The Tavistock and Portman
NHS Foundation Trust

Board of Directors

Agenda and papers of a meeting to be held in public

Thursday 9th May 2024

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

Please refer to the agenda for timings.

The Tavistock and Portman
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS – PART TWO
MEETING HELD IN PUBLIC
ON THURSDAY 9TH MAY 2024 AT 2.00PM – 5.00 PM
VENUE LECTURE THEATRE, TAVISTOCK CLINIC AND VIRTUAL

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	2.00 (5)	
002	Confirmation of Quoracy	Information	Chair	V		
003	Declarations of Interest	Information	Chair	E		
004	Service Presentation	Discussion	Chair	V	2.05 (20)	
005	Minutes of the Previous Meeting held on 21 February 2024	Approval	Chair	E	2.25 (5)	
006	Matters Arising from the Minutes and Action Log Review	Approval	Chair	E	2.30 (5)	
007	Chair and Chief Executive's Report	Discussion	Chair, Chief Executive Officer	E	2.35 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
CORPORATE REPORTING (COVERING ALL STRATEGIC OBJECTIVES)						
008	Integrated Quality and Performance Report (IQPR)	Discussion	Chief Clinical Operating Officer, Chief Medical Officer, Chief Nursing Officer	E	2.40 (15)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
009	Integrated Audit and Governance Committee (IAGC) Assurance Report	Assurance	IAGC Committee Chair	V	2.55 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
Comfort Break (10 minutes) 3.00pm – 3.10pm						
PROVIDING OUTSTANDING PATIENT CARE						
010	Quality and Safety Committee (QSC) Assurance Report	Assurance	QS Committee Chair	E	3.10 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒

011	Quality Priorities 2024-2025	Discussion	Chief Nursing Officer	E	3.15 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
DEVELOPING PARTNERSHIPS TO IMPROVE POPULATION HEALTH and building on our reputation for innovation and research in this area						
012	Winding Up of the UCL Health Alliance	Information	Chair	E	3.30 (5)	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 Assurance Report	Assurance	POD EDI Committee Chair	E	3.35 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
014	Staff Survey Results and Action Plan	Discussion	Chief People Officer	E	3.40 (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	3.50 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
IMPROVING VALUE, PRODUCTIVITY, FINANCIAL AND ENVIRONMENTAL SUSTAINABILITY						
016	Performance, Finance and Resources Committee (PRFC) Assurance Report	Assurance	PFR Committee Chair	E	3.55 (5)	Limited ☐ Partial ☐ Adequate ☐ N/A ☒
017	Finance Updates • Finance Report – Month 12 • Financial Plan Update 2024-2025 (for approval)	Information	Chief Finance Officer	E E	4.00 (10)	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
018	Medium Term Financial Plan update	Approval	Chief Finance Officer	V	4.10 (10)	
CLOSING ITEMS						
019	Board Schedule of Business 2024/2025	Information	Chair	E	4.20 (5)	Limited ☐ Partial ☐ Adequate ☒ N/A ☐
020	Questions from the Governors	Discussion	Chair	V	4.25 (5)	
021	Any other business (including any new risks arising during the meeting): *Limited to urgent business notified to the Chair and/or the Trust Secretary in advance of the meeting*	Discussion	Chair	V		
022	Questions from the Public	Discussion	Chair	V		

023	Reflections and Feedback from the meeting	Discussion	Chair	V	4.30 (5)	
DATE AND TIME OF NEXT MEETING						
024	Thursday 11th July 2024 at 2.00pm – 5.00pm					

REGISTER OF DIRECTORS' INTERESTS - 2024/25 (LAST UPDATED 01/05/2024)

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
NON-EXECUTIVE DIRECTORS						
ARUNA MEHTA	Non-Executive Director	01 November 2021 (1st Term)	Director, Dr A Mehta Limited (1)	01/04/2012	Present	Personal company – no conflict
			Chair Surrey and Borders Partnership FT	01/04/2024	Present	No perceived conflict as its an acute trust in a different area
			Associate, The Value Circle	01/04/2020	Present	Consultancy work for organisations outside of London- no conflict
			Closed Interests			
			Non-Executive Director, Clarion Housing (1)	01/11/2013	19/11/2022	No conflict
			Member, Kemnal Academy Trust	01/01/2020	01/12/2021	No conflict
			Non-Executive Director, Epsom St Helier NHS Trust (1)	01/02/2016	31/01/2024	No perceived conflict as its an acute trust in a different area
			Governor, University of Greenwich (4)	01/09/2020	31/08/2023	No conflict
CLAIRE JOHNSTON	Non-Executive Director	01 November 2022 (1st Term)	Registrant Council Member, Nursing and Midwifery Council	01/09/2018	Present	
			Chair, Our Time (3)	01/05/2018	Present	Charity supporting families with serious mental illness
			Member IFR panel NCL Intergrated Care Board (3)	05/04/2020	Present	
			Spouse is a journalist specialising in health and social care			
			Nurse member, Liverpool Community health Independent Investigation, NHSE	08/05/2024	Present	
DAVID LEVENSON	Senior Independent Director and Non-Executive Director	01 September 2019 (2nd Term)	Non-Executive Director, Industrial Dwelling Society (1)	01/01/2022	Present	Registered social housing provider – no conflict
			Director, The Executive Service Limited t/a Coaching Futures (1)	01/04/2016	Present	Personal Service Company – provides coaching and training services – no conflict
			Academy member, Institute of Chartered Accountants of England and Wales	01/10/2020	Present	Design and teach ICAEW Academy's courses on Corporate Governance, paid consultancy – no conflict
			Closed Interests			
			Non-Executive Director, Qualitas Housing CBS (1)	01/01/2022	06/12/2023	Housing provider for people with long term disabilities – no conflict
DEBORAH COLSON	Non-Executive Director and Vice Chair	01 October 2017 (2nd Term)	Member of the HRA SE Thames Research Ethics Committee (REC) (unpaid)	01/11/2018	22/03/2023	Resigned from being a member HRA SE Thames Research Ethics Committee (REC) on 22/03/23. No conflict
JANUSZ JANKOWSKI	Non-Executive Director	01 November 2022 (1st Term)	Non-Executive Director RDASH NHS Doncaster (1)	01/11/2022	Present	No conflict
			Consultant Advisor and Provost, Dubai Medical University, United Arab Emirates	13/12/2023	Present	No conflict
			Hon Professor University College of London	01/02/2020	Present	No conflict
			Chair EU Translational Cancer Panel (3)	01/08/2022	Present	No conflict
			Consultant Industry ad hoc	01/08/2021	Present	No conflict
			Healthnix (HealthTec Start up London)	01/12/2023	Present	No conflict
			Closed Interests			
			Clinical Consultant Placement Agency ad hoc (3)	01/10/2021	01/01/2024	No conflict
			Magistrate HMCTS (3)	01/11/2019	01/04/2024	No conflict
JOHN LAWLOR, OBE	Chair	06 June 2022 (2nd Term)	Trustee of the national charity, Think Ahead, under contract to DHSC to provide postgraduate education in mental health social work. (3)	01/09/2019	Present	No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by Think Ahead and vice versa
			Wife is an Associate Director at Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW) (1)	07/04/2019	Present	No perceived conflict - Will withdraw from relevant business in relation to CNTW discussed by the Tavistock and Portman
			Wife is a Trustee of Carers' Resource serving parts of West and North Yorkshire	01/07/2023	Present	No perceived conflict - Will withdraw from relevant business in relation to Carers' Resource discussed by the Tavistock and Portman

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
			Providing advice and guidance to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service providers to develop their Provider Collaborative	12/02/2024	Present	No perceived conflict - Will withdraw from relevant business in relation to the Humber and North Yorkshire ICB and its associated Mental Health, Learning Disabilities and Autism service discussed by the Tavistock and Portman
SABRINA PHILLIPS	Associate Non-Executive Director	01 November 2022 (1st Term)	Employed by the Lambeth Living Well Network Alliance as Service Director (The alliance is a partnership of 5 organisations SLaM, SEL ICS (Lambeth),Lambeth ASC,Certitude, Thamesreach) - I am seconded out to the Alliance from SLaM (4)	01/01/2020	Present	Full time employment - No perceived conflict - Will withdraw from any business in relation to Tavistock and Portman discussed by the Alliance.
			Interim Deputy Chief Operating Officer at SLaM	20/09/2023	30/11/2023	
			Employed as a Managing Director, adult mental health and learning disability services at Central and North West London NHS FT	01/11/2024	Present	Will withdraw from business decisions in competition with CNWL
SAL JARVIS	Non-Executive Director	01 November 2022 (1st Term)	Deputy Vice Chancellor Education, University of Westminster	06/01/2020	23/02/2023	Will withdraw from business decisions in competition with University of Westminster
			Governor, Londale PNI School, Brittan Way, Stevenage	18/09/2018	Present	No perceived conflict - Will withdraw from business decisions in relation to the school as discussed by The Tavistock and Portman
SHALINI SEQUEIRA	Non-Executive Director	01 November 2021 (1st Term)	Director, Sonnet Consulting Services Limited (1)	10/07/2018	Present	Personal company for consulting work - no conflict
KEN BATTY	Non-Executive Director	01 April 2024 (1st Term)	Council member QMUL : which includes Barts and the London Medical School	01/01/2022	Present	No perceived conflict
			Chair, Mosaic LGBT+ Young Persons Trust : which is based in Camden	01/09/2019	Present	No perceived conflict
			Vice Chair, Inner Circle Educational Trust : which provides support for looked after children in Camden	01/10/2020	Present	No perceived conflict
			Independent Chair, Nominations Committee, Royal College of Emergency Medicine : which is a professional body	01/02/2021	Present	No perceived conflict
EXECUTIVE DIRECTORS						
ELISA REYES-SIMPSON	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	16 June 2022	Company Secretary Simpson Practice Ltd (1)	19/11/2004	Present	No perceived conflict - Small psychotherapy private practice. As there are no direct referrals from the NHS and no lonk to Tavistock & Portman clinical services.
GEM DAVIES	Chief People Officer	1 February 2022	'Silent associate' of Careerships, a privately run company that specialises in career coaching.	01/10/2020	Present	No perceived conflict - This is unpaid.
MICHAEL HOLLAND	Chief Executive Officer	14 November 2022	Senior Fellow at London School of Economics. Lead and teach module on Quality Management in Healthcare on MSc in Health Economics, Policy and Management. Also occasionally undertake consulting work with LSE Enterprise as part of role.	01/07/2010	Present	No conflict - This is a paid post at £10,375 per year.
			Executive Fellow at King's Business School. Occasional lectures and speaking engagements. Collaborate with KBS faculty to co-create research projects.	01/04/2020	Present	No conflict - This is unpaid
SALLY HODGES	Deputy Chief Executive and Chief Clinical Operating Officer	12 November 2016	NIL RETURN			

NAME	POSITION HELD	FIRST APPOINTED	DESCRIPTION OF INTERESTS (INCLUDING DECLARED/CATEGORIES)	RELEVANT DATES		DECLARATION COMMENTARY
				FROM	TO	
PETER O'NEILL	Interim Chief Financial Officer	15 May 2023	NIL RETURN			
CLARE SCOTT	Chief Nursing Officer	27 July 2023	NIL RETURN			
CHRIS ABBOTT	Chief Medical Officer	21 August 2023	NIL RETURN			
ADEWALE KADIRI	Director of Corporate Governance	7 August 2023	Partner is an NHS GP in Ipswich, Suffolk	01/10/2023	Present	No conflict - no connection to the Trust
ROD BOOTH	Director of Strategy, Transformation & Business Development	26 June 2023	NIL RETURN			
JANE MEGGITT	Director of Communications & Engagement	24 April 2023	NIL RETURN			

UNCONFIRMED MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS – PART TWO HELD IN PUBLIC
WEDNESDAY, 21 FEBRUARY 2024 AT 2 P.M.

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

PRESENT:

John Lawlor	Chair of the Board of Directors	JL
Deborah Colson	Non-Executive Director and Vice Chair	DC
Aruna Mehta	Non-Executive Director, Chair of the Performance, Finance and Resources Committee	AM
David Levenson	Non-Executive Director and Chair of the Integrated Audit and Governance Committee	DL
Shalini Sequeira	Non-Executive Director and Chair of the People, Organisational Development, Equalities Diversity and Inclusion Committee	SS
Claire Johnston	Non-Executive Director and Chair Quality and Safety Committee	CJ
Janusz Jankowski	Non-Executive Director, Deputy Chair Quality and Safety Committee	JJ
Michael Holland	Chief Executive Officer	MH
Chris Abbott	Chief Medical Officer	CA
Sally Hodges	Deputy Chief Executive and Chief Clinical Operations Officer	SH
Clare Scott	Chief Nursing Officer	CS
Rod Booth	Director of Strategy and Business Development	RB
Elisa Reyes-Simpson	Interim Chief Education and Training Officer and Dean of Postgraduate Studies	ERS
Peter O'Neill	Interim Chief Finance Officer	PON

IN ATTENDANCE:

Kathy Elliot	Stakeholder Governor and Lead Governor	KE
Michael Rustin	Public Governor	
Sabrina Phillips	Associate Non-Executive Director	SP
Adewale Kadiri	Director of Corporate Governance	AK
Gem Davis	Chief People Officer	GD
Mike Smith	Head of Communications and Engagement	MS
Amanda Hawke	Corporate Governance Manager (Minutes)	AH
Sarah Relton	Educational Psychologist, Highly Specialist Clinician	
Claire Vaughan	Clinical Psychologist, South MHST Manager	
Nell Nicholson	Specialist Service Manager, Integrated Schools Service	

APOLOGIES:

Sal Jarvis	Non-Executive Director and Chair Education and Training Committee	SJ
Jane Meggitt	Interim Director of Communications and Marketing	

MINUTE NO.		ACTION (INITIALS)
001	**WELCOME AND APOLOGIES FOR ABSENCE**	
	The Chair, JL welcomed all in attendance. Apologies for absence were received from Sal Jarvis and Jane Meggitt.	
002	**CONFIRMATION OF QUORACY**	

JL confirmed that the meeting was quorate.

