine themes and this shows the progress we are making. The results place us as the second most improved trust for staff engagement as compared to last year, nonetheless we are still at the bottom of our benchmark, and we need to make significant further improvement for our people. The areas of greatest concern are in relation to staff feeling they have a voice that counts and staff morale.		
Background:	The staff survey is the Trust's current primary method by which organisational culture is measured. This includes how well-led staff feel and whether they feel sufficiently supported to enable them to fulfil their potential. This can be best described as staff experience. We therefore use the results to inform improvements in working conditions and practices. The survey is conducted annually between October and the end of November. The 2023 Staff Survey is again aligned to the NHS People Promise, and additional questions were added this year around sexual safety and access to nutritious food. It balances the need to keep modernising with the need to maintain comparability of survey results which ensures that results are of the highest value; aligning the survey with the NHS People Promise enables progress to be tracked against the ambition to make the NHS the workplace we all want it to be.		
Assessment:	As this is the second year that the results have been aligned to the People Promise we are able to review comparisons in line with each theme, and whilst the numbers are still lower than we would want to be, we have improved in every area. In 3 of the 9 themed results, we are rated 'significantly higher' than 2022. These areas are 'We are always learning' and 'Staff Engagement' (in both of which we scored 'significantly lower' last year) and 'We are at team'. The turnaround from significantly		

	lower to significantly higher for 'We are always learning' and 'Staff Engagement' is positive, as is the fact that we are not significantly lower in any area for 2023 than the previous year, however we fully recognise we still have work to do to improve employee experience further.
Key recommendation(s):	The Council is asked to **DISCUSS** the approach and **NOTE**: The service level data will be taken to each service lead by the people team to be discussed in depth and they will be supported to create bespoke and targeted staff survey action plans for their teams. In addition, they will be supported by the Associate Director of EDI to produce A3s which address the EDI issues within their teams; the A3 approach includes plans to mitigate and improve the issues accordingly. At the end of June, the action plans and A3 outputs will be collated into an overview organisational plan and communicated widely within the organisation to provide update, assurance, and feedback to the people in the organisation of the due care and consideration we have taken with the information they provided via the survey. In addition to the structured approach with service leads, we will continue to develop and expand our staff engagement mechanisms, to allow people the best opportunities to raise concerns and queries, be heard, receive information, and to feel informed and engaged about the actions and decision we are taking to improve their experience within the organisation.

Implications:

Strategic Ambitions:

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

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

Link to the Risk Register:	BAF ☒		CRR ☐		ORR ☐	
	Risk Ref and Title: BAF 5: Lack of workforce development, retention, recruitment BAF 6: Lack of a fair and inclusive culture BAF 7: Lack of management capability and capacity					

Legal and Regulatory Implications:	Yes ☐		No ☒
	There are no specific legal and/ or regulatory implications associated with this report at this time.		

Resource Implications:	Yes ☐		No ☒
	There are no specific resource implications associated with this report at this time.		

Equality, Diversity and Inclusion (EDI) implications:	Yes ☒		No ☐	
	There are multiple equality, diversity and inclusion implications associated with this report and these will be mitigated via the staff survey response actions and the EDI A3s generated at service level.			
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.	
Assurance:				
Assurance Route - Previously Considered by:	Board Seminar; and Joint BoD/CoG meeting – 11 April 2024			
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – 30 May 2024

Committee:	Meeting Date	Chair	Report Author	Quorate	
Education and Training Committee	14 March 2024	Sal Jarvis, Non-Executive Director	Elisa Reyes-Simpson Interim CETO/Dean of Postgraduate Studies	☒ **Yes**	☐ **No**

Appendices:	None	**Agenda Item: 15**

Assurance ratings used in the report are set out below:

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

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

Key headline	Assurance rating
1. Development of Education & Training related BAF risks • The Committee conducted a BAF development session to identify and articulate risks which could hinder the Trust's strategic ambitions (risk of non-compliance with regulatory requirements; the potential contraction of national and international student recruitment).	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
2. Finance and Performance • There are ongoing pressures surrounding the delivery of the three-year full-time doctorate (M4), necessitating strategic modelling and exploration of alternative delivery methods. • There are concerns about the Trust's ability to manage student debt effectively, with risks associated with historical issues and the need to secure additional resource to mitigate future challenges.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
3. CETO Update • The Committee noted various initiatives aimed at addressing staffing challenges, enhancing student experience, and facilitating organizational growth, with an emphasis on strategic planning and resource allocation. • There has been progress on securing sustainable bursary provision and rationalizing the use of visiting lecturers (VLs) was highlighted.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. Workforce Innovation Unit • A Consultancy firm have been supporting Tavistock Consulting in a project focused on modelling modules and evaluating the Trust's commercial and biodiversity aspects. Discussions revolved around exploring the income-generating potential and diversification of Tavistock Consulting's offerings while maintaining its scientific development model. • Positive feedback was received from workshops, emphasizing team cohesion and generating ideas for future income generation and model improvement.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
5. Development • There has been a decline in short course income due to the loss of the perinatal contract, but a resurgence of interest in perinatal courses through individual organisation commissioning.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

• Internationally, there are efforts to develop our partnerships, strengthen existing ones, and expand provision through commission.	
6. Student experience and the Annual Student Survey • Significant progress has been made, particularly with the implementation of "SkillsFest", a new initiative aimed at enhancing student experience. • The Committee approved additional recommendations related to disability, culture, equality, diversity and inclusion and support.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
7. Systemic and Multimodal Portfolio • The Committee discussed the potential growth of the MA in Systemic Psychotherapy, including the impact of reducing placement costs on securing placements, and the hope to increase internal placements, as well as potential merger-related capacity.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
8. A3 update aligned with growth targets and strategic objectives • **For student intake**, a targeted approach was explained, involving problem statements, vision and goal setting, and root cause analysis through fishbone diagrams. Countermeasures were devised to address these issues, with a focus on data enhancement, market intelligence, and strategic planning. • **For sustainable partnerships**, similar methodologies were applied to identify problems and root causes hindering partnership development and growth. The importance of data-driven decision-making and market intelligence was highlighted, along with the need to adapt to global trends like transnational education.	Limited ☐ Partial ☐ Adequate ☒ N/A ☐

Summary of Decisions made by the Committee:

• The Committee **APPROVED** the additional annual student survey recommendations.

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 associated with historical issues of student debt and the need to secure additional resources to mitigate future challenges.
- There is a risk around the national training contract, which has been raised at PFRC.

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
None		

CHAIR'S ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS – 30 May 2024					
Committee:	**Meeting Date**	**Chair**	**Report Author**	**Quorate**	
Performance Finance and Resources Committee	18 March 2024	Aruna Mehta, Non-Executive Director	Sally Hodges, CCOO and Peter O'Neill, CFO	☒ **Yes**	☐ **No**
Appendices:	None		**Agenda Item: 16**		

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

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

Key headline	Assurance rating
1. **Integrated Quality and Performance report:** • Report continues to be going in the right direction, but now the data is more visible, the gaps in performance are also more apparent, with slow progress on the waiting times performance, hence a limited assurance rating this month from partial the previous. • Concern was raised about the status of PCPCS and the HEE funding based on the contracts at risk item on the IQPR	Limited ☒ Partial ☐ Adequate ☐ N/A ☐
2. **Finance report:** • Finance Report was presented to the Committee. There continue to be concerns about the team level budget data not being clear. • HEE funding is £5.1m. We have received 25% of this in Q1, with HEE indicating that this contract in unlikely to change in 24.25 but will be subject to recommissioning in 25/26. At the time of writing the final contract had not been received. • PCPCS - this contract (value £1.2m) has an under performance that could result in a reduction in income in future periods if activity levels do not increase back up to contracted levels. No contract reduction has been advised in 24.25. • Agency fees especially in GIC still high and the GIDs publicity is making it difficult to hire	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
3. **Business planning** • RB went through the new business planning process and the committee was assured of the robust processes in place • GIC performance and other performance in general (Trauma and PCPCS) will take 6 months to improve - lots of reassurance on operational process discipline but acceptance that it will take time to turn around - also bearing in mind increasing demand • Accommodation in particular room availability contributing to our performance - in addition loss of Leif house needs to be factored in	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
4. **BAF and Operational Risks:**	Limited ☐ Partial ☒

The Committee felt that the specific risks around performance need to be more clearly articulated, and this has now been done.	Adequate ☐ N/A ☐
5. Escalation • Complaints pertaining to Information Governance had been escalated to the Integrated Audit & Governance Committee.	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

Summary of Decisions made by the Committee:

• The Committee was not required to make any decisions

Risks Identified by the Committee during the meeting:

Finance risks associated with the PCPCS and HEE contracts

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
Financial risk to the Integrated Audit & Governance Committee.	Action	