003 **DECLARATIONS OF INTEREST**

The following declarations of interest were made.

AM: Chair of Surrey and Boarders from April 2024; and Associate at the Value Circle. The Trust is working with the Value Circle, but AM is not involved with this work.

CJ: Appointed to work on the national enquiry by NHSE on Liverpool Community Health

JL: Working with six mental health services in North Yorkshire and Humber

SP: Managing Director at Central and North West London NHS.

004 **PATIENT/ SERVICE USER EXPERIENCE**

Sarah Relton, Claire Vaughan and Nell Nicholson attended to speak about the work of the Mental Health Support Team (MHST). They gave a presentation on the work that they do with schools across Camden and of the various projects that are in place to support schools in ensuring that children and young people receive mental health support.

Details were given of a work experience pilot that was held at a girls sixth form. This was around work experience for sixth formers in the field of mental health and psychology. The event was very well received and will be followed up with the girls who attended who are now applying to universities. The girls particularly liked the tour of the Tavistock Library given by Thereasa Callaghan. It is hoped that another such event will be held, as well as benefitting the individuals who attend it is also part of the service development.

Ms Relton noted that this event has identified champions in schools who they can work with to facilitate a future event.

005 **MINUTES OF THE PREVIOUS MEETING HELD ON 13th December 2023**

The minutes of the previous meeting held on 13th December 2023 were agreed as an accurate record.

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

It was noted that there were no matters arising.

It was noted that dates for when actions are due should be added to the action log.

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

The CEO Report was taken as read.

MH further advised that we have cover in place for the coming industrial action by Junior Doctors. We are looking at how our validation and regulation processes will impact on our relationship with the University of Essex.

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

SH advised that on Monday we were made aware of an issue with CareNotes that may impact the information that is on some patient Care Plans. An audit has been carried out and information is being checked to ensure that duty of candour is undertaken.

The Integrated Quality and Performance Report has been discussed in full at the Performance, Finance and Resources Committee which was held on 13th February. SH advised that all data is now gathered for the reports on one date. Appointments must be outcome for them to show on the reports. It was noted that as staff adapt to this new process the data may not be as robust for the next two months. It will now be possible to triangulate job planning, staffing, activity and absences and we will be able to scrutinise reductions in activity where it is unexpected.

CS noted the improved quality of the data and reports provided.

She advised that Service User engagement work is underway, this had dipped below 90% in December.

Response times to complaints is improving. The number of overdue complaints is being reduced and we are looking to respond to all new complaints in a timely way. The response time has been increased from 25 days to 40 days as most complaints are complex.

There is a new metric on restraint which relates to Gloucester House School.

PON advised that for the first time Finance has been included in the IQPR Report. AM advised that the IQPR Report has provided transparency and the data provided allows for meaningful discussions. We are seeking assurance on strategic priorities and the information provided has allowed this.

CJ asked about the information given out on waiting lists. SH advised that there are gaps between first and second appointments, but this is to do with assessments as it is not always possible to say now long an assessment will take.

009	**QUALITY AND SAFETY COMMITTEE ASSURANCE REPORT**

The report from the January Quality and Safety Committee was taken as read. Various points were highlighted.

A presentation on Patient Safety Incident Reporting Framework (PSIRF) was given this morning at the Board Development session this morning. We are on track with this work.

An update on complaints was given. CS advised that from now we should be able to respond to complaints within 40 days.

010 **GUARDIAN OF SAFE WORKING REPORT**

CA advised that we remain stable with minimal fines on hours. There has been no impact as a result of the junior doctors' industrial action.

CA has met with the Guardian of Safe Working who has advised that she will stand down if another doctor comes forward to fulfil this role but is content to carry on in the meantime.

It was clarified that any money that we do pay in fines for breaching working hours is used to support training for junior doctors.

011 **MORTALITY/LEARNING FROM DEATHS**

The report was presented at the previous Board of Directors. PSIRF will impact on how we learn from deaths. A group on mortality and learning from deaths has been led by Dr Caroline McKenna. This group will be looking at deaths on waiting lists. NHSE will assist the Trust in learning from deaths of patients on waiting lists. Physical health of these patients is also being looked into.

012 **PATIENT AND CARER RACE EQUALITY FRAMEWORK (PCREF)**

CA advised that South London and Maudsley were a pilot site for this work. From the beginning of the financial year this work will be mandatory for all Trusts. It was found that accessing mental health care and outcomes of care for some minorities was not as good and non-minority people. We will be looking at how we can make mental health care more accessible for all. This will involve culture change, making changes in healthcare and seeking feedback to monitor the progress of changes.

There are six competencies for this work on which to focus. We will be looking at referrals and outcomes for all ethnicities. This work will be done with the EDI Team. It will involve the Staff Networks - Purple Circle (disability), Race Equality Network (REN) and LGBTQI and will report back to the Quality and Safety Committee. The Executive Lead for this will be CA.

CA advised that we are not receiving 100% of ethnic data from patients. SH advised that this is not a mandatory field so it may be changed. There were questions about how staff work with communities. CA advised that staff are working with communities and different ethnic groups, but there needs to be a focus on the people we are not yet accessing. Work is being done with the teams to look at this.

AK advised that there is a wider scope to this work on population health. There are requirements for us to provide information on how we are tackling health inequalities.

CA advised that PCREF will be reported to the Board every six months. CA

013	**PEOPLE, ORGANISATIONAL DEVELOPMENT, EQUALITY, INCLUSION AND DIVERSITY**

Thanda Mhlanga brought a paper on equality, diversity and inclusion to the POD EDI Committee. An action plan on governance on EDI was noted.

A leadership and management development programme is in place, to ensure that we have a consistent approach to this work. Good feedback on the programme has been received, but some modules may be reviewed.

Work continues on reviewing policies.

The Integrated Governance Action Plan needs to be completed by the end of March and is on track to do so.

014	**EDUCATION AND TRAINING COMMITTEE ASSURANCE REPORT**

ER-S highlighted various points from the report.

A review of staffing and structure of DET to make a contribution for growth was undertaken and the proposal for this work was approved.

A SITS review took place. This will improve the quality of data and give flexibility on training. Data management and degree awarding powers were discussed.

SJ highlighted concerns over staffing following the decommissioning of the National Workforce Skills Development Unit. It was noted that redundancy costs and the loss of overheads has been included in the financial plan. SJ also noted concerns over the i-thrive financial position and Tavistock Consulting. The Value Circle has been commissioned to work with the Trust.

DET now has a dedicated IT team which will help greatly.

A proposal has been put forward for Visiting Lecturers' pay and engagement. Currently this is not in keeping with how they should be employed. It was felt that some work that VLs currently undertake could be undertaken by substantive staff. HR are working with DET staff to resolve.

There have been some issues in supplying information to the Office for Students.

ER-S advised that as we have uncovered various issues within DET we are now in a position to resolve these so are optimistic about the way forward. Thre have been many engagement events for staff so morale has improved.

ER-S advised that student appeals and student complaints are all being worked on and that we have taken learning from the complaints.

015	**PERFORMANCE, FINANCE AND RESOURCES COMMITTEE ASSURANCE REPORT**

The Performance, Finance and Resources Committee (PFRC)was held on 13th February, so a verbal report was given.

PON advised the following points.

The ICS have advised that the capital allocation will be reduced by £200,000, the capital programme will be refreshed accordingly. The draft capital programme for next year has been discussed at the Executive Leadership Team meeting.

The salary over and under payments have been referred to the Integrated Audit and Governance Committee.

Team level budget reports were not finalised at Month 9, but information at cost centre level was shared with teams and queries raised. As the Financial Management team is now up to full strength progress should be possible. It was noted that team level budgets are yet to be in a standardised format, this work will be progressed and reported in the A3 quality improvement format.

The medium-term financial plan was shared for discussion at the Board Seminar.

The procurement strategy update will be referred to the Integrated Audit and Governance Committee report, no concerns were raised by PFRC.

Integrated Governance Action Plan actions were on schedule for completion by 31st March 2024.

SH highlighted the following points.

The report continues to evolve and the next stage is the automation of the data collection across all domains at a defined time. This will ensure all staff are reporting on the same data. As we are moving to a single date the January performance data is lower than expected, we are expecting this to improve as staff outcome appointments in a more timely way.

December data is lower than expected due to staff illness and leave.

The IQPR allows us to triangulate staffing, staff absence, job planning and performance to have a clear understanding of local issues in performance. We will be watching the metrics which enable us to track areas of concern more effectively. We are also able to demonstrate areas of success such as the Camden referral to treatment target of 4 weeks has been achieved in 82% of cases.

AM advised all the work done on reporting on waiting lists, job planning, and vacancies has highlighted where gaps are so work can be done to address this.

This will assist the Trust in fulfilling contracts. She wished to congratulate the team on the work done to improve this reporting.

SH advised that the level of assurance on this work has moved from 'limited' to 'partial' which is an improvement.

016 **FINANCE REPORT – MONTH 9**

PON spoke to this report.

It is expected that we will reach our forecast of £2.5 million. We are ahead of plan at month 10. We are awaiting ongoing clarification from NHS England for support for the GIDS decommissioning costs. We expect to maintain our capital expenditure within the limit stated. If expenditure gets to a critical level this will be flagged. We will aim to make best use of funds and we do have a 10% contingency for urgent issues.

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

DL wished to highlight five items from the report and to confirm that the Committee was assured by the reports received.

A new procedure for Committee to Committee escalation has been created by Dorothy Otite. It will enable committees to ask another committee to look into a matter that falls within their area of work.

Counter Fraud identified an item on pre-employment checks, this will be passed onto the POD EDI Committee.

A meeting has been held with Grant Thornton, our new Auditors. They are willing to support our merger journey. An integrated audit plan for 2023-24 will be produced. AK advised that this integrated audit plan could be shared with other committees.

The Integrated Governance Action Plan has an overview of governance. This work will be completed by 31st March 2024. Some aspects of the integrated governance work will be on-going, e.g., trust Culture, Quality and Safety Framework, financial controls and job planning. These will be reported back to the Integrated Audit and Governance Committee (IAGC).

Given the difficulties with the previous Auditors who produced the annual accounts very late the Board sought assurance that this would not be repeated with the new Auditors. DL advised that he will work with Grant Thornton to ensure this situation does not re-occur.

AK advised that the Committee to Committee reporting process will be taken forward with the Committee administrators and will be part of the formal process. He outlined the plans to bring in a Board Committee Secretary at Band 6. They will be responsible for the agenda, minutes and action logs of all Board committees. The Corporate PAs will assist with this work as necessary. It is hoped that this new post will provide consistency to papers and minutes.

018 **EMERGENCY PLANNING ANNUAL REPORT, LETTER OF DECLARATION AND SELF-ASSESSMENT AGAINST CORE NHS STANDARDS FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)**

CS advised that the annual report on EPRR sets out the Trust position. This has been discussed at IAGC and further comments have been made to provide clarification. We have partial compliance on EPRR which is an improvement on the previous year. We need to focus on the IG Toolkit.

AK advised that for two years we have not reached the IG Training compliance. It was noted that there was an issue with data quality so AK is working with the IG Team on data cleansing. It is suggested that if staff do not complete their IG training their IT access will be suspended. Staff cannot complete their appraisal if they have not completed all mandatory training and would not therefore be able to move up pay scales.

CS advised that Directors have all completed IG Training and additional training is undertaken for dealing with incidents, e.g., HazMat Training.

JL asked for an explanation of the partial compliance we have reported. CS advised that the CQC gave positive feedback on the progress we have made and the more robust processes that we have put in place for EPRR. A resilience Group has been established to start in April to look at the various factors for EPRR.

SH pointed out that if we are not 100% compliance on mandatory training there may be issues with progressing the merger plans. In addition, as a Board, it is necessary to understand the plans for business continuity that are in place.

EPRR and Business Continuity will be added to the Schedule of Business for the Board. GD and AK will have scrutiny over mandatory training and it will be backed up by the Integrated Quality and Performance Reports.

019 **BOARD FORWARD PLANNER**

The forward planner is now called the Schedule of Business. The Schedule of Business was noted.

020 **QUESTIONS FROM THE GOVERNORS**

	There were no questions from the Governors, however Michael Rustin advised that he had become aware of a play in Shepherd's Bush which relates to the Tavistock & Portman. He will forward the details for circulation to the Board.
021	**ANY OTHER BUSINESS**
	We will not be having another Board meeting before the Gender Identity Development Service closes. The Board wishes to acknowledge all the work that the staff have done over the years for young people with gender dysphoria. Governors have been contacted about observing the Board Committees and we have allocated a Governor to each committee. The Committee chairs will be contacting the Governors ahead of the meetings. Feedback from the Governors will be sought and reported on at the Council of Governors meeting. It was noted that this is the last formal Board meeting for Debbie Colson as she will be stepping down at the end of March. Many thanks were extended to Debbie for the six years of service she has given to the Trust. A recruitment process is underway to recruit a new Non-Executive Director. Debbie said that it had been a privilege to work at the Tavistock. She praised the impressive staff for their work and the extraordinary results they achieve. She felt that the work they do is often hidden. Thanks, were also extended to Amanda Hawke who will be retiring from the Trust after nearly 23 years of service.
022	**QUESTIONS FROM THE PUBLIC**
	There were no questions from the public.
023	**REFLECTIONS AND FEEDBACK FROM THE MEETING**
	It was suggested that the number of items on the Board Seminar session in the morning should be reduced as this section ran over time. The excellent presentation from the Mental Health Support Team was noted. It was thought that the work of the Mental Health Support Team could be built on.
	Close
	The Chair closed the meeting at 4.30 p.m.

Date of Next Meeting in public: Thursday 9th May 2024 at 2pm (time and venue to be confirmed).

Signature _____ Date _____

Board of Directors Part II (Public)
Actions Log (Open Actions)

Actions are RAG rated as follows: ->				Open - New action	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**	**Progress Note / Comments**
27.7.23	5	Matters arising and action log	Non-Executive Directors to be assisted in completing mandatory training.	13.12.23	Adewale Kadiri, Director of Corporate Governance	**To Close - propose for closure**	All NEDs now have online access to the modules. The position regarding the 2nd part of the Oliver McGowan training is to be clarified
27.7.23	14	ETC Chair's Assurance Report	Chair of the Tavistock and Portman Charity to be invited to a future meeting to discuss bursaries for students	13.12.23	Elisa Reyes-Simpson, Interim Director of Education & Training	**In progress**	Discussion had with Chair of Tavistock and Portman Charity. An invitation to be extended to him for a future Board meeting and added to the Schedule of Business.
11.10.23	8	Integrated Quality & Performance Report IQPR	IQPR should be included on the Agenda for a future Board Seminar.	15.11.23	Adewale Kadiri, Director of Corporate Governance	**To Close - propose for closure**	IQPR added to the updated Board development programme with a recommendation that it be covered at the April seminar
11.10.23	11	Annual Infection Prevention & Control Plan	The Annual Infection Prevention and Control report should be included on the agenda at a future meeting of the ~~Performance, Finance and Resources Committee~~ Quality and Safety Committee	12.12.23	Clare Scott, Chief Nursing Officer	**To Close - propose for closure**	This action is complete. The Annual IPC report was presented to the November 2023 Quality and Safety Committee meeting.
11.10.23	12	Response to NHSE letter about the Lucy Letby Case	Information on freedom to speak up and performance data should be promoted in all public areas and online.	13.12.23	Jane Meggitt, Interim Director of Communications & Marketing	**To Close - propose for closure**	There is a poster informing staff of the FTSU process, and including contact information, by the lift doors on each floor of the Tavistock Centre, as well as in each staff kitchen and common room. These posters are being refreshed to make them more accessible, and new versions are being rolled out across all Trust sites. Further information will be provided in due course as the 2nd Guardian has been appointed.
11.10.23	14	Education & Training Committee Assurance Report	PON to speak to the Director of Education and Training about Estates, the 2023/24 budget and financial viability work.	13.12.23	Peter O'Neill CFO & Elisa Reyes-Simpson Interim CETO	**To Close - propose for closure**	Estates - issues are being picked up with DET. Finance - A small working group has met and has identified a number of actions in order to identify potential routes for income generation for the purposes of bursaries. The joint working group is meeting regularly to progress discussions.

Meeting Date	Agenda Ref.	Agenda Item (Title)	Action Notes	Action Due date	Action owner (Name and Job Title)	Status	Progress Note / Comments
11.10.23	17	Performance, Finance & Resources Committee Assurance Report	It is important that learning recommendations on Carenotes is shared across the organisation, this can also be included in a clinical service newsletter.	13.12.23	Sally Hodges, Chief Clinical Operations Officer	**To Close - propose for closure**	There is no longer a newsletter and information is being disseminated through the Clinical Services Delivery Board to the Clinical Service Lines

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 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 Board of Directors should be sighted on.		
Assessment:	This report covers the period since the meeting on 21 February 2024.		
Key recommendation(s):	The Board of Directors is asked to receive this report, discuss its contents, and note the progress update against leadership responsibilities within the CEO's portfolio.		
Implications:			
Strategic 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 - 9 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 Board's decision in June.

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 BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 May 2024			
Report Title: Integrated Quality and Performance Report (IQPR)			**Agenda No.: 8a**
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 through the local teams, the service line IQPRs and the Performance, Finance and Resources Committee (PFRC) on 18 April 2024. Wait time data has not improved but recruitment of staff is now underway/near completion. 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 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. 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 Board is asked to review and **DISCUSS** the contents of this report.		

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

Relevant <u>CQC Quality Statements</u> (we statements) Domain: (tick)	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
	BAF ☒	CRR ☐	ORR ☐		

Link to the Risk Register: (tick)	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

The Tavistock and Portman
NHS Foundation Trust

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

The Tavistock and Portman NHS Foundation Trust

Integrated Quality and Performance Report

Month 11

	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

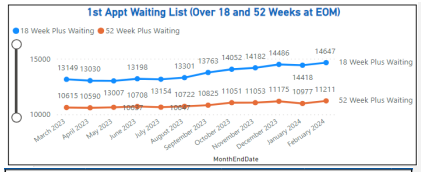
G1. Clearly defined pathways for patients within next 4 months

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

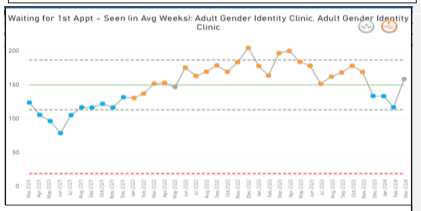
G3. Increase in patients in treatment vs on a waiting list

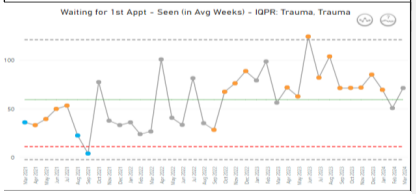
G4. Clear dormant caseload of patients waiting 12 Months+ in the next 6 months

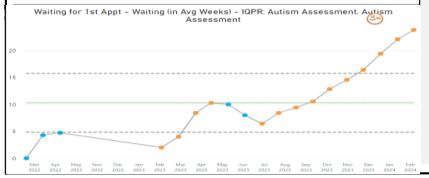
Historical Performance



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



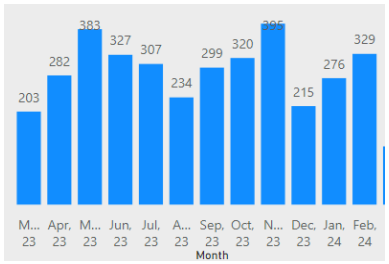




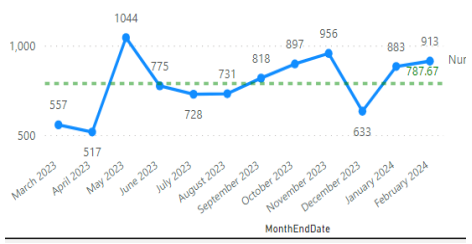
These 3 charts indicate the time waiting for patients who have been seen in each calendar month, this shows on average how long they waited for their appointments in the 3 identified areas of concern

Monthly Stratified Data

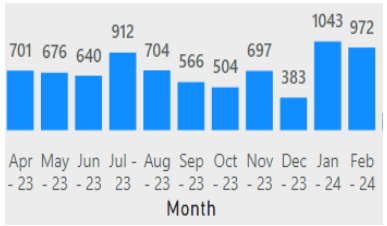
A. Number of first appointments conducted



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

Integrated Quality and Performance Report — Month 11

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

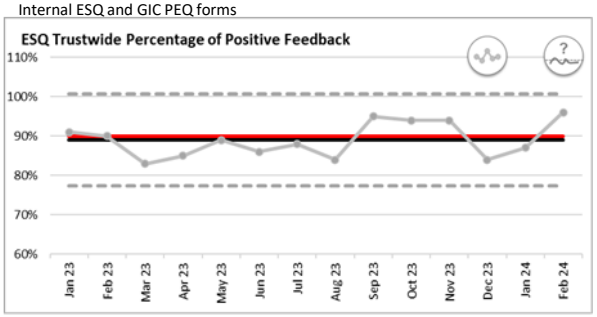
Vision: For all users to have a positive experience across the trust.

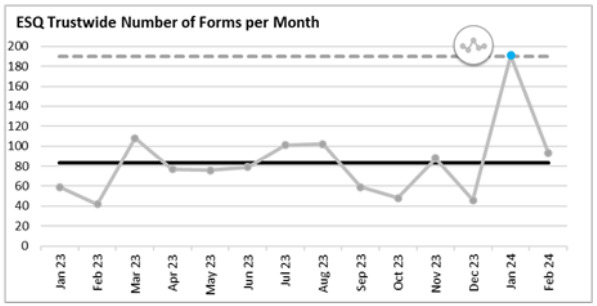
G1: Number of ESQ form rates to be monitored against benchmarks set in March 2024 every 3 months for the next 12mnths action plans put in place per service line to support progress

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





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

4

Integrated Quality and Performance Report — Month 11

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.

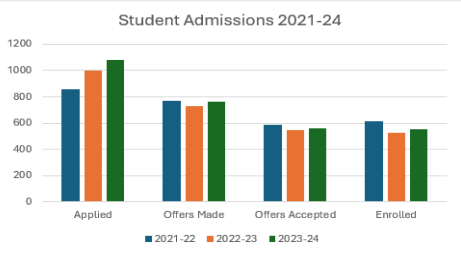
Vision & Goals

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



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 marketing, recruitment and admissions team based on marketing intelligence, data and conversion from enquiry to application	Increased student applications and new markets and reduce number of incomplete applications and increase number of complete applications	ERS
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

5

Integrated Quality and Performance Report — Month 11

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.) OSCP 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	£94,910	£44,329	£50,581	£14,237	53%
2020-21	£88,065	£1,648	£86,417	£18,210	98%
2021-22	£116,586	£10,785	£105,801	£17,489	91%
2022-23	£76,186	£12,552	£63,634	£11,428	84%
Grand Total	£559,554	£151,887	£407,666	£78,646	
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 Lack of data to identify key applicant audience on a regional and national level	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 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

Integrated Quality and Performance Report — Month 11

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

Integrated Quality and Performance Report — Month 11

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

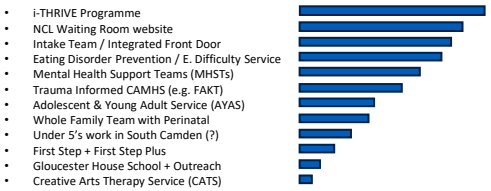
Vision: To be a regional leader in the delivery of preventative interventions for CYP which positively impacts population health outcomes

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')



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

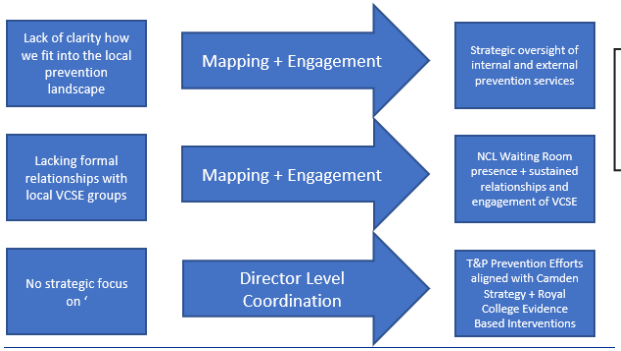
Current initiatives in Camden:

- 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



- 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

Integrated Quality and Performance Report

Month 11

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.

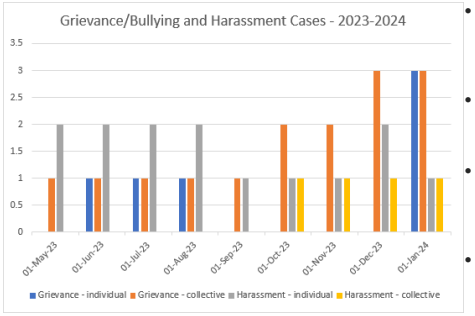
Historical Performance

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.



- 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

Integrated Quality and Performance Report — Month 12

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
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	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

Integrated Quality and Performance Report — Month 11

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.

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.

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

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

The Tavistock and Portman NHS Foundation Trust

Business Rules

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

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

Watch Metrics Score Card

The Tavistock and Portman NHS Foundation Trust

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

The Tavistock and Portman NHS Foundation Trust

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										

Are we safe?

Delivering our vision – How are we doing?

Safe – People are protected from abuse and avoidable harm

The Tavistock and Portman NHS Foundation Trust

The Trust reported 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**

Are we effective?