MEETING OF THE COUNCIL OF GOVENORS PART II – PUBLIC – Thursday, 30 May 2024

Report Title: Finance Report - As at 31st March 24 (Reporting Month 12)		Agenda No. 17a
Report Author and Job Title:	Hanh Tran, Deputy Chief Finance Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	None		

Executive Summary:			
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The report provides the Month 12 (cumulative position to 31st March 24) Finance Report. **Income & Expenditure** The Trust incurred a net deficit of £2,517k in the period, against a planned deficit of £2,517k; on track with the plan. **Capital Expenditure** To date capital spend totals £2,224k, versus the plan of £2,196k. The small variance against the original plan of £28k is offset by an agreed M12 distribution of unused capital in the ICS. **Cash** The cash balance at the end of M12 is £2,350k against the planned figure of £3,091k. The negative variance of £741k reflects the timing of income receivables from NHS sources, the payment of some GIDS estates related decommissioning costs before the cash was received, and an overpayment of PDC to NHSE.		
Background:	The Trust had a plan for a revenue deficit for 2023/24 of £2.5m, with Capital Expenditure of £2.2k and a year-end cash position of £3.1m.		
Assessment:	**Income and Expenditure** The Trusts planned deficit of £2.5m required 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 decommissioned the GIDS at the end of March 24. The cost of decommissioning and associated agreed NHSE income are included in the reported position at the year end. The actual cash flows associated with these anticipated costs, including significant redundancy costs, will be paid in the main in the next financial year. **Capital Expenditure** The agreed capital spend for the year is £2.2m, was a reduction from the previous year of £0.9m. **Cash** The agreed plan included a reduction in cash over the year to an outturn of £3.1m, which reflects the planned deficit position, but not the then unknown impact of GIDS decommissioning.		
Key recommendation(s):	The Council is asked to **NOTE** the position outlined in the report.		
Implications:			

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

Relevant <u>CQC Quality Statements</u> (we statement) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	BAF 9: Delivering Financial Sustainability Targets. BAF 11: Sustainable Income Streams		

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.		

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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MEETING OF THE COUNCIL OF GOVERNORS PART II – PUBLIC – Thursday, 30 May 2024			
Report Title: Financial Plan 24/25 Update as at 3rd May 2024			**Agenda No. 17b**
Report Author and Job Title:	Peter O'Neill, Interim Chief Financial Officer	**Lead Executive Director:**	Peter O'Neill, Interim Chief Financial Officer
Appendices:	N/A		

Executive Summary:	
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐
Situation:	The Trust submitted its latest version of the Financial Plan on the 29th April 24 to the ICB, and then as agreed with the ICB and in line with national deadlines submitted this plan directly to NHSE on the 2nd May 24; a deficit plan of £2.4m as previously discussed. This revenue plan has since been updated as part of the NHSE driven improvement to the ICS overall plan, to achieve a balance across the ICS. The Trusts shared of this reduction being £200k, leaving a revised deficit plan of £2.2m in 24/25. There has also been an increase in available capital to £2,200k from the previously agreed £1,950k. It is worth noting that the plan is still subject to final approval by NHSE.
Background:	The Trust had a deficit plan of £2,517k for 23.24 and has an updated deficit plan of £2,200k for 24.25.
Assessment:	**Income and Expenditure** As previously advised the Trust's initial planned deficit of £2,400m required the delivery of a £5.2m efficiency to achieve this. This is to be delivered by £2.656k of non-recurrent income and identified balance sheet schemes plus the delivery of £2,500m of recurrent efficiency schemes. The additional £200k reduction is planned to be achieved (consistent with ICS wide plans) by a reduction in year-end annual leave accrual. This level of risk is consistent with other Trusts in the ICS. The plan is yet to be signed off by NHSE. **Capital Expenditure** The agreed capital spend for the year is £2,200k, the same as 23.24. This was confirmed by the ICB and is an increase of the initially indicated funding of £1.95m. **Cash** The Trust is predicting to run out of cash in Q1 and has accessed the NHS cash support mechanisms in the early weeks of 24.25.
Key recommendation(s):	The Council is asked to **NOTE** the position outlined in the report.

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

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	national & international provider of training & education	on our reputation for innovation and research in this area	equality, diversity and inclusion	environmental sustainability
Relevant [CQC Quality Statements](#) (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒		CRR ☐		ORR ☐

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