Education and Training

The Tavistock and Portman NHS Foundation Trust

Successes

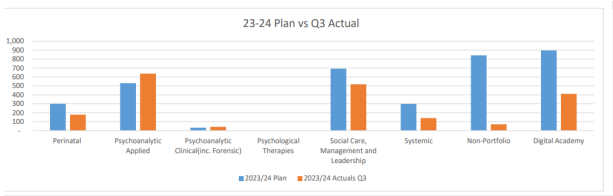
- **Staffing structure review completed – with proposal discussed at FIRM (23/01/2024)**
- **Comprehensive review of SITS commencing in February 2024**
- **367 applications received for M4 *Child, Community & Educational Psychology* doctorate (c.50% increase on 2023)**
- **73 applications received for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

Challenges

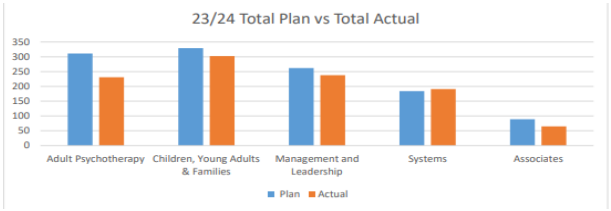
- **Impact of SITS on associated systems (eg proposed CRM)**
- **Staffing resource – particularly in Academic Registry; Student Marketing, Recruitment & Admissions**
- **Lack of dedicated resource for staff CPD**
- **Increased reporting and analysis requirements internally and externally without supporting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

Current Situation

Short courses:



Long courses:



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

Identified areas of concern

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

Risk A

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

Risk B

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

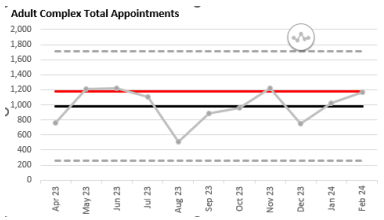
Next Steps

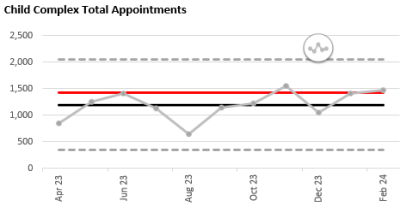
Concern	Cause	Countermeasure
Competing with HEIs able to deliver degree apprenticeships / flexible teaching modes	Lack of staffing resource; degree awarding powers; systems issues	Updated review needed looking into the feasibility of degree apprenticeships as well as degree awarding powers
Data quality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

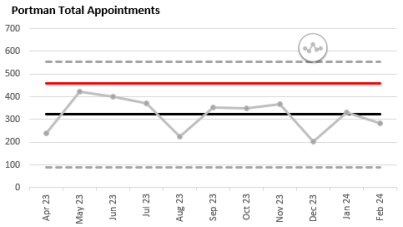
Complex Mental Health Overview

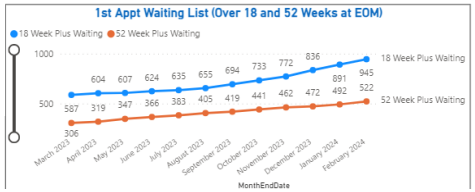
	Successes	Challenges
Safe	• The FDAC new building is a safer & more bespoke for patients and staff. ERF funding supporting staff morale, shorter waits and continuity service in trauma & autism services .	• Further staff consultation likely to engender trauma response from staff group.
Effective	• Staff 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.

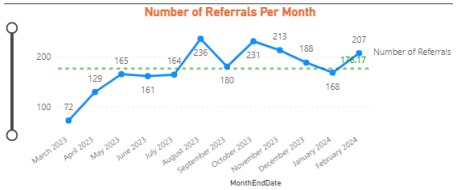
Activity Overview

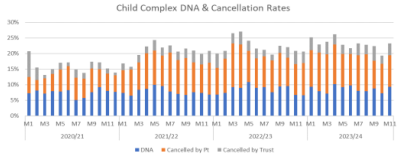


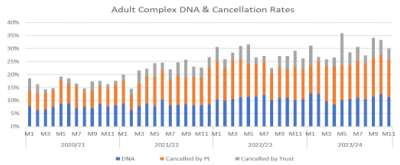








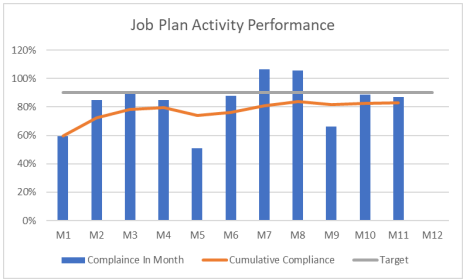




Analysis

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.



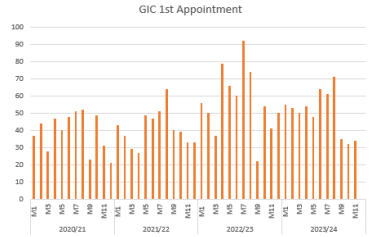
Next Steps

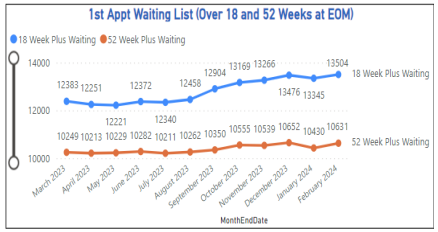
Concern	Cause	Countermeasure
Job Plan / Activity Performance	Patient engagement complexity	Pathway and modality of treatment review
Demand vs Capacity & Pathways in Trauma & Autism Assessment	Varied – see A3 slides 7-10	See A3 slides 7-10

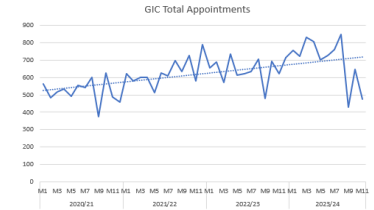
Adult Gender Identity Clinic

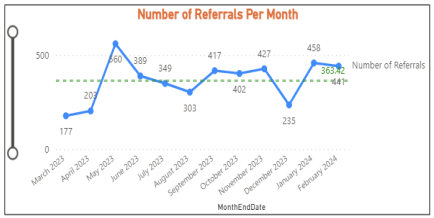
	Successes	Challenges
Safe	• The service has initiated a letter sign off process where a clinician is away long term to enable patients to receive clinic letters on time	• Allocating responsibility and managing risk on the waiting list of 16000 patients
Effective	• GP sessions led by the service where 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

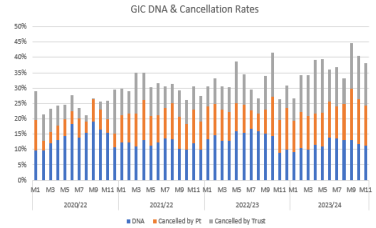
Activity Overview







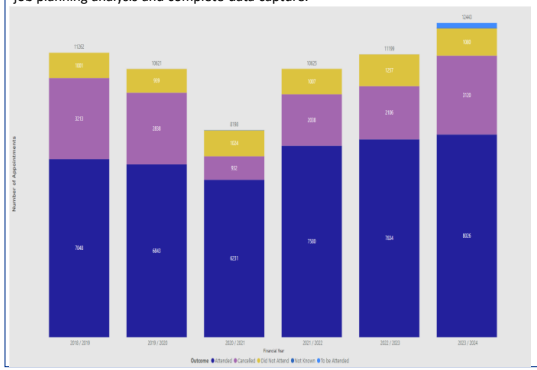




Analysis

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.



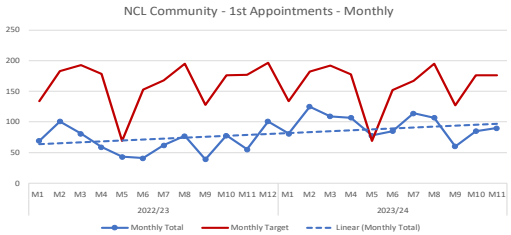
- As part of the Quality improvement project the service is prioritising how to capture noncommissioned activity and the induction and training process into the service
- 18-week RTT target for Gender is a challenge as we have patients waiting 5-6 years for fist appointment
- We have no job plans for Medics currently and are working to develop those.
- Wait between 1st and second appointments are steadily reducing.

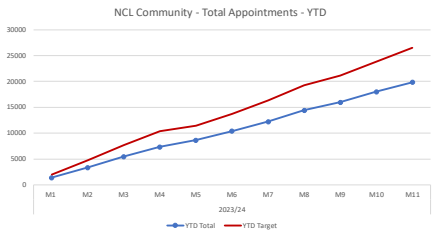
Next Steps

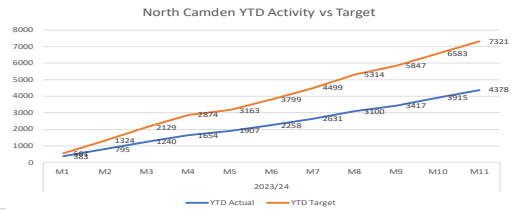
Concern	Cause	Countermeasure
Staff not meeting job plans	Job plans not fully developed	To be approved so that service can assess demand vs capacity and report on job plan analysis
High Vacancy Rates	Candidates not meeting JD and person Spec	To revise the current job descriptions to better accommodate 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

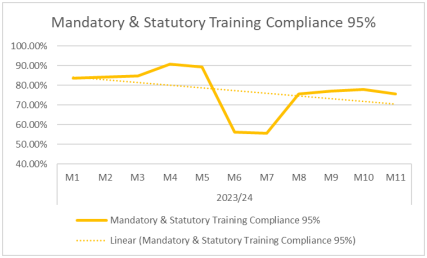
Community and Integrated

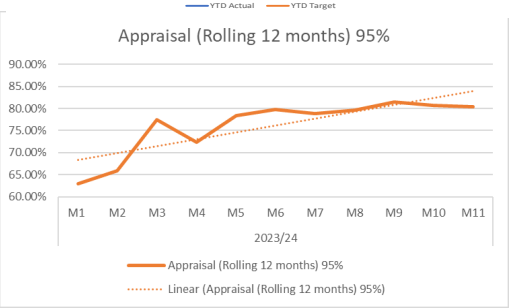
	Successes	Challenges
Safe	• Camden teams undertaking focused work on attaching notes. Overall improvement in notes completion 90% • B7 recruited to Advantage Arsenal FC project	• Gloucester House's risks are currently being held on a separate register, overseen by the steering committee. Going forward, 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?

Delivering our vision – How are we doing?

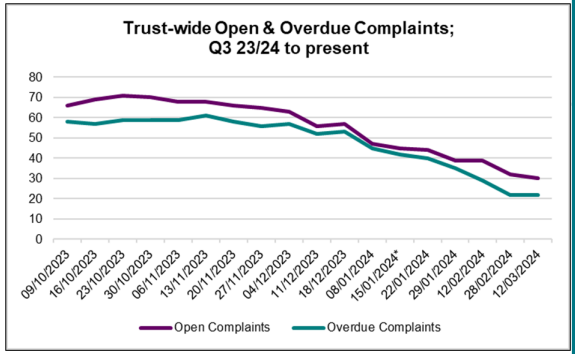
Caring- service involves and treats people with compassion, kindness, dignity and respect

The Tavistock and Portman NHS Foundation Trust

The Trust recorded 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.



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%

The Tavistock and Portman
NHS Foundation Trust

Are we responsive?

Delivering our vision – How are we doing?

Responsive – services meet people's needs

The Tavistock and Portman NHS Foundation Trust

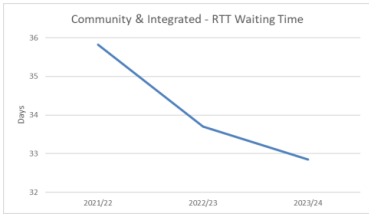
The Trust has declared RTT 14,850 18-week breaches across our services

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)

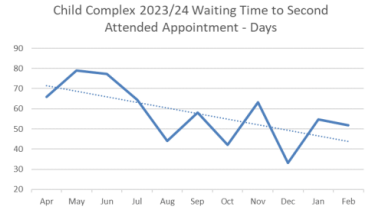
Our Community and Integrated service line reviewed their intake processes in 2023 following a rise in waiting times. They instigated a review using QI methodologies and we have seen a steady improvement across the service line. Their RTT average for February is 26 days.



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.



Average Wait - Patients seen
65 days

Are we well-led?

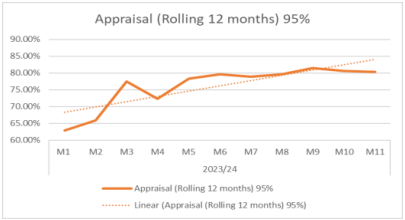
Delivering our vision – How are we doing?

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

The Tavistock and Portman NHS Foundation Trust

The Trust declared 80.36 % of Appraisal Completion

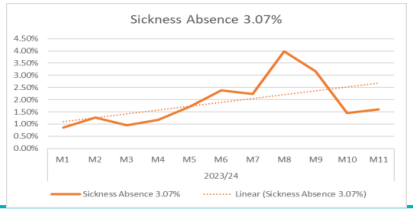
Although appraisal rates are steadily improving, and a considerable increase in compliance has been achieved over the year, further improvement is still required. The upcoming merger processes make career conversations and development opportunities even more important, and managers are reminded to prioritise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



% Appraisal completion
80.36

The Trust declared 3.17 % of Staff Sickness in February 2024

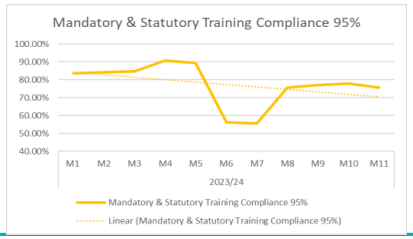
The increase in sickness reporting following the introduction of the new Supporting Health and Wellbeing Policy (and associated training) is positive. For the coming months we expect to see a further increase in reporting, in light of the new ESR self-service roll out which will enable managers to accurately 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.



% 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.



MAST training (%)
75.68

Do we use resources effectively?

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**

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS – Thursday, 9 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:			**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. 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 BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 May 2024			
Report Title: Quality Priorities			**Agenda No.: 11**
Report Author and Job Title:	Emma Casey, Associate Director of Quality	**Lead Executive Director:**	Clare Scott, Chief Nursing Officer
Appendices:	Appendix 1: Update on Quality Priorities performance 2023/24 Appendix 2: Quality Priorities for 2024/2025		
Executive Summary:			
Action Required:	Approval ☐ Discussion ☒ Information ☐ Assurance ☐		
Situation:	This report informs the Board on progress of the Quality Priorities set for 2023/24, alongside a summary of the approach the Trust has taken to develop the Quality Priorities for 2024/25.		
Background:	As set out in the Health Act 2009 and Health and Social Care Act 2012, providers of NHS services are required to produce and publish an Annual Quality Account about the quality of services offered. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and demonstrate improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided. A mandated part of the Quality Account is for providers to set quality priorities for the coming year, as well as report against progress for those set in the reporting year.		
Assessment:	The progress to date against the Trust's Quality Priorities for 2023/24 is noted in Appendix 1. In some areas, it has been challenging to identify leadership and accountability, with a perceived mismatch between some of the priorities and other programmes of work in the Trust. This has led to progress against some targets progressing more slowly than planned. For the setting of 2024/25 quality priorities, the Chief Nursing Officer led a stakeholder event in Quarter 4 of 2023/24 to engage stakeholders in developing quality priority proposals for 2024/25. The plan this year is to align the new quality priorities to the strategic pillars and build on quality improvement work in these areas. The event provided patients and other key stakeholders with the opportunity to understand what some of the key areas of quality focus are for the Trust, why they have been chosen and how it will benefit patient care. The themes from the stakeholder event were presented to the Council of Governors for comment.		
Key recommendation(s):	The Board is asked to **NOTE**; • progress made against 2023/2024 quality priorities and governance around closing them. • the approach to setting the Quality Priorities. • the Quality priorities for 2024/2025 approved by Quality and Safety Committee for 2024/2025. • the timeline for approval and submission of the Quality Account.		

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 1: Inequality of access for patients BAF 2: Failure to provide consistent, high-quality care BAF 13: Insufficient capacity to meet demand for services				
Legal and Regulatory Implications:	Yes ☒	No ☐			
	The Health Act 2009 and Health and Social Care Act 2012 requires providers of NHS services to produce and publish an Annual Quality Account about the quality of services offered. A mandated part of the Quality Account is for providers to set quality priorities for the coming year, as well as report against progress for those set in the reporting year.				
Resource Implications:	Yes ☒	No ☐			
	There may be some resource implications with delivery of quality priorities for 2023/24 and 2024/25.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☒	No ☐			
	There is a current Quality Priority for 2023/24 focused on Equalities.				
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:	First iteration of this report previously received by Quality and Safety Committee in January 2024. Second iteration and Quality Priorities reviewed and approved at Quality and Safety Committee in 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	

Quality Priorities

1. Purpose of the report

1.1. This report informs the Board on progress for the Quality Priorities set for 2023/24, alongside a summary of the approach the Trust has taken to develop the Quality Priorities for 2024/25.

2. Background

2.1. As set out in the Health Act 2009 and Health and Social Care Act 2012, providers of NHS services are required to produce and publish an annual Quality Account about the quality of services provided during the previous year. The reports are published annually by each provider, including the independent sector, and are available to the public.

2.2. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

2.3. A mandated part of the Quality Account is for providers to set a series of quality priorities for the coming year, as well as report against progress for those set in the reporting year.

3. Quality Priorities set for 2023/24

3.1 The progress to date against the Trust's Quality Priorities for 2023/24 is noted in Appendix 1. In some areas it has been challenging to identify leadership and accountability, with a perceived mismatch between some of the priorities and other programmes of work in the Trust. This has led to progress against some targets progressing slower than planned.

3.2 There are a number of the quality priorities that the Trust is not able to demonstrate as completely achieved in the year; where this is the case, the priorities will be closed and progressed via other Trust programmes of work already in place. This is an acceptable governance process for quality priorities i.e. where progress has not achieved, a priority can be marked as such but it should be clear where it will be picked up elsewhere, or where it is no longer appropriate.

4. Quality Priorities planning & stakeholder event

4.1 For the setting of 2024/25 quality priorities, the Chief Nursing Officer led a Stakeholder event in quarter 4 of 2023/24 to engage stakeholders in developing quality priority proposals for 2024/25. Key stakeholders invited included service users, staff, commissioners and local Healthwatch.
The plan this year is to align the new quality priorities to the strategic pillars and build on quality improvement work in these areas.

4.2 The event provided patients and other key stakeholders with the opportunity to understand what some of the key areas of quality focus are for the Trust, why they have been chosen and how it will benefit patient care.
The themes from the stakeholder event were presented to the Council of Governors for comment.
Additionally a survey for service users and public to contribute, has been sent out to service users on the engagement and involvement register and has been made available on the Trust website.

4.3 This is recognised good practice when setting quality priorities, involving the patients and key stakeholders to understand and contribute to our Quality Account planning. This the first time that the Trust has taken this approach in recent years.

5. Preparation for Quality Account 2023/24

5.1. Work has progressed to prepare the draft template for our Quality Account 23/24 to prepare the Trust to meet the publication deadline of 30 June 2024.

5.2. The National Quality Board had been undertaking a review of Quality Accounts to determine how they could be improved and updated. It has since approved a refresh of the process, bringing it in line with changes to legislation and NHS structures and policy. It is anticipated that changes may come into effect for the 2023-24 requirements. It is not yet clear what that means for the production of the Account in actual terms, however in the absence of guidance at this stage, planning for inclusion of information previously required has been used.

5.3. There has been a significant amount of work undertaken in respect of quality & safety throughout the Trust in 2023/24 which will be highlighted throughout the report, alongside other good practice examples.

5.4. As part of the preparation and development of the new Quality Priorities, it will be ensured that the correct governance for them exists. This includes the following;

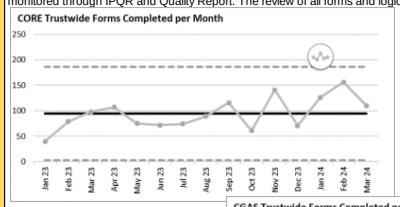
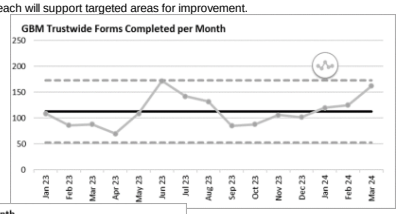
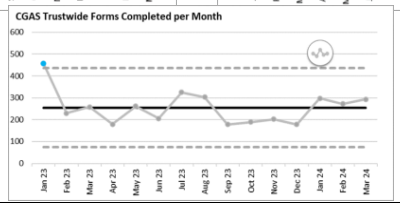
- Confirming leads for quality priorities including ownership and accountability
- Success criteria (if these are different to the sub-objectives).
- Oversight of performance through existing corporate governance routes
- Governance and accountability for progress

6. Conclusion

6.1. The process for both setting Quality Priorities, and the monitoring and accountability of them throughout the year, required strengthening. This is the first step towards that; progress against the improvements around the monitoring of quality priorities will be reported to Quality and Safety Committee each quarter. The Board is asked to note the update on performance for 2023/24 and take assurance that steps are in place to make the improvements needed to the process.

Quality Priorities Progress Update - March 2024

Extra attention and increased effort required to get work back on track. Completion of workstream currently unlikely.	Some issues with progressing workstream. Extra attention required in the following quarter to get work back on track.	No major issues encountered. Work progressing as planned. Completion of the workstream is expected.

	Detail of objective	Success criteria	RAG Rating	Update	Monitoring Group
Quality Priority 1 - Equalities	Improve the process by which Accessible Information Standards (AIS) data is captured and recorded	As per objective		This is a work in progress to automate the process on Carenotes.	IPQR
	Use data collected via Experience of Service Questionnaire (ESQ) by protected characteristics *(list to be defined in line with what is collected)* to understand how experiences of services differ, and devise a plan to address any areas identified for improvement	As per objective		The Trust launched new startegy in 2023/24, under the 'Outstanding Patient Care' Pillar a strategic aim was identified for service user experience. This quality priority has been absorde into the work to progress the strategic aim which is being progessed through quality improvement approach, with an A3 in place.	SUEG Q&SC Trust Board
	In collaboration with Quality Improvement, seek to understand barriers within the local community to accessing treatment and develop a quality improvement project that will seek to address these barriers. We will first pilot this is one area to focus efforts and increase impact and learning.	As per objective		The Trust has developed a plan to implement the Patient and Carer Race Equality Strategy; this quality priority has been absorbed into the PCREF plan which is overseen by the PCREF Implementation Group and reports to Quality and Safety Committee.	PCREF Group Q&SC Trust Board
Quality Priority 2 - Waiting Times	Building on the clinical harm SOP, develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions	As per objective		Work has progressed in adult gender services to implement clinical harm reviews, with new nursing roles starting this work in line withthe Standard Operating Procedure. A new lead role has been created and is being recuited to. This quality priority is now part o fthe 'waiting list' stratgic aim, also under 'Outstanding Care' strategic pilllar of the Trust Strategy. The work started in GIC will be expanded to other areas with waiting lists.	IQPR Q&SC Trust Board
	Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support	As per objective		Covered by a number of initiatives including NCL Waiting Room and review of public website. Development of the new GIC patient portal will also be a source of support - expected trial of portal in February 2024	TBC
Quality Priority 3 - Outcome Measures	To increase OM returns across all services by 25% above baseline by year end	25% increase on 21/22 baseline (Trust level). 21/22 data used as the baseline due to inaccuracy of 22/23 data		Data indicates the 25% baseline increase is not being achieved when combined, however there are increases in some OM forms and some individual services. Performance is monitored through IPQR and Quality Report. The review of all forms and logic for each will support targeted areas for improvement.   	IPQR Quality & Safety Committee
	Embed and establish a meaningful data set and process for outcome measures, that can support us to articulate a measurable improvement for our service users	A clear and streamlined set of outcome measuring forms in place across all appropriate Trust services, including an agreed logic for timings		Outcome Measures are being reviewed by the CMO. This work will continue as a quality priority in 24/25 ESQ usage under review by AD Nursing with view to separate from the Outcome Measure catgeory, as part of A3 User Experience project.	IPQR Quality & Safety Committee
	Continue to develop the use of electronic support such as of Qualtrics to other service user completed Outcome Measures across the Trust	Increased use of Qualtrics or other electronic capture of Outcome and Experience monitoring forms		Qualtrics has been used in additional services however uptake has not been substantially improved for OMs. ESQ usage under review by AD Nursing with view to make the process, logic and reporting clearer across all services, as part of A3 User Experience project.	TBC
Quality Priority 4 - Quality in Gender Services	Continue to support our children and young people in GIDS whilst awaiting transfer of care to the new regional hub model	As per objective		Demobilisation working group, and the sub-groups of that, focused on ensuring a safe transfer of patients to new models. CQC undertook a reinspection of GIDS in September 2023 - draft report submitted. No immediate safety concerns raised, and report acknowledges work undertaken to improve safety since previous inspection. Patients and carers spoke of feeling supported and positive patient care	GIDS Demobilisation working group
Quality Priority 5 - Endings	Co-designing and co-producing what an 'Endings' strategy looks like with patient groups, making sure our processes and approaches around discharge are correct and consistent	Year 1 – production of the strategy	TBC	To be discussed at Clinical Services Delivery Board GIDS Demobilisation programme includes an Endings area of work.	GIDS Demobilisation
Quality Priority 6 - Learning	Review current processes in place for sharing of learning and ensure that these are fit for purpose, including triangulation of key quality metrics, meeting structures to support clinical governance and information flow from service to Board	Evidence of learning being shared via both meeting structures and communications Evidence of a new triangulation/thematic report presented to the Quality & Safety Committee, and other meetings as required		Governance structure for Quality & Safety Committee in final stages of implementation. New incident process includes thematic review via Clinical Governance meetings, through to Incident Panel (renamed) & QSC as appropriate. This will mean that Clinical Governance meetings may need to review how incidents/reports/learning is discussed, plus information flow up to the QSC. Further work needed on how all staff comms/learning lessons events will be developed building on this learning PSIRP approved in September 2023; PSIRF training scheduled for January 2024. Clinical Incident and Safety Group in December 2023 actioned to consider and agree template(s) for sharing of learning at team and Trust level.	PSIRF Transition Group
	Working on the outcomes of this review, develop and embed a clear and accountable structure for learning and triangulation throughout the Trust	Implementation of PSIRF		New individual reports for complaints and incidents, plus the overall Quality & Safety report, focuses on identifying themes and embedding actions.	Incident and Risk Management Board

Owner
CCOO
CNO PPI
CMO EDI
CCOO CNO
CCOO ACD
CMO COD
ADoQ Informatics
CCOO
CCOO PPI
CNO ADoQ
CNO IT

The Tavistock and Portman
NHS Foundation Trust

Developing Our Quality Priorities for 2024/25

Looking back on the past year

- New vision, mission and values agreed for the whole Trust
- New members of the Executive Leadership team
- Strengthened accountability framework through the Integrated Quality and Performance Report, and reviewed 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.

Patient Safety

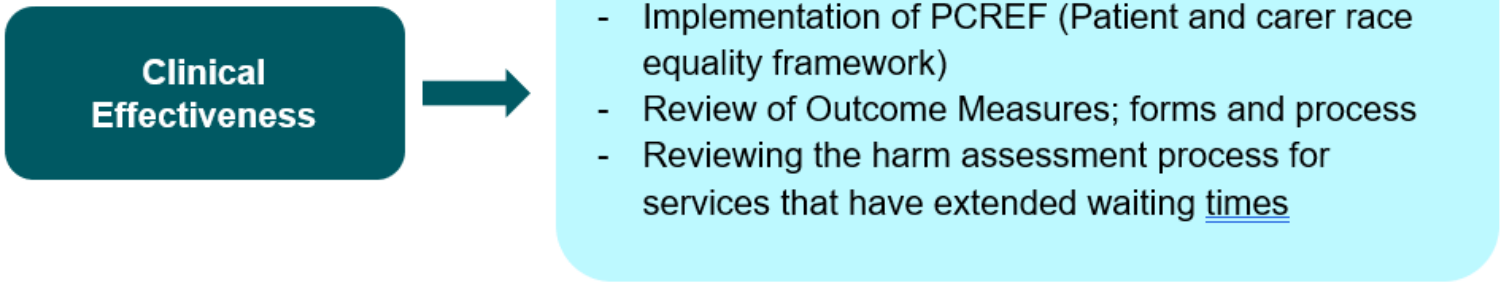
The Tavistock and Portman NHS Foundation Trust

Strengthening our Patient Safety culture

- 85% of staff will be trained in the Level 1 Essentials of Patient Safety syllabus
- Training for staff in new PSIRF investigative techniques
- 100% of patients/families involved in Patient Safety Incident Investigations are included in the investigation process
- Investigation templates include reflection on Fair & Just Culture & Compassionate Engagement

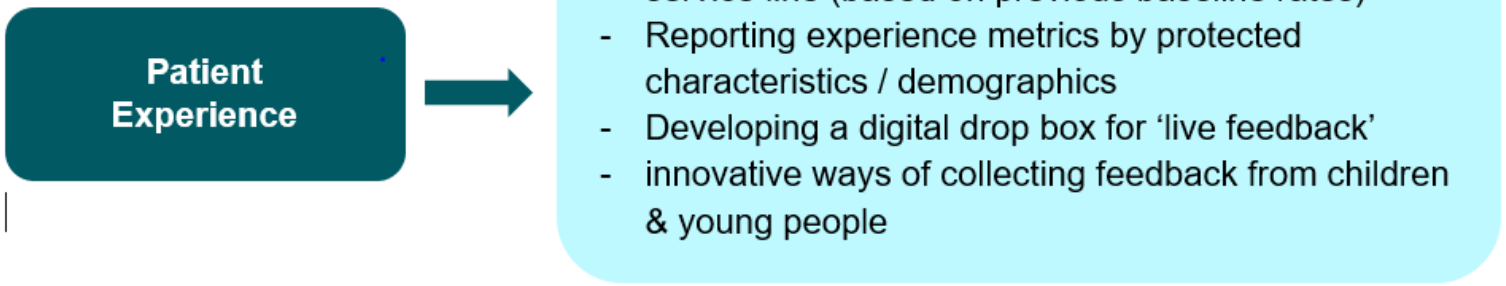
Clinical Effectiveness

The Tavistock and Portman NHS Foundation Trust



Patient Experience

The Tavistock and Portman NHS Foundation Trust



Quality Account Timelines

The Tavistock and Portman NHS Foundation Trust

- Survey on possible focus areas of Quality Priorities for internal and external feedback – currently live
- Draft Quality Account to be shared with Quality and Safety Committee and stakeholders for comment – ***w/b 29th April; due back Friday 17th May***
- Board review 13th June 2024
- Quality & Safety Committee 20th June 2024
- Upload of Quality Account by 30th June 2024

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 May 2024			
Report Title: Winding up of the UCL Health Alliance			**Agenda No.: 12**
Report Author and Job Title:	Michael Holland, Chief Executive Officer (CEO)	**Lead Executive Director:**	Michael Holland, CEO
Appendices:	Appendix 1: Letter to CEO and Boards – April 2024 Appendix 2: NCL HA Board Certification (Unwinding) Appendix 3: Financial position 23 - 24		
Executive Summary:			
Action Required:	Approval ☒ Discussion ☐ Information ☒ Assurance ☐		
Situation:	The purpose of this report is to inform the Board of Directors of the attached letter (Appendix 1) proposing the winding up of the UCL Health Alliance. NHS England (NHSE) require a formal submission supported by each member Trust Board that the risks to each individual organisation have been considered and mitigated.		
Background:	In November 2023, the UCL Health Alliance and UCL Partners established a partnership known as the UCL Health Alliance, with the UCL Health Alliance becoming a ring-fenced division of UCL Partners (UCLP). The UCL Health Alliance has completed the process to remove UCL as a formal partner and the branding change to become NCL Health Alliance. Part of the original establishment of the UCL Health Alliance was the creation of a Limited Liability Company to support potential transactions.		
Assessment:	As UCLP is an LLP, there is no longer a need for the LLP "UCL Health Alliance" to exist, as there is no funding held by the company, it will have no employees and undertake no transactions on partners behalf. Attached with the letter in Appendix 1, is the proforma completed as part of the review process (including finance report), which requires formal approval (see Appendices 2 and 3). Once NHSE approve the submission, each organisation will be informed of the date that the LLP ceases to exist.		
Key recommendation(s):	The Board of Directors is asked to: • **NOTE** the contents of this report; and • **APPROVE** it is supportive of the contents of the report (setting out the risks and mitigations).		
Implications:			
Strategic Ambitions:			

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

	international provider of training & education	for innovation and research in this area	equality, diversity and inclusion		
Relevant CQC Quality Statements (we statements) Domain:	Safe ☒	Effective ☒	Caring ☒	Responsive ☐	Well-led ☐
Link to the Risk Register:	BAF ☐	CRR ☐	ORR ☐		
	Risk Ref and Title: There are no related risks on the BAF.				
Legal and Regulatory Implications:	Yes ☐	No ☒			
	There are no direct legal implications to the Trust.				
Resource Implications:	Yes ☐	No ☒			
	There are no resource implications for the Trust.				
Equality, Diversity and Inclusion (EDI) implications:	Yes ☐	No ☒			
	There are no EDI implications relevant to 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	

UCLPartners
3rd Floor
170 Tottenham Court Road
London W1T 7HA

020 7679 6633
Kate.petts@uclpartners.com
www.uclpartners.com

Date as per email

Dear

In May 2023 the boards of UCL Health Alliance and UCL Partners supported the proposal to create a single innovation partnership for NCL to maximise the collective impact on health outcomes. This partnership was successfully established in November 2023, with UCL Health Alliance moving to become a ring-fenced division of UCLP.

As part of the partnership formation, we have created a new organisational structure, including the appointment of the Executive committee chair and vice chair posts. The financial flows and management have been confirmed and the core team successfully recruited. The UCL Health Alliance has also completed the process to remove UCL has a formal partner and the branding change to become NCL Health Alliance.

Part of the original establishment of the UCL Health Alliance was the creation of a Limited Liability Company to support potential transactions. As UCLP is an LLP there is no longer a need for the LLP "UCL Health Alliance" to exist, as no funding will be held by the company, it will have no employees and undertake no transactions on partners behalf. It has therefore been proposed that the LLP is disestablished. A process to review the risks including the confirmation to mitigate anything material has been completed and discussed and approved at the UCL Health Alliance Executive meeting. Each named director of the LLP has also reviewed and approved the process confirming unanimously that there are no risks to the winding up of the LLP.

NHSE require a formal submission supported by each member Trust board that the risks to each individual organisation have been considered and mitigated. Any risks not identified through this process will be reviewed by the existing governance arrangements for NCL HA (Alliance Executive and UCLP board) and mitigated accordingly. Attached with this letter is the proforma completed as part of the review process (including finance report), which requires formal approval. Once NHSE approve the submission each organisation will be informed of the date that the LLP ceases to exist.

I would be grateful if you would review the attached and confirm on behalf of your Trust board that you are supportive of its content setting out the risks and mitigations.

Your sincerely

Kate Petts - Managing Director – NCL Health Alliance

UCL Partners Ltd.
Registered England and Wales No: 06878225
Registered office: 3rd Floor, 170 Tottenham Court Road, London, W1T 7HA

Appendix 1

Proposal to wind up the company limited by guarantee which currently hosts UCL Health Alliance (the Alliance) (the Transaction), as part of a wider proposal for the Alliance to become a division of UCLPartners

Pro forma Trust Board certification

March 2024

System risks

The Trust Board should certify that it has, in relation to system risks:

Board certification set out in the Addendum	Bespoke Board certification for this Transaction	Additional information requested by the NHSE review panel	Board comment
Considered a detailed options appraisal before deciding that the proposed subsidiary transaction aligns with wider system plans and is at least financially neutral for the wider system and delivers benefits for patients and the trust, and that the subsidiary is the best vehicle to deliver these benefits	**Considered a detailed options appraisal before deciding the most appropriate model for delivery of the objectives of the alliance in future. As part of this, considered whether there is a clear rationale for removing University College London (UCL) as a member and unwinding the existing subsidiary structure and becoming a division of UCLPartners.** **Considered whether the proposed changes align with and support wider system plans.**	N/A	The Trust board is satisfied that a detailed options appraisal process was completed The recommendations of the appraisal were reviewed by all organisational CEOs and Chairs and were unanimously endorsed The options appraisal was also supported by the UCL Provost and Council. The options appraisal was also reviewed and supported by the ICB Executive leadership.

Financial risks

The Trust Board should certify that it has, in relation to financial risks:

Board certification set out in the Addendum	Bespoke Board certification for this Transaction	Additional information requested by the NHSE review panel	Board comment
A clear commercial strategy for the proposals which is independent of the subsidiary enabling a different VAT treatment from that of the current trust arrangements	**Clarity on the taxation implications of the proposal to unwind the subsidiary and become a division of UCLPartners.** **As part of this, clarity that the strategic rationale for unwinding the subsidiary and becoming a division of UCLPartners is not dependent on any taxation benefits.**	N/A	There are no tax implications for the unwinding of the subsidiary. The strategic reasons for unwinding the UCL HA LLP is that UCLP is already an LLP and therefore there is no added benefit of retaining the LLP for UCL HA.
Conducted an appropriate level of financial, clinical and market due diligence relating to the proposed subsidiary.	N/A	N/A	N/A
Considered the implications of the proposed subsidiary on the Single Oversight Framework (SOF) segment of both the parent trust and the subsidiary where applicable, focusing on the finance and use of resources metrics and taking full account of reasonable downside sensitivities	*N/A*	N/A	N/A

Financial risks (cont.)

The Trust Board should certify that it has, in relation to financial risks (cont.):

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Taken into account the implications for access to capital and revenue funding from the Department of Health and Social Care (DHSC) as well as tariff-related funding in developing the financial plan for the subsidiary, and agreed key assumptions in the business plan with relevant stakeholders, including DHSC where appropriate.	*N/A*	N/A	N/A
Taken into account the independence of the subsidiary in relation to the delivery plans for the parent trust's own efficiency and CIP targets.	N/A	N/A	N/A
Ensured relevant commercial risks are understood and mitigated, including risks to the trust from the subsidiary's credit arrangements and the relationship between any existing guarantee arrangements and funding arrangements for the subsidiary.	• **Ensured clear arrangements to agree the annual budget for the alliance including clear arrangements for significant over or underspends.** • **Ensured that the alliance will have access to adequate cash, particularly in the first few months after the unwinding of the subsidiary and the transfer to UCLPartners.**	Please set out the rights and obligations of individual members in relation to funding where significant over or underspends arise.	If there are any significant forecast under or overspends then the Alliance Executive will be asked to approve the most appropriate action including deferring funding to future years against specific programmes, returning unused funds to members, increasing contributions or suspending work programmes.

Financial risks (cont.)

The Trust Board should certify that it has, in relation to financial risks (cont.):

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Ensured that any transactions between the trust and the subsidiary do not pose a risk to existing credit arrangements, such as loan agreements with DHSC	N/A	N/A	N/A
Ensured that the risks associated with any transactions between the trust and the subsidiary are understood: for example, the risk associated with any asset transfers, including the impact of any existing guarantee arrangements on such transactions.	N/A	N/A	N/A
Received appropriate external advice from independent professional advisers with relevant experience and qualifications, including tax advice where the subsidiary enables a different VAT treatment from that of the current trust arrangements.	**Received appropriate external advice from independent professional advisers with relevant experience and qualifications on the taxation implications of the proposed arrangements, including any arrangements for the secondment of Trust staff.**	Please set out the taxation treatment of any assets or liabilities in existence when the subsidiary is wound up or confirm a nil asset/liability position at the date of unwinding.	There are no current assets or liabilities for UCL HA, so none will remain at the date of unwinding

Financial risks (cont.)

The Trust Board should certify that it has, in relation to financial risks (cont.):

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Resolved any issues relating to the proposed subsidiary and its treatment for accounting purposes and received appropriate professional advice	**Clarity on the accounting treatment for the unwinding of the subsidiary and transfer to UCLPartners, including operating as a division of UCLPartners.**	Please provide the most recent financial report which confirms that there have been no material changes in the financial position of the subsidiary since January 2023. Please set out the accounting treatment of any assets or liabilities in existence when the subsidiary is wound up or confirm a nil asset/liability position at the date of unwinding. Please also set out how any initial capital contributions of the partners will be treated when the subsidiary is wound up.	Financial report attached There will be a nil liability/asset position at the date of unwinding of UCL HA There are no capital contributions related to the LLP

Operational risks

The Trust Board should certify that it has, in relation to operational risks:

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Ensured that there is a robust and comprehensive plan for implementation of the transaction, including for the realisation of benefits over the longer term.	**Ensured that there is a robust and comprehensive plan for implementation of the transaction, including for the realisation of benefits over the longer term.**	N/A	The Trust board is reassured that the plan to implement the transaction is robust and long term.
Conducted appropriate enquiry about the probity of any partners involved in the proposed subsidiary that considers the nature of the services provided and the likely reputational risk.	*N/A*	N/A	N/A
Conducted appropriate enquiry about the organisational and management capacity and capability of any partners involved in the proposed subsidiary that considers the nature and scope of services to be provided by the subsidiary and the potential risks to clinical, finance and operational sustainability.	**Conducted appropriate enquiry about the organisational and management capacity and capability of any partners involved in the proposed subsidiary that considers the nature and scope of services to be provided by the subsidiary and the potential risks to clinical, finance and operational sustainability.**	N/A	The Trust board is reassured that the options appraisal took into consideration the management and organisational capacity/capability of the partners and no risks were identified
Conducted an appropriate assessment of the nature of services to be provided by the subsidiary and any implications for reputational risk arising from these.	**Conducted an appropriate assessment of the nature of services to be provided by the subsidiary and any implications for reputational risk arising from these.**	N/A	The Trust board is reassured that the options appraisal took into consideration nature of the services and no reputational risks were identified

Operational risks (cont.)

The Trust Board should certify that it has, in relation to operational risks (cont.):

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Sought legal advice on the transaction, including those associated with any transfer of staff and TUPE arrangements, with no indicators of risk that transaction cannot legally proceed.	**Sought legal advice as required on the transaction, including those associated with any transfer of staff and TUPE arrangements, with no indicators of risk that transaction cannot legally proceed.**	N/A	The Trust boards is satisfied that appropriate advice was sought as part of the options appraisal on staff arrangements. No staff required to be transferred or subject to TUPE as part of the transaction
Engaged staff in decisions that affect them and the services they provide as pledged in the NHS Constitution, and has plans to comply with any consultation requirements, including staff consultations.	**Engaged staff in decisions that affect them and the services they provide as pledged in the NHS Constitution, and has plans to comply with any consultation requirements, including staff consultations.**	N/A	The Trust board is satisfied that staff have been consulted on the plans, all questions raised were comprehensively answered and no risks identified
Established the organisational and management capacity and skills to deliver the planned benefits of the proposed subsidiary, including where relevant the delivery of services at scale, including but not limited to assuring itself that the subsidiary will be able to attract and retain staff with the appropriate skills and experience to deliver the service requirements, both immediately and over the life of the business plan.	**Established the organisational and management capacity and skills to deliver the planned benefits of the proposed subsidiary, including where relevant the delivery of services at scale, including but not limited to assuring itself that the subsidiary will be able to attract and retain staff with the appropriate skills and experience to deliver the service requirements, both immediately and over the life of the business plan.**	N/A	The Trust board is satisfied that sufficient attention was paid to the capability and capacity of current staff and the ability to attract and retain staff both immediately and over the life of the business plan. No risks were identified

Operational risks (cont.)

The Trust Board should certify that it has, in relation to operational risks (cont.):

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Made provision for the transfer of all relevant assets and liabilities.	**Made provision for the transfer of all relevant assets and liabilities**.	N/A	The Trust board is satisfied that there are no liabilities or assets
Ensured that the subsidiary will seek any leases or licences required to deliver the services set out in the business case	**Ensured that the subsidiary will seek any leases or licences required to deliver the services set out in the business case**	Please confirm that there are no other leases or licences required other than the UCL trademark licence agreement mentioned in Document 1 of the Transaction submissions.	The Trust board is satisfied that there are no other leases or licences other than the UCL trademark agreement

Quality risks

The Trust Board should certify that it has, in relation to quality risks:

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Involved senior clinicians at the appropriate level in the decision-making process and they have confirmed they have no material clinical concerns in proceeding with the proposed subsidiary, including consideration of the subsequent configuration of clinical services.	**Involved senior clinicians at the appropriate level in the decision-making process and they have confirmed they have no material clinical concerns in proceeding with the proposed subsidiary, including consideration of the subsequent configuration of clinical services.**	N/A	The Trust board is satisfied that the appropriate level of clinical engagement was undertaken and there are no material clinical concerns

Governance risks

The Trust Board should certify that it has, in relation to governance risks:

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Taken into account the good practice advice in NHS Improvement's transaction guidance or commented by exception where this is not the case.	N/A	N/A	N/A
Ensured regulatory requirements are understood and complied with, including the potential requirement for the subsidiary to hold an NHS controlled provider's licence.	N/A	N/A	N/A
For a parent trust that is an NHS trust, complied with paragraph 20(2) of Schedule 4 of the National Health Service Act 2006, and specifically ensured that the subsidiary proposal has Secretary of State consent pursuant to directions to NHS trusts relating to exercise of powers under Section 7(2) and (7A) of the Health and Medicines Act 1988 (September 2002).	N/A	N/A	N/A

Governance risks (cont.)

The Trust Board should certify that it has, in relation to governance risks (cont.) :

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Ensured that there are systems and processes in both the parent trust and the subsidiary which interact to provide the parent trust board with assurance that it has suitable clinical, financial and operational oversight of the subsidiary. Specifically, the systems and processes should ensure that the parent trust board is made aware on a timely basis of overall clinical, financial and operational performance and significant risks in the subsidiary and can monitor development and implementation of mitigations to address any significant risks. As part of this, the parent trust board is assured that there is sufficient capability and capacity at board level in the subsidiary to provide effective organisational leadership, and that the subsidiary has systems and processes to provide the board of the subsidiary with suitable clinical, financial and operational oversight	**Ensured that there are systems and processes in both the parent trust and the subsidiary which interact to provide the parent trust board with assurance that it has suitable clinical, financial and operational oversight of the subsidiary. Specifically, the systems and processes should ensure that the parent trust board is made aware on a timely basis of overall clinical, financial and operational performance and significant risks in the subsidiary and can monitor development and implementation of mitigations to address any significant risks. As part of this, the parent trust board is assured that there is sufficient capability and capacity at board level in the subsidiary to provide effective organisational leadership, and that the subsidiary has systems and processes to provide the board of the subsidiary with suitable clinical, financial and operational oversight**	**Please set out the governance systems and processes for managing and escalating any risks post-Transaction.**	The Trust board is satisfied that there the processes in place to manage and escalate risk are sufficient. The process that will be implemented is - Risks to delivery of work programmes and organisational business are monitored by the Managing Director - Concerns are escalated for discussion at the UCL HA Executive Meeting, with a parallel report to UCLP board - Actions from this meeting will then either be escalated to individual Trust boards or the NCL ICB executive as necessary

Governance risks (cont.)

The Trust Board should certify that it has, in relation to governance risks (cont.) :

Board certification set out in the Addendum	Bespoke Board certification for the Transaction	Additional information requested by the NHSE review panel	Board comment
Ensured that the trust is able to continue to comply with all legal requirements following completion of the subsidiary transaction.	**Ensured that the trust is able to continue to comply with all legal requirements following completion of the subsidiary transaction.**	**N/A**	The Trust board is satisfied that the subsidiary transaction does not in any way interfere with individual organisations ability to comply with all legal requirements

23/24 Finance report for NCL Health Alliance

Summary

The report below sets out the draft year end position (23/24) for NCL HA and the proposal for the use of the deferred non-recurrent funding into 24/25.

Financial position

The draft year end position for the financial year 2023/24 is a cost of £414k against an income of £735k, resulting in an underspend of £321k. The budget of £735k rep resents a contribution per member organisation of £45k/year, plus a carry forward from 22/23 of £105k.

The main factors that have driven the underspend is the suspension of recruitment during the process in transferring into UCLP and subsequent delays in recruiting to vacant posts. The unexpected resignation of the programme co-ordinator just after the transition was completed further impacted on recruitment. The non-pay underspend was also driven by delays in recruitment.

A gap between the organisational transition and transfer of funds from UCLH to UCLP meant that it was difficult to effectively forecast a year end position. Final transfer of funds was completed in late March 24.

Table 1 – Outturn position 23/24

	£
Opening balance 1 Apr 2023	105,730
2023/24 income	630,000
Pay costs UCLH Apr 2023 - Mar 2024	268,987
Non pay costs UCLH Apr 2023 - Mar 2024	7,303
Additional UCLH costs	9,844
Total UCLH costs	**286,134**
Pay costs UCLP Oct 2023 - Mar 2024	103,386
Non pay costs UCLP Oct 2023 - Mar 2024	24,958
Total UCLP costs	**128,344**
Total costs	414,478
Forecast closing balance 31 Mar 2024	**321,252**

24/25 plans

The 24/25 income for NCL HA reduces by £45k following the removal of UCL as a partner. The expenditure for NCL HA funds the pay and non-pay for the core team (6 WTE), the 10% corporate overhead paid to UCLP and a £34k contribution to the salary of the UCLP chair (agreed as part of the move).

For 24/25 the core team will be fully staffed, by the end of Q1including the appointment to the full time Managing Director Role. A financial review of the income and expenditure has identified a funding shortfall for future years, despite a significant reduction in the non-pay budget for the team. This is

driven by the loss of the UCL contribution, combined with the continuation of the Chair's salary contribution and the corporate overhead.

While the 3 post holders that transferred into UCLP are seconded from the NHS (Managing Director and the 2 Senior Programme Managers), the commitment was that all new staff into the team will be employed directly by UCLP. UCLP use a different salary structure to agenda for change meaning that there is a risk that direct employees may have a higher salary than similar NHS banded roles.

The current forecast for the 24/25 budget is an underlying deficit position based of approximately £55k, a position that could worsen if the NHS posts were subject to any national pay awards.

Main work programme for 24/24

- Development of Long-Term Health Hubs a service innovation that improves the management of patients with long term multi-morbidity disease. These community base health hubs will be delivered in partnership between primary and secondary care, linking to place based initiatives, led by a specialist workforce. The overall aim will be to deliver sustainable, effective and coordinated care for patients with high-risk complex, multi-morbid disease.

In order to deliver the planned programmes of work it is proposed that the surplus is deferred to 24/25 to support in the following way:

- £50k - interim programme director support
- £70k - clinical and operational sessions across NCL
- £100k - evaluation programme funding
- £50k programme contingency
- £50k pay cost contingency

A mid year forecast position will be presented to the NCL Alliance executive for review and approval.

CHAIR'S ASSURANCE REPORT TO THE BOARD OF DIRECTORS (BoD) - 9 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 ☐

• We are adjusting to a new culture and how we need to not blame but learn from experience. • 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. • 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.	Partial ☐ Adequate ☐ N/A ☒

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 BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 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 Board is asked to discuss the approach and provide support to our services to create meaningful, sustainable remedial responses: 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 BOARD OF DIRECTORS – 9 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. • Discrepancies in library service expenses were noted, prompting concerns about the transparency and accuracy of financial reporting.	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	Limited ☐ Partial ☐

• 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. • Internationally, there are efforts to develop our partnerships, strengthen existing ones, and expand provision through commission.	Adequate ☒ N/A ☐
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 BOARD OF DIRECTORS – 9 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, although we have received 25% of this we have little confidence that we will receive anymore or indeed whether it will be clawed back. This is a significant financial risk to the Trust • PCPCS - this contract is also at risk - £1.2m. • 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: The Committee felt that the specific risks around performance need to be more clearly articulated, and this has now been done.	Limited ☐ Partial ☒ Adequate ☐ N/A ☐
5. Escalation	Limited ☐

• Ten complaints pertaining to Information Governance had been escalated to the Integrated Audit & Governance Committee.	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 of losing PCPCS and the HEE budget

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 BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 May 2024			
Report Title: Finance Report - As at 31st March 24 (Reporting Month 12)			**Agenda No. 17**
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 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 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. A detailed breakdown of these costs is included in the report. **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 Board of Directors is asked to **NOTE** the position outlined in the report.				
Implications:					
Strategic Ambitions:					
☒ Providing outstanding patient care	☐ To enhance our reputation and grow as a leading local, regional, national & international provider of training & education	☐ Developing partnerships to improve population health and building on our reputation for innovation and research in this area	☐ Developing a culture where everyone thrives with a focus on equality, diversity and inclusion	☒ Improving value, productivity, financial and environmental sustainability	
Relevant CQC Quality Statements (we statements) Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 9: Delivering Financial Sustainability Targets. 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	

Report Title: Finance Report – At 31st March 24 (Reporting Month 12)

1. Overview

1.1 The table below shows a summary of the Trusts reported cumulative position against its agreed financial plan for the month ended 31st March 24.

Financial Reporting Summary - Month 12 2024

	Current Plan	Actual	Variance
£'000	Mar 24	Mar 24	Mar 24
	YTD	YTD	YTD
Income	**67,426**	**76,115**	**8,689**
Agency	(2,531)	(3,077)	(546)
Other pay	(47,873)	(53,944)	(6,071)
Pay	**(50,404)**	**(57,021)**	**(6,617)**
Non-Pay	**(19,539)**	**(21,611)**	**(2,072)**
Of which non- Operating Items	*(93)*	*(251)*	*(158)*
TOTAL Provider Surplus/(Deficit)	**(2,517)**	**(2,517)**	**0**

1.2 For the period ended 31st March 24, the Trust recorded a deficit of £2,517k, compared with a planned deficit of £2,517k.

1.3 Agency costs at the year-end were £3,077k, £546k over the budget of £2,531k. The run rate in recent months has fallen significantly with the additional spend in M12 being only £132k. This reduced spend is a consequence of the in-year review of posts, also because of GIDS decommissioning by 31.03.24 and is expected to continue into the new year.

1.4 Additional cost pressures emerged via the IPQR project. This was originally thought to be mainly capital in nature, but investigative work indicates a significant revenue component. The impact is included in the reported position to date and is not expected to be an additional cost pressure in 24/25.

1.5 Additional NHS-wide pay awards received in June fell outside of the original plan, but have been fully funded via NHSE, resulting in large positive income and corresponding negative pay variances.

1.6 The reported position does now include the costs and agreed income associated with the decommissioning of the GIDs. The estimated decommissioning costs of £3.8m are shown in the table below.

Cost	Total £000's
Estates - Leeds	437
Estates - Birmingham	199
Estates - Exeter	0
Estates - Bristol	0
Removals/Waste Disposal	50
IM&T - Casenotes	0
KC Redundancy Advise	50
Staff Redundancy	2315
13 Week Liability	748
Legal Support Future Periods	50
Total Cost Per Year	**3,849**

2. Income

2.1 Income was £76,115k ahead of target for the period of £67,426k by £8,682k.

2.2 This continues to reflect the pay award funding received from NHSE and previously advised planed deferred income being received ahead of plan, The excess pay award funding being received from NHSE that was not part of the original income plan. In addition, NHSE agreed to fund GIDS decommissioning of £3.4m, hence the significant variance

3. Staffing Costs

3.1 Staff costs are of £57,021k, showing an adverse variance of £6,617k, against planned expenditure for the period of £50,404k.

3.2 The adverse variance is driven by previously advised, quicker than expected recruitment to date, increased agency costs, effects of the pay award, and the GIDS redundancy costs. The pay award excess cost and GIDS redundancy cost not being reflected in the agreed plan.

3.3 Agency costs (shown in Appendix 2) in the period total £3,077k, an overspend of £546k. This is driven in the main by the need to fill higher than anticipated vacant posts in Gender services.

4. Operating Non-Pay Costs

4.1 The adverse variance of the operating non pay costs now reflect the decommissioning cost of GIDS.

5. Cash

5.1 The reduced cash position of £2.4 against the planned position at M12 of £3.1m, is an adverse variance of £0.7m.

5.2 The adverse variance in the main reflects the payment of some of the GIDS estates related decommissioning costs before the associated cash receipts, and an overpayment of PDC to NHSE which is expected to be recovered in future periods.

5.3 It is estimated that the expected deficit in 24/25 will generate a negative cash balance in Month04 in the next financial year.

6. Other Costs (Bank interest, Dividends)

6.1 Non-operating costs are behind plan by £158k at the year end. This reflects the non-recurrent adverse PDC dividend expense higher than plan

7. CIP Delivery

7.1 The balance of the £3m target was actioned in months 12.

8. Balance Sheet

8.1 No movements of note to report at Month 12.

9. Full year Outlook/ Key Risks and Opportunities

9.1 The position outlined above is subject to confirmation via the annual accounts process that is scheduled to conclude at the end of June 24.

9.2 At the time of writing no significant risks to this reported position were known.

Appendix 1. ICB Month 11 results

	M11 Year to date			M11 Forecast Outturn			M12 Improvement bottom-line required	
Organisation	YTD Plan (17th May submission)	YTD Actual	YTD Variance	Annual Plan (17th May submission)	Forecast Outturn	FOT Variance	M11 run rate	Improvement in M12 to achieve FOT
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
BEH	927	501	(426)	1,003	593	(410)	547	46
C&I	653	303	(350)	673	673	(0)	331	342
GOSH	134	(7,028)	(7,162)	620	(4,203)	(4,823)	(7,667)	3,464
MEH	2,959	10,175	7,216	3,400	11,196	7,796	11,100	96
NMUH	650	1,012	362	1,143	1,553	410	1,105	449
RFL	(35,680)	(50,702)	(15,022)	(36,994)	(36,994)	0	(55,311)	18,317
RNOH	(1,021)	(4,817)	(3,796)	41	(2,045)	(2,086)	(5,255)	3,210
T&P	(3,333)	(2,933)	400	(2,517)	(2,517)	-	(3,200)	683
UCLH	12,625	19,168	6,543	20,010	20,010	-	20,910	(900)
WHIT	(9,451)	(16,353)	(6,902)	2,000	1,109	(891)	(17,840)	18,949
Trust Total	**(31,537)**	**(50,674)**	**(19,137)**	**(10,621)**	**(10,625)**	**(4)**	**(55,280)**	**44,656**
NCL ICB	9,737	9,737	(0)	10,622	10,622	0	10,622	1
System Total	**(21,800)**	**(40,937)**	**(19,137)**	**1**	**(2)**	**(3)**	**(44,658)**	**44,656**

Appendix 2

Agency Spend Summary - March 24

Directorate	Cost centre description	YTD Cost	YTD WTE
Corporate	Commercial Directorate	77	0.55
Corporate	Estates Property Manageent	167	2.19
Corporate	Finance	276	2.13
Corporate	Head of Nursing	69	0.71
Corporate	HR GENERAL	233	1.69
Corporate	Med Dir & Clin Gov Gen	54	0.33
Corporate	TRUST WIDE MANAGEMENT	12	0.21
Corporate	Trust Board	16	0.20
Corporate	CHIEF EXECUTIVE OFFICE	83	1.02
Corporate Total		**988**	**9.02**
CMH, C&I	CHILD & FAMILY GENERAL	0	-
CMH, C&I	C&F SV LINE CAM CAMHS(AW)	51	0.04
CMH, C&I	SOUTH CAMDEN CAMHS	6	0.07
CMH, C&I	DAY UNIT	156	5.63
CMH, C&I	Gloucester House Outreach	2	0.10
CMH, C&I	CI - Admin, Operations and Senior Le	288	3.15
CYAF Total		**503**	**9.00**
DET	Academic Governance and Quality As	54	0.89
DET	Course Administration	41	0.58
Education and Training Total		**95**	**1.47**
Gender	G.I.C	859	10.24
Gender	GENDER IDENTITY	550	8.50
Gender Total		**1,409**	**18.74**
Trust Managemen	Junior Doctors	82	0.53
Trust Management Total		**82**	**0.53**
Grand Total		**3,077**	**38.75**

Board of Directors (Public) – May 9th 24			
Report Title: Financial Plan 24.25 Update as at 3rd May 24			**Agenda No. 7**
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. This revenue plan is unchanged from the previously submitted versions discussed and agreed previously. The only significant difference being 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 initially agreed a deficit plan of £2,400k with the ICB for 24.25.		
Assessment:	**Income and Expenditure** As previously advised the Trusts planned deficit of £2,400m requires 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. 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 Committee is asked to **NOTE** the position outlined in the report.		

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

& communities we serve.	compassion & collaboration.		care & reducing health inequalities.		
Relevant CQC Domain:	Safe ☐	Effective ☐	Caring ☐	Responsive ☐	Well-led ☒
Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐		
	BAF 8: Delivering Financial Sustainability Targets. A failure to deliver a medium / long term financial plan that includes the delivery of a recurrent efficiency program bringing the Trust into a balanced position in future periods. This may lead to enhanced ICB/NHSE scrutiny, additional control measures and restrictions on autonomy to act. **BAF 10: Suitable Income Streams** The result of changes in the commissioning environment, and not achieving contracted activity levels could put some baseline income at risk, impacting on financial sustainability. This could also prevent the Trust 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.				
Diversity, Equality and Inclusion (DEI) implications:	Yes ☐		No ☒		
	There are no DEI implications associated with this report.				
Freedom of Information (FOI) status:	☒ This report is disclosable under the FOI Act.		☐ This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test.		
Assurance:					
Assurance Route - Previously Considered by:	None				
Reports require an assurance rating to guide the discussion:	☐ Limited Assurance: There are significant gaps in assurance or action plans	☒ Partial Assurance: There are gaps in assurance	☐ Adequate Assurance: There are no gaps in assurance	☐ Not applicable: No assurance is required	

MEETING OF THE BOARD OF DIRECTORS PART II (PUBLIC) – Thursday, 9 May 2024			
Report Title: Public Board of Directors Schedule of Business 2024/2025 (Public)			**Agenda No.: 19**
Report Author and Job Title:	Fiona Fernandes, Business Manager Corporate Governance	**Lead Director:**	John Lawlor, Trust Chair
Appendices:	Appendix 1: Board of Directors (Public) Schedule of Business 2024/2025		

Executive Summary:	
Action Required:	Approval ☐ Discussion ☐ Information ☒ Assurance ☐
Situation:	This report provides the Public Board of Directors Schedule of Business for 2024/2025.
Background:	It is good corporate governance practice for the Board and its Committees to agree a forward Schedule of Business of its activities ahead of a new financial year. **Process undertaken:** The process of producing the Board schedule of business is conducted annually (ahead of the March/ April cycle of meetings) and it is facilitated by the Corporate Governance team function in consultation with the Chief Executive and /or the Chair.
Assessment:	The Board is asked to note that the Schedule of Business is a live document, and it may be updated overtime depending on the Trust's priorities and other external/ regulatory factors. The Board Schedule of Business will be presented at each meeting of the Board for information highlighting any changes to the planner. Diary appointments for the 2024/2025 meetings have been issued to members. Any future changes to dates will be reflected in the Forward Planner.
Key recommendation(s):	The Board is asked to **NOTE** the Public Board of Directors Schedule of Business for 2024/2025.

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

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

Link to the Risk Register:	BAF ☒	CRR ☐	ORR ☐
	This report does not specifically mitigate any linked risk on the BAF or Trust Risk Register. However, the BAF is a standing item on the Board Schedule of Business.		
Legal and Regulatory Implications:	Yes ☒	No ☐	
	The Board Schedule of Business includes Statutory items for oversight by the Board.		
Resource Implications:	Yes ☐	No ☒	
	There are no additional resource implications associated with this report.		
Equality, Diversity, and Inclusion (EDI) implications:	Yes ☐	No ☒	
	There are no 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

The Tavistock and Portman NHS Foundation Trust

Key: ▼ - indicates drop down on template; P - planned, D - Deferred, M - Missed, X - discontinued, R - received

			2024					2025							
Agenda Item	**Category ▼**	**Sponsor / Lead ▼**	**May ▼**	**Jul▼**	**Sept▼**	**Nov ▼**	**Jan ▼**	**Mar▼**	**Previous committee/group ▼**	**Onward approval ▼**	**Board / Committee / Meeting Agenda Section ▼**	**Frequency ▼**	**Purpose** Matches the purpose on the request sent to the report owner and author following agenda setting.	**Author(s)**	**Delivery ▼**
Date of Meeting			09-May	11-Jul	12-Sep	14-Nov	16-Jan	13-Mar							
Paper Deadline			25-Apr	27-Jun	29-Aug	31-Oct	02-Jan	27-Feb							
Standard monthly meeting requirements															
Opening / Standing Items (every meeting)															
Chair's Welcome and Apologies for Absence	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Verbal
Confirmation of Quoracy	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Verbal
Declarations of Interest	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Patient/ Service User / Staff Story / Student Story	Discussion	CNO / CPO/	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Minutes of the Previous Meeting	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Matters arising from the minutes and Action Log Review	Approval	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Chair's Report	Information	Chair	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Chief Executive Officer's report	Information	CEO	P	P	P	P	P	P			Opening / Standing Items	Bi-monthly			Enclosure
Closing Matters (every meeting)															
Annual Board Schedule of Business (For approval in May 24)	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Enclosure
Any other business (including any new risks arising during the meeting)	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Questions from the Public	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Reflection and Feedback from the meeting	Discussion	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Date and Venue of Next meeting	Information	Chair	P	P	P	P	P	P			Closing Matters	Bi-monthly			Verbal
Bi-monthly (6)															
Integrated Quality Performance Report (IQPR)	Discussion	CCOO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly			Enclosure (inc.FS)
Our Future Direction – Update & Next Steps	Discussion	CEO	P	P	P	P	P	P			Corporate Reporting	Bi-monthly			Enclosure (inc.FS)
Quality Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			High Quality Clinical Services	Bi-monthly			Enclosure (inc.FS)
Performance, Finance & Resources Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Develop & Deliver a Strategy & Financial Plan	Bi-monthly			Enclosure (inc.FS)
Finance Report - Month (insert)	Assurance	CFO	P	P	P	P	P	P	Performance, Finance & Resources Committee		Develop & Deliver a Strategy & Financial Plan	Bi-monthly			Enclosure (inc.FS)
People, Organisational Development, Equality, Diversity & Inclusion Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly			Enclosure (inc.FS)
Education & Training Committee Chair's Assurance Report	Assurance	NED	P	P	P	P	P	P			Great & Safe Place to Work, Train & learn	Bi-monthly			Enclosure (inc.FS)
Integrated Governance Action Plan Report	Assurance	CEO		P	P	P	P	P	Audit Committee		Well-led & Effectively Governed	Bi-monthly	Review progress of governance recommendations and seek assurance of embedding required improvements. Board to receive updates bi-monthly from the Audit Committee	Dorothy Otite, Governance Consultant	Enclosure (inc.FS)
Quarterly (3 - 4)															
Board Assurance Framework (BAF) and Trust Risk Registers (TRR)	Discussion	IDOCG	P			P	P	P			Well-led & Effectively Governed	Quarterly		Frazer Tams, Interim Risk & Assurance	Enclosure (inc.FS)
Audit Committee Chair's Assurance Report	Assurance	NED		P			P	P			Well-led & Effectively Governed	Quarterly			Enclosure (inc.FS)
Executive Appointment and Remuneration Committee Chair's Assurance Report (as required)	Assurance	NED			P	P	P	P			Great & Safe Place to Work, Train & learn	Quarterly			Enclosure (inc.FS)
Guardian of Safer Working Report	Information	ICMO			P		P	P			High Quality Clinical Services	Quarterly			Enclosure (inc.FS)
Six-monthly (2)															
Mortality / Learning from Deaths	Assurance	ICMO			P			P			High Quality Clinical Services	6 monthly			Enclosure (inc.FS)
PCREF Update Report	Assurance	ICMO			P						High Quality Clinical Services	6 monthly			
Annual (1)															
Annual Self Assessment of Committee's Effectiveness and Committee Annual Reports (Audit; POD EDI; ETC; PFR; Quality; EA&R)	Discussion	Chair		P							Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Review of Committee Terms of Reference	Approval	Chair				P					Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Medical Revalidation	Discussion	ICMO				P					Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Freedom to Speak Up Guardian Annual report	Discussion	IDOCG			P				POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Emergency Planning Annual Report, Letter of Declaration and Self Assessment against Core NHS Standards for Emergency Prepardness, Resilence and Response (EPRR)	Discussion	ICNO					P		Audit Committee		Well-led & Effectively Governed	Annual			Enclosure (inc.FS)
Quality Priorities 2024-2025	Discussion	ICNO	P						Quality Committee		High Quality Clinical Services	Annual			Enclosure (inc.FS)
Staff Survey Results and Action Plan	Discussion	CPO	P				P		POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)
Workforce Disability Equality Standard (WDES)	Approval	CPO			P				POD EDI		Great & Safe Place to Work, Train & learn	Annual			Enclosure (inc.FS)

